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

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Valley Medical Corporation

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

April 2001 *AOS/FWAP-01-036C*

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

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Mr. Grover L. Davis, Owner
Valley Medical Corporation
3734 B Glenway Avenue
Cincinnati, Ohio 45205

Re: Medicaid Review of Provider Number #0933655

Dear Mr. Davis:

We have completed our review of selected medical services rendered to Medicaid recipients by the Valley Medical Corporation for the period January 1, 1997 through June 30, 2000. We identified overpayments in the amount of $358.192.44, which must be repaid to the Ohio Department of Job and Family Services. A "provider remittance form" is located at the back of this report for remitting payment.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours Truly,

JIM PETRO
Auditor of State

APRIL 3, 2001

TABLE OF CONTENTS

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 Valley Medical Corporation, Provider Number 0933655, doing business at 3734B Glenway Avenue Cincinnati, Ohio 45205-1354. During this audit, findings amounting to $358,192.44 were identified for recovery. The cited funds are recoverable as they resulted from Medicaid claims submitted by Valley Medical, Inc., for services unallowable under the Durable Medical Equipment Manual and the Ohio Administrative Code.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews to assess Medicaid providers' compliance with Federal and State claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a Federal/State financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The Ohio Department of Job and Family Services (ODJFS) administers the Medicaid program. The rules and regulations that providers must follow are 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".

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

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

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program.

PURPOSE SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter they were selected for a compliance review. An Entrance Conference was held on November 28, 2000 at the provider's facility with Grover L. Davis, Owner.

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

[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.

ODJFS' local level codes.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period January 1, 1997 through June 30, 2000. During this audit period, the Provider was reimbursed $392,643.40 for 2,218 durable medical equipment services provided to 382 Medicaid recipients. Ninety nine (99) percent ($391,760.64) of the Provider's total reimbursements were for oxygen usage supplied by concentrator equipment, which is a piece of equipment that "concentrates" room air into oxygen. The Provider almost exclusively billed Procedure Code Y2076 with Procedure Code Modifier QK for these services. Procedure Code Y2076 with the QK modifier is used to claim oxygen usage between 2,001 and 3,000 cubic feet per month.

To facilitate an accurate and timely review of paid claims, we analyzed a statistical random sample of 100 oxygen services. We then performed a detailed review of the Provider's patient records to determine whether they supported the paid claims for these services. Table 1 summarizes the sample.

Table 1: Sample of 100 Randomly Selected Oxygen Services (January 1, 1997 through June 30, 2000)

Type of Service Documented	Procedure Code	Procedure Code Modifier	Number of Services	Amount Provider Reimbursed
Oxygen Concentrator for Long Term Care Facility	Y2076	QK	100	$17,856.00

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

FINDINGS

Our finding of $358,192.44 resulted from overpayments in three areas. The basis for the finding in each area, the number of instances found, and the dollar amount overpaid are detailed below.

Failure to Charge Usual and Customary Fee

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, IV-1 (B), a "provider agreement" is a contract between the Ohio Department of Job and Family services and a provider of medical services in which the provider agrees to comply with the terms of the "provider agreement," state statutes, and Ohio Administrative Code rules, and federal statutes and rules, and agrees to:

> Charge Medicaid no more than the usual and customary fee charged for other patients for the same service.

During the entrance conference the Provider stated that his usual and customary charge was $120.00 per month and /or $30.00 per week for oxygen services, which represented a commercial "discount rate" given to twelve nursing homes serviced by the Provider. We verified the Provider's rates for non-Medicaid patients by contacting several of the nursing homes and obtaining a copy of their contract with Valley Medical, along with copies of invoices for monthly and weekly services that were billed by Valley Medical, Inc. for oxygen via concentrator.

The Medicaid monthly reimbursement for Y2076 is $178.56 per recipient or the Provider's usual and customary fee, which ever is less. Our review of the Providers paid claims showed 2,194 instances where the Provider billed and was reimbursed by ODJFS for oxygen services in excess of the usual and customary amount charged to others for the same service.

We calculated the difference between what was paid to the Provider by Medicaid and the rate charged by the Provider to nursing homes for the audit period, which resulted in findings of $128,480.64.

Other Issues

The following findings are based on an analysis of 100 randomly selected oxygen services billed as CPT code Y2076. We identified findings associated with 97 of the 100 services in our sample.

Oxygen Usage Not Documented

According to OAC 5101:3-10-13 [Oxygen Covered Services and Limitations], Section (C) [Oxygen Services Provided to Residents of Long Term Care Facilities], (2):

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the date of service. The prescription, or certification of medical necessity, must specify; (a) diagnosis; (b) oxygen flow rate; and (c) duration (hours per day); or (d) indications for usage.

OAC 5101:3-10-13, Section (C) (5) adds:

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

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

The review of our statistical random sample of 100 oxygen services identified 77 services where the Provider billed and was reimbursed by ODJFS, but had not documented that oxygen was provided. Specifically, patient records did not contain meter readings to support amounts of oxygen used. Furthermore, 11 of the 77 service records did not contain evidence of a physician's prescription. Without any evidence that services had been provided, and in some cases ordered, we were not able to verify that services had been provided as billed.

Provider Reimbursed Full Month for Partial Month's Service

According to Ohio Administrative Code 5101:3-10-13 (C)(5):

> All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient. The amount of oxygen actually used each month (as determined from a meter reading) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of the amount of oxygen used each month must be maintained in the provider's file.

During our sample review, we identified 20 services where the Provider billed and was reimbursed for a whole month, when the documented meter readings only supported 1 to 2 weeks of services. We concluded that Provider should only have billed and been reimbursed for services actually provided. In as much as the Provider's usual and customary fee for oxygen services was $30 per week, we used that amount to calculate the amount to which the Provider was entitled.

Findings From Sample Review

The findings for no documentation of oxygen usage and the findings for the difference between the Provider's whole month oxygen fee and the Provider's partial month (1-2 weeks) meter readings were projected across the total population of oxygen services paid to Valley Medical. This resulted in findings of $229,711.80.[3]

[3] Note: Calculations for this finding were made after consideration of the finding associated with the Provider receiving more than his usual and customary fee. Therefore, the total finding is $358,192.44.

PROVIDER'S RESPONSE

A draft of this report was mailed to the Provider on February 14, 2001 to afford the Provider an opportunity to provide additional documentation or otherwise respond in writing. The Provider's attorney responded on February 28, 2001 that their client disagreed with the findings on the basis that their client had furnished these services in an appropriate, professional and lawful manner. However, because the Provider failed to provide any additional documentation for us to consider, the Provider is responsible for findings in the amount of $358,192.44 which must be repaid to the Ohio Department of Job and Family Services.

APPENDIX I

**Table 1: Summary of Analysis for Stratified Sample of Valley Medical, Inc.
For the period January 1, 1997 to June 30, 2000**

Description	Audit Period January 1, 1997- June 30, 2000
Number of Oxygen Services, Procedure Code Y2076	**2,218**
Type of Examination	**Statistical Random Sample of 100 Oxygen Services, Procedure Code Y2076**
Number of Oxygen Services Sampled	**100**
Amount Paid for Services Sampled	**$17,856.00**
Projected Overpayment From Statistical Sample	**$229,711.80**
Upper Limit at 95% Confidence Level	**$242,935.59**
Lower Limit at 95% Confidence Level	**$216,488.01**

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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:	Valley Medical Corporation 3734 B Glenway Avenue Cincinnati, Ohio 45205-1354
Provider Number:	0933655
Audit Period:	January 1, 1997 through June 30, 2000
AOS Finding Amount:	$358,192.44
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.

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

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VALLEY 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
APRIL 3, 2001