Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Omnicare Respiratory Services DBA Respiratory Care Resources

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

October 19, 2006

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

Re: Audit of Omnicare Respiratory Services
DBA. Respiratory Care Resources
Provider Number: 2336510

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Omnicare Respiratory Services, doing business as Respiratory Care Resources for the period April 1, 2002 through March 31, 2005. We identified $1,978,108.65 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 Omnicare Respiratory Services, d.b.a Respiratory Care Resources, the Ohio Attorney General, and the Respiratory Board. 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
DBA	Doing Business As
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
LTCF	Long Term Care Facility
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Omnicare Respiratory Services DBA Respiratory Care Resources (hereafter called the Provider), Provider # 2336510, doing business at 4824 Socialville Foster Rd.; Suite 100; Mason, OH 45040. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified $1,978,108.65 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] 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 provider 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, such as oxygen, 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: "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 subpopulation used for analysis.*

[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 July 27, 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 $3,909,047.89 for 23,633 services rendered on 23,623 claims. About 79.9 percent of these reimbursements and 95.3 percent of the services were for providing oxygen services to Medicaid recipients.

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 tests included checks for:

- Services billed to deceased recipients for service dates after their date of death.
- Potentially duplicate oxygen services billed by the Provider. (Defined as more than one oxygen service billed for the same recipient, for the same month of service, and by the Provider.)
- Potentially duplicate oxygen service combinations billed by the Provider and another provider. (Defined as more than one oxygen service billed for the same recipient, for the same month of service, and by the Provider and a different provider.)
- Oxygen services billed for places of service not covered by the procedure code used.
- Supplies dispensed in excess of the Medicaid maximum allowable price or quantity.

All of the exception tests identified potentially incorrect reimbursements. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations claims identified by our exception analyses.

Additionally, we reviewed the Provider's nursing home contracts for the audit period to determine whether the Provider charged Medicaid more than their usual and customary fee for oxygen concentrator services. This test was performed because past AOS audits identified providers who appeared to be charging Medicaid more for oxygen concentrators in a long-term care facility than the fee charged to commercial clients.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a statistically random sample of 246 oxygen claims (246 services).

Our work was performed between November 2004 and September 2006.

RESULTS

We identified $7,967.96 in findings from our exception tests, $418,730.87 in projected findings from our statistical sample, and $1,551,409.82 for services reimbursed in excess of the Provider's usual and customary fee.

The total findings of $1,978,108.65 are repayable to ODJFS and are discussed in more detail below.

Exception Test Results

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…

***

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

(B) Portable oxygen systems.

***

(4) In a long term care facility, rented oxygen systems are included in the cost report and are not separately billable. Purchased oxygen systems will be denied as noncovered.

***

(H) …Payment for oxygen services for recipients in an LTCF is as follows:

(1) …The amount of oxygen actually used each month…must be determined and documented by the provider prior to submitting the monthly claim for reimbursement…

***

(3) Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.

***

Oxygen services providers typically bill for oxygen services on a monthly basis. Our computer analysis checked for potentially duplicate billed services in which two or more oxygen claims were billed and paid for the same recipient within the same month. We then analyzed the Provider's patient records supporting these services to ascertain whether multiple services had been rendered or a duplicate billing had occurred.

Our analysis identified two different types of duplicate billed services. The first duplicate type involved claims filed solely by the Provider. The second type involved duplicate or overlapping claims submitted by the Provider and another oxygen provider.

Our initial computer analysis identified 3,707 services (1,851 combinations of duplicates) where the Provider appeared to have billed for more than one oxygen service for the same recipient in

the same month (Type I duplicate). However, a review of the Provider's billing procedures and a test of 50 potential duplicate combinations determined that most of the potential duplicates were caused by incorrect periods of service entered on reimbursement claims, which the Provider attributed to their third-party biller. Our test included pulling a statistically random sample of 50 potential duplicate combinations (involving 116 services) as a control test. Once the correct dates of service were used, the control test determined that only one potential duplicate combination was double paid (a two percent error rate). The control test identified five other errors that did not involve a duplicate payment. The six errors, which resulted in $844.80 in findings, occurred because:

- The Provider billed twice for one recipient in the same monthly cycle causing an oxygen reimbursement duplicate for the month.
- The level for one service was overstated; therefore, we recoded it from a HCPCS Y2076 (oxygen concentrator, Long Term Care Facility (LTCF)) to a HCPCS Y2081 (oxygen, LTCF, 501-750 cubic feet) based on the liter flow and meter reading.
- The Provider did not retain the beginning meter hours for two services. Therefore, we were unable to determine the amount of oxygen actually used for the month.
- The Provider billed for two services that had "zero" hours documented as the total amount of oxygen used for the month.

Our computer analysis also identified 295 duplicate combinations (729 services) where the Provider and another oxygen provider billed for more than one oxygen service for the same recipient in the same month (Type II duplicate). Because of the issues with the Type I potential duplicate claims regarding incorrect dates of service on bills submitted to ODJFS, a control test was also performed on the Type II potential duplicates. This control test consisted of 53 randomly selected potential duplicate combinations (130 services). Because the Type II duplicate control test error rate was higher (eight duplicate errors) than the acceptable error rate for the test (one error), we reviewed all 295 Type II potential duplicate claim combinations billed by the Provider. Our 100 percent review identified 32 errors, totaling $2,663.04 in findings, as follows:

- The Provider billed for 15 services where they did not have or retain documentation to determine the amount of oxygen actually used for the month.
- The Provider billed for six services that had "zero" hours documented as the total amount of oxygen used for the month.
- The level for six services were overstated; therefore, we recoded them from a HCPCS Y2076 (oxygen concentrator, LTCF) to the appropriate HCPCS code based on the liter flow and meter reading. In addition, for two services, the Provider included portable hours into the overall oxygen hours for the month. Since portables are not directly reimbursable, we only allowed the hours used for the concentrator.
- The Provider billed for two services where portable liquid oxygen was used. The Provider should not have billed directly for this service; it should have been reimbursed in the cost report from the facility.
- The Provider billed twice for one recipient in the same monthly cycle causing an oxygen reimbursement duplicate for the month.

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 established maximum dollar amount 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 Dispensed in Excess of the Medicaid Maximum

Appendix A of Ohio Adm.Code 5101:3-10-03 establishes maximum dollar amounts and/or quantities that Medicaid will cover for specific items. Our computer analysis identified 4 services, where the Provider billed and was reimbursed for supplies that exceeded the allowed maximum. After subtracting the allowed maximum from the amount paid to the Provider, we identified findings totaling $2,300.00 for the items shown in Table 1.

Table 1: Listing of Items Dispensed in Excess of the Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Number of Exceptions	Overpayment
A6219	Gauze, non-impregnated, pad size more than 48 sq. in., without adhesive boarder	$50.00 per month	1	$50.00
E0450	Positive pressure volume ventilator, stationary or portable included	1 per month, always rented	3	$2,250.00
		Total	***4***	***$2,300.00***

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 April1, 2002 through March 31, 2005.

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 two items billed by the Provider where the cumulative rental billings exceeded the purchase price. Table 2 lists these items and the corresponding overpayment.

Table 2: Listing of Items Exceeding "Rent to Purchase" Price

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Number of Exceptions	Overpayment
E0570	Nebulizer with compressor	1 per 5 years R/P price of $133.00	12	$493.60
E0600	Suction pump, home model, portable or stationary, complete	1 per 4 years R/P price of $217.00	10	$863.00
		Total	***22***	***$1,356.60***

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 April1, 2002 through March 31, 2005.

Place of Service Disagreed with Location Billed

Ohio Adm.Code 5101:3-10-03, Appendix A lists the HCPCS codes to use when billing for oxygen services. Furthermore, there are special oxygen codes to use for Long Term Care Facility (LTCF) residents and separate codes for recipients not in a LTCF. In addition, Ohio Adm.Code 5101:3-10-13 breaks down the oxygen rules by personal residence oxygen (sections D through F) and LTCF oxygen (sections G and H). In accordance with these rules, a provider should bill the HCPCS code that coincides with a recipient's residence.

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

> (B) Portable oxygen systems.
>
> ***
>
> (4) In a long term care facility, rented oxygen systems are included in the cost report and are not separately billable. Purchased oxygen systems will be denied as noncovered.
>
> ***
>
> (H) …Payment for oxygen services for recipients in an LTCF is as follows:
>
> (1) …The amount of oxygen actually used each month…must be determined and documented by the provider prior to submitting the monthly claim for reimbursement…
>
> ***
>
> (3) Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for

> that purpose listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.
>
> ***

Our computer analysis identified 29 oxygen services, dispensed to 24 recipients, where the HCPCS code that was billed indicated the recipient was a LTCF resident, but the place of service field on the reimbursement claim indicated otherwise. Our 100 percent review identified six errors, totaling $779.52 in findings, as follows:

- The level for one service was overstated; therefore, we recoded the oxygen service to the appropriate HCPCS code based on the liter flow and meter reading. In addition, for three services, the Provider included portable hours into the overall oxygen hours for the month. Since portables are not directly reimbursable, we only allowed the hours used for the concentrator.
- The Provider billed for one service where portable oxygen was used. The Provider should not have billed directly for this service; it should have been reimbursed in the cost report from the facility.
- The Provider was unable to supply documentation for one service showing the recipient was in the LTCF during the month in question.

Services Billed for Deceased Recipients

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 computer analysis testing, we determined that the Provider billed Medicaid for one service rendered after the recipient's date of death. Therefore, a finding was made for the $24.00 in reimbursement received for this service.

Sample Results

Our sample was a simple random sample of 246 oxygen claims (246 services). This was taken from a subpopulation of 18,528 oxygen service claims that excluded all Medicare co-payments and all services already identified by our exception tests for 100 percent review. Our review determined that 44 of the 246 claims sampled were overpaid and resulted in projected findings of $418,730.87. The bases for these findings are presented below.

Portable Oxygen Not Reimbursable in LTCF

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

> (B) Portable oxygen systems.
>
> ***
>
> (4) In a long term care facility, rented oxygen systems are included in the cost report and are not separately billable. Purchased oxygen systems will be denied as noncovered.
>
> ***

During our field review, we identified two services where the Provider erroneously billed HCPCS Y2076 (oxygen concentrator, LTCF) when the Provider actually supplied portable liquid oxygen. To determine if Medicaid would otherwise have paid for portable oxygen in these instances, we referred to Appendix B of Ohio Adm.Code 5101:3-10-13, which states that portable oxygen contents are only reimbursable if the recipient owns either the stationary or portable unit used to dispense the oxygen. Because the recipient records did not support equipment ownership, we disallowed the reimbursement for the portable oxygen services, resulting in actual overpayments of $357.12 prior to projection.

Missing Required Documentation

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

> (A)(1) A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.
>
> ***
>
> (G)(4) For each resident who receives oxygen services for six months or more, the resident's PO_2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter.
>
> ***
>
> (H)(1) …The amount of oxygen actually used each month (as determined from a meter reading or refill amount and delivery information) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement.
>
> ***

During our field review, we identified 37 services where the Provider's service records were missing part of the required documentation. Specifically,

- For 34 services, the Provider did not obtain the required pulse oximetry readings, including one service that was also missing a physician signature on the prescription.
- For two services, the Provider was missing meter readings which made the amount of oxygen used for the month undeterminable.
- For one service, the Provider's documentation was missing a physician prescription.

Therefore, we disallowed the reimbursement for these services, resulting in actual overpayments of $5,490.24 prior to projection.

Level of Service Overstated

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

> Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose and listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.

During our field review, we identified one service where the Provider billed for a higher level of service than the documentation supported. We recoded the service from HCPCS Y2076 (oxygen concentrator, LTCF, 1,000+ cubic feet) to HCPCS Y2083 (oxygen, LTCF, 0-250 cubic feet) based on liter flow and meter reading. We determined the findings by taking the difference between what was reimbursed and what should have been reimbursed for the cubic feet of oxygen documented. The actual overpayments prior to projection totaled $154.56.

Billing of "Zero" Hours

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

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

During our field review, we identified four services where the Provider billed for services that had "zero" hours documented as the total amount of oxygen used for the month. Reimbursement is based on the amount of oxygen actually used for each month; therefore, if "zero" hours were used there should not be any reimbursement as no oxygen was consumed. Consequently, we disallowed the payment for these services. Actual overpayments prior to projection totaled $96.00.

Sample Projection

We took exception with 44 of 246 statistically sampled claims (246 services) from a simple 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 $2,194,370.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $2,001,951.00 to $2,386,790.00 (+/- 8.77 percent.) We then calculated audit findings repayable to ODJFS by subtracting the projected correct population amount ($2,194,370.00) from the amount paid to the Provider for this population ($2,613,100.87), which resulted in a finding of $418,730.87. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Provider Should Use Correct HCPCS Code when Billing

According to Appendix A of Ohio Adm.Code 5101:3-10-03, when the equivalent of 750 cubic feet or more of oxygen is consumed, the Provider should bill HCPCS code Y2076 for use of an oxygen concentrator and should bill code Y2079 for use of liquid oxygen. Both codes should also be modified as necessary to reflect the oxygen volume consumed above 750 cubic feet.

During our review of claims in the exception tests and sample, we identified 15 services where the Provider billed for HCPCS Y2076 (oxygen concentrator, LTCF) instead of HCPCS Y2079 (liquid oxygen). There is currently no dollar difference in the reimbursement amounts for these codes and therefore no overpayment. We, however, are advising the Provider to use the correct HCPCS codes for future billings to prevent further errors and avoid potential future overpayments.

Services Reimbursed at a Greater Amount than Usual and Customary Fee

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 render medical services as medically necessary for the patient…and, bill the department for no more than the usual and customary fee charged other patients for the same service.
>
> ***

In addition, Ohio Adm.Code 5101:3-10-13(H)(4) states:

> Payment 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.

In a June 2002 report[5], when the company was under different ownership and operating as Respiratory Care Resources, we questioned the billing rate used to charge Medicaid for oxygen concentrator services provided to patients in long term care facilities because the billings appeared to exceed the Provider's usual and customary charges for similar services to non-Medicaid patients in the same facilities. Specifically, Respiratory Care Resources had charged and been reimbursed $178.56 per month by Medicaid for oxygen concentrator services, but charged long term care facilities a median rental rate of $108.50 per month for concentrators used by non-Medicaid patients.

To determine if a similar situation existed under the new ownership during our April 1, 2002 through March 31, 2005 audit period, we requested that the Provider furnish us with copies of rental contracts to provide oxygen concentrator services to long term care facilities. The Provider furnished 75 rental contracts, which upon review, showed that the Provider charged monthly rental rates well below what was being charged to Medicaid[6]. During our audit period, 64.7 percent of oxygen concentrator service payments and 83.2 percent of the total amount paid by Medicaid were paid at $178.56 per month. (The other 35.3 percent were paid at more or less than $178.56 per month). After removing findings associated with our exception tests, we calculated the difference between what Medicaid paid to the Provider for 22,479 services during our audit period ($3,118,123.03) and the corresponding mean monthly rate charged by the Provider to long term care facilities. A separate mean monthly rate was calculated and used for services provided in calendar years 2002 through 2005 respectively. The final net difference between what Medicaid paid and the Provider's "usual and customary" mean monthly rate was $1,970,140.69. This net difference was then reduced by the projected findings from the oxygen service sample ($418,730.87) to determine the final usual and customary findings of $1,551,409.82.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on March 30, 2006 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation on May 12, 2006 and June 23, 2006 that was used to adjust our findings. In the May 12, 2006 letter, the Provider's legal representative disagreed with our findings regarding services reimbursed at a greater amount than the usual and customary fee. The Provider's legal representative stated:

> The largest portion of the draft finding is the conclusion that OCR billed an amount greater than its U&C fee for oxygen. This conclusion is utterly without legal support.

[5] *Review of Medicaid Provider Reimbursements Made to Respiratory Care Resources; June 18, 2002; AOS/FWAP-02-017C.*

[6] *Specific rental rates are not shown due to concern about divulging pricing information that might place the Provider at a competitive disadvantage with other oxygen service providers..*

This finding is based on the fact that OCR bills Medicaid for actual oxygen used. This is the method by which OCR has billed Medicaid. Medicaid will not permit any other method of determining charges other than "oxygen used". §O.A.C. 5101:3-10-13(H)(1). It should also be noted that the required method of billing makes it clear that Medicaid is paying for a product, not a service. Medicaid does not permit the provider to bill for a "rental contract". Moreover, this is contrary to the industry understanding and practice.

Additionally, the analysis in the draft report is based entirely on "average" charges without discussing the amount of oxygen consumed. In other words, it cannot be determined that the payment by other payors is for the same amount of oxygen.

For this reason, there is no comparison between the product purchased by Medicaid and the product or service rented by other payors. The price Medicaid reimburses does not exceed the usual and customary price for oxygen. It bears no relationship to the price paid for a concentrator.

AOS Response

We disagree that our analysis is faulty, on the premise that the analysis is based on the Provider's usual and customary fee for providing oxygen concentrator services to non-Medicaid nursing home residents in the same setting as Medicaid residents. Based on the usual and customary fee rule, we do not see a rationale basis for charging Medicaid what amounts to three times the amount being charged other like customers for essentially the same service.

The Provider's May 12, 2006 letter has been forwarded in its entirety to ODJFS for its consideration in making a final determination of the recovery of the audit findings and accrued interest.

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APPENDIX I

Summary of Statistical Sample Analysis of Omnicare Respiratory Services
Oxygen Claims Sample
Audit Period: April 1, 2002 – March 31, 2005

Description	Audit Period Apr. 1, 2002 – Mar. 31, 2005
Type of Examination	**Simple Random Sample of Oxygen Claims**
Population Description	**All Oxygen Services Less Services Identified by Exception and Potential Duplicate Service Tests**
Number of Population Claims	**18,528**
Number of Population Claims Sampled	**246**
Total Medicaid Amount Paid for Population	**$2,613,100.87**
Actual Amount Paid for Population Services Sampled	**$35,233.02**
Projected Correct Population Payment Amount	**$2,194,370.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$2,386,790.00**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$2,001,951.00**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$418,730.87**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$192,420 (+/- 8.77%)**

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

Appendix II
Summary of Overpayment Results for:
Omnicare Respiratory Services
For the period April 1, 2002 to March 31, 2005

Description	Audit Period April 1, 2002 to March 31, 2005
Services Billed for Deceased Recipients	$24.00
Supplies Exceeding the Medicaid Maximum	$3,656.60
Duplicate Claims	$3,507.84
Place of Service Disagrees with HCPCS Billed	$779.52
Projected Results from Statistical Sample	$418,730.87
Services Reimbursed at a Greater Amount than Usual and Customary Fee	$1,551,409.82
TOTAL	$1,978,108.65

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

Auditor of State
Betty Montgomery

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OMNICARE RESPIRATORY SERVICES
D.B.A.
RESPIRATORY CARE RESOURCES

WARREN 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
OCTOBER 19, 2006