



Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Regency Manor Rehabilitation*

A Compliance Audit by the:

Medicaid/Contract Audit Section



Mary Taylor, CPA

Auditor of State

February 15, 2008

Kim Griffin
Regional Director of Finance
Regency Manor Rehabilitation
4700 Ashwood Dr., Suite 200
Cincinnati, OH 43241

Dear Ms Griffin:

Attached is our report on Medicaid reimbursements made to Regency Manor Rehabilitation, Medicaid provider number 2424291, for services rendered for the period July 1, 2004 through June 30, 2005. We identified \$58,540.97 in findings plus \$2,674.35 [as of February 15, 2008] in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After the date of the audit's release (February 15, 2008), additional interest will accrue at \$3.97 a day until repayment occurs. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code (ORC) and our interagency agreement with ODJFS. The specific procedures employed during this audit are described in the scope and methodology section of this report. Interest is calculated pursuant to Ohio Administrative Code 5101:3-1-25(B) for overpayments on services not covered by the Combined Proposed Adjudication Order (CPAO) process.

We are forwarding this report to ODJFS because as the state agency charged with administering Ohio's Medicaid program, ODJFS is responsible for making a final determination regarding recovery of the findings and any accrued interest. However, if you are in agreement with the findings contained herein, you may expedite repayment by contacting ODJFS's Legal Office at (614) 466-4605. To facilitate repayment, a "provider remittance form" has been attached to this report.

Copies of this report are being sent to Regency Manor Rehabilitation, the Ohio Attorney General, the Director and Legal Division of ODJFS, the Ohio Department of Health, and the Ohio Nursing Home Association. In addition, copies are available on the Auditor of State website (www.auditor.state.oh.us).

Ms. Kim Griffin
February 15, 2008
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Questions regarding this report should be directed to Jeffrey Castle, Chief Auditor,
Medicaid/Contract Audit Section at (614) 466-7894, or toll free at (800) 282-0370.

Sincerely,

A handwritten signature in cursive script that reads "Mary Taylor".

Mary Taylor, CPA
Auditor of State

cc: Ohio Attorney General
Ohio Department of Health
Ohio Nursing Home Association
Director, Ohio Department of Job and Family Services
Legal, Ohio Department of Job and Family Services

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ACRONYMS

AOS	Auditor of State
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPAO	Combined Proposed Adjudication Order
CPT	Current Procedural Terminology
ICF-MR	Intermediate Care Facility – Mental Retardation
LTCF	Long-Term Care Facility
MMIS	Medicaid Management Information System
Ohio Admin.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
Ohio Rev.Code	Ohio Revised Code
SNF	Skilled Nursing Facility

SUMMARY OF RESULTS

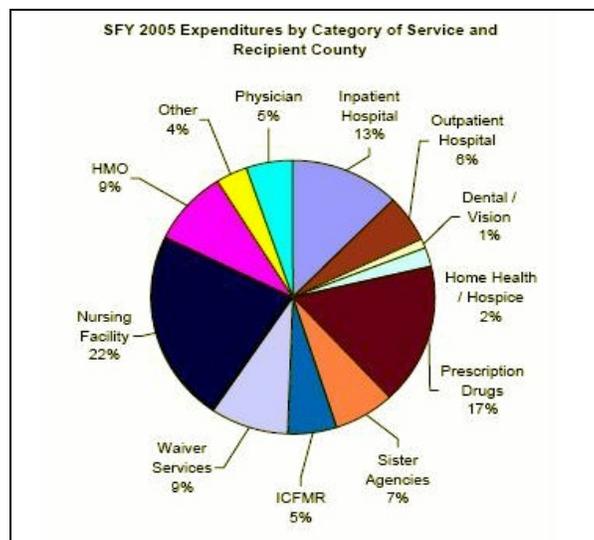
The Auditor of State performed an audit of Regency Manor Rehabilitation (hereafter called the Provider), Provider #2424291, doing business at 2000 Regency Manor Circle, Columbus, Ohio 43207. We performed our audit in accordance with Ohio Rev. Code § 117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified \$58,540.97 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest¹ of \$2,674.35 are repayable to ODJFS. Additional interest of \$3.97 per day will accrue after the date of the audit's release (February 15, 2008) until repayment.

We are forwarding this report to ODJFS because as the state agency charged with administering Ohio's Medicaid program, the Department is responsible for making a final determination regarding recovery of the findings and any accrued interest.

BACKGROUND

As of October 1, 2005, the Ohio Auditor of State (AOS) acted on its legislative authority under Ohio Rev. Code § 117.10 to independently audit providers who render Medicaid services. Under that new authority, providers who render services to patients residing in nursing facilities (NF) were selected for audit.

Table 1: Ohio Medicaid Expenditures²



¹ Ohio Admin. 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 Admin. Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was April 12, 2006, the latest payment date for the paid claims being analyzed.

² Source: Ohio Medicaid Report 2005, Ohio Department of Job and Family Services

As shown in Table 1, expenditures for services to patients residing in NFs accounted for 22 percent of Ohio's State Fiscal Year (SFY 2005) Medicaid expenditures, making it the largest Medicaid expense category. Prescription drugs, the second largest expense category, accounted for 17 percent of Ohio's Medicaid expenditures.

Title XIX of the Social Security Act, known as Medicaid, was established in 1965, and provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. 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. Ohio's Medicaid program is administered by ODJFS. Regulations that Medicaid providers must follow are promulgated in the Ohio Administrative Code. The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Long-term care services which occur in nursing facilities provide "skilled" care for people who are unable to care for themselves in their home and who need help with activities of daily living (ADL) such as dressing, bathing, eating, grooming, and taking medicine. Patients must apply for long-term care services. They must show proof of income, resources, disability, citizenship (legal residency), other health insurance, and meet transfer of resource provisions. Once financial requirements are met, a level of care assessment is conducted to identify the appropriate type of long-term care services Medicaid will provide to each patient.

Per Ohio Admin.Code 5101:3-3-05(B)(3):

"Skilled care level" means that an individual receives at least one skilled nursing service at least seven days per week, and/or a skilled rehabilitation service at least five days per week. For the delivery of skilled services to qualify for the skilled care level, the services must be ordered by a physician, and must be delivered by the licensed or certified professional due to either:

- (a) The instability of the individual's condition and the complexity of the prescribed service; or
- (b) The instability of the individual's condition and the presence of special medical complications.

Nursing facilities are required, as are all Medicaid providers, to complete a "provider agreement" with ODJFS. A "provider agreement" is a contract between ODJFS and an operator of a NF or an Intermediate Care Facility for Mental Retardation (ICF-MR) for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator, or the operator's authorized agent, binds the operator to the terms of the agreement.

The provider agreements of nursing facilities differ from those of other providers. Ohio Admin. Code 5101:3-3-02, states in pertinent part:

(B) A provider of a NF or ICF-MR shall:

(2) Apply for and maintain a valid license to operate if required by law; and

(3) Comply with all applicable federal, state, and local laws and rules and

(4) Keep records and file reports as required in rule 5101:3-3-20 of the Administrative Code; and

(5) Open all records relating to the costs of its services for inspection and audit by ODJFS and otherwise comply with rule 5101:3-3-20 of the Administrative Code;

Ohio Admin.Code 5101:3-3-20 presents the medicaid cost report filing, record retention, and disclosure requirements for NFs and ICFs-MR. This rule states in pertinent part:

As a condition of participation in the Title XIX medicaid program, each NF and ICF-MR shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, [JFS 02524N-appendix A of rule 5101:3-3-202 of the Administrative Code] including supplements and attachments as specified under paragraphs (A) to (M) of this rule or other approved forms for the state-operated ICFs-MR, must be filed within ninety days after the end of the reporting period.

**

(L) Financial, statistical and medical records (which shall be available to ODJFS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODJFS issues an audit report in accordance with rule 5101:3-3-21, or six years after all appeal rights relating to the audit report are exhausted.

Ohio Admin.Code 5101:3-1-27(B)(1) states in part "... The department [ODJFS or designee] shall have the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department [ODJFS]."

Ohio Admin.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."

Additionally, Ohio Admin.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."

According to Ohio Admin.Code 5101:3-3-19, dependant upon the specific type of service received by a patient, the services rendered in NFs are reimbursable to either the rendering provider or the nursing facility. The following services are reimbursable to the provider who rendered the services:

- Dental
- Laboratory
- X-ray
- Various medical supply services (such as oxygen concentrators and prosthesis)
- Medications listed in the "Ohio Medicaid Drug Formulary"
- Therapy services provided through the NF rendered by licensed practitioners
- Physician
- Vision
- Podiatry

Ohio Admin.Code 5101:3-3-19(E)(1) states:

- (1) For NFs, the costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed practitioners are reimbursed directly to the NF as specified in rules 5101:3-3-47 to 5101:3-3-47.3 of the Administrative Code. The costs incurred for these services provided by nursing staff of the NF are reimbursable through the facility cost report mechanism as specified in rule 5101:3-3-46 of the Administrative Code.

**PURPOSE, SCOPE, AND
METHODOLOGY**

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of 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 a skilled nursing facility (SNF).

42 U.S.C. § 1395i-3 states in pertinent part:

... the term "skilled nursing facility" means an institution (or a distinct part of an institution) which –

(1) is primarily engaged in providing to residents –

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental disease.

The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered care to patients for room and board, and therapy services from July 1, 2004 through June 30, 2005. During this period, the Provider was reimbursed \$12,178,879.26 (excluding Medicare crossovers), for 2,743 monthly claims, with a total of 77,726 patient days, for 378 patients. Following a notification letter, we held an entrance conference at the Provider's place of business on November 16, 2006, to discuss the purpose and scope of our audit.

We used the Ohio Revised Code and the Ohio Administrative Code 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 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.

Therapy services are billed to ODJFS using Current Procedural Terminology (CPT) five digit codes issued by the American Medical Association (AMA). Charges for patients' monthly room and board services are billed using revenue codes listed in Appendix A of Ohio Admin.Code

5101:3-2-02.

Prior to beginning our fieldwork, 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:

- Potentially duplicate payments where payments were made for the same recipient on the same date of service for the same revenue codes and for the same dollar amount.
- Payments made for services to deceased patients for dates of service after their date of death.

The exception test for deceased patients was negative. The exception test for duplicate payments identified potential overpayments; however, after a 100 percent review of the supporting claims documentation, no findings were made for duplicate payments.

Our fieldwork was performed between August 2006 and April 2007.

FINDINGS

We identified findings of \$40,437.50 for incorrectly billed room and board services for patients. An additional \$18,103.47 in findings was identified for improperly billed therapy services. The total findings of \$58,540.97 are repayable to ODJFS. The bases for our findings are discussed below.

Incorrectly Billed Room and Board Services

Pursuant to Ohio Admin. Code 5101:3-3-59:

(A) Definitions:

(2) "Bed-hold days," also referred to as "leave days," are the span of time that a bed is reserved for the resident, through medicaid payment, while the resident is outside the facility for hospital stays, visitations with friends and relatives, or participation in therapeutic programs and has the intent to return to that facility. . .

(B) To determine whether specific days during a resident's stay are payable through medicaid payments as bed-hold days or occupied days, the following criteria shall be used:

(2) The day of discharge is not counted as either a bed-hold or occupied day.

(C) For Medicaid-eligible residents in certified NFs, . . .the Ohio department of job and family services (ODJFS) may pay the NF to reserve a bed only for as long as the resident intends to return to the facility but for not more than thirty days in any calendar year. Reimbursement for bed-hold days shall be paid at fifty per cent of the facility's per diem rate. . . . The NF shall report a resident's use of bed-hold days on the "Nursing Facility Payment and Adjustment Authorization" (JFS 09400, rev 12/2001) for dates of service prior to July 1, 2005....

In order to determine if the Provider was reimbursed appropriately for room and board charges billed for the facility's patients, we completed the following procedures:

- Obtained the NF's daily and monthly population census reports for the entire span of the audit period.
- Compared, for each Medicaid patient for each month in the facility, the number of days the patient was in the facility, including therapeutic leave and bed-hold days, to the number of days billed on the Medicaid claim for the patient.
- Calculated the correct payment amount using the census data and the daily per diem rate for each patient if a discrepancy was found. (Note: leave days are reimbursed at 50 percent of the daily per diem rate).
- Subtracted our calculated correct payment amount from the actual amount reimbursed to the Provider for that month and the difference became a finding.
- Reviewed various data sources, such as the patient's accounts receivable registers and ODJFS' remittance advices, to determine if any payment adjustments had been made for that month. If adjustments were found, we subtracted the adjustment amount from the findings.

We reviewed all 2,743 monthly room and board claims within our audit period and found 13 patients with incorrect room and board payments. One patient had a finding with two deficiencies, thereby causing the total of 14 deficiencies (more than the number of payments with a finding.) We found incorrect payments of:

- Eight instances where Medicaid paid for unoccupied non bed-hold days;
- Four claims with bed-hold days, paid at 100 percent of the per diem rate instead of the proper 50 percent; and
- Two instances where Medicaid paid for Medicare covered days.

While reviewing the incorrect payments, we found that the Provider had previously sent adjustments to ODJFS for 12 of the identified incorrect payments; however, we did not find the reciprocal credits made by ODJFS. During the Combined Proposed Adjudication Order (CPAO)

process, ODJFS performs retrospective financial reviews of long-term care facilities, prepares final fiscal audit reports, and negotiates settlements with providers. Therefore, we informed ODJFS' Bureau of Audit of the incorrect payments and recommended that it make any necessary debits or credits during the CPAO process.

Based upon our review of the Provider's room and board documentation, we identified incorrect payments which resulted in potential findings of \$40,437.50.

Improperly Billed Therapy Services

Ohio Admin.Code 5101:3-3-47.1, Coverage and limitations-nursing facility therapy services, states in pertinent part:

(A) Definitions.

(1) "Therapy services" means physical therapy (PT), occupational therapy (OT), audiology, and speech therapy (ST) that are provided by appropriately licensed individuals practicing within the scope of their licensure.

(8) "Reasonable and medically necessary."

To be considered reasonable and medically necessary, a covered therapy service must meet all of the following conditions:

(a) Be a specific and effective treatment for the resident's condition; and

(b) Be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by or under the direct supervision of a licensed therapist and

(c) There must be an expectation that the resident's condition will improve significantly in a reasonable and generally predictable period of time based on the assessment made by the physician of the resident's restoration potential, or the service must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and

(d) The amount, frequency, and duration of the service must be reasonable.

(9) "Treatment plan."

The treatment plan must include a diagnosis, current physical status, rehabilitation potential, specific functional goals, a reasonable estimate of when the goals will be reached (e.g., three weeks), specific procedures, and frequencies and duration of treatment.

Additionally, Ohio Admin.Code 5101:3-3-47.1, Coverage and limitations-nursing facility therapy services, also states in pertinent part:

(B) Covered therapy services.

(1) In accordance with medicare guidelines, the following therapy services are covered when the services relate directly and specifically to a written treatment plan established by a physician . . .

(a) For a PT service, the service must be required for evaluation and ongoing assessment of a resident's rehabilitation needs and potential, or must be a skilled service related to the restoration of a specific loss of function. PT services are covered only so long as significant functional improvement is occurring and is documented, . . .

(b) For an OT service, the service must be an evaluation, reevaluation, or therapeutic service or must be the teaching of compensatory techniques which improve the resident's ability to perform those tasks required for independent functioning. OT services are covered only as long as significant functional improvement is occurring and is documented, . . .

(c) For a ST service, the service must be necessary for the diagnosis and treatment of a speech or language disorder which results in a communication disability, or for the diagnosis and treatment of a swallowing disorder (dysphagia). ST services are covered only so long as significant functional improvement is occurring and is documented, . . .

The Provider billed for 2,386 therapy services during the audit period for which it was reimbursed \$133,614.15. The rendered services included physical and occupational therapy evaluations, neuromuscular re-education, and therapeutic exercises. We reviewed the documentation for all 2,368 services and identified 437 services rendered to 43 patients who were overpaid.

We found 367 services where the units of service were incorrectly billed and the Provider was reimbursed for more services than were rendered. We could not locate documentation to substantiate an additional 69 services. Additionally, there was one (1) service that was billed using an incorrect Health Care Procedural Coding System (HCPCS) Code.

A finding of \$18,103.47 was identified for these improperly billed therapy services.

Summary of Findings

A total of \$58,540.97 in findings was identified. These findings resulted from the combination of our findings for incorrectly billed room and board services (\$40,437.50); and for incorrectly billed therapy services (\$18,103.47).

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on December 10, 2007, to afford it an opportunity to provide additional documentation or otherwise respond in writing. The Provider was initially given until December 21, 2007 to submit any documentation. Subsequently, the Provider received an extension until January 15, 2008 to submit its response; however, no response was received. As of January 29, 2008, the Provider has agreed to work through ODJFS during the adjudication process on any refuted findings.

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
Office of Fiscal Services (Attn: Accounts Receivable)
P.O. Box 182367
Columbus, Ohio 43218-2366

1. Provider Name and Address:

Regency Manor Rehabilitation

2000 Regency Manor Circle

Columbus, Ohio 43201

2. Provider Number:

2424291

3. Review Period:

**July 1, 2004 through
June 30, 2005**

4. AOS Finding Amount (including accrued interest):

\$61,215.32

5. Interest "as of" Date:

February 15, 2008

6. Date Payment Mailed:

7. Additional Interest Owed:

**(Calculated by multiplying \$3.97 by the difference in days
between #5 and #6)**

8. Total Amount Repaid:

(Sum of #4 and #7)

IMPORTANT:

To help ensure that your payment is properly credited, please fax copies of this remittance form and your check to our office at (614) 728-7398, ATTN: Medicaid/Contract Audit Section.



Mary Taylor, CPA
Auditor of State

REGENCY MANOR REHABILITATION

FRANKLIN 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
FEBRUARY 15, 2008**