Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to HCMC, Inc. d.b.a. We Care Medical

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

January 10, 2006

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

Re: Audit of HCMC, Inc. d.b.a. We Care Medical
Provider Number: 0991566

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to HCMC, Inc., d.b.a. We Care Medical for the period October 1, 2001 through June 30, 2004. We identified $1,010,404.26 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 any final determinations 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 HCMC, Inc. d.b.a. We Care Medical 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
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of HCMC, Inc., d.b.a. We Care Medical (hereafter called the Provider), Provider # 0991566, doing business at 8914 Glendale Milford Rd. Suite A, Cincinnati, OH 45140. 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 $1,010,404.26 in repayable findings. The findings are based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio 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, such as oxygen, which are "consumable, disposable, or have a limited life expectancy."

[1] *Ohio Adm.Code 5101:3-1-19.8(F) states: "Overpayments are recoverable by the department at the time of discovery…"*

[2] *Ohio Adm.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was June 30, 2004, the latest payment date in the population.*

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

Ohio Adm.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in part: "…In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

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 overutilization 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 claims to Medicaid for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a medical equipment supplier.

Following a letter of notification, we held an entrance conference at the Provider's place of business on November 9, 2004 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 June 30, 2004. The Provider was reimbursed $1,436,907.52 for 7,993 claims during the audit period.

All of the Provider's reimbursements were for the supply of oxygen concentrator services to Medicaid residents of long term care facilities. An oxygen concentrator is a device that extracts oxygen from room air. It works on the principle that room air contains oxygen and nitrogen. The concentrator draws in room air and filters out the nitrogen, leaving nearly pure oxygen to be delivered to the user.

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.]

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 tests included:

- Checking for services to deceased recipients for service dates after their date of death.
- Checking for potentially duplicate oxygen billed and paid services. (Defined as more than one oxygen service billed for the same recipient, for the same month of service, and by the Provider.)
- Checking for potentially duplicate oxygen billed and paid services for the Provider as well as another provider. (Defined as more than one oxygen service billed for the same recipient, for the same month of service, and by the Provider and a different provider(s).)
- Identifying where the Provider was reimbursed for multiple units of oxygen service during one month.
- Verifying that the living arrangement of recipients for the time span of the billed service was a long term care facility.

The test for living arrangements was negative, but the other exception tests identified potentially inappropriate service code combinations. When performing our audit field work, we reviewed the Provider's supporting documentation for all claims with potentially inappropriate service code combinations identified by our exception analyses.

Additionally, we reviewed the Provider's nursing home contracts for the audit period to determine whether the Provider charged Medicaid more than their usual and customary fee for oxygen concentrator services. This last step was performed because a prior AOS audit of this Provider (FWAP-03-004C, August 20, 2002) had identified $493,617.20 in questioned costs due to the Provider charging Medicaid substantially more for oxygen concentrators in a long-term care facility than the usual and customary fee charged to commercial clients.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed two census reviews and a statistically random sample from services not already identified by an exception test for 100 percent review. The census reviews were conducted for HCPCS code Y2076 claims with a QE modifier, containing a total of 49 services; and HCPCS code Y2076 claims with a QG modifier, containing a total of 19 services. The statistically random sample was of unmodified HCPCS code Y2076 claims contained a total of 30 services.

[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.*

Our work was performed between November 2004 and November 2005.

RESULTS

We identified $33,803.70 in findings from our exception analyses, $446.40 from our combined census reviews, and $976,154.16 for services reimbursed in excess of the Provider's usual and customary fee. No findings were identified in our statistically random sample of unmodified HCPCS code Y2076 claims, other than those associated with charges in excess of the Provider's usual and customary fee.

The total findings of $1,010,404.26 are repayable to ODJFS and are discussed in more detail below.

Exception Test Results

Services Billed for Deceased Recipients

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…
>
> ***

During our computer analysis testing, we identified that the Provider billed Medicaid for eight services, involving seven recipients, for services rendered after the recipients' dates of death. Therefore, a finding was made for the $1,428.48 in reimbursements received for these services.

Duplicate Claims

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…
>
> ***

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

> Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.

Ohio Adm.Code 5101:3-10-13(G)(2) states in pertinent part:

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription…[which] must specify: (a) Diagnosis; (b) Oxygen flow rate; and (c) Duration (hours per day); or (d) Indications for usage.

Ohio Adm.Code 5101:3-10-13(H)(1) states in pertinent part:

> …The amount of oxygen actually used each month…must be determined and documented by the provider prior to submitting the monthly claim for reimbursement…

During our field review, we checked for duplicate claims in which two or more claims were billed and paid for the same procedure code, the same recipient, and the same month of service. We then analyzed patient record files for the audit period to ascertain whether multiple services had been rendered or a duplicate billing had occurred.

We identified two different types of duplicates. The first duplicate type involved duplicate claims filed solely by the Provider. The second type involved duplicate (or overlapping) claims submitted by the Provider and another oxygen provider.

For the first duplicate type, our computer analysis identified 34 potential duplicates totaling 68 services where the Provider billed for more than one oxygen service for the same recipient in the same month. During our review, we found documentation supporting that only one service had been provided for 26 of the 34 potential duplicate combinations, and the Provider concurred that a billing error could have occurred. Therefore, we disallowed the reimbursements for 26 of the 68 services. In addition, we determined that the level for one service had been overstated based on the liter flow and meter reading. We took the difference between the Medicaid maximum reimbursement for the level documented and the amount paid for the service billed as a finding. Findings for these exceptions totaled $4,357.44.

For the second duplicate type, our computer analysis identified 63 potential duplicates (137 services) where the Provider and another provider billed for oxygen services for the same recipient in the same month. We limited our review of these potential duplicates to supporting documentation maintained by the Provider in determining which provider supplied the service. We identified 13 services where either no documentation at all was supplied to support the service was rendered; or at least one of the following required billing components was missing: a physician order prior to the first date of service; a meter reading (hours used during the month);

an oxygen flow rate; or a legible physician order. As a result, we disallowed the reimbursement for these services and identified findings totaling $2,214.72.

Erroneous Units of Service

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

> Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose and listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.

According to Appendix A, an oxygen concentrator "unit of service" represents one month of service.

Our computer analysis identified 31 instances where overpayments occurred because the Provider billed days as units instead of months. This resulted in multiple units of service being billed for one month of service. During our review of these services, we also identified one service where no patient chart was found to support service was rendered and two services where the Provider billed for a higher level of service than that supported by the recorded liter flow and hours used in the patient chart. We reduced the payments for the multiple unit billed services to one unit of service which resulted in $25,091.16 in findings. In addition, we disallowed the reimbursement for the service missing a supporting patient chart; and took the difference between the Medicaid maximum reimbursement for the level documented and the amount paid for the two over billed level services as a finding. These errors added $147.84 in findings. Thus, the total findings for oxygen services billed with multiple units were $25,239.00.

Services Reimbursed at a Greater Amount than Billed

Ohio Adm.Code 5101:3-10-13(C)(1) states:

> 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, or (b) The patient has used no more than one thousand cubic feet…

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

> …The department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in division-level designation 5101:3 of the Administrative Code.

During our computer analysis, we determined that 79 HCPCS code Y2076 QE services had been reimbursed $96.42 for each service, although the Provider had only billed $89.28. The $96.42 rate represents the maximum rate allowed by the Medicaid claims processing system at the time of payment. Since Ohio Adm.Code 5101:3-1-17.2(B) stipulates that the lesser billed amount

($89.28) should have been paid, we identified a $7.14 finding for each service payment, resulting in total findings of $564.06 for the 79 services.

Sample Results

As already stated in the methodology section, all statistical samples were drawn from a population that excluded services identified by our exception tests.

HCPCS Y2076 QE Census Review Results

Ohio Adm.Code 5101:3-10-13(G)(2) states in pertinent part:

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription…[which] must specify: (a) Diagnosis; (b) Oxygen flow rate; and (c) Duration (hours per day); or (d) Indications for usage.

We took exception with the reimbursement of one of the 49 Y2076 QE services from a census review of the Provider's sub-population of Y2076 QE paid services. The exception occurred because the Provider billed for HCPCS code Y2076 QE when there was no liter flow listed on the physician prescription. We disallowed the payment for this service and made a finding for $89.28.

HCPCS Y2076 QG Census Review Results

Ohio Adm.Code 5101:3-10-13(C)(2) states in pertinent part:

> Modifier QG shall be used and the payment amount increased by fifty percent when: (a) The prescribed amount of oxygen is greater than four liter per minute continuous…

We identified errors with four of 19 services from a census review of the Provider's sub-population of the Provider's Y2076 QG paid services. The Provider billed for HCPCS code Y2076 QG when the prescribed liter flow was four liters per minute or less and non-continuous. Therefore, the Provider should have billed HCPCS Y2076 with no modifier. We made a finding of $89.28 against the Provider's reimbursement for each of these services, which represented the difference between the Medicaid maximum payment for an unmodified Y2076 and the actual amount paid to the Provider. This resulted in a total finding of $357.12.

Statistical Sample of Unmodified Y2076 Services

No billing errors were found in the statistically random sample of unmodified Y2076 oxygen services other than those associated with billings in excess of the Provider's usual and customary fee. Discussion of this matter follows.

Services Reimbursed at a Greater Amount than Usual and Customary Fee

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 render medical services as medically necessary for the patient…and, bill the department for no more than the usual and customary fee charged other patients for the same service.
>
> ***

In addition, Ohio Adm.Code 5101:3-10-13(H)(4) states:

> Payment will be limited to the lower of the usual and customary charge of the supplier, or the medicaid maximum as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.

In an August 2002 report[5], we questioned the Provider's Medicaid reimbursements for oxygen concentrator services provided to patients in long term care facilities because they appeared to exceed the Provider's usual and customary charges for similar services to non-Medicaid patients in the same facilities. More specifically, the Provider charged and was reimbursed $178.56 per month by Medicaid for oxygen concentrator services, but charged long term care facilities a median rental rate of $58.75 per month for concentrators used by non-Medicaid patients. We determined that the $119.81 per month difference amounted to $586,589.56 over our three year audit period (October 1, 1998 through September 30, 2001). The Provider's position was that the additional Medicaid charges were justified by the additional administrative costs incurred in servicing Medicaid recipients. However, there is no provision in Medicaid rules to consider additional presumed costs. Ohio Adm.Code 5101:3-1-17.2 (A) simply defines "usual and customary" as the fee charged other customers for the same service.

To determine if the situation had changed during our October 1, 2001 through June 30, 2004 audit period, we requested that the Provider furnish us with copies of rental contracts to provide oxygen concentrator services to long term care facilities. The Provider furnished 21 rental contracts, which upon review, showed that the Provider continued to charge monthly rental rates well below what was being charged to Medicaid[6]. During our audit period, 97 percent of the oxygen concentrator services billed to Medicaid were billed and paid at $178.56 per month.

[5] *Review of Medicaid Provider Reimbursements Made to HCMC, Inc. – D.B.A. "We Care Medical; August 20, 2002; AOS/FWAP-03-004C.*

[6] *Specific rental rates are not shown because the Provider expressed concern about divulging pricing information that would place him at a competitive disadvantage with other oxygen service providers..*

(The other 3 percent were billed for more or less than $178.56). After removing findings associated with our exception tests, we calculated the difference between what Medicaid paid to the Provider for 7,946 services during our audit period ($1,402,894.54) and the corresponding mean monthly rate charged by the Provider to long term care facilities. The difference was $976,154.16 ("the total overpayment").

Summary of Findings

In total, we identified $1,010,404.26 in findings for our October 1, 2001 to June 30, 2004 audit period that are repayable to ODJFS. The following table summarizes the basis for our findings.

Summary of Audit Findings for: HCMC, Inc. d.b.a. We Care Medical
For the period October 1, 2001 to June 30, 2004

Description	Audit Period October 1, 2001 to June 30, 2004
Services Billed for Deceased Recipients	$1,428.48
Duplicate Claims Billed by the Provider	$4,357.44
Duplicate Claims Billed by the Provider and another Oxygen Provider	$2,214.72
Erroneous Units of Service	$25,239.00
Services Reimbursed at a Greater Amount than Billed	$564.06
HCPCS Y2076 QE Census Review Results	$89.28
HCPCS Y2076 QG Census Review Results	$357.12
Services Reimbursed at a Greater Amount than Usual and Customary Fee	$976,154.16
TOTAL	**$1,010,404.26**

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

PROVIDER'S RESPONSE

Initially, the Provider disagreed with representing long term care rental rates as a usual and customary charge on the basis that additional costs are incurred to provide services to Medicaid patients. The Provider supplied a breakdown of the additional costs to support his Medicaid charges. Subsequently, a draft report was mailed to the Provider on September 20, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. In transmitting the draft report, we asked the Provider to supply data to support his cost breakdown.

The Provider's legal representative responded on October 20, 2005, stating that the Provider did not contest the findings from our exception testing, but disagreed with our findings regarding usual and customary fee charges. The legal representative declined to supply additional support for the Provider's cost breakdown, but instead argued that our analysis of usual and customary fee charges was based on an "apples to oranges" comparison. More specifically, the legal representative argued that Medicaid reimbursements are based on the consumption of oxygen,

while the nursing home rates used in our comparison were based on the rental of a piece of equipment. We disagree that our analysis is faulty, on the premise that our comparison is based on essentially the same service – the monthly charge for providing oxygen to nursing home residents via oxygen concentrators. Based on the usual and customary fee rule, we do not see a rational basis for charging Medicaid what amounts to three times the amount being charged to nursing homes for essentially the same service.

The Provider's October 20, 2005 response is attached in full for the review and consideration of ODJFS.

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October 20, 2005

Robert I. Lidman
Health Care and Contract Audit Section
35 N. Fourth Street, First Floor
Columbus, Ohio 43215

Re: HCMC, Inc., dba We Care Medical

Dear Mr. Lidman:

On behalf of HCMC, Inc., dba We Care Medical, I am submitting the Provider's response to your draft audit report issued September 20, 2005.

A. Exception Test Results

The provider does not contest the findings made in the Exception Test Results section totaling $34,250.10.

These sums represent actual overpayments which have been verified by the provider, and are not derived from a questionable statistical sampling methodology. They were inadvertently made over a period of nearly three years and occurred as a result of clerical error. In fact, the largest overpayment, $25,239.00 for erroneous service units, was correctly billed by the provider but occurred as a result of a payment error by the Ohio Department of Job and Family Services for 31 claims which went undetected by both the provider and the Department

B. Usual and Customary Fees

In contrast, the provider strenuously contests the Auditor's finding relating to services reimbursed at a greater amount than usual and customary fee.

The Auditor found that the provider billed Medicaid $178.56 per month for oxygen services the provider delivered to Medicaid residents, and that it billed nursing facilities an average charge of $58.75 per month for each concentrator it rented to the facility for the facility's use. Based on Medicaid rules which require that a provider bill Medicaid no more than the usual and customary fee charged to other patients for the

same service, the Auditor concluded the provider was overpaid the sum of $976,154.16 (the difference 7,946 services billed at $178.56 and 7,946 billed at $58.75).

This conclusion is wrong because Medicaid does not reimburse for the use or rental of a *concentrator*, i.e., a good. According to the plain language of its own regulations Medicaid reimburses for the *consumption of oxygen*, i.e., a service. In trying to compare a good (the concentrator) to a service (oxygen consumption) the Auditor wrongly attempts to make an apples-to-oranges comparison.

1. The Medicaid Consumption-Based Service

Under the current regulations governing Medicaid recipients residing in long term care facilities, oxygen providers are only permitted to bill, and Medicaid will only pay, for the amount of oxygen actually consumed by a recipient, regardless of the delivery modality. See O.A.C. 5101:3-10-13(H) ("Billed charges shall be the provider's usual and customary charge *for oxygen actually used by the recipient*.") [Emphasis added.] In other words, Medicaid's reimbursement system is based upon how much oxygen is consumed, regardless of whether it is consumed through a gaseous system, a liquid system, or a concentrator. See O.A.C. 5101:3-10-13(H)(3).

Pursuant to this system, Medicaid has adopted by regulation various levels of reimbursement based upon the volume of oxygen consumed. There are higher rates for greater consumption and lower rates for lesser consumption, but the vast majority of oxygen is consumed and billed at the usual and customary rate of $178.56 per month. These are the usual and customary rates We Care Medical charges Medicaid for this service.

To further illustrate this consumption-based reimbursement system, it should be noted that Medicaid will not reimburse the provider if no oxygen is consumed, even if an oxygen concentrator is dedicated to a patient and not available for use elsewhere. Furthermore, Medicaid also will not pay for oxygen consumed pursuant to a "PRN" or "as needed" physician order, again, even though a concentrator is used and services provided.

In other words, Medicaid pays for levels of *consumption*, and it is billed accordingly. Under Medicaid, it is the oxygen provider who delivers and bills the oxygen services based on *consumption*. Medicaid does not pay for the lease or rental or possession of a mere *concentrator*.

2. Concentrators

With the exception of Medicaid, every other payor reimburses for the *possession of a concentrator*, regardless of usage or the amount of oxygen consumed. In those cases, the oxygen provider does not deliver a service, but is merely a deliverer of goods.

Nursing facilities rent concentrators and other oxygen delivery systems from oxygen providers for their own uses, including typically keeping a reserve supply for use when needed. In those cases, it is the nursing home, not the oxygen provider, who is delivering the oxygen services, typically to non-Medicaid residents. Oxygen providers furnish no other services except for the pick-up and delivery of clean and properly operating concentrators and therefore charge a flat fee for each regardless of consumption or the level of use. Unlike Medicaid, the oxygen providers get paid for each rental regardless of whether the equipment is used, in use, re-used, sitting idle, or used as a plant stand. For example, one or more concentrators may sit in storage for six months and never be used, but the provider still gets. Medicaid would not pay for these unused concentrators. Moreover, a provider may rent the same piece of equipment five or six separate times during the same month and get paid a flat fee for each rental. Medicaid pays once and only after a certain amount of oxygen is consumed.

This arrangement bears no relationship to Medicaid's consumption-based payment system. As mentioned above, in a nursing home non-Medicaid oxygen services are delivered by the nursing home (not the oxygen provider) which builds the rental cost of the concentrator into the usual and customary fee it reports on its cost report, or that it bills to private payors, for that service. We Care has no idea what usual and customary fee these homes charge their non-Medicaid residents.

We Care Medical does not dispute that the facility agreements reviewed by the Auditor reflect an average rate of $58.75 per month for the possession of a concentrator. But concentrators are not the only deliver modality offered by We Care Medical. This rate represents We Care Medical's usual and customary rate for *possession of a concentrator*, as opposed to its usual and customary rate for the *consumption of oxygen*.

It also should be noted that the Auditor avoided comparing the average rate We Care Medical charges for other oxygen delivery modalities such as liquid or gaseous based systems or E-cylinders. This comparison is explained further below.

3. Analysis

The Auditor's report inappropriately confuses the concept of oxygen consumption with the concept of possession of a concentrator. In fact, the audit report is very carefully drafted to avoid using consumption versus possession language at all. But this creative drafting cannot hide the effect of the regulations.

As stated above, Medicaid's regulations clearly specify that it pays only for an amount of oxygen specifically consumed. O.A.C. 5101:3-10-13(H). The Auditor's report avoids this provision and cleverly converts the requirement of billing for "oxygen consumed" into one of merely supplying "oxygen concentrators," "oxygen concentrator services," and "oxygen concentrator fees," and paying "oxygen concentrator

reimbursements." See Report at 2, 3, 8 and 9, and the cover letter. No where does the audit report admit that We Care Medical bills, and Medicaid pays, for *oxygen consumed*, not for *possession of a concentrator*. Contrary to the position the Auditor would like to take, Medicaid does not pay for "a concentrator."

The only delivery system that can be compared to Medicaid's consumption based system would be the delivery of oxygen by E-cylinder, because an E-cylinder contains a fixed amount of oxygen in a tube which, once consumed, is gone. A standard E-cylinder contains 22 cubic feet of oxygen. Thus, a patient would use more than 34 E-cylinders in order to consume 750 cubic feet of oxygen, the volume at which a provider may begin to charge Medicaid $178.56. Since the average private-pay price for an E-cylinder is $8.00, the cost of consuming 750 cubic feet of oxygen by E-cylinder is $272.00 ($8.00 X 34). Thus, when apples are compared to apples, this example clearly illustrates that the usual and customary charge of $178.56 to Medicaid for *the consumption* of 750+ cubic feet of oxygen is much less than the private-pay charge of $272 to private pay payors *for the same consumption.* The Auditor conveniently overlooks this analysis.

Medicaid requires that providers "bill the department no more than the usual and customary fee charged other patients *for the same service*." [Emphasis added.] O.A.C. 5101:3-1-172. We Care Medical has not violated this rule. Its usual and customary charge for *oxygen consumption* is $178.56, plus or minus the rates established by Medicaid for greater or lesser volume ranges. Its usual and customary charge for the rental and possession of a *concentrator* is an average of $58.75.

Near the end of the report the Auditor admits that oxygen providers incur more costs delivering oxygen to Medicaid recipients than to other customers, and then proceeds to analyze a breakdown of various cost categories furnished earlier by We Care Medical in response to a request from the Auditor, made in connection with an independent administrative review of oxygen reimbursement rules. We Care Medical declines any further comment on this breakdown as it believes the emphasis placed on it by the Auditor shifts attention from the real issue. The issue is not the difference between the cost of delivering a concentrator versus the cost of delivering Medicaid oxygen therapy services. The issue here is that while Medicaid's rules for oxygen therapy require billing and payment pursuant to a consumption-based reimbursement system, the Auditor is now unlawfully attempting to impose a "per concentrator" reimbursement system where none currently exists.

The Auditor's conduct in this matter becomes transparent upon review of Medicaid's newly proposed oxygen reimbursement rules. See attached exhibits. The new rules propose to eliminate the consumption based reimbursement system in place now and, like every other payor, establish a flat rate for the delivery of concentrators. We Care Medical apparently was the "test case" for this new legislation. But the Auditor here has simply "jumped the gun" and gone out of her way to avoid applying the existing

consumption based system and is unlawfully attempting to impose upon We Care Medical a reimbursement system that is not yet adopted.

This position is entirely inconsistent with the position Medicaid has taken on previous occasions. During prior audits of oxygen providers, this exact issue was raised by the provider itself and both the Surveillance and Utilization Review Section of the Ohio Department of Job and Family Services and the Ohio Attorney General Health Care Fraud Section reviewed similar practices and determined that the practices were appropriate and that no overpayment existed.

The bottom line here is that this policy position, which has never been communicated to providers, has been very unclear and indecisive. The Auditor and the Department have both taken months just to determine whether this should even be considered an overpayment. Couple that with the Department's flip flop in position and its subsequent decision to modify the existing regulations to reflect the reimbursement system the Auditor would *like* to enforce, and you have a recipe for arbitrary and capricious conduct. The Auditor has taken a known practice and made it something it never has been before. Policy positions that are as this unclear, and regulatory interpretations that are this strained, simply are not fair and equitable and should not be enforced.

As a Medicaid provider, We Care Medical is entitled to an administrative hearing pursuant to R.C. Chapter 119 to contest these findings once they are finalized. The Department of Job and Family Services, and any other agency acting on its behalf, are barred by Ohio law from taking any action against We Care Medical until certain administrative remedies have been exhausted, including the issuance of a proposed adjudication order and a 30-day notice of the right to request a hearing. We Care Medical intends to exercise its right to administrative review and accordingly requests such a hearing with this response.

Sincerely,

J. Randall Richards
Attorney at Law

JRR:gl
cc: File
Client
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HCMC, INC. dba WE CARE MEDICAL

HAMILTON 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 10, 2006