STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Professional Medical Equipment Services

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

March 2001 *AOS/FWAP-01-035C*

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

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Mike Detweiler, Chief Financial Officer
Professional Medical Equipment Services
4719 Fulton Rd.
Canton, Ohio, 44718

Dear Mr. Detweiler:

We have completed our audit of selected medical services rendered to Medicaid recipients by Professional Medical Equipment Services for the period January 1, 1995 through June 30, 2000. We identified findings in the amount of $375,965.36, which must be repaid to the Ohio Department of Job and Family Services. The attached report details the basis for the findings.

In light of your agreement that an overpayment occurred and your request to repay over time, we are referring this matter to the Ohio Attorney General's Office, which has authority to make payment arrangements. In the event you are able to repay in full, please use the Provider Remittance Form at the back of this report to assure that you receive proper credit. We appreciate your cooperation during the course of our review.

If you have any questions, please contact Johnnie L. Butts, Jr., Chief of the Fraud, Waste and Abuse Prevention Division at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

March 6, 2001

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ABBREVIATIONS

AMA	American Medical Association
AOS	Auditor of State
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

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SUMMARY OF RESULTS

The Auditor of State performed a review of Professional Medical Equipment Services, Provider Number 0227918, doing business at 4719 Fulton Rd, Canton, Ohio 44718. During this audit, findings amounting to $375,965.36 were identified for recovery. The cited funds are recoverable as they resulted from Medicaid claims submitted by Professional Medical Equipment Services, for services unallowable under the Durable Medical Equipment Manual and the Ohio Administrative Code. Therefore, findings are issued against Professional Medical Equipment Services in the amount of $375,965.36.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews designed 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 issued by ODJFS in the form of an Ohio Medicaid Provider Handbook and Ohio Administrative Code Section 5101:3.

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 judgement 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".

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 they were selected for a compliance review. An Entrance Conference was held on August 24, 2000 at the Provider's facility with Mike Detweiler, Chief Financial Officer, and Kristen Stenger, Office Manager.

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. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],
- Health Care Financing Administration's[2] (HCFA) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during

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

[2]HCFA has federal oversight of the Medicaid program.

the period January 1, 1995 through June 30, 2000. During this audit period, the Provider was reimbursed $1,209,705.05 for 8,264 durable medical equipment services provided to 1,844 Medicaid recipients.

To facilitate an accurate and timely review of paid claims, we performed two separate statistical analyses of recipients. During the first analysis, we took a statistically stratified random sample of 60 recipients who received durable medical equipment services other than long term care oxygen services, and performed a detailed review of the durable medical equipment records supporting the paid claims for these recipients.
We examined the amounts reimbursed by ODJFS and conducted an on-site review of the recipients' records. Based made no monetary findings based on this review.

The second analysis involved only oxygen services provided to recipients in long term care facilities. We took a stratified statistically random sample of 151 monthly oxygen services and performed a detailed review of the Providers' records supporting the paid claims for these services. This sample accounted for $23,212.68 (3.1%) of the total amount reimbursed ($741,569.58) and 3.5% of the total number of services (4,307) billed by the Provider during the audit period for oxygen services delivered at long term care facilities[3]. The Provider did not keep records which quantified the amount of oxygen used during a month as required. However, the Provider kept records for a portion of these files which logged oxygen concentrator meter readings at the beginning and ending of each week and medical records which documented the prescribed liter flow of oxygen for the concentrators. To facilitate a timely review of the records, the Provider agreed to document the liter flow of oxygen and meter readings of the concentrators used per month for the 151 oxygen services in the sample.

FINDINGS

After reviewing the Provider's calculations for the 151 services, we found that the Provider did not document meter readings for 78 of these services. Of the remaining 73 oxygen services, the Provider was overpaid for 1 service. Table 1 summarizes the reimbursements and observed overpayments for the 151 sampled oxygen services.

[3]These totals and percentages are exclusive of duplicate charges and charges incorrectly made for deceased recipients.

Table 1: Reimbursements for 151 Randomly Selected Oxygen Services (January 1, 1995 through June 30, 2000)

Type of Service Documented	Correct Procedure Code	Correct Modifier	Number of Services	Amount Paid to Provider	Overpayment
Oxygen Concentrator for LTCF	Y2076	None & QG	72	$11,131.38	$0
Oxygen Concentrator for LTCF, prescribed oxygen < 1 LPM	Y2076	QE	1	$178.56	$82.14
Oxygen Concentrator for LTCF, no meter documentation	Should not bill	Should not bill	78	$11,902.74	$11,902.74
TOTALS	----------	----------	151	$23,212.68	$11,984.88[4]

Source: Paid Claims contained in ODJFS' Medicaid Management Information System.

The instances of non-compliance resulting in overpayments found in the detailed analysis sample were then projected to the overall population of paid claims using standard sampling projection techniques. This resulted in a finding for $362,757.07 in inappropriate billing for oxygen use. In addition, we found an overpayment of $11,594.41 in billings for deceased recipients, and $1,613.88 in duplicate payments. Our overall finding of $375,965.36 resulted from overpayments in the three categories. The category of finding, the number of instances found, the basis for the overpayment, and the dollar amount overpaid are detailed in the sections below. Appendix I explains to the basis for our statistical projection.

Inappropriate Billing for Oxygen Usage

Pursuant to OAC Section 5101:3-10-13, oxygen services provided in long term care facilities must be billed based on the amount of oxygen used during the billing month as measured by meter reading and they must keep the documentation of oxygen usage. According to OAC Section 5101:3-10-13, (C)(5):

> The amount of oxygen actually used each month (as determined from a meter reading) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of

[4]This is the amount overpaid from the statistical random sample. This number and error rate will be compared to the total population of services for these codes and an estimated overpayment will be calculated.

> the amount of oxygen used each month must be maintained in the provider's file.

Procedure code Y2076 must be used to bill oxygen usage for recipients in a long term care facility. The monthly reimbursement for Y2076 is $178.56 per recipient. According to Ohio Administrative Code 5101:3-10-13 (C)(6):

> Payments for claims for oxygen services with service dates on or after July 1, 1994 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.

As specified in OAC Section 5101:3-10-13(D)(2)(a)(i), modifier code QE shall be used and the payment amount reduced by fifty percent when:

- The prescribed amount of oxygen is 1 liter per minute or less; or
- When the prescribed amount of oxygen is greater than 1 LPM AND the recipient has used more than seven hundred and fifty cubic feet of gaseous oxygen or sixty pounds of liquid oxygen or the equivalent generated by a concentrator, and no more than one thousand cubic feet of gaseous oxygen or eighty pounds of liquid oxygen, or the equivalent generated by a concentrator, in a thirty day billing period.

If the prescribed amount of oxygen is greater than 4 LPM continuous (twenty-four hours per day), the modifier code is QG.. If the prescribed amount of oxygen is greater than 1 LPM and no more than 4 LPM no modifier is used.

During our Entrance Conference we were informed the Provider was not aware of the correct codes used to bill oxygen services in long term care facilities.

Our review of patient records for the 151 randomly selected oxygen services showed that the Provider was overpaid for 79 services because there was no documentation of the services in 78 cases and one service was coded with the incorrect modifier. We calculated the difference between what was billed and reimbursed to the Provider and the established maximum fee for the correct procedure code. We projected the overpayment of oxygen services in the sample to the total population for all oxygen services billed and reimbursed. A finding in this category is made for $362,757.07.

Billing for Deceased Recipients

Pursuant to 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.

During our review of the Provider's paid claims for the period, we discovered 44 recipients with 71 oxygen services billed by the Provider for recipients subsequent to their date of death. The Provider was not aware of the recipients' deaths at the time of billing.

A finding is made for $11,594.41, which represents the amount reimbursed to the Provider for oxygen services billed in any month subsequent to the month of the recipients' death. This total was not part of the total population to which the overpayment described above was projected.

Duplicate Payment

Pursuant to 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.

During our review of the Provider paid claims for the period, we discovered 26 sets of duplicate payments where the Provider billed and was reimbursed for two stationary oxygen services with concentrators, CPT code Y2076, in a nursing home in the same month. Of these services, the Provider was able to show repayment documentation to ODJFS for 17 of the duplicate sets.

A finding is made for $1,613.88, which represents the amount reimbursed to the Provider for 9 (nine) duplicate payments that have not been reimbursed to the ODJFS. This total was not part of the total population to which the overpayment described above was projected.

Other Reportable Conditions

Our review noted four other problem areas as being weaknesses within the oxygen records. These deficiencies were brought to the Providers attention during this review. The four areas where the Provider did not meet the compliance criteria of medical necessity or minium requirements of the program are listed below together with recommendations intended to prevent future instances of non-compliance and lessen the risk of future overpayments.

Outdated Oxygen Prescriptions for Nursing Home Recipients

According to OAC 5101:3-10-05, new prescriptions must be obtained and documented for ongoing services at least every 12 months. We found eight prescriptions in the nursing home sample of oxygen services that were outdated.

Recommendation: The Provider does log expiration dates for all services for tracking purposes. These logs must be maintained, checked and updated at regular intervals. The Provider needs to contact physicians for prescriptions for ongoing services.

Using Prescription of "Oxygen PRN"[5]

All prescriptions for oxygen must specify the oxygen flow rate and duration. OAC 5101:3-10-13 (C)(3) specifically states that prescriptions of "oxygen PRN" without liter flow or indications of usage does not meet the requirements. On the spreadsheet that the Provider filled out for us to record liter flow and hours, the Provider highlighted all oxygen services that used "oxygen PRN" on their prescriptions without specifying a liter flow. A total of 35 "oxygen PRN" services were found in the sample of the nursing home oxygen services.

Recommendation: The Provider should check all oxygen prescriptions for oxygen flow rates and duration (hours per day) of usage and obtain a prescription for specific oxygen usage.

No Prescription of Oxygen Services in Nursing Homes

According to OAC 5101:3-10-05 (A), the Provider needs to keep a copy of the prescription in their records for each claim that is reimbursed by Medicaid. There were 18 services reimbursed by Medicaid that did not have copies of prescriptions in the sample of nursing home oxygen services. Up until this point, the Provider was unaware that they are required to keep prescriptions for oxygen services delivered in nursing homes, assuming that nursing home requests were sufficient documentation.

Recommendation: The Provider must receive a prescription for all services rendered to recipients.

No Documentation of Lab Work for Oxygen Services for Nursing Home Recipients

For recipients who receive oxygen services for six months or more in a nursing home, the Provider must keep a copy of either an arterial blood gas (ABG) or a pulse oximetry (PO2) in certain circumstances. Either of these laboratory reports must be ordered and evaluated by the prescribing physician. The Provider was unaware of this requirement prior to the audit.

Recommendation: The Provider should initiate controls to ensure that necessary documentation of laboratory reports for oxygen services are kept in a patient's file.

Audit of Claims Subsequent to the Audit Period

The Provider has requested that we audit their nursing home oxygen accounts for July 1, 2000 through December 31, 2000. Given that they were unaware of some of the documentation requirements until September 24, 2000, they did not start implementing new procedures until

[5] "Oxygen PRN" is used to mean oxygen as necessary.

October of 2000. Therefore, they want to ensure that all errors are found at this point in time will preclude future audit findings. The AOS agreed to audit a sample of the Provider's nursing home oxygen services and project findings back the population of nursing home oxygen services for July 1, 2000 through December 31, 2000 when the data is available.

PROVIDER'S RESPONSE

A draft of this report was mailed to the Provider on December 06, 2000 to afford the Provider an opportunity to provide additional documentation or otherwise respond in writing. The Provider responded verbally that they agreed with the findings and expressed their desire to make payment arrangements. We told the Provider that any such payment arrangements would need to be made through the Revenue Recovery Section of the Attorney General's Office. Thus, we are referring this report to them for their attention.

APPENDIX I

Table 1: Summary of Analysis of Oxygen Usage in Long Term Care Facilities: Professional Medical Equipment Services
For the period January 1, 1995 to June 30, 2000

Description	Audit Period January 1, 1995- June 30, 2000
Total Medicaid Oxygen Concentrators (LTCF)	**$741,569.58**
Number of Oxygen Services, Procedure Code Y2076	**4,307**
Type of Examination	**Stratified Statistical Random Sample of 151 Oxygen Services, Procedure Code Y2076**
Number of Oxygen Services Sampled	**151**
Amount Paid for Services Sampled	**$23,212.68**
Projected Overpayment From Statistical Sample	**$362,757.07**
Upper Limit at 95% Confidence Level	**$431,390.72**
Lower Limit at 95% Confidence Level	**$294,123.42**

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PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Professional Medical Equipment Services 4719 Fulton Rd. Canton, Ohio, 44718
Provider Number:	0227918
Audit Period:	January 1, 1995 through June 30, 2000
AOS Finding Amount:	$375,965.36
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: Charles T. Carle at (614) 728-7398.

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Facsimile 614-466-4490

PROFESSIONAL MEDICAL EQUIPMENT

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
MARCH 6, 2001