Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Burlington House

A Compliance Audit by the:

Medicaid/Contract Audit Section

October 2007 ***AOS/MCA-08-007C***

Mary Taylor, CPA
Auditor of State

October 11, 2007

Ms Kim Griffin
Regional Director of Finance
Burlington House
2222 Springdale Rd
Cincinnati, OH 45231

Dear Ms. Griffin:

Attached is our report on Medicaid reimbursements made to Burlington House, Medicaid provider number 2438106, for services rendered for the period July 1, 2004 through December 31, 2005. We identified $287,369.48 in findings plus $176.13 in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After October 11, 2007, additional interest will accrue at $0.40 a day until repayment occurs. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement with the ODJFS. The specific procedures employed during this audit are described in the scope and methodology section of this report. Interest is calculated pursuant to Ohio Administrative Code Section 5101:3-1-25(B) for overpayments on services not covered by the Combined Proposed Adjudication Order (CPAO) process.

We are forwarding this report to ODJFS, because as the state agency charged with administering Ohio's Medicaid program; ODJFS is responsible for making a final determination regarding recovery of the findings and any accrued interest. In addition this will also allow ODJFS an opportunity to review the results disclosed within this report pursuant to Ohio Revised Code § 5111.061 in an effort to avoid duplications in adjustments with their Combined Proposed Adjudication Order (CPAO) process. However, if you are in agreement with the findings contained herein, you may expedite repayment by contacting ODJFS' Legal Office at (614) 466-4605. To facilitate repayment, a "provider remittance form" is located at the back of this report.

Copies of this report are being sent to Burlington House, the Ohio Attorney General, the Ohio Department of Health, and the Ohio Nursing Home Association. In addition, copies are available on the Auditor's web site (www.auditor.state.oh.us).

88 E. Broad St. / Fifth Floor / Columbus, OH 43215-3506
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

Questions regarding this report should be directed to Robert R. Hinkle, Chief Deputy Auditor, at (614) 728-7108, or toll-free (800) 282-0370.

Sincerely,

Mary Taylor

Mary Taylor, CPA
Auditor of State

Cc: Burlington House
Ohio Attorney General
Ohio Department of Health
Ohio Nursing Home Association
Legal, Ohio Department of Job and Family Services
Director, Ohio Department of Job and Family Services

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ACRONYMS

AOS	Auditor of State
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPAO	Combined Proposed Adjudication Order
CPT	Current Procedural Terminology
ICF-MR	Intermediate Care Facility – Mental Retardation
LTCF	Long-Term Care Facility
MMIS	Medicaid Management Information System
NF	Nursing Facility
Ohio Admin.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
Ohio Rev.Code	Ohio Revised Code
SNF	Skilled Nursing Facility

SUMMARY OF RESULTS

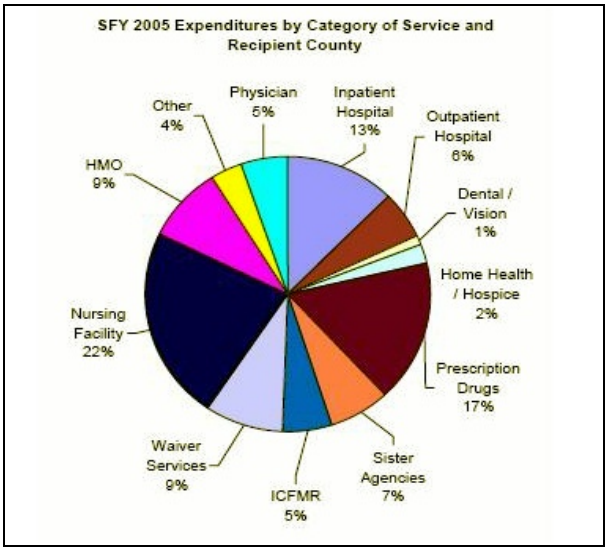
The Auditor of State performed an audit of Burlington House (hereafter called the Provider), provider #2438106, doing business at 2222 Springdale Road, Cincinnati, OH 45321. We performed our audit in accordance with Ohio Rev. Code § 117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified $287,369.48 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest[1] of $176.13, on non CPAO covered services, are repayable to ODJFS. Additional interest of $0.40 per day will accrue after October 11, 2007 until repayment.

We are forwarding this report to ODJFS because as the state agency charged with administering Ohio's Medicaid program, the Department is responsible for making a final determination regarding recovery of the findings and any accrued interest.

BACKGROUND

As of October 1, 2005, The Ohio Auditor of State (AOS) acted on its legislative authority under Ohio Rev. Code § 117.10 to independently audit providers who render medical services to Medicaid patients. Under that new authority, providers who render services to patients residing in nursing facilities (NF) were selected for audit.

Table 1: Ohio Medicaid Expenditures[2]



[1] *Ohio Admin.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 August 16, 2006, the latest payment date for the paid claims being analyzed.*

[2] *Source: Ohio Medicaid Report 2005, Ohio Department of Job and Family Services*

As shown in Table 1, expenditures for services to patients residing in NFs accounted for 22 percent of Ohio's State Fiscal Year (SFY 2005) Medicaid expenditures, making it the number one category of Medicaid expenditure. Prescription drugs, the second largest expenditure category, accounted for 17 percent of Ohio's Medicaid expenditures.

Title XIX of the Social Security Act, known as Medicaid, was established in 1965, and provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. Ohio's Medicaid program is administered by ODJFS. The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules. Regulations which providers of services to Medicaid patients must follow are promulgated in the Ohio Administrative Code.

Ohio's Medicaid program offers a variety of services including but not limited to: inpatient/outpatient hospital, prescription drugs, physician, and nursing facility. Long term care services which occur in nursing facilities (NF) provide "skilled" care for people who are unable to care for themselves in their home and who need help with activities of daily living (ADL) such as dressing, bathing, eating, grooming, and taking medicine.

Patients must apply for long term care services. They must show proof of income, resources, disability, citizenship (legal residency), other health insurance, and meet transfer of resource provisions.

Once financial requirements are met, a level of care assessment will be conducted to identify the appropriate type of long-term care services Medicaid will provide to each patient.

Per Ohio Admin.Code § 5101:3-3-05(B)(3):

> "Skilled care level" means that an individual receives at least one skilled nursing service at least seven days per week, and/or a skilled rehabilitation service at least five days per week. For the delivery of skilled services to qualify for the skilled care level, the services must be ordered by a physician, and must be delivered by the licensed or certified professional due to either:
> (a) The instability of the individual's condition and the complexity of the prescribed service; or
> (b) The instability of the individual's condition and the presence of special medical complications.

Nursing facilities are required, as are all Medicaid providers, to have a "provider agreement" with ODJFS. A "Provider agreement" is a contract between ODJFS and an operator of a NF or Intermediate Care Facility – Mental Retardation (ICF-MR) for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator, or the operator's authorized agent, binds the operator to the terms of the agreement.

The provider agreements of nursing facilities differ from those of other providers. Ohio Admin. Code § 5101:3-3-02, states in pertinent part:

> (B) A provider of a NF or ICF-MR shall:
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> ***
>
> (2) Apply for and maintain a valid license to operate if required by law; and
>
> (3) Comply with all applicable federal, state, and local laws and rules and
>
> (4) Keep records and file reports as required in rule 5101:3-3-20 of the Administrative Code; and
>
> (5) Open all records relating to the costs of its services for inspection and audit by ODJFS and otherwise comply with rule 5101:3-3-20 of the Administrative Code;
>
> ***

Ohio Admin.Code § 5101:3-3-20 contains the medicaid cost report filing, record retention, and disclosure requirements for NFs and ICFs-MR. This section states in pertinent part:

> As a condition of participation in the Title XIX medicaid program, each NF and ICF-MR shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, [JFS 02524N "Medicaid Nursing Facility Cost Report"(Rev. 09/05) as found in appendix A of rule 5101:3-3-20.2 of the Administrative Code] including supplements and attachments as specified under paragraphs (A) to (M) of this rule or other approved forms for the state-operated ICF's-MR, must be filed within ninety days after the end of the reporting period . . .
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> ***
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> (L) Financial, statistical and medical records (which shall be available to ODJFS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODJFS issues an audit report in accordance with rule 5101:3-3-21 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.
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> ***

Ohio Admin.Code 5101:3-1-27(B)(1) states in part "… The department [ODJFS or designee] shall have the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department [ODJFS]."

Ohio Admin.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."

Additionally, Ohio Admin.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."

According to Ohio Admin.Code § 5101:3-3-19, dependant upon the specific type of service received by a patient, the services rendered in nursing facilities (NF) are reimbursable to either the rendering provider or the nursing facility. The following services are reimbursable to the provider who rendered the services:

- Dental
- Laboratory
- X-ray
- Various medical supply services (such as oxygen concentrators and prosthesis)
- Medications listed in the "Ohio Medicaid Drug Formulary"
- Therapy services provided through the NF rendered by licensed practitioners
- Physician
- Vision
- Podiatry

Ohio Admin.Code § 5101:3-3-19(E)(1) states:

> (1) For NFs, the costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed practitioners are reimbursed directly to the NF as specified in rules 5101:3-3-47 to 5101:3-3-47.3 of the Administrative Code. The costs incurred for these services provided by nursing staff of the NF are reimbursable through the facility cost report mechanism as specified in rule 5101:3-3-46 of the Administrative Code.

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of 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 skilled nursing facility (SNF).

A SNF is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental disease.

The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered care to patients for room and board; and therapy services from July 1, 2004 through December 31, 2005. During this period, the Provider was reimbursed $5,187,109.09 (excluding Medicare crossovers), for 1,234 monthly claims, with a total of 33,110 patient days, for 123 patients. Following a notification letter, we held an entrance conference at the Provider's place of business on September 15, 2006, to discuss the purpose and scope of our audit.

The Ohio Department of Jobs and Family Services, effective July 1, 2005, changed the method used for paying SNF monthly room and board services from a presumptive payment system (9400 process) to a "direct bill" system. After July 1, 2005, providers are to bill ODJFS electronically only for room and board services actually rendered to patients instead of getting automatic presumptive payments and then making any necessary adjustments based upon the patients' residency in the SNF.

In order to make a preliminary assessment of the impact that the change to a direct bill system made on overpayments to the provider, we extended our audit period into the first six (6) months of direct billing, July 1, 2005 through December 31, 2005.

We used the Ohio Rev.Code and the Ohio Admin.Code 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 (MMIS), 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.

Therapy services are billed to ODJFS using Current Procedural Terminology (CPT) five digit codes issued by the American Medical Association. Charges for patients' monthly room and board services are billed using revenue codes listed in Appendix A of Ohio Admin.Code § 5101:3-2-02.

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:

- Potentially duplicate payments where payments were made for the same recipient on the same date of service for the same revenue codes and for the same dollar amount.
- Payments made for services to deceased patients for dates of service after their date of death.

The exception tests for duplicate payments and for deceased patients were both negative.

Our work was performed between September 2006 and March 2007.

FINDINGS

We identified findings of $285,522.12 for incorrectly billed room and board services for patients. An additional $1,847.36 in findings was identified for incorrectly billed therapy services. The total findings of $287,369.48 are repayable to ODJFS. The bases for our findings are discussed below.

Incorrectly Billed Room and Board Services

Pursuant to Ohio Admin. Code § 5101:3-3-59:

> (A) Definitions:
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> (2) "Bed-hold days", also referred to as "leave days," are the span of time that a bed is reserved for the resident, through medicaid payment, while the resident is outside the facility for hospital stays, visitations with friends and relatives, or participation in therapeutic programs and has the intent to return to that facility. . .
>
> ***
>
> (B) To determine whether specific days during a resident's stay are payable through medicaid payments as bed-hold days or occupied days, the following criteria shall be used:
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> ***
>
> (2) The day of discharge is not counted as either a bed-hold or occupied day.
>
> (C) For Medicaid-eligible residents in certified NFs, . . . the Ohio department of job and family services (ODJFS) may pay the NF to reserve a bed only for as long as the resident intends to return to the facility but for not more than thirty days in

> any calendar year. Reimbursement for bed-hold days shall be paid at fifty per cent of the facility's per diem rate. . . . The NF shall report a resident's use of bed-hold days on the "Nursing Facility Payment and Adjustment Authorization" (JFS 09400, rev 12/2001) for dates of service prior to July 1, 2005….
>
> ***

In order to determine if the Provider was reimbursed appropriately for room and board charges billed for the facility's patients we completed the following procedures:

- Obtained the NF's daily and monthly population census reports for the audit period.
- Compared, for each Medicaid patient for each month in the facility, the number of days the patient was in the facility, including therapeutic leave and bed-hold days, to the number of days billed on the Medicaid claim for the patient.
- We calculated the correct payment amount using the census data and the daily per diem rate if a discrepancy was found. (Note: leave days are reimbursed at 50 percent of the daily per diem rate).
- Subtracted our calculated correct payment amount from the actual amount reimbursed to the Provider for that month and the difference became a finding.
- Reviewed various data sources, such as the patient's accounts receivable registers and ODJFS' remittance advices, to determine if any payment adjustments had been made for that month. If adjustments were found, we subtracted the adjustment amount from the findings.

We reviewed all 1,234 monthly room and board claims within our audit period and found 134 incorrect room and board payments. Numerous payment errors were found both under the presumptive payment system and the direct billing system. More than 60 percent of the direct billing errors were for dates of service four months or later after the conversion to the direct billing system. This may indicate that additional provider education needs to be done by ODJFS on the new system.

For dates of service July 1, 2004 through June 30, 2005, the portion of audit period covered by the presumptive payment process, we found 90 claims with incorrect payments. Some payments with a finding had more than one deficiency, thereby causing the total number of deficiencies (106) to be more than the number of payments with a finding. The claim deficiencies that our audit identified included:

- Thirty seven (37) claims with bed-hold days, paid at 100 percent of the per diem rate instead of the proper 50 percent.
- Thirty (30) instances where Medicaid paid for Medicare covered days.
- Fourteen (14) instances where Medicaid paid for Hospice or private insurance covered days.

- Fourteen (14) instances where Medicaid paid for unoccupied days.
- Eleven (11) instances where Medicaid paid for private pay covered days.

While reviewing the incorrect payments, we found that the Provider had previously sent an adjustment to ODJFS for only seven (7) of the above listed incorrect payments; however, we did not find the reciprocal credit made by ODJFS. During the Combined Proposed Adjudication Order (CPAO) process, ODJFS performs retrospective financial reviews of long-term-care facilities, prepares final fiscal audit reports, and negotiates settlements with providers. Therefore, we informed ODJFS' Bureau of Audit of the incorrect payments and recommended they make any necessary debits or credits during the CPAO process.

Our review of the Provider's room and board documentation, for services rendered during the period, July 1, 2004 through June 30, 2005, identified incorrect payments with potential findings of $235,231.16.

Additionally, for dates of service July 1, 2005 through December 31, 2005, the portion of the audit period covered by the direct bill process, we found 44 claims with incorrect payments. A total of 45 payment deficiencies were found, with one claim having two deficiencies. The payment deficiencies identified were as follows:

- Thirty three (33) claims had bed-hold days paid at 100 percent of the per diem rate instead of the proper 50 percent.
- Five (5) instances where Medicaid paid for Hospice or private insurance covered days.
- Three (3) instances where Medicaid paid for bed-hold days when the patients' annual day allotments were exhausted.
- Two (2) instances where Medicaid paid for private pay covered days.
- One (1) instance where Medicaid paid for an unoccupied day.
- One (1) instance where Medicaid paid for Medicare covered days.

Our review of the Provider's room and board documentation, for services rendered during the period, July 1, 2005 through December 31, 2005, found incorrect payments with potential findings of $50,290.96.

Summary of Incorrect Payments for Room and Board Services

Total combined potential findings of $285,522.12 resulted from our 100 percent review of room and board payments for the periods July 1, 2004 through June 30, 2005 ($235,231.16 in potential findings) and July 1, 2005 through December 31, 2005 ($50,290.96 in potential findings).

Improperly Billed Therapy Services

Ohio Admin.Code § 5101:3-3-47.1, Coverage and limitations-nursing facility therapy services,

states in pertinent part:

> (A) Definitions.
>
> ***
>
> (1) "Therapy services" means physical therapy (PT), occupational therapy (OT), audiology, and speech therapy (ST) that are provided by appropriately licensed individuals practicing within the scope of their licensure.
>
> ***
>
> (8) "Reasonable and medically necessary."
> To be considered reasonable and medically necessary, a covered therapy service must meet all of the following conditions:
>
> (a) Be a specific and effective treatment for the resident's condition; and
>
> (b) Be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by or under the direct supervision of a licensed therapist and
>
> (c) There must be an expectation that the resident's condition will improve significantly in a reasonable and generally predictable period of time based on the assessment made by the physician of the resident's restoration potential, or the service must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and
>
> (d) The amount, frequency, and duration of the service must be reasonable.
>
> (9) "Treatment plan."
> The treatment plan must include a diagnosis, current physical status, rehabilitation potential, specific functional goals, a reasonable estimate of when the goals will be reached (e.g., three weeks), specific procedures, and frequencies and duration of treatment.

The Provider billed for 187 therapy services during the audit period, for which they were reimbursed $11,968.17. The rendered services included physical and occupational therapy evaluations, neuromuscular re-education, and therapeutic exercises.

Additionally, Ohio Admin.Code § 5101:3-3-47.1, Coverage and limitations-nursing facility therapy services, also states in pertinent part:

> ***
>
> (B) Covered therapy services.
>
> (1) In accordance with medicare guidelines, the following therapy services are covered when the services relate directly and specifically to a written treatment plan established by a physician . . .
>
> (a) For a PT service, the service must be required for evaluation and ongoing assessment of a resident's rehabilitation needs and potential, or must be a skilled service related to the restoration of a specific loss of function. PT services are covered only so long as significant functional improvement is occurring and is documented, . . .
>
> (b) For an OT service, the service must be an evaluation, reevaluation, or therapeutic service or must be the teaching of compensatory techniques which improve the resident's ability to perform those tasks required for independent functioning. OT services are covered only as long as significant functional improvement is occurring and is documented, . . .
>
> (c) For a ST service, the service must be necessary for the diagnosis and treatment of a speech or language disorder which results in a communication disability, or for the diagnosis and treatment of a swallowing disorder (dysphagia). ST services are covered only so long as significant functional improvement is occurring and is documented, . . .
>
> ***

We reviewed all therapy services billed with dates of service of July 1, 2004 through December 31, 2005. A total finding of $1,847.36 was made for 26 incorrectly billed claims for therapy services. All 26 claims were over-billed by one unit of service.

Summary of Improperly Billed Therapy Services

Total combined findings of $1,847.36 results from our 100 percent review of payments for therapy services for the period July 1, 2004 through December 31, 2005.

Summary of Findings

A total of $287,369.48 in findings was identified. These findings result from the combination of our findings from incorrectly billed room and board services ($285,522.12) and findings from incorrectly billed therapy services ($1,847.36).

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on May 23, 2007 to afford them an opportunity to provide additional documentation or otherwise respond in writing. We received a letter from the Provider on June 4, 2007 requesting clarification of the adjustment process. In our response to the Provider, we informed them that adjustments will be made through the ODJFS pursuant to Ohio Rev.Code 5111.061.

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
Office of Fiscal Services (Attn: Accounts Receivable)
P.O. Box 182367
Columbus, Ohio 43218-2366

1. Provider Name and Address:
Burlington House
2222 Springdale Road
Cincinnati, Ohio 45321

2. Provider Number:	**2438106**
3. Review Period:	**July 1, 2004 through December 31, 2005**
4. AOS Finding Amount (including accrued interest):	**$287,545.61**
5. Interest "as of" Date:	**October 11, 2007**
6. Date Payment Mailed:	
7. Additional Interest Owed: (Calculated by multiplying $0.40 by the difference in days between #5 and #6)	
8. Total Amount Repaid: (Sum of # 4 and #7)	

IMPORTANT:

To help ensure that your payment is properly credited, please fax copies of this remittance form and your check to our office at (614) 728-7398, ATTN: Medicaid/Contract Audit Section.

Mary Taylor, CPA
Auditor of State

BURLINGTON HOUSE

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
OCTOBER 11, 2007

88 E. Broad St. / Fourth Floor / Columbus, OH 43215-3506
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us