Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Satellite Laboratory Services, LLC

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

June 13, 2006

Barbara Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Satellite Laboratory Services, LLC
Provider Number: 2286244

Dear Director Riley:

Attached is our report on Medicaid reimbursement made to Satellite Laboratory Services, LLC for the period July 1, 2001 through September 30, 2005. We identified $113,683.32 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 accrued interest.

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 Satellite Laboratory Services, LLC and the Ohio Attorney General. In addition, copies are 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

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

AMA	American Medical Association
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
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
Ohio Rev.Code	Ohio Revised Code
MMIS	Medicaid Management Information System
RDOS	Recipient Date of Service
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Satellite Laboratory Services, LLC. (hereafter called the Provider), Provider #2286244, doing business at 1400 Industrial Way, Redwood City, CA 94063. 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 $113,683.32 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.

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 accrued interest.[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 Ohio Medicaid Providers Handbook. 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 department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

[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 September 28, 2005, the latest payment date in the exception reports used for analysis.*

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

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. Within the Medicaid program, the Provider is listed as an Independent Laboratory Provider whose primary Ohio Medicaid activity was performing laboratory testing for renal dialysis patients.

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 July 1, 2001 through September 30, 2005. During this period the Provider was reimbursed $389,606.56 for 27,965 services rendered.

We used the Ohio Revised Code, the Ohio Administrative Code, and the Ohio Medicaid Providers Handbook 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, which contains an electronic file of services billed to and paid by the Medicaid program. This 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:

- Services billed for recipients who died prior to the billed date of services.
- Duplicate billings, occurring on separate claims, for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and the same payment amount.
- Duplicate billings, occurring on the same claim, for services involving the same recipient, the same date of service, the same procedure code and the same procedure code modifier.

[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.*

- Multiple individual billings of laboratory tests that are routinely included in the dialysis center composite fee for dialysis treatment.
- Services billed for Medicare eligible recipients to the Medicaid program.

The test for services billed for recipients who died prior to the date of service was negative, but all the other exception tests identified potentially inappropriate billings. All supporting records for the potential duplicate services were requested and a 100 percent review of these services was performed.

In order to gain a better understanding of the Provider's billing procedures and to verify the accuracy of our computerized test for services that should have been included in the composite fee for dialysis treatments; we first reviewed the Provider's complete billings for 8 of the 251 Medicaid recipients serviced during the audit period. This limited review, combined with interviews with Provider staff, confirmed that Medicaid had been billed for services that should have been billed directly to the respective centers providing dialysis.

In light of the Provider's concurrence with the issues identified by our preliminary work and the resource requirements of performing out-of-state field work, we accepted the Provider's offer to perform a self-audit of their Medicaid paid claims as a method of determining any overpayments. To facilitate the identification and recovery of all overpayments made prior to identification of the conditions leading to the overpayments, the original audit period was extended from June 30, 2004 to September 30, 2005. Using computerized MMIS data and records supplied by the Provider, AOS staff then reviewed the self audit results as a validity check.

Our work was performed between August 2004 and May 2006.

RESULTS

We identified a total of $113,683.32 in findings that are repayable to the State of Ohio. The circumstances leading to these findings are discussed below:

Billing Medicaid for Services Included in the Dialysis Treatment Composite Rate

Ohio Adm. Code 5101:3-13-07(F) specifies the laboratory services that are included in the composite rate paid for dialysis treatment. It states in pertinent part:

> ***
>
> (F) Reimbursement issues:
>
> (1) End-stage renal disease clinics are eligible for reimbursement for facility services.
>
> ***
>
> (3) Services for in-facility and method I home patients will be reimbursed using a composite rate.

(a) The composite rate will include the following services:
(i) All maintenance dialysis services, equipment and supplies;
(ii) Certain labs at specific frequencies;

***

(c) The laboratory tests described below are considered routine for recipients receiving dialysis treatments. These routine laboratory tests are included in the composite fee for in-facility and method I home patients receiving services for hemodialysis, intermittent peritoneal dialysis (IPD) or continuous cycling peritoneal dialysis (CCPD) and may not be billed separately by the free-standing dialysis center or by any laboratory. Routine tests are categorized by frequency as follows:
(i) Tests performed with each dialysis treatment
(a) Hematocrit
(b) Hemoglobin
(c) Clotting time
(ii) Tests performed on a weekly basis;
(a) Prothrombin time (for patients on anticoagulants);
(b) Serum creatinine
(iii) Tests performed weekly or thirteen per quarter.
(a) Blood urea nitrogen (BUN)
(iv) Tests performed on a monthly basis.
(a) Serum calcium
(b) Potassium
(c) Chloride
(d) Albumin
(e) Bicarbonate
(f) Lactic acid dehydrogenase (LDH)
(g) Total protein
(h) Alkaline phosphatase
(i) Complete blood count (CBC)
(j) Serum glutamic oxaloacetic transminase (SGOT)
(k) Phosphate

***

(d) The laboratory tests described below are considered routine for patients receiving in-facility or method I home dialysis, are included in the composite rate for continuous ambulatory peritoneal dialysis (CAPD) and may not be billed separately by the clinic or other laboratory. Routine tests are categorized by frequency as follows:
(i) Tests performed on a monthly basis.
(a) Dialysate protein;
(b) BUN;

(c) Creatinine;
(d) Albumin;
(e) Sodium;
(f) Potassium;
(g) Alkaline phosphatase;
(h) Phosphate;
(i) Magnesium;
(j) Carbon dioxide;
(k) LDH;
(l) AST (SGOT);
(m) Total protein;
(n) Calcium;
(o) HBG; and
(p) HCT.

(ii) Tests performed every three months.
(a) WBC;
(b) RBC; and
(c) Platelet count.

(iii) Tests performed every six months.
(a) twenty four hour urine volume residual renal function.

(e) Laboratory tests not included in the composite rate or that exceed the frequency described in the composite rate may be separately reimbursed provided the medical record documents the medical necessity for the laboratory test and is a covered medicaid service.

***

The Provider performed a self-audit of their billings for the 27,933 non-duplicate laboratory services billed to Medicaid during our audit period and determined that 11,037 services should not have been paid by the Medicaid program because these services were included in the composite rate fee for dialysis treatment. We reviewed the Provider's methodology and analysis and concurred with most of their results. We, however, identified an additional 819 services that should not have been paid by the Medicaid program. Therefore, we took exception with 11,856 services identified as overpaid, resulting in findings of $89,259.65.

Billing Medicaid for Medicare-Covered Services

For services not included in the dialysis treatment composite rate, Medicaid is the payer of last resort. Ohio Adm.Code 5101:3-13-07(E) stipulates in pertinent part:

(E)Medicaid eligibility for end-sage renal disease services:

(1) Clinic responsibility for third party insurance issues:

> Medicaid is the payer of last resort. Any provider must determine whether medicare or another third party insurer covered the recipient's dialysis treatment for the date of treatment.

The Provider billed Medicaid for services rendered to 251 unique recipients during the audit period, of which 119 unique recipients had Medicare Part A coverage. Using eligibility information and coverage dates maintained in Ohio's Medicaid Management Information System (MMIS), we determined that Medicaid paid for 1,353 laboratory services for 76 recipients who had Medicare Part B coverage at the time of service. For those recipients with Part B coverage, Medicare should have paid for dialysis services instead of Medicaid. Therefore, we took exception with all 1,353 services, resulting in findings of $24,219.48.

Duplicate Billings

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...
>
> ***

We identified 16 duplicate billings involving the same patient, the same procedure code, and the same date of service. Because the Provider's medical records supported that only one service was rendered, we took exception with the 16 duplicative billings, which amounted to $204.19 in findings.

Summary of Findings

We took exception with 13,225 of the 27,965 paid services. Table 1 summarizes the exceptions found by reason.

Table 1: Summary of Findings
For the Period of July 1, 2001 – September 30, 2005

Basis for Exception	Number of Services with Exceptions	Amount of Overpayment
Billing for Services Included in the Composite Fee for Dialysis Treatment	**11,856**	**$89,259.65**
Billing Medicaid for Medicare-Covered Services	**1,353**	**$24,219.48**
Duplicate Billings	**16**	**$204.19**
Total Services with Exceptions	**13,225**	**$113,683.32**

Source: Provider self-audit results and AOS analysis of the self audit results based on the Provider's MMIS claims history.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on March 21, 2006 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation that was used to adjust our findings. Following review of the adjusted findings, the Provider agreed, in a letter dated May 17, 2006, to refund the $113,683.32 in findings to the State of Ohio. The Provider's May 17 response, which also includes actions planned to prevent future billing errors and suggestions for clarifying Medicaid rules, starts on page 9 of this report.

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SATELLITE
LABORATORY SERVICES

May 17, 2006

Betty Montgomery
Ohio Auditor of State
Fraud and Investigation Audit Group
Health Care and Contract Audit Section
35 N. Fourth Street, First Floor
Columbus, OH. 43215

Ms. Betty Montgomery,

This letter is to serve as Satellite Laboratory Services (SLS) Provider response to the Ohio Medicaid audit performed for services billed and reimbursed during the time span of July 1, 2001 through September 30, 2005. This response is to address the three billing issues discovered during the course of the audit.

1. Billing for tests included in the dialysis composite reimbursement
2. Billing for tests provided to Medicare recipients
3. Billing for duplicated tests

The following is a brief explanation of how these billing errors occurred, as well as a summary of corrective action taken by SLS to prevent such errors in the future.

1. Composite Rate Tests Billed in Error

During the course of the provider audit, it was discovered that laboratory tests included in a composite reimbursement to Ohio dialysis facilities were paid to Satellite Laboratory Services (SLS). The following explains how these tests were billed to the Ohio Department of Jobs and Family Services (ODJFS) and why billing was discontinued in May 2004.

On August 6, 2002 Tracie Sylvia with SLS, had a conversation with Ed Zachrich in the Ohio Medicaid provider assistance area to determine whether or not Ohio Medicaid followed Medicare guidelines for composite rate testing. Mr. Zachrich was not aware of any reimbursement being made to the dialysis facility for laboratory tests or restrictions on laboratory billing for ESRD patients. This led SLS to believe that Ohio did not follow Medicare's composite reimbursement guidelines.

To confirm Mr. Zachrich's response, Tracie Sylvia reviewed the ODJFS Laboratory Provider Manual for clarity, looking for some reference to Medicare's guidelines for composite rate testing. There was, and still is, no reference to an

1400 Industrial Way Redwood City CA 94063 (800) 800 5855 www.satellitelabs.com

ESRD composite rate reimbursement structure inclusive of laboratory testing in the Laboratory Provider Manual (5101:3-1 1-03 Laboratory services coverage and limitations). Based on this information, SLS submitted claims for all laboratory services performed, including tests included under the Medicare guidelines for composite rate tests.

ODJFS paid the submitted claims with no payment denial or notification that Ohio Medicaid does not reimburse laboratories for ESRD composite testing.

In Mid-April of 2004, SLS directed a focused effort on clean up of outstanding accounts receivable and referenced the ODJFS Laboratory Provider Manual searching for time limitations on claim submissions. A clause effective April 1, 2004 appeared in section 5101:3-11-08 Reimbursement for Laboratory which stated, "For a lab service that is payable under the Medicare lab fee schedule the Medicaid payment for the service shall not exceed the Medicare carrier's lab fee schedule for that service."

Although this clause did not specifically reference composite rate tests, it did reference payment not to exceed Medicare's fee schedule. Since Medicare does not reimburse the laboratory for composite rate tests, SLS made a conservative decision to voluntarily discontinue billing composite rate tests to ODJFS and began billing these tests to the individual dialysis facilities where the laboratory orders originated and the patients were receiving dialysis treatments.

Currently, no information exists regarding composite rate laboratory testing in the laboratory section of the ODJFS provider manual. However, there is language regarding composite rate tests published in the Clinic section for End Stage Renal Disease (5101:3-13-07) provider manual. This is not a section of the provider manual a laboratory would normally reference. However, since the language is clear that composite rate tests are inclusive under the dialysis facility reimbursement, it is SLS's intent to refund all composite rate tests paid to SLS by the ODJFS.

It is SLS's recommendation that a section be added to the Laboratory section of the provider manual indicating the billing rules for patients with End Stage Renal Disease, preventing laboratory provider confusion in the future.

2. Billing Medicaid for Medicare-Covered Services

The audit brought to light several patients with Medicare coverage with services incorrectly billed to Medicaid. SLS is reliant upon the dialysis facility to provide current insurance benefit information on all patients requiring laboratory testing. The dialysis facilities occasionally fail to notify the laboratory when new insurance coverage information is obtained. SLS was unaware of the coverage status change for these patients.

It is SLS's practice to train all new staff in proper billing procedures. This training includes education that conveys Medicaid as the coverage of last resort. Billing personnel are instructed that all other coverage is to be billed prior to submitting claims to Medicaid. However, when Medicaid is the only coverage provided, and SLS verifies benefits with ODJFS, the conclusion is that no other coverage exists.

SLS has implemented a new coverage verification procedure to check for Medicare eligibility on current Medicaid recipients every 60 days. However, we do not have the staff to perform this more frequently.

It would be helpful if ODJFS would deny SLS's claims indicating that the patient has other insurance or Medicare coverage. That would enable us to immediately discontinue billing Medicaid and prevent the administrative burden of overpayment and refund processing.

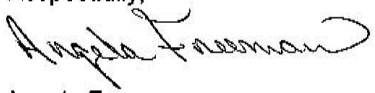
3. Duplicate Claim Submission

SLS incorrectly duplicated billing for 17 tests. These duplicate charges were isolated to two patients for 5 different dates of service. The billing error was difficult to ascertain, but has been identified as a software issue.

To prevent future duplicate billings from automated software programs, SLS has implemented front-end edits to capture and review potential duplicate services prior to claim submission. Additionally, SLS performs routine patient audits to review individual patient accounts checking for continuity in billing based on ordered and resulted tests.

It is the desire of SLS to maintain a strong relationship with the State of Ohio. Through this investigative process we have been proactive in identifying and correcting billing issues to continually improve our compliance processes. SLS has a strong and active compliance team. This audit has helped SLS implement additional steps to prevent inaccurate future billing. SLS agrees with the audit findings and refund amount of $113,683.32 to the State of Ohio.

Respectfully,



Angela Freeman
Director of Reimbursement

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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

SATELLITE LABORATORY SERVICES, L.L.C.

(OUT-OF-STATE)
CALIFORNIA

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
JUNE 13, 2006