Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Tuscan, Inc., d.b.a. Halsom Home Care

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 27, 2005

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

Re: Audit of Tuscan, Inc., d.b.a. Halsom Home Care
Provider Number: 0922890

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Tuscan, Inc., d.b.a. Halsom Home Care for the period October 1, 2001 through September 30, 2004. We identified $50,481.73 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 interest accruals.

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 Tuscan, Inc., d.b.a. Halsom Home Care and the Ohio Attorney General. 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
DME	Durable Medical Equipment
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
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code
RDOS	Recipient Date of Service
TCN	Transaction Control Number

SUMMARY OF RESULTS

The Auditor of State performed an audit of Tuscan, Inc., d.b.a. Halsom Home Care (hereafter called the Provider), Provider #0922890, doing business at 7905 Clyo Rd., Centerville, OH 45459. 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 $50,481.73 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Medicaid Provider Handbook (OMPH).

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 interest accruals.[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 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 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.

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. It also includes certain medical supplies which are "consumable, disposable, or have a limited life expectancy."

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

1 Ohio Adm.Codes 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 29, 2004, the latest payment date in the random sample used for analysis*.

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

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."

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 applicable, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as durable medical equipment supplier.

Following a letter of notification, we held an entrance conference at the Provider's place of business on April 11, 2005 to discuss the purpose and scope of our audit. 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 October 1, 2001 through September 30, 2004. The Provider, excluding Medicare co-payments, was reimbursed $497,444.45 for 6,656 services rendered on 4,385 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH 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 (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 & Medicaid Services (CMS).[4.]

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.

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 date of services.
- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and the same payment amount.
- Medical supplies billed in excess of price or quantity limits set by ODJFS.

The test for services billed for recipients who died prior to the date of services was negative, but the other exception tests identified potentially erroneous reimbursements. Therefore when performing our audit field work, we reviewed the Provider's supporting documentation for all potentially erroneous reimbursed claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical supply services, we also analyzed three samples of the Provider's services during the audit period.

The first sample was a census (100 percent review) of all services for HCPCS codes Q0036 (Oxygen concentrator, including supplies) and Q0046 (Portable oxygen system rental, including supplies) rendered by the Provider, which consisted of 302 services. The second sample was a control test of wheelchair services consisting of 23 randomly selected paid Medicaid claims consisting of 34 services. The third sample was drawn from incontinence services not already identified for review by our exception tests and consisted of 157 recipient dates of service (RDOS) comprising 195 services.

Our work was performed between November 2004 and November 2005.

RESULTS

We identified a total of $50,481.73 in findings that are repayable to the State of Ohio. This total consisted of $7,069.13 in findings identified by our exception tests, $483.60 in findings from our oxygen service census, and $42,929.00 in projected findings from our sample of incontinence services. The circumstances leading to these findings are discussed below:

Results of Exception Tests

Medical supplies billed in excess of price or quantity limits set by ODJFS

Ohio Adm.Code 5101:3-10-03 states:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in Appendix A of this rule…
>
> ***

Appendix A of Ohio Adm.Code 5101:3-10-03 establishes maximum dollars amounts and/or quantities that medicaid will cover for specific items. Our computer analysis identified 127 services, involving 11 different HCPCS service codes, where the Provider billed and was reimbursed for supplies that exceeded the allowed maximum. After subtracting the allowed maximum from the amount paid to the Provider, we identified $3,196.12 in findings for the items shown in Table 1.

Table 1: Listing of Supplies Exceeding Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Repayable Findings ($)	Number of Exceptions
A4554	Disposable underpads	300 per 2 months	$1,938.36	25
A4619	Tubing, aerosol (per foot)	50 feet per 3 months	$75.00	3
A4629	Tracheostomy care kit for established patients	30 per month	$33.15	13
A7000	Canister, disposable, used with suction pump	3 per month	$502.50	67
A7035	Headgear, used w/pos, airway press, device	1 per year	$34.95	1
E0600	Suction pump, home model	1 every 4 years	$217.00	1
A4522, A4526, A4527, A4528, and A4535	Incontinence garments	300 per moth	$395.16	17
		Totals	***$3,196.12***	***127***

Source of Medicaid maximum Allowed: Ohio Adm.Code 5101:3-10-03, Appendix A – Medicaid Supply List

Source of estimated overpayments and exceptions: AOS analysis of the Provider's paid claims in MMIS and Provider patient records for October 1, 2001 through September 30, 2004

Surgical Gloves Billed with Erroneous Units of Service

Ohio Adm. Code 5101:3-10-03(F) defines the "Max Units" indicator:

> A maximum allowable (MAX) indicator means the maximum quantity of the item which may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.
>
> ***

On April 1, 2003, the reimbursement rate for non-sterile gloves (HCPCS code A4927) changed in price from $22 per 100 gloves to $8.69 *per box* of 100 gloves. Concurrently, the definition of a "unit of service" changed from "per individual glove" to "per box of 100 gloves." During our review of the Provider's patient records, we identified overpayments that resulted from the

Provider continuing to bill "per glove," instead of "per box". We identified 303 services where the Provider billed and was overpaid for HCPCS A4927. After adjusting the amount paid to the Provider to account for the actual units supplied, we identified findings totaling $3,297.31.

Duplicate Billings

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for service actually performed…
>
> ***

We identified five duplicate billings involving the same patient, the same procedure code, and the same date of service. Our review of patient medical records only supported that one service was rendered. Therefore, we disallowed the five duplicate billings resulting in findings totaling $575.70.

Summary of Exception Tests

We took exception with the reimbursement of 435 of the 458 services segregated from the sample population for special examination. Table 2 summarizes the exceptions found by reason and overpayment amount.

Table 2: Summary of Billing Exceptions
For the Period of October 1, 2001 - September 30, 2004

Basis for Exceptions	Number of Services with Exceptions	Repayable Findings ($)
Items Dispensed in Excess of the Medicaid Maximum	127	$3,196.12
Surgical Gloves Billed with Erroneous Units of Service	303	$3,297.31
Duplicate Billings	5	$575.70
Total Services with Exceptions	**435**	**$7,069.13**

Source: AOS analysis of the Provider's MMIS claims history.

Results of Oxygen Services Census

Ohio Adm.Code 5101:3-10-13(C) states in pertinent part:

> To receive a payment adjustment, one of the following modifiers must be used with stationary oxygen system codes when appropriate. This applies to oxygen used with concentrators, liquid and gaseous systems.
>
> (1) Modifier code QE shall be used and the payment amount reduced by fifty percent when:
> (a) The prescribed amount of oxygen is one liter per minute or less…
>
> ***

We reviewed 100 percent of all payments to the Provider for oxygen services billed as HCPCS codes Q0036 (Oxygen concentrator, including supplies) and Q0046 (Portable oxygen system rental, including supplies). Out of 302 services reviewed, we identified five services where the recipients' prescribed amount of oxygen was one liter per minute or less, but Medicaid was billed without the appropriate QE modifier. As a result, the Provider was overpaid for the five services, and we identified a finding for the difference between the payment for the unmodified claims ($193.44 per service) and a modified claim ($96.72 per service), resulting in a finding for $483.60.

Results of Wheelchair Service Sample

Our control test of 34 wheelchair service claims identified no exceptions and no findings. Consequently, no further review during this audit was deemed necessary for services in this area.

Results of Incontinence Services Sample

Our sample of incontinence services not included in our exception analysis consisted of 157 RDOS (195 services). Our analysis of the supporting documentation for these services identified overpayments for 64 of the 157 RDOS (75 of 195 services). The issues causing these overpayments are discussed below.

Missing Consumer Request for Incontinence Supplies

Ohio Adm.Code 5101:3-10-21(D) states:

> Providers must ascertain from the consumer or the consumer's caregiver on a monthly basis the required type and amount of incontinence garments and/or related supplies.
>
> (1) The providers must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider

> ascertained the required type and amount from the consumer or consumer's care giver. The date that the provider ascertained the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
>
> (2) The type and amount required may be ascertained verbally or in writing. For each month's worth of incontinence garments and supplies, the date of service entered on the Medicaid claim (dispensing date) should not be prior to the date that the provider ascertained the type and amount of incontinence supplies required for the month.
>
> (3) Documentation of the type and amount of incontinence garments and/or related supplies requested must include the first and last name of the provider's employee that took the request and the first and last name of the consumer, or consumer's care giver, making the request.
>
> ***

We identified 43 services out of 195 sampled services where the Provider's documentation of the consumer's request lacked one or more of the following elements: the required type and amount of incontinence garments or related supplies needed; the first and last name of the consumer, or the care giver making the request. Because the Provider lacked documentation of the supplies ordered and who ordered them, we could not verify that the proper quantify and type was provided. We therefore disallowed the payment for all 43 services.

Billing Errors Resulted in Overpayments

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of Medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules and the provider certifies and agrees:
>
> (A) To …submit claims only for services actually performed…
>
> ***

We identified 36 services out of sample of 195 where the Provider billed for items that were not shipped to the recipient. For example in several instances, the amount ordered and shipped in one case was 150 units of A4554 ~ Disposable underpads; but the amount billed by and reimbursed to the Provider was 151 units. The Provider attributed the error to a computer glitch that had also caused underbillings. However, because the Provider billed and was reimbursed for items that were not shipped to the recipient, we took exception with the payments for these 36

services and identified a finding for the difference between what was paid and what should have been paid.

Missing Required Diagnosis or Type of Incontinence

Ohio Adm.Code 5101:3-10-21(B) states:

> A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months. The prescription must be obtained by the provider prior to the first date of service in the applicable twelve-month period and must specify:
>
> (1) The applicable diagnosis of the specific disease or injury causing the incontinence; or
> (2) Developmental delay or disability, including applicable diagnoses; and
> (3) Type of incontinence…

We identified three services out of our sample of 195 that were missing either an applicable diagnosis of the specific disease or injury causing the incontinence, or the type of incontinence. Because the Provider did not maintain the required information in the recipients' medical records, a determination could not be made if the services rendered were Medicaid eligible. We therefore took exception with the reimbursement for all three services.

Missing Prescriptions

Ohio Adm.Code 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…For medical supplies only, other than incontinence garments and related supplies, an oral prescription with all of the required information recorded in writing by the provider will suffice. For ongoing services, a new prescription must be obtained at least every twelve months. Medical providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-17.2 and 5101:3-1-17.3 of the Administrative Code.
>
> ***

Of the 195 services in our sample, we identified 10 services where the provider did not maintain prescriptions for the services billed. Because the Provider did not maintain the required documentation in the recipients' medical records, a determination could not be made if the services rendered were Medicaid eligible. We therefore took exception with the payments for all 10 services

Billing for Items Not Shipped

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for service actually performed…
>
> ***

Of the 195 services in our sample, we identified three services where the Provider erroneously billed for incontinence supplies that were not shipped to the recipient. Because the Provider billed and was reimbursed for supplies that were not shipped, we took exception with the payments for these three services.

Projected Findings from the Sample

Overall, we identified 95 exceptions in our random sample of 157 RDOS (195 services). Table 3 summarizes the bases for our exceptions.

Table 3: Summary of Exceptions from the Incontinence Services Sampled For the Period of October 1, 2001 – September 30, 2004

Exception Category	Number of Services with Exceptions
Missing Contact Information	**43**
Over Billing for Items	**36**
Missing Required Diagnosis or Type of Incontinence	**3**
Missing Prescription	**10**
Billing for Items Not Shipped	**3**
Total Exceptions	**95**

Note: The 95 exceptions represent exceptions taken with 75 services. This occurred because some services had exceptions under more than one category; although only one combined finding was made per service.

Source: AOS analysis of all other services sample of 195 medical supply services.

The overpayments identified for 64 of 157 recipient dates of service (representing 75 of 195 services) from our stratified random sample of the Provider's subpopulation of paid incontinence services, excluding services associated with Medicare co-payments and our exception analyses, were projected across the Provider's total subpopulation of paid recipient dates of service for incontinence supplies. This resulted in a projected overpayment of $54,136 with a precision of plus or minus $13,354 at the 95 percent certainty level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, 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 amount is at least $42,929. A detailed summary of our statistical sample and projection results is presented in Appendix I.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings we mailed a draft report to the Provider on October 19, 2005. The Provider supplied additional information on November 7, 2005 that resolved some of the deficiencies addressed in the draft and resulted in a reduction in our findings from $51,405.57 to $50,481.73. We subsequently discussed the audit findings in a November 22, 2005 phone conference with the owner of Tuscan, Inc, d.b.a. Halsom Home Care. After we answered questions regarding our sampling and projection methodology, the owner agreed with the audit findings.

In addition, the Provider committed to correcting the deficiencies identified by our audit and has adopted policy and procedure changes to alleviate potential problem in the future. The Provider has now limited all supplies to the maximum allowed quantities until prior authorization is obtained and regularly monitors the ODJFS web site for changes in the Medicaid maximum allowed quantities. The Provider has adjusted its entire glove inventory to bill correctly at 1 box of 100 per month. The Provider staff will add all appropriate modifiers to claims for oxygen when applicable and audit claims prior to submission to ODJFS. The Provider has implemented an improved system for determining what incontinence products a consumer may need for the month. Provider staff members taking any type of supply order now have a format of questions to ask to ensure that all information required by ODJFS will be obtained. This information will then be entered directly into the client's computer record. No order for incontinence products will be processed until the prescription form is completed in full and signed by the physician. Over-billing for shipped quantities have been corrected and the Provider will perform monthly audits to make sure that billing for supplies not shipped does not happen in the future.

APPENDIX I

Summary Table of Sample Record Analysis for
Tuscan, Inc, d.b.a. Halsom Home Care
Subpopulation of Incontinence Services net of Adjustment and
Excluding Medicare Co-payments, 100% Exceptions tests,
Q0036 and Q0046 Services, and Non Wheelchair and Wheelchair Repair Services
For the period October 1, 2001 to September 30, 2004

Description	Audit Period October 1, 2001 – September 30, 2004
Type of Examination	**Statistical Simple Random Sample**
Description of Population	**Incontinence services net of adjustments and excluding Medicare Co-payments, 100% Exception tests, Q0036 and Q0046 services, and Wheelchair services**
Number of Population Recipient Date of Services	**2,077**
Number of Population Services Provided	**2,482**
Total Medicaid Amount Paid For Population	**$186,923.20**
Number of Recipient Date of Services Sampled	**157**
Number of Services Sampled	**195**
Amount Paid for Services Sampled	**$17,860.29**
Estimated Overpayment using Point Estimate	**$54,136**
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	**$42,929**

Source: AOS analysis of MMIS information and the Providers' medical records.

APPENDIX II

Summary of Audit Findings for Tuscan, Inc., d.b.a Halsom Home Care
Audit Period: October 1, 2001 to September 30, 2004

Basis for Exception	Amount of Overpayment
Items Dispensed in Excess of the Medicaid Maximum	**$3,196.12**
Surgical Gloves Billed with Erroneous Units of Service	**$3,297.31**
Duplicate Billings	**$575.70**
Actual Findings for Oxygen Census Sample	**$483.60**
Projected Findings for the Incontinence Services Sampled	**$42,929.00**
Total Services with Exceptions	**$50,481.73**

Source: AOS analysis of MMIS information and the Provider's records.

Auditor of State
Betty Montgomery

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TUSCAN, INC., dba HALSOM HOME CARE

MONTGOMERY 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
DECEMBER 27, 2005