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

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to American Homepatient

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

June 2002 *AOS/FWAP-02-026C*

STATE OF OHIO
OFFICE OF THE AUDITOR
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David Shirk, Director of Compliance & Reimbursement
American Homepatient
1051 South Town Drive
Waterloo, Iowa 50704

Re: Medicaid Review of Provider Number 2009801

Dear Mr. Shirk:

We have completed our review of selected medical services rendered to Ohio Medicaid recipients by American Homepatient for the period October 1, 1998 through September 30, 2001. We identified findings amounting to $63,301.19, 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

June 18, 2002

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ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
LTCF	Long Term Care Facility(s)
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of American Homepatient, Provider #2009801, doing business at 2415 East High Street, Springfield, Ohio 45505. We identified findings amounting to $63,301.19. The cited funds are recoverable as they resulted from Medicaid claims submitted by American Home Patient for services that did not meet reimbursement rules under the Ohio Durable Medical Equipment Manual and the Ohio Administrative Code (OAC).

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 that they were selected for a compliance review. An Entrance Conference was held on November 26, 2001 at the provider's billing and distribution center in Worthington, Ohio with Ms. Heather Oskowis, billing center 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.

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

[2]The Center for Medicare and Medicaid Services (formerly known as HCFA) has federal oversight of the Medicaid program. HCFA has federal oversight of the Medicaid program.

During our audit period (October 1, 1998 through September 30, 2001), the Provider was reimbursed $719,665.08 for 6,067 durable medical equipment services provided to 699 Medicaid recipients. The scope of our review was limited to $327,742.08 in reimbursements for 2,648 services related to oxygen concentrators for patients residing in a personal residence and patients residing in Long Term Care Facilities (LTFC). These services were billed as procedure code Y2076 for recipients in LTFCs and procedure codes Q0036 and Q0046 for recipients in personal residences.

To facilitate an accurate and timely review of paid claims, we analyzed two statistical random samples of oxygen services. The first sample was comprised of 96 LTCF recipient dates of service, which is defined as all oxygen services for a given recipient on a given day. The second was a stratified sample of 133 home oxygen service TCNs. A TCN is the identifier for a bill for services for one recipient. Together, these two samples accounted for $61,708.39 in Medicaid reimbursement to the Provider during the audit period. The review involved determining whether the Provider's records contained required documentation to support claims payment history from MMIS.

In addition, we looked for "duplicate" payments – payments in which two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We also checked for other types of overpayments, such as payments for services to recipients who were deceased at the time of service and whether the Provider charged Medicaid more than their usual and customary fee for oxygen concentrator services.

Work performed on this audit was done in accordance with government auditing standards. Detailed below are the results of this review.

FINDINGS

We identified findings in six areas during our review: No Patient Charts (Residents of Long Term Care Facilities and Recipients Residing in a Personal Residence), No Physician Orders and No Physician Signatures, No Meter Readings, Services Billed for Deceased Recipients, and Duplicate Payments. The total findings for all of the six categories amounted to $63,301.19. Although we made no monetary finding, we are also recommending that the Provider maintain delivery tickets to support that patients received oxygen equipment. The basis for the finding in each area, the number of instances found, and the dollar amount are detailed below.

No Patient Charts (Residents of Long Term Care Facilities and Recipients Residing in a Personal Residence)

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.

According to the Ohio Medicaid Provider Handbook, Chapter 3334 (IV-B), states..the provider must 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 or until any initiated audit is completed, whichever is longer.

Out of 96 sampled recipient dates of service for ***Residents of Long Term Care Facilities***, we identified 21 dates of service that were missing a patient chart in support of oxygen services billed by the Provider.

Out of 133 sampled claims for ***Recipients Residing in a Personal Residence***, we identified 9 claims that were missing a patient chart in support of oxygen services billed by the Provider.

No Physician Order and No Physician Signature

According to the Ohio Administrative Code, Section 5101:3-10-05 (A),

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . . For medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code.

Prescriptions for durable medical equipment services are a physician's tool to verify that a patient truly needs medical goods and/or services. By retaining prescriptions, the durable medical equipment supplier verifies the need to provide all necessary medical equipment for a patient. For ongoing prescriptions, the medical equipment supplier must verify that more services are necessary by obtaining a new prescription every twelve months.

In our sample review of oxygen services provided to ***Residents of Long Term Care Facilities***, we found 14 of the 96 recipient dates of service were not supported by a prescription.

No Meter Readings

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

> 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.

All oxygen services are billed according to the amount of oxygen used, in cubic feet. Providers must use the meter reading in part of the calculation to determine the cubic feet of oxygen used for the month's services. Therefore, a meter reading is essential in determining the correct code to bill for oxygen services.

During our review of the Provider's oxygen records, patient records did not contain meter readings to support amounts of oxygen used. Specifically, we found 47 out of the 96 sampled claims where the Provider billed and was reimbursed for oxygen services provided to residents of long term care facilities where there were no meter readings documented in the patients' files. Without these meter readings, the Provider could not have determined the correct level of oxygen to claim for reimbursement on these services.

Findings Projection for Long Term Care Facilities

We projected the total number of errors (including no patient charts, no physician orders or no physician signatures, and no meter readings) found for ***residents of long term care facilities*** who received oxygen services billed as procedure codeY2076. This was projected across the entire population of recipient dates of service to determine a finding amount. Based on the 84 dates of service with errors found in our sample, we projected the total finding to be $48,831.14, with a 95% certainty that it fell between $45,665.08 and $51,997.20.

Findings Projection for Personal Residence

We identified 9 sampled claims, in our sample that did not meet Medicaid requirements for reimbursement which were projected across the total population of recipients ***residing in a personal residence***, procedure codes Q0036 and Q0046, paid to the Provider. This resulted in a projected finding of $12,641.32. The finding was calculated by projecting the correct population reimbursement amount ($256,864.59) and taking the difference between it and the actual amount paid to the provider ($269,505.91) during our audit period. The projected correct population reimbursement of $256,864.59 has a 95 percent certainty that the true population value would fall within the range of $265,826.24 to $245,357.30, a precision of +/- 4.48%.

Findings for Services Billed 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.

In our deceased recipient test, we found 2 oxygen services provided to recipients residing in a personal residence where the Provider had received reimbursements for deceased recipients. Therefore, an actual finding was made for $221.69, which represents the amount reimbursed to the Provider for services billed in months subsequent to the month of the recipients' deaths.

Findings for Duplicate Payments

We found one recipient date of service in which there were two billings for oxygen services provided to a resident of long term care facilities by the Provider. We determined a duplication occurred by identifying the Provider billed for the same recipient on the same day and received reimbursements for both claims rendering an overpayment of $178.56.

In addition to our field review, we checked for instances of duplicate claims...two or more claims filed for the same procedure code, the same recipient, and the same month of service. We analyzed the Provider's paid claims history for the audit period and identified 8 pairs of claims that appeared to include a duplicate claim. All 8 of the pairs involved one claim submitted by American Homepatient and one claim submitted by another provider. In one of the pairs, the other provider submitting the duplicate claim was another branch of American Homepatient who has a different provider number. We sent out a letter to the Provider on January 9, 2002 asking that they forward any relevant documentation to verify these billings to the Auditor of States Office on or before January 18, 2002.

Since the deadline has expired, with no documentation being received, we have rendered these services ineligible for reimbursement under the rules of the Ohio Department of Job and Family Services (ODJFS) Durable Medical Equipment Services Handbook. The total finding amount of $1,428.48 must be must be repaid to the Ohio Department of Job and Family Services since it was reimbursed for duplicate billings.

Need to Maintain Equipment Delivery Documentation

According the OAC 5101-3-10-13 (F)(1) and (H)(1)... Oxygen services are paid on a monthly basis. 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 plus the usual and customary monthly rental charge for equipment and supplies; e.g., concentrator, stand or cart, regulator with flow gauge, humidifier, cannula or mask, and tubing. Billed charges for gaseous and liquid oxygen shall be the provider's usual and customary charge for the oxygen actually used by the recipient. For recipients receiving gaseous or liquid oxygen, documentation of the amount of oxygen actually used each month (as determined from a meter reading or documented refill amount and delivery information) must be

maintained in the provider's file.

Although we are not identifying monetary findings, our review noted one other deficiency in the Provider's oxygen records. For oxygen services provided to ***recipients residing in a personal residence and long term care facilities***, we noted that 4 patient charts did not have delivery tickets. Delivery tickets are necessary to verify that equipment was delivered to the patient for oxygen services.

Recommendation

The Provider should ensure that delivery tickets are kept in the patient's chart to verify that services were rendered and medically necessary.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on May 13, 2002, to afford them an opportunity to provide additional documentation or otherwise respond in writing. We subsequently contacted the Provider several times to solicit their comments but no response or additional documentation was received. The Provider is aware that the finding, if not paid in 45 days, will be referred to the Attorney General's Office for collection.

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APPENDIX I
Table 1: Summary of Overpayment Results for American Homepatient
For the period October 1, 1998 to September 30, 2001

Description	Audit Period October 1, 1998 to September 30, 2001
Oxygen Services Provided to Residents of Long Term Care Facilities (Projected to the Population)	$48,831.14
Services Provided to Recipients Residing in a Personal Residence (Projected to the Population)	$12,641.32
Actual Finding for Deceased Recipients	$221.69
Actual Findings for Duplicate Payments	$1,607.04
TOTAL FINDINGS	$63,301.19

APPENDIX I
Table 2: Summary Projection for American Homepatient
Oxygen Services Provided to Residents of Long Term Care Facilities
For the period October 1, 1998 to September 30, 2001

Description	Audit Period October 1, 1998 to September 30, 2001
Total Medicaid Amount Paid for Oxygen Services	$55,943.34
Number of Oxygen Recipient Dates of Service	323
Type of Examination	Random sample of Oxygen Recipient Dates of Services Provided to Residents of Long Term Care Facilities.
Number of Oxygen Recipient Dates of Services Sampled	96
Amount Paid for Services Sampled	$16,574.10
Projected Overpayment From Statistical Sample	$48,831.14
Upper Limit at 95% Confidence Level	$51,997.20
Lower Limit at 95% Confidence Level	$45,665.08

APPENDIX I
Table 3: Summary Projection for American Homepatient
Oxygen Services Provided to Recipients Residing in a Personal Residence
For the period October 1, 1998 to September 30, 2001

Description	Audit Period October 1, 1998 to September 30, 2001
Total Medicaid Amount Paid for Oxygen Services	$269,505.91
Number of Oxygen TCNs (Claims)	1,285
Type of Examination	Stratified random sample of Oxygen Services Provided to Recipients Residing in a Personal Residence.
Number of DME Services Sampled	133
Amount Paid for Services Sampled	$45,134.29
Projected Correct Population Payment	$256,864.59
Upper Limit Population Correct Payment at 95% Confidence Level	$265,826.24
Lower Limit Population Correct Payment at 95% Confidence Level	$245,357.30
Projected Overpayment From Statistical Sample ($269,505.91 - $256,864.59)	$12,641.32

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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:	**American Homepatient** **655 Dearborn Park Lane** **Worthington, Ohio 43085-5702**
Provider Number:	**2009801**
Review Period:	**October 1, 1998 through September 30, 2001**
AOS Finding Amount:	**$63,301.19**
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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AMERICAN HOMEPATIENT

CLARK 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
JUNE 18, 2002