STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Respiratory Care Resources

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

June 2002 ***AOS/FWAP-02-017C***

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490
www.auditor.state.oh.us

Thomas Jordan, President
Respiratory Care Resources
4780 Socialville-Foster Road
Mason, Ohio 45040

Re: Medicaid Review of Provider Number #0576363

Dear Mr. Jordan:

We have completed our review of selected medical services rendered to Medicaid recipients by Respiratory Care Resources for the period January 1, 1997 through December 31, 2000. We identified overpayments in the amount of $40,983.14, which must be repaid to the Ohio Department of Job and Family Services. A "provider remittance form" is located at the back of this report for remitting payment. In addition, we have questioned cost amounting to $255,514.60 which Medicaid paid the Provider for concentrator services that appear to exceed the Provider's usual and customary charges

Please be advised that in accordance with Ohio Revised Code Section 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 Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

June 18, 2002

TABLE OF CONTENTS

ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
PRN	Abbreviated Latin term meaning "as necessary"
TCN	Transaction Control Number

This Page Intentionally Left Blank.

SUMMARY OF RESULTS

The Auditor of State performed a review of Respiratory Care Resources, Provider #0576363, doing business at 4780 Socialville-Foster Road; Mason, Ohio 45040. We identified findings amounting to $40,983.14. The findings are recoverable as they resulted from Medicaid claims submitted by Respiratory Care Resources for services that did not meet reimbursement rules under the Ohio Durable Medical Equipment Manual and the Ohio Administrative Code (OAC). We are also questioning $255,514.60 of Medicaid's costs for concentrator services because they appear to exceed the Provider's usual and customary charges

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services (ODJFS), performs reviews to assess Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. ODJFS administers the Medicaid program. The rules and regulations that providers must follow are issued by ODJFS in the form of an Ohio Medicaid Provider Handbook.

ODJFS' Medicaid Provider Handbook, General Information, Section II, Subsection (B),Chapter 3334, (OAC Section 5101:3-1-01), states in part, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must render or authorize medical services within the scope of their licensure and based on their professional judgement of those services needed by an individual. "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

Durable medical equipment services are among the services reimbursed by the Medicaid program when delivered by eligible providers to eligible recipients. Durable medical equipment encompasses equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. Requirements for providers of durable medical equipment services are covered in ODJFS' Durable Medical Equipment Manual, which is a part of the Ohio Medicaid Provider Handbook. All durable medical equipment services that are reimbursed by Medicaid must be prescribed by a physician. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Providers must keep copies of prescriptions which include a diagnosis in their files.

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172,(E), 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 form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

In addition, rule 5101:3-1-29 (C) of the OAC states: "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.

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program.."

PURPOSE SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter they had been selected for a compliance review. An Entrance Conference was held on June 13, 2001, with Thomas Jordan, President, Art Hollerbach, Pharmacist, and other staff members.

We utilized ODJFS' Ohio Medicaid Provider Handbook and the OAC 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 Medicaid. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],
- Center for Medicare and Medicaid Service's[2] (CMS) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period January 1, 1997 though December 31, 2000. We used computer programs to analyze the Provider's paid claims history for that audit period. We specifically looked for "duplicate" payments – payments made twice for the same service to the same recipient. We also checked for other types of overpayments, such as payments for services to recipients who were hospital inpatients at the time of service (and which should have been covered by payments made to their hospital), and payments for services to recipients who were deceased at the time of service.

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

[2]The Center for Medicare and Medicaid Services (formerly known as HCFA) has federal oversight of the Medicaid program.

In addition, we reviewed three statistical random samples of the Provider's records, which were used to support Medicaid claims paid by ODJFS. The samples included services from 170 transaction control numbers (TCNs), which is the identifier for a durable medical equipment service bill for one recipient. In the case of oxygen services, the TCNs were further broken down by service periods (typically a month). The oxygen sample contained 50 TCN service periods. The second sample, totaling 60 TCNs, was for Medicare crossover claims; and the third sample, comprising 60 TCNs, contained all other procedure codes which had not been previously sampled. These claims represented 237 different durable medical equipment services, of which 55 services were in the oxygen sample, 97 services were in the Medicare crossover sample, and 85 services were in the sample comprising all other codes. We examined the amounts reimbursed by ODJFS and conducted an on-site review of durable medical equipment records.

After analyzing a pilot sample of claims to determine if there were potential material discrepancies in the records which would lead to an overpayment, we determined that, statistically, only the oxygen sample had discrepancies which could cause a potentially material overpayment. Therefore, we expanded the oxygen sample. The second oxygen sample contained 297 TCN dates of service, totaling 315 services, and included the original pilot sample. We reviewed this sample at the Provider's facility on August 28, 2001.

During our 4-year review period, the Provider was reimbursed $2,481,371.69 for 17,177 Medicaid durable medical equipment services, including $80,340.75 for the 497 services in our sample.

Work performed on this audit between February 2001 to April 2002 was done in accordance with government auditing standards.

FINDINGS

We identified findings in six areas: Level of Service for Oxygen, Missing Prescriptions, Oxygen Prescriptions stated as PRN, No Physician Signatures, In-Hospital Patients, and Duplicate Payments. The total findings for all six categories amounted to $40,983.14. A discussion of each deficiency, the number of instances found, the basis for the overpayment, and the amount overpaid -- follows:

Level of Service for Oxygen

According to the Ohio Administrative Code, Section 5101:3-10-13 (G)(2), states

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. The prescription, or certification of medical necessity, must specify:
>
> (a) Diagnosis;

(b) Oxygen flow rate; and
(c) Duration (hours per day); or
(d) Indications for usage.

During our review of oxygen services, we found 10 TCNs, comprising 11 service periods, where the Provider billed for a higher level of oxygen service than could be supported by the physicians' orders. In all 10 TCNs, the Provider billed according to the nursing home notes, which did not contain valid physicians' orders and which indicated a higher level of service than the order. Billing in this manner resulted in the Provider being reimbursed $267.84 per service period, instead of $178.56 per service period. Therefore, we adjusted these claims to reflect the liter flow ordered by the patients' physicians.

Missing Prescriptions

According to the Ohio Administrative Code, Section 5101:3-10-05 (A),

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . . For medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code. (Emphasis added)

In addition, the Ohio Administrative Code, Section 5101:3-10-13 (C)(2), states

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service.

Prescriptions for durable medical equipment services are a physician's tool to verify that a patient truly needs medical services. By retaining prescriptions, the durable medical equipment supplier verifies the need to provide all necessary medical equipment for a patient. For ongoing prescriptions, the medical equipment supplier must verify that more services are necessary by obtaining a new prescription every twelve months. In our review we found 3 TCNs, comprising 3 services, were not supported by a prescription. Therefore, we were unable to verify that the medical services provided were medically necessary.

Oxygen Prescriptions Stated as PRN

Pursuant to the Ohio Administrative Code, Section 5101:3-10-13 (G)(3), prescriptions written as "oxygen PRN" without liter flow or indications of usage do not meet the requirements for a prescription as stated in rule 5101:3-10-05 (A). Physicians use "PRN" to indicate "as needed", which inappropriately in this case leaves the determination of medical necessity up to a nursing home or the DME provider. During our review, we found 1 TCN, totaling 1 service, where the Provider maintained a prescription for oxygen services with the indications for usage as PRN. As such, the prescription is invalid as it does not contain information to make the service medically necessary.

Prescriptions with no Physician Signatures

Again, Ohio Administrative Code, Section 5101:3-10-05 (A), states:

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . .

Without a physician signature on a prescription, the services rendered may not be medically necessary, and therefore, not reimbursable by Medicaid. In our review of 297 TCN dates of service, we found 1 TCN in which the Provider had a prescription for oxygen services that was not signed by a physician. Therefore, the claim was not eligible for reimbursement.

Total Projected Finding For Oxygen Services

We projected the error rate for the 15 TCNs with missing medical information across the total population of oxygen services. This resulted in a projected overpayment of $77,716.41, with a 95 percent confidence that the actual finding fell within a range of $124,488.42 to $30,944.40[3]. The large variance in the sampling error led us to make a finding for $30,944.40 -- the lower amount in our range. We believe that using the lower amount is conservative because we can state with 97.5 percent certainty that the actual finding would have been at least this amount had we reviewed all of the Provider's claims for the audit period.

Finding for In-Hospital Patients

As stated earlier, we performed a computer match to identify payments for services to recipients who were hospital inpatients at the time of service (and which should have been covered by payments

[3]Our sample results were projected to the Provider's universe of claims for the audit period after removal of the duplicate claims, deceased recipients and in-hospital claims. Therefore, our projected findings do not overlap.

made to their hospital). This test revealed 74 TCNs, comprising 79 services, where the Provider billed for services in which the recipient appeared to be a hospital inpatient. After reviewing records submitted by the Provider, we identified 25 TCNs, comprising 25 services, in which the Provider billed for services while the recipient was in the hospital. These 25 services totaled $2,849.70 in unallowable reimbursements.

Finding for Duplicate Payments

According to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

We found $37,726.55 in potential duplicate payments where the Provider billed for oxygen services twice in the same month. Upon review, we determined that many of these claims were for services where the 30-day billing cycle fell twice in a month or the Provider started a new contract. However, we found $7,189.04 in overpayments, either from duplication of services or billing at a higher level of service than the documentation allowed. The duplicated services accounted for $5,694.76 of this finding, while the higher levels of services accounted for $1,494.28 of this finding.

Questioned Costs Regarding Usual and Customary Fee

In order to supply medical services to Medicaid recipients, providers sign a provider agreement. The Ohio Administrative Code, Section 5101:3-1-172, states, in part:

> A "Provider Agreement" is a contract between the Ohio department of job and family services and a provider of medical ASSISTANCE services in which the provider agrees to comply with the terms of the "Provider Agreement," state statutes and ODJFS Administrative Code rules, and federal statutes and rules, and agrees to:
>
> (B) Bill the Ohio department of job and family services for no more than the usual and customary fee charged other patients for the same service.

In addition, the Ohio Administrative Code Section 5101:3-10-13 C(5), Oxygen: covered services and limitations, states ". . . billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient . . . ."

During the entrance conference the Provider submitted documentation showing that the company supplied oxygen concentrators to other nursing home patients for $108.50 per month. Our subsequent review of contracts that the Provider held with 48 nursing home supported this statement. We found that the Provider charged seventeen of the facilities $108.50 per month for oxygen services, slightly higher rates to five facilities, and lesser amounts to other facilities.

We are questioning $255,514.60 of Medicaid's costs for concentrator services because they appear

to exceed the Provider's usual and customary charges. The Provider charged Medicaid $178.56 per concentrator per month of service approximately 50 percent of the time, while charging nursing homes $108.50 per concentrator per month. Our questioned costs are conservative because we took a weighted average of all Medicaid claims paid to the Provider, thus likely including some partial months of service. We calculated the difference between the Medicaid average monthly claim amount paid to the Provider for oxygen concentrator services ($124.56) and the $108.50 monthly rate typically charged by the Provider to nursing homes, and then multiplied the difference ($16.06) by the number of claims (15,910) paid to the Provider during the audit period. This resulted in a $255,514.60 difference between what the Provider was reimbursed by Medicaid, and what the Provider would typically be reimbursed under the monthly rate paid by nursing homes.

We did not gather detailed information on any differences in services required for Medicaid and non Medicaid oxygen concentrators. However, due to the disparity of $16.06 per month/per concentrator between what the Provider charged Medicaid and what was charged for patients in a same setting, we question whether the amounts billed Medicaid were a "usual and customary" charge. In addition, Medicaid, like a nursing home, is a volume purchaser and should expect to benefit from reductions or discounting of fees and charges. Therefore, we recommend that the Ohio Department of Job and Family Services review the questioned claims to verify the amounts billed for oxygen concentrators are appropriate under Ohio Administrative Code 5101:3-1-172 and Ohio Administrative Code 5101:3-10-13 C(5) and to assure that any and all overpayments are recovered.

CONCLUSION

The Provider was given an opportunity on March 19, 2002 to review our findings and provide additional documentation. We received supporting documentation from the Provider on March 25, 2002, and adjusted our findings accordingly. To afford an opportunity to respond to our adjusted findings, we faxed a revised draft copy of the report to the Provider on April 23, 2002. The Provider telephoned to say that an additional response would be received on May 8, 2002. However, no further information was received despite a follow up call from us to solicit the response.

The provider is aware that if payment is not made within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's Office for collection.

This Page Intentionally Left Blank

APPENDIX I

Table 1: Summary of Record Analysis of Respiratory Care Resources
For the period January 1, 1997 to December 31, 2000

Description	Audit Period January 1, 1997 - December 31, 2000
Total Medicaid Oxygen Services Paid	$1,981,953.84
Number of Oxygen TCN Dates of Service	15,640
Type of Examination	A statistical random sample of oxygen services by TCN and date of service.
Number of Oxygen TCN Dates of Service Sampled	297
Amount Paid for Services Sampled	$46,164.70
Projected Overpayment From Statistical Sample	$77,716.41
Upper Limit at 95% Confidence Level	$124,488.42
Lower Limit at 95% Confidence Level	$30,944.40

This Page Intentionally Left Blank

PROVIDER 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

Provider:	Respiratory Care Resources 4780 Socialville-Foster Road Mason, Ohio 45040
Provider Number:	0576363
Review Period:	January 1, 1997 through December 31, 2000
AOS Finding Amount:	$40,983.14
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: Charles T. Carle at (614) 728-7398.

This Page Intentionally Left Blank

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

RESPIRATORY CARE RESOURCES

WARREN 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
JUNE 18, 2002