



Dave Yost • Auditor of State

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Lincare, Inc. (Franklin County)*

A Compliance Audit by the:

Medicaid/Contract Audit Section



Dave Yost • Auditor of State

January 17, 2012

Jenna Pederson
Corporate Compliance Officer
Lincare, Inc.
19387 US 19N
Clearwater, FL 33764

Re: *Medicaid Provider No. 2142069*

Dear Ms. Pedersen:

We enclose our audit report on Medicaid reimbursements made to Lincare Inc., Medicaid provider number 2142069, for the period November 1, 2007 to October 29, 2009. Our audit was performed according to our authority in Ohio Rev. Code § 117.10 and our Letter of Arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified \$64,993.00 in findings for improper charges to Ohio Medicaid plus \$9,558.42 in interest totaling \$74,551.42 that is due and payable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After January 17, 2012, additional interest will accrue at \$14.25 per day until repayment occurs. Interest is calculated pursuant to Ohio Admin. Code § 5101:3-1-25.

We are forwarding this report to ODJFS because it is the state agency charged with administering Ohio's Medicaid program. ODJFS is responsible for making a final determination regarding recovery of our findings and any accrued interest. However, if you agree with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are being sent to the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Respiratory Care Board. In addition, copies are available on the Auditor of State website at www.auditor.state.oh.us.

Jenna Pedersen, CCO
Lincare, Inc.
January 17, 2012
Page 2

Questions regarding this report should be directed to Charles Brown, III, Chief Auditor, Medicaid/Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

A handwritten signature in black ink that reads "Dave Yost". The signature is written in a cursive style with a large, looping "D" and "Y".

Dave Yost
Auditor of State

cc: Stacey Murphy, Division Reimbursement Manager, Lincare, Inc.
Ohio Department of Job and Family Services, Surveillance and Utilization Review
Section
Ohio Attorney General, Medicaid Fraud Control Unit
U. S. Department of Health and Human Services, Office of Inspector General
Ohio Respiratory Care Board

TABLE OF CONTENTS

SUMMARY OF RESULTS	1
BACKGROUND	1
PURPOSE, SCOPE, AND METHODOLOGY	2
RESULTS	2
A. Statistical Sampling of Oxygen Services	3
1. Timing of Oxygen Testing	3
2. Certificates of Medical Necessity	3
3. Medical Evaluations	4
4. Portable Oxygen Services	4
5. Summary of Statistical Sample Results	5
CONCLUSION	5
PROVIDER RESPONSE	5
APPENDIX I	6

ACRONYMS

AOS	Auditor of State
CMN	Certification of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
SPO ₂	Partial Pressure of Oxygen
RMOS	Recipient Month of Service

SUMMARY OF RESULTS

The Auditor of State performed an audit of Lincare Inc., provider number 2142069, doing business at 975 Eastwind Drive, Suite 170, Westerville, Ohio 43081 (Lincare or the Provider). The provider's parent corporation is a national supplier of durable medical equipment with offices in cities all over the United States and throughout Ohio. The provider was one of 34 separate Lincare Inc operations in Ohio during the audit period. Within the Medicaid program, the Provider is listed as a supplies and medical equipment provider.

We performed our audit of Medicaid reimbursements to the provider for oxygen concentrator services between November 1, 2007 and October 29, 2009, according to Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified \$64,993.00 in findings for improper charges to Ohio Medicaid, based on reimbursements that did not meet the rules of the Ohio Administrative Code in effect during the audit period. Additionally, we assessed accrued interest of \$9,558.42 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of \$74,551.42, which is due and payable to ODJFS as of the release of this audit report. Additional interest of \$14.25 per day will accrue after January 17, 2012 until repayment.

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 Ohio Medicaid Provider Handbook. A fundamental concept underlying 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. See Ohio Admin. Code § 5101:3-1-01(A).

The Auditor of State (AOS) performs audits to assess provider compliance with reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, medical necessity, and sound fiscal, business, or medical practices. According to Ohio Admin. Code § 5101:3-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated with the six year period is completed. When the AOS identifies fraud, waste or abuse by a provider in an audit,¹ "any amount in excess of that legitimately due to the provider will be

¹ "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are defined as practices that are inconsistent with professional standards of care;

recouped by ODJFS through its office of fiscal and monitoring services, the state auditor, or the office of the attorney general.” Ohio Admin. Code § 5101:3-1-29(B).

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider’s Medicaid claims for reimbursement of oxygen services were in compliance with regulations and if not, to identify findings from non-compliance.

An entrance conference was held on October 14, 2010, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of November 1, 2007 through October 29, 2009 (excluding Medicaid co-payments for Medicare or third-party insurance claims; or claims containing services outside of the audit period). The Provider was reimbursed \$236,742.45 for 1,944 services for the scope of our audit during the audit period.

A review of the Provider’s paid claims history was obtained from ODJFS’ Medicaid Management Information System (MMIS) database of services billed to and paid by the Medicaid program. The claims data included: patient name, patient identification number, date of service, and reimbursement per service billed. Providers bill services to the Medicaid program using the Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).

The claims analysis revealed that four service codes accounted for approximately 66 percent of the Provider’s reimbursement during the audit period: oxygen concentrator, single delivery port (HCPCS code E1390), stationary liquid oxygen, rental (HCPCS code E0439), portable gaseous oxygen (HCPCS E0431), and portable liquid oxygen (HCPCS code E0434). Oxygen services require that a physician authorize or certify the need for a patient to receive oxygen services by means of a certification of medical necessity (CMN).

A statistically random sample of billed oxygen services was selected to analyze the Provider’s substantive documentation and patient files for the selected services. We performed our fieldwork between October 2010 and September 2011.

RESULTS

We identified findings that projected \$64,993.00 in Medicaid overcharges from our statistical sample. The bases for our findings are discussed below in more detail.

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. Ohio Admin. Code § 5101:3-1-29(A)

A. Statistical Sampling of Oxygen Services

We selected a statistically random sample of oxygen services from the subpopulation of oxygen concentrator and stationary liquid oxygen services billed by the Provider during the audit period. Our sample consisted of 147 oxygen services from 100 recipient months of service (RMOS). A RMOS contains all of the services a recipient received within a specified month. We reviewed patient medical records for the audit period and identified errors with the documentation for 93 services. The reimbursements for these services were disallowed and used in calculating the projected finding of \$64,993. While certain services had more than one error, only one finding was made per service. The bases for these errors are presented below.

1. Timing of Oxygen Testing

One requirement for providing oxygen services is testing patients to determine the level of oxygen in their body. Regulations indicate that either a pulse oximetry (SPO₂) or arterial blood gas (ABG) measurement can be used as the testing method. The provider of oxygen services such as Lincare, may conduct the pulse oximetry test but may not perform an ABG measurement. Ohio Admin. Code § 5101:3-10-13(B)(2).

There are also specific time frames during which SPO₂ testing must occur in order for patients to qualify for oxygen services. *See* Ohio Admin. Code § 5101:3-10-13 (C)(2)(e) and (3)(a).

We found 31 instances where we did not receive documentation to verify the test results written on the CMN.

The reimbursement of the sampled services covered by these tests results were disallowed and used in calculating the projected findings.

2. Certificates of Medical Necessity

A provider of oxygen services must document qualification for Medicaid coverage by obtaining a CMN prior to submitting a claim for reimbursement. *See* Ohio Admin. Code § 5101:3-10-13 (C)(2)(b).

During our review of the patient files of the sampled services we found:

- 42 instances where the CMN was not signed within the required 30 days of the first date of service.
- 31 instances where the CMN was not signed within the required 90 days of the recertification date.
- 6 instances with no CMNs covering the date of the sampled service.

However, before taking a finding for a missing or inconclusive CMN, we reviewed each patient file to determine if other documentation could provide the missing information. We found none.

Consequently, reimbursement for the sampled services covered by these CMNs was disallowed and used in calculating the projected findings.

3. Medical Evaluations

Patients must be evaluated by their physician in order to qualify for oxygen services. See Ohio Admin. Code §§ 5101:3-10-13(C)(2)(e) and 5101:3-10-05(A)(2)(a).

We reviewed the Provider's patient files for recipients receiving oxygen services to determine whether patients were evaluated by their treating physician when receiving prescriptions for oxygen services. The CMNs covering the dates of the sampled service were reviewed, if available, for the date of "last medical examination" field. If the date was blank or there was no CMN, the patient's entire file was reviewed for evidence of the medical examination. We also determined whether the date of last medical evaluation was more than 12 months from the physicians' signature date on the CMN.

We identified errors with the medical exams as follows:

- In 56 instances, documentation could not be found indicating the patient was evaluated by the prescribing physician.
- In 39 instances, the medical exam occurred *after* the initial or recertification date of the oxygen service.
- In 15 instances, the medical exam occurred more than 30 days prior to the initial date of service.
- In 2 instances, the medical exam date was greater than 12 months prior to the physician's signature date of the CMN.

The reimbursements for these services were disallowed and used in calculating the projected findings.

4. Portable Oxygen Services

Portable or ambulatory oxygen systems are a covered service when prescribed as a medically necessary as an adjunct to stationary oxygen service. However, conditions must be met, such as the patient must be mobile within their home and the provider must have documentation that the patient needs the portable oxygen system to accomplish activities outside of their home such as school or work. Ohio Admin. Code § 5101:3-10-13(D)(1) and (D)(2).

Our sample included claims where the Provider billed both stationary (concentrator) and portable oxygen systems for the same patient for the same date of service. However, when we reviewed the patient files to determine whether the need for portable oxygen systems to accomplish outside activities was documented, we did not find such documentation in 49 instances.

We also reviewed the Provider's files to determine whether there was documentation of the delivery of the portable oxygen systems to the patients during the months which the Provider

billed for portable oxygen. See Ohio Admin. Code § 5101:3-10-13(F)(4). In 44 instances we did not find delivery documentation of portable oxygen.

In addition, Ohio Medicaid regulations require that portable and stationary oxygen services billed for a patient whose prescribed liter continuous flow is greater than 4 to bill for both services using one code modified by “QF”, as the reimbursement for the portable service in this instance is included in the reimbursement for the stationary service. In two instances the liter flow of oxygen prescribed for the patient was greater than four however, the Provider did not bill the portable and stationary oxygen services together with modifier QF as required. Therefore, the Provider was overpaid for the services.

The reimbursements for these services were disallowed and used in calculating the projected findings.

5. Summary of Statistical Sample Results

The overpayments identified for 72 of 100 RMOS (93 of 147 oxygen services) from our statistical random sample were projected across the Provider’s paid population of oxygen services. This resulted in a projected overpayment amount of \$76,478 with a 95 percent degree of certainty that the true population overpayment fell within the range of \$62,753 to \$90,203, a precision of plus or minus \$13,725 (17.95 percent). Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain the population overpayment is at least \$64,993. A detailed summary of our statistical sample and projection results is presented in Appendix I.

CONCLUSION

We found the Provider was overpaid by Ohio Medicaid for oxygen services between November 1, 2007 and October 29, 2009 in the amount of \$64,993.00 from statistical sampling of the Provider’s records. This finding plus interest in the amount of \$9,558.42 through January 17, 2012 totaling \$74,551.42 is immediately due and payable to ODJFS as of the date of release of this audit report. After January 17, 2012, additional interest will accrue at the rate of \$14.25 per day until the finding and interest is paid in full.

PROVIDER’S RESPONSE

A draft report along with a detailed list of services for which AOS took findings was mailed to the Provider on November 16, 2011 and the Provider was afforded an opportunity to respond to this audit report. A written response was received from the Provider on December 12, 2011.

APPENDIX I

Summary of Sample Record Analysis for Lincare, Inc. – Franklin County
For the period November 1, 2007 through October 29, 2009
Oxygen Sample Population – Provider Number 2142069

Description	Audit Period [Nov. 1, 2007 – Oct. 29, 2009]
Type of Examination	Random Sample
Description of Population Sampled	All paid oxygen concentrator services excluding Medicare co-payments, and third party claims
Number of Recipient Months of Service Provided	794
Number of Recipient Months of Service Sampled	100
Number of Population Services Provided	1,144
Number of Services Sampled	147
Total Medicaid Amount Paid For Population Sampled	155,796.58
Amount Paid for Population Services Sampled	19,560.93
Projected Population Overpayment Amount	\$76,478
Upper Limit Overpayment Estimate at 95% Confidence Level	\$90,203
Lower Limit Overpayment Estimate at 95% Confidence Level	\$62,753
Precision of Population overpayment projection at the 95% Confidence Level	13,725 (17.95 percent)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare Audits) Used for Finding Amount	\$64,993

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LINCARE, INC.

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
JANUARY 17, 2012