Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Responsive Home Health Care, Inc. d.b.a. Richards Medical

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 30, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Responsive Home Health Care, Inc.
d.b.a. Richards Medical
Provider Number: 2069363

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Responsive Home Health Care, Inc. d.b.a. Richards Medical for the period April 1, 2002 through March 31, 2005. We identified $34,159.18 in findings that are repayable to the State of Ohio. We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make a final determinations regarding recovery of the findings and any interest accruals.

Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers and Section 117.10 of the Ohio Revised Code. The specific procedures employed during this audit are described in the scope and methodology section of this report.

Copies of this report are being sent to Responsive Home Health Care, Inc. d.b.a. Richards Medical and the Ohio Attorney General. In addition, copies are available on the Auditor's web site (www.auditor.state.oh.us).

If you have questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Responsive Home Health Care, Inc. d.b.a. Richards Medical (hereafter called the Provider), Provider # 2069363, doing business at 826 Cookson Ave. SE, New Philadelphia, OH 44663. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) and in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified $34,159.18 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook.

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make a final determination regarding recovery of the findings[1] identified herein, and any interest accruals.[2]

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. The fundamental concept of 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.[3] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

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. It also includes certain medical supplies, which are "consumable, disposable, or have a limited life expectancy."

Ohio Adm.Code 5101:3-1-17.2(D) states that 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

[1] Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

[2] Ohio Adm.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 Adm.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was March 30, 2005, the latest payment date in the population.

[3] See Ohio Adm.Code 5101:3-1-01(A) and (A)(6)

date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

In addition, Ohio Adm.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."

Ohio Adm.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."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical 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 medical equipment supplier.

Following a notification letter, we held an entrance conference at the Provider's place of business on June 15, 2005 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2002 through March 31, 2005. During this period (the audit period), the Provider was reimbursed $367,905.76 for 3,695 services rendered on 2,114 claims.

We used the Ohio Revised Code, the Ohio Administrative Code, and the Ohio Medicaid Providers Handbook 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, 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. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[4]

[4] These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.

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:

- Billings for deceased recipients for dates of service after their date of death.
- Supplies dispensed in excess of Medicaid maximum allowable prices or quantities.
- Duplicate oxygen services billed by and paid to the Provider.
- Duplicate oxygen services billed by and paid to two different providers, one of which was Responsive Home Health Care.
- Verifying that the living arrangement of recipients for the time span of the billed service was a personal residence.
- Incorrect billing of a portable oxygen system in conjunction with a stationary unit.
- Services reimbursed greater than the maximum amount set forth by Medicaid payment schedules.

The tests for deceased recipients and living arrangements were negative, but the remaining exception tests identified potentially incorrect payments. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially incorrect payments identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a statistically random sample of 131 claims, containing a total of 368 services.

Our work was performed between November 2004 and October 2005.

RESULTS

We identified $8,629.51 in findings from our exception analyses and $25,529.67 in projected findings from our statistically random sample. The total findings of $34,159.18 are repayable to ODJFS and are discussed in more detail below.

Exception Test Results

Supplies Exceeding the Medicaid Maximum

Ohio Adm.Code 5101:3-10-03 states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule…
>
> ***

Appendix A establishes maximum dollar amounts and/or quantities that Medicaid will cover for specific items. This appendix also defines some items supplied by Medicaid as "rent to purchase" items.

Items Exceeding "Rent to Purchase" Price

Ohio Adm.Code 5101:3-10-03(G) states in pertinent part: "'R/P' means item may be purchased or rented until purchase price is reached." We identified several items billed by the Provider where the cumulative rental billings exceeded the purchase price. Table 1 lists these items and the corresponding overpayment.

Table 1: Listing of Items Exceeding "Rent to Purchase" Price

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Number of Exceptions	Overpayment
E0180	Pressure pad, alternating with pump, complete	1 per 4 years R/P price of $138.00	11	$302.80
E0570	Nebulizer with compressor	1 per 5 years R/P price of $133.00	221	$5,165.90
E0601	Nasal continuous airway pressure (CPAP)	1 per 4 years R/P price of $775.00	1	$133.00
E0910	Trapeze bar, bed mounted with grab bar	1 per 8 years R/P price of $101.00	9	$278.60
E0940	Trapeze bar, freestanding, complete with grab bar	1 per 8 years R/P price of $130.00	4	$161.00
		Total	***246***	***$6,041.30***

Source of Medicaid Maximum Allowed: Ohio Adm.Code 5101:3-10-03, Appendix A – Medicaid Supply List.

Source of Estimated overpayments and exceptions: AOS analysis of the Provider's paid claims in MMIS and provider patient records for April 1, 2002 through March 31, 2005.

Items Dispensed in Excess of the Medicaid Maximum

Our computer analysis identified two services where the Provider billed and was reimbursed for supplies that exceeded the maximum quantity allowed. The Provider was reimbursed over the maximum quantity for HCPCS K0183 (nasal application device, used with CPAP), which has an allowable quantity of one device every year. The Provider supplied two recipients with two devices within a year. Therefore, we allowed the reimbursement of the first device and took exception with the reimbursement of the second device for each recipient, identifying findings totaling $133.42.

Surgical Gloves Billed with Erroneous Units of Service

Ohio Adm.Code 5101:3-10-03(F) defines the "Max Units" indicator:

> A maximum allowable (MAX) indicator means the maximum quantity of the item which may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the

> quantity authorized will be based on medical necessity as determined by the department.

On April 1, 2003, the reimbursement rate for non-sterile surgical gloves (HCPCS A4927) changed from $0.22 *per glove* to $8.69 *per box* of 100 gloves. Concurrently, the definition of a "unit of service" changed from "per individual glove" to "per box of 100 gloves." During our review of the Provider's claims, we identified overpayments that appeared to result from the Provider continuing to bill "per glove," instead of "per box," which resulted in overpayments. We identified one service, where the Provider improperly billed and was overpaid for HCPCS A4927. After adjusting the amount paid to the Provider to account for the actual units supplied, we identified findings totaling $13.31.

Oxygen Services Exceptions

Duplicate Claims

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for services actually performed…
>
> ***

During our field review, we checked for duplicate claims in which two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We noted two different types of duplicates where this occurred.

The first duplicate type identified were those instances where duplicate claims were filed by the Provider. The second type identified involved duplicate claims submitted by the Provider and another oxygen provider. We analyzed the Provider's paid claims history and patient record files for the audit period and determined whether multiple services had been rendered or duplicate billing had occurred.

For the first duplicate type, our computer analysis identified one potential duplicate billing where the Provider billed for more than one oxygen service for the same recipient in the same month. During our review, we found documentation supporting that only one service had been provided for the potential duplicate combination, and the Provider concurred that a billing error could have occurred. Therefore, we disallowed the reimbursements for one service. Findings for this exception totaled $180.94.

For the second duplicate type, our computer analysis identified four potential duplicates (nine services) where the Provider and another provider billed for oxygen services for the same

recipient in the same month. We limited our review of these potential duplicates to supporting documentation maintained by the Provider in determining which provider supplied the service. We identified four services where no documentation was supplied to support that the service was rendered. As a result, we disallowed the reimbursement for these services and identified findings totaling $608.57.

Inappropriately Modified Service

Ohio Adm.Code 5101:3-10-13(C)(3) states in pertinent part:

> Modifier code QF shall be used and the payment amount increased by fifty per cent when:
>
> ***
>
> b) The prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is also prescribed…

Our computer analysis originally identified 17 services where the Provider billed for HCPCS Q0046 (portable oxygen) in conjunction with HCPCS Q0036 (oxygen concentrator, personal residence) with a QF modifier. Normally, a provider is not entitled to separate reimbursement for HCPCS Q0046 because the reimbursement for HCPCS Q0036 with a QF modifier includes reimbursement for portable oxygen. In these cases, however, because patient records indicated that oxygen from the concentrator was not being dispensed continuously, .the Provider was entitled to bill separately for portable oxygen, but not for the modified oxygen concentrator services. Therefore, we took the difference between a modified Q0036 claim and an un-modified Q0036 claim ($96.72 in findings for each service). Findings totaled $1,644.24.

Reimbursement Amount Greater than Allowed Amount

Ohio Adm.Code 5101:3-10-13(C)(1) states in pertinent part:

> Modifier code QE shall be used and the payment amount reduced by fifty percent…

Our computer analysis identified one service where the reimbursement for a QE modified claim for Q0036 was not appropriately reduced by 50 percent. Therefore we took the difference between the amount reimbursed ($104.45) and the allowed amount ($96.72) for a HCPCS Q0036 service with a QE modifier. Findings totaled $7.73.

Sample Results

Our sample was a stratified random sample of 368 services (131 reimbursement claims). This statistical sample was taken from a subpopulation of 3,422 services (1,880 claims) that excluded all Medicare co-payments and all services already identified by our exception tests for 100

percent review. This sample identified 37 services (11 claims) that were overpaid and which resulted in projected findings of $25,529.67. The bases for these findings are presented below.

Billing Inappropriate for Documented Liter Flow

Ohio Adm.Code 5101:3-10-13(C) states in pertinent part:

> (1) Modifier code QE shall be used and the payment amount reduced by fifty percent when:
>
> (a) The prescribed amount of oxygen is one liter per minute or less…
>
> ***
>
> (2) Modifier code QG shall be used and the payment amount increased by fifty per cent when:
>
> (a) The prescribed amount of oxygen is greater than four liter per minute continuous…
>
> ***

During our field review, we identified 18 services where the documented liter flow did not support the Provider's billings. We identified six services where the flow rate was 1 liter per minute and required billing with a QE modifier. Because the Provider had not modified billings for these services, we reduced the reimbursement by 50 percent (the maximum amount allowed) in accordance with Ohio Adm.Code 5101:3-10-13(C)(1)(a). This reduction resulted in actual overpayments prior to projection of $580.32.

In addition, we identified 12 services billed with a QG modifier where the flow rate was not documented as continuous in accordance with Ohio Adm.Code 5101:3-10-13(C)(2)(a). Therefore, we reduced the reimbursement for these services to an unmodified HCPCS Q0036 and took the difference between what was paid and what should have been paid as an overpayment. Actual overpayments prior to projection were $1,160.64.

Missing Annual Renewal for Oxygen Services

Ohio Adm.Code 5101:3-10-13(A)(1) states in pertinent part:

> A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.

During the field review, we identified eight services where the Provider did not obtain a renewed order for oxygen services at least annually. Therefore, we were unable to verify that a physician found these services medically necessary and beneficial to the patient's health. We disallowed

the reimbursement for these services, resulting in actual overpayments prior to projection of $886.76.

Erroneously Billed Portable Oxygen Services

Ohio Adm.Code 5101:3-10-13(B) states in pertinent part:

> A portable oxygen system is covered…Additional criteria is as follows:
>
> ***
>
> (2) The qualifying blood gas study must be performed while at rest (awake) or during exercise.
>
> ***

During the field review, we identified 11 services where the portable oxygen service (HCPCS Q0046) should not have been reimbursed. The qualifying studies (a pulse oximetry reading) for these 11 services were performed while the recipients were asleep. According to Ohio Adm.Code 5101:3-10-13(B)(2), the study must be performed while the recipient is at rest (awake) or during exercise. Therefore, we disallowed the reimbursement for these services which totaled $310.75 in actual findings prior to projections.

Sample Projection

We took exception with 37 of 368 statistically sampled recipient services (11 of 131 claims) from a stratified 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 $332,271.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $310,794.00 to $353,748.00 (+/- 6.46 percent.) We then calculated audit findings repayable to ODJFS by subtracting the projected correct payment amount ($332,271.00) from the amount paid to the Provider for this population ($357,800.67), which resulted in a finding of $25,529.67. A detailed summary of our statistical sample and projection results is presented in Appendix I.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on November 28, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider's corporate office, Rotech Healthcare Inc., subsequently submitted a letter on December 20, 2005 which states the following: "We have reviewed all of your enclosures regarding the Medicaid Provider Audit and we do not contest your findings totaling $34,159.18." The Provider's response is being sent separately to ODJFS for their use in recovering the findings.

APPENDIX I

**Summary of Statistical Sample Analysis of Responsive Home Health Care, Inc.
d.b.a. Richards Medical
Audit Period: April 1, 2002 – March 31, 2005**

Description	Audit Period Apr. 1, 2002 – Mar. 31, 2005
Type of Examination	**Stratified Random Sample of Claims**
Description of Population	**Oxygen Service Claims Excluding Medicare Cross-over Payments and Services Selected for 100 % Exception Review**
Number of Population Claims (TCN)	**1,880**
Number of Population TCN Sampled	**131**
Number of Population Services Provided	**3,422**
Number of Population Services Sampled	**368**
Total Medicaid Amount Paid for Population	**$357,800.67**
Actual Amount Paid for Population Services Sampled	**$53,522.97**
Projected Correct Population Payment Amount	**$332,271.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$353,748.00**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$310,794.00**
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	**$21,477.00 (+/- 6.46%)**
Projected Overpayment Amount (Finding) = Actual Amount Paid for Population Services Sampled – Projected Correct Population Payment Amount	**$25,529.67**

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

APPENDIX II
Summary of Overpayment Results for:
Responsive Home Health Care, Inc.
d.b.a. Richards Medical
For the period April 1, 2002 to March 31, 2005

Description	Audit Period April 1, 2002 to March 31, 2005
Supplies Exceeding the Medicaid Maximum	$6,174.72
Surgical Gloves Billed with Erroneous Units of Service	$13.31
Oxygen Services Exceptions	$2,441.48
Projected Findings for Statistical Sample	$25,529.67
TOTAL	**$34,159.18**

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

Auditor of State
Betty Montgomery

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RESPONSIVE HOME HEALTH CARE

TUSCARAWAS 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
DECEMBER 30, 2005