Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to McKinley Health Care Center, LLC

A Compliance Audit by the:

Medicaid/Contract Audit Section

May 2008 ***AOS/MCA-08-005C***

Mary Taylor, CPA
Auditor of State

May 13, 2008

Robert Knapp
Administrator
McKinley Health Care Center, LLC
800 Market Avenue North
Canton, Ohio 44702

Dear Mr. Knapp:

Attached is our report on Medicaid reimbursements made to McKinley Health Care Center, LLC, Medicaid provider number 2130750, for the period July 1, 2004 through June 30, 2005. We identified $9,506.72 in findings plus $2,234.05 in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After May 13, 2008, additional interest will accrue at $2.05 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 Section 5101:3-1-25(A) 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' Legal Office at (614) 466-4605.

Copies of this report are being sent to McKinley Health Care Center, LLC, 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).

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,

Mary Taylor, CPA
Auditor of State

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

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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
NF	Nursing Facility
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

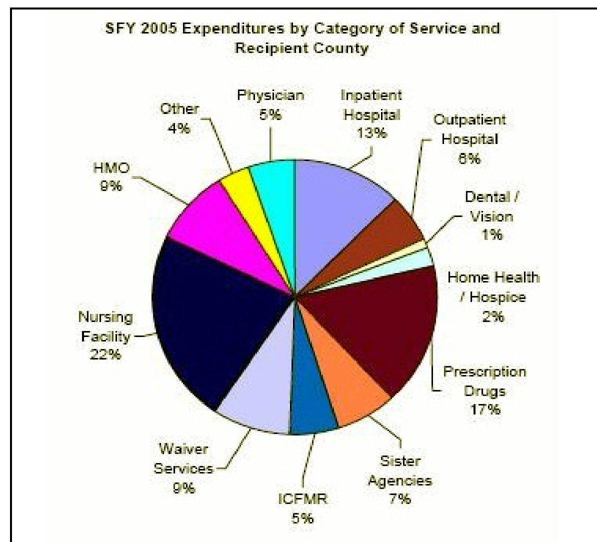
The Auditor of State performed an audit of McKinley Health Care Center, LLC (hereafter called the Provider), Provider number 2130750, doing business at 800 Market Avenue North, Canton, Ohio 44702.. We performed our audit in accordance with Ohio Rev.Code § 117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified $9,506.72 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest of $2,234.05 are repayable to ODJFS. Additional interest of $2.05 per day will accrue after May 13, 2008 until repayment.[1]

We are issuing 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 medical services to Medicaid patients. Under that new authority, providers who render services to patients residing in nursing facilities (NF) were selected for audit.

Table 1: Ohio Medicaid Expenditures[2]



[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 May 18, 2005, 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. NF expenditures were almost 30 percent higher than the second largest expenditure: prescription drugs.

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 (NF) 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 will be 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 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 NFs and ICFs-MR. This section states in pertinent part:

> As a condition of participation in the Title XIX medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICFs-MR) shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, [JFS 02524-appendix A of rule 5101:3-3-20.2 of the Administrative Code] including its supplements and attachments as specified under paragraphs (A) to (M) of this rule or other approved forms for the state-operated ICF's-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 of the Administrative Code, 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 nursing facilities 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 $5,834,070.09 (excluding Medicare crossovers), for 1,402 monthly room and board claims, with a total of 41,455 patient days, for 178 patients. Following a notification letter, we held an entrance conference at the Provider's place of business on April 27, 2006 to discuss the purpose and scope of our audit.

We used the Ohio Rev.Code and the Ohio Admin.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. 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 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:

- 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 tests for duplicate payments and for deceased patients were both negative.

Our fieldwork was performed between May 2006 and April 2007.

FINDINGS

We identified findings of $164.05 for incorrectly billed room and board services for patients. An additional $9,342.67 in findings was identified for incorrectly billed therapy services. The total findings of $9,506.72 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 audit period.
- Compared each month's 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 claims for the patients.
- 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 amount from the amount reimbursed to the Provider for that month and the difference became a finding.
- Reviewed various data sources, such as the patients' accounts receivable registers and ODJFS' remittance advices, to determine if any payment adjustments had been made for that month. If any adjustments were found, the adjustment amount was subtracted from the findings.

We reviewed all 1,402 monthly room and board claims within our audit period and found two instances where bed-hold days were paid at 100 percent of the per diem instead of 50 percent. 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 found incorrect payments which resulted in potential findings of $164.05.

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 1,045 therapy services during the audit period for which they were reimbursed $30,412.67. The rendered services included physical and occupational therapy evaluations, neuromuscular re-education, and therapeutic exercises. We reviewed a sample of 100 recipient dates of services (comprising 182 services) and identified 62 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 nine services, and two services were billed using an incorrect Health Care Procedural Coding System (HCPCS) Code.

Therefore, we disallowed the reimbursement for these services, resulting in actual overpayments prior to projection of $1,621.22.

We took exception with 73 of 182 statistically sampled recipient services (59 of 100 recipient dates of service) from a statistical random sample of the Provider's population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review.) Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $21,070, with a 95 percent certainty that the actual correct

payment amount fell within the range of $19,070 to $23,071 (+/- 9.49 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population amount ($21,070) from the amount paid to the Provider for this population ($30,412.67), which resulted in a finding of $9,342.67. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Therefore, a finding for therapy services was made in the amount of $9,342.67.

Summary of Findings

A total of $9,506.72 in findings was identified. These findings result from the combination of our findings from incorrectly billed room and board services ($164.05) and projected findings from incorrectly billed therapy services ($9,342.67). Findings plus accrued interest of $2,234.05 (applicable only to therapy services) result in a total amount repayable to ODJFS of $11,740.77.

PROVIDER'S RESPONSE

A draft report was mailed to McKinley Health Care Center on December 6, 2007 to afford the Provider an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently requested and received an extension until January 15, 2008 to submit its response. On January 7 and 14, 2008, we received additional documentation for therapy services and adjustment information for room and board payments that was not available during the fieldwork phase of the audit.

Our review of the additional documentation revealed that appropriate adjustments had been made to the room and board payments, reducing the finding amount from $178,884.93 to $164.05. Further, our review of the additional therapy documentation resulted in a re-projection and ultimately a reduction in the finding amount from $9,579.00 to $9,342.67.

APPENDIX I

Summary of Statistical Sample Analysis of McKinley Health Care, LLC
Nursing Facility Services Sample
Audit Period: July 1, 2004 through June 30, 2005

Description	Audit Period July 1, 2004 - June 30, 2005
Type of Examination	**Statistical Random Sample of RDOS**
Number of Population Recipient Dates of Service (RDOS)	**569**
Number of Population RDOS Sampled	**100**
Number of Population Services Provided	**1,045**
Number of Population Services Sampled	**182**
Total Medicaid Amount Paid for Population	**$30,412.67**
Actual Amount Paid for Population Services Sampled	**$5,324.26**
Projected Correct Population Payment Amount	**$21,070**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$23,071**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$19,070**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$9,342.67**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$2,000 (+/- 9.49%)**

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

Mary Taylor, CPA
Auditor of State

McKINLEY HEALTH CARE CENTER, LLC

STARK 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
MAY 13, 2008

88 E. Broad St. / Fourth Floor / Columbus, OH 43215-3506
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us