STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to JMH Long Term Care/DME Services

A Compliance Review prepared by the:

Fraud, Waste and Abuse
Prevention Division

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

Ms. Joyce Humphrey, President
JMH Long Term Care/DME Services
1724 East Prospect Road
Ashtabula, Ohio 44004

Dear Ms. Humphrey:

We have completed our review of selected medical services rendered to Medicaid recipients by JMH Long Term Care/DME Services for the period April 1, 1999 through March 31, 2002. We identified findings in the amount of $47,963.04, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "provider remittance form" is located at the back of this report for remitting payment.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if repayment of the findings 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.

We also identified questioned costs of $244,926.60 for services that we believe were billed in excess of your usual and customary fee for oxygen concentrator services to nursing home recipients. We are recommending that ODJFS as the program administrator make the final determination on these questioned costs and pursue the appropriate recovery action.

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

January 9, 2003

TABLE OF CONTENTS

ABBREVIATIONS

AMA	American Medical Association
AOS	Auditor of State
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
HCPCS	HCFA Common Procedure Coding System
LPM	Liters Per Minute
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Auditor of State performed a review of JMH Long Term Care/DME Services, Medicaid Provider # 2127568, doing business at 1724 East Prospect Road, Ashtabula, Ohio 44004. As a result of this review, we identified $47,963.04 in findings that did not meet reimbursement rules contained in the Durable Medical Equipment Manual and the Ohio Administrative Code.

We also identified questioned costs of $244,926.60 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services. We are recommending that ODJFS as the Medicaid program administrator make the final determination on these questioned costs and pursue the appropriate recovery action.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, 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. The Ohio Department of Job and Family Services (ODJFS) administers the Medicaid program. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Medicaid Provider Handbook.

ODJFS' Medicaid Provider Handbook, Chapter 3334, General Information, Section II, Subsection (B) states, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must authorize medical services within the scope of his/her licensure and based on their professional judgment 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 Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code 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 from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

Pursuant 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.

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 that they were selected for a compliance review. An Entrance Conference was held on August 20, 2002 at the Provider's facility with Joyce Humphrey, President.

We utilized ODJFS' Medicaid Durable Equipment Manual and the Ohio Administrative Code (OAC) as guidance in determining the extent of service and applicable reimbursement rates. We obtained the Provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to Medicaid and paid to providers. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. Services are billed using the five (5) digit Current Procedural Terminology (CPT)[1] coding system or ODJFS local level codes[2].

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period April 1, 1999 through March 31, 2002. During this review period, the Provider was reimbursed $554,468.24 for 2,374 durable medical equipment services provided to 451 Medicaid recipients. Of the $554,468.24, the Provider was reimbursed $421,949.28 for oxygen concentrator services provided to patients residing in long term care facilities and $125,250.00 for ventilators provided to patients residing in long term care facilities.

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

[2] Local level codes are published in the Ohio Medicaid Providers Handbook.

To facilitate an accurate and timely review of paid claims, we analyzed statistical random samples of oxygen services and ventilator services. Our samples entailed 134 dates of service in which oxygen concentrator services were provided to patients in a long term care facility and 30 preauthorized ventilator services.

We also analyzed the Provider's claims history to determine whether the Provider billed and was reimbursed

- for services to a deceased recipients,
- more than once for the same service (a duplicate payment), and
- oxygen concentrator services billed with a "QE" modifier, which prior reviews have demonstrated to be problematic because of a processing error in ODJFS' claims processing system.

A draft report was mailed to the Provider on December 12, 2002 to afford an opportunity to provide additional documentation or otherwise respond in writing. We held a phone conference with the President of JMH Long Term Care/DME Services and the Provider's legal representative on December 20, 2002 to discuss our results. Subsequently, the Provider submitted a written response on December 30, 2002. The Provider's position regarding our findings and questioned costs have been incorporated into the report.

Our work was performed between July 2002 and December 2002 in accordance with government auditing standards.

FINDINGS

Our sample analyses did not identify any material deficiencies with the Provider's claims for ventilator services; however, we identified findings in two areas of claims for oxygen concentrator services: Missing Oxygen Usage Readings and Unsupported Level of Service for Oxygen. Outside of our sample, we also identified findings associated with Duplicate Payments, Deceased Recipients, and an error in reimbursements for "QE" modified claims. The total findings were $47,963.04.

Additionally, we identified questioned costs of $244,926.60 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services. The bases for the findings and questioned cost are detailed below.

Missing Oxygen Usage Readings

Section 5101:3-10-13 (C) (5)[4] of the Ohio Administrative Code states:

> All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient. The amount of oxygen actually used each month (as determined from a meter reading), must

[4] OAC 5101:3-10-13 (C)(5) was amended by the ODJFS effective 10/11/2001. OAC 5101:3-10-13 (H)(1) states "a meter reading **or** refill amount and delivery information must be determined and documented by the provider prior to submitting the monthly claim for reimbursement." This rule change did not affect our audit finding.

> be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of the amount of oxygen used each month must be maintained in the provider's file.
>
> Provider maintenance and documentation of the amount of oxygen used does not meet the requirements of this rule when such documentation is created, or collected, from sources other than the provider, after the service has been billed.

All oxygen services are billed in cubic feet according to the amount of oxygen used. Providers must use meter readings to calculate the cubic feet of oxygen used for the month's services. Therefore, a meter reading is essential in determining the correct code to bill for oxygen services.

During our review of oxygen services, we found 2 services out the 134 services in our sample where Provider did not have a meter reading documented in the patient file.

Unsupported Level of Service for Oxygen

Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code 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 11 services out of the 134 services in our sample where the Provider billed for a higher level of oxygen service than could be supported by the prescribed flow and the meter reading provided in each patient's record. Additionally, 4 instances were found where the Provider billed for oxygen services when the nursing home flow sheets indicated that the recipient did not use any oxygen during the month.

Total Projected Finding

We projected the 17 errors for missing oxygen usage readings and unsupported levels of service across the total population of oxygen services paid to the provider during the review period. This resulted in a total projected finding of $45,777.06.

Duplicate Payments

Section 5101:3-1-198 (E) (Payment errors and overpayments) of the Ohio Administrative Code states:

> Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery . . .

During our field review, we checked for instances where two or more claims were filed for the same procedure code, the same recipient, and the same month of service. Forty-nine (49) potential duplicate claims were identified. Within the 49 claims, we noted two types of potential duplicates:

- 12 potential duplicates which resulted from two or more claims being filed for the same procedure code, the same recipient, and the same month of service by JMH Long Term Care.
- 37 potential duplicates which resulted from two or more claims being filed for the same procedure code, the same recipient, and the same month of service by JMH Long Term Care and another provider.

The total amount paid to JMH Long Term Care/DME Services for these potential duplicated claims was $8,585.16. Of the 49 claims, we took exception with 12 totaling $1,964.58. Within the 12 exceptions, the following was noted:

- The Provider was unable to supply supporting documentation for one of the services.
- 5 services were identified as being duplicates.
- 3 services were identified where the Provider did not have a meter reading documented in the patient file for the services in question.
- 1 instance was identified where the Provider billed for oxygen services when the nursing home flow sheets indicated that the recipient did not use any oxygen during the month.
- 2 instances were identified where the Provider billed for a higher level of oxygen service than could be supported by the Provider's documentation based upon the prescribed flow and the meter reading provided in each patient's record.

Services Billed for Deceased Recipients

In our deceased recipient test, we found that the Provider had received reimbursements for a deceased recipient. OAC Section 5101:3-1-198 (E) (Payment errors and overpayments) prohibits payments for these services.

We determined that the Provider billed Medicaid for one service rendered subsequent to the recipient date of death. The amount reimbursed to the Provider was $178.56.

QE Modifier

During our review period the Provider billed for eight oxygen services using procedure code Y2076 in conjunction with a "QE modifier", reflecting a lesser amount of oxygen usage. In accordance with 5101:3-10-13(C)(1) of the OAC, both procedure codes, when billed with a QE modifier, are paid at 50% of the maximum allowable amount of $178.56, or $89.28. We determined, however, that the Provider had been reimbursed at a higher rate ($96.42) in these instances, amounting to an overpayment of $7.14 for each occurrence, or a total of $42.84 during our review period. [5]

Policy staff from ODJFS' Office of Ohio Health Plans believe the excessive reimbursement may have occurred because the Medicaid claims processing system is programmed to pay at the higher rate in response to an agreement reached between providers and ODJFS (then the Ohio Department of Human Services) in 1993. However, because the agreement was never formalized in the OAC, and because 5101:3-1-198 of the OAC states that errors in payment, caused by either the provider or the department, are recoverable by the department at the time of discovery, we are identifying $42.84 in findings that are repayable to ODJFS.

Because this processing error likely affects reimbursements to other oxygen services providers, we have also recommended to ODJFS that it correct the error and review the extent to which recoveries are due from other providers.

Provider's Response to our Findings

In consideration of additional documentation from the Provider to support two duplicate payment claims, we reduced our findings accordingly. The Provider's legal representative stated his client did not plan to contest the other findings.

QUESTIONED COSTS: Usual and Customary Fee

In order to supply medical services to Medicaid recipients, providers sign a provider agreement. The Ohio Administrative Code § 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.

[5] Although the Provider actually billed for 8 services with a QE Modifier, we are only taking exception with six services because exceptions were previously taken for the other two services.

In addition, the Ohio Administrative Code § 5101:3-10-13 (H)(4), 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.

Upon review of 11 contracts that the Provider held with long term care facilities during our audit period, we found that the Provider normally charged $75.00 per month for the use of oxygen concentrators. Because the Provider charged Medicaid $178.56 per concentrator per month of service approximately 99 percent of the time, we are questioning $244,926.60 of Medicaid's costs for concentrator services because they appear to exceed the Provider's usual and customary charges. To arrive at these questioned costs, we calculated the difference between what was paid to the Provider by Medicaid (an average of $179.11 per month) and the rate charged by the Provider to long term care facilities for the period April 1, 1999 through March 31, 2002; which amounted to $421,444.44 for 2,353 dates of service. This calculation also included claims filed with procedure codes Y2076 "QE" (corrected to $89.28) and Y2076 "QG" (paid at $267.84), which accounted for about 1 percent of the Provider's claims for oxygen concentrator services.

In responding to our draft report, the Provider disagreed with our questioning whether the Provider's Medicaid charges for oxygen concentrator services represented the Provider's "usual and customary" fee. The Provider opted not to provide any specific rebuttal or response to this portion of the report, because we did not make a specific finding that necessitates recovery of the questioned costs. The Provider noted, however, that the charges being compared across payers were actually for dissimilar items and/or services, thereby producing dissimilar charge amounts.

We did not gather detailed information on any differences in services required for Medicaid and non Medicaid oxygen concentrators. However, due to the large disparity of $103.56 per month/per concentrator between what the Provider charged Medicaid and what was charged for patients in a similar setting, we question whether the amounts billed to Medicaid were a "usual and customary" charge. Medicaid, like a nursing home, is a volume purchaser and should expect to benefit from reductions or discounting of fees and charges. Therefore, we are recommending that ODJFS as the program administrator make the final determination as to whether these questioned costs are recoverable.

APPENDIX I

Table 1: Summary of Statistical Sample Review of Oxygen Services of JMH Long Term Care/ DME Services for the Period April 1, 1999 – March 31, 2002

Description	Audit Period April 1, 1999 – March 31, 2002
Population number of Oxygen Services[3]	**2,312**
Total Actual Population Amount Paid for Oxygen Services[3]	**$413,364.12**
Type of Statistical Analysis	**Stratified Random Sample of Oxygen Services**
Number of Oxygen Services Sampled	**128**
Dollar Amount of Oxygen Services Sampled	**$23,389.08**
Projected Correct Population Payment Amount for Oxygen Services at 95% Confidence Level	**$367,587.06**
Upper Limit at 95% Confidence Level of Correct Population Payment Amount	**$390,031.54**
Lower Limit at 95% Confidence Level of Correct Population Payment Amount	**$345,142.58**
Projected Overpayment amount for Oxygen Services (Actual Population payment amount less Projected Correct Population payment amount.)	**$45,777.06**

Table II: Summary of Audit Findings for JMH Long Term Care/DME Services For the Audit Period April 1, 1999 – March 31, 2002

Description of Audit Finding	Dollar Amount of Finding
Oxygen Service Overpayment	**$45,777.06**
Duplicate Oxygen Service	**$1,964.58**
Service Charged for Deceased Recipient	**$178.56**
Incorrect QE Modifier Payment	**$42.84**
Total Audit Findings:	**$47,963.04**

3 Population totals exclude claims identified as duplicate payments, charges for deceased recipients, and incorrect use of QE modifier.

AUDITEE 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

Auditee Name & Address:	Joyce Humphrey, President JMH Long Term Care/DME Services 1724 East Prospect Road Ashtabula, Ohio 44004
Auditee Provider Number:	2127568
Review Period:	4/1/99 through 3/31/02
AOS Finding Amount:	$47,963.04
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: Thomas Tedeschi 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

JMH LONG TERM CARE/DME SERVICES

ASHTABULA 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
JANUARY 9, 2003