Dave Yost · Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Lincare, Inc. – Ashtabula, Ohio

A Compliance Audit by the:

Medicaid/Contract Audit Section

Dave Yost • Auditor of State

September 8, 2011

Jenna Pedersen
Corporate Compliance Officer
Lincare, Inc.
19387 US 19N
Clearwater, Fl 33764

Dear Ms. Pedersen:

Attached is our audit report on Medicaid reimbursements made to Lincare, Inc., Medicaid provider number 2117159, for the period November 1, 2007 to October 29, 2009. Our audit was performed according to our authority in Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $40,590.00 in findings plus $4,679.53 in interest accruals totaling $45,269.53 that are repayable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After September 8, 2011, additional interest will accrue at $8.90 per day until repayment occurs. Interest is calculated pursuant to Ohio Admin. Code § 5101:3-1-25.

We are forwarding this report to ODJFS because it is the state agency charged with administering Ohio's Medicaid program. ODJFS is responsible for making a final determination regarding recovery of our findings and any accrued interest. However, if you agree with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are being sent to the corporate office of the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Respiratory Care Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

88 E. Broad St. / Ninth 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 Charles H. Brown, III, Chief Auditor of the Medicaid Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Dave Yost
Auditor of State

cc: Stacey Murphy, Region Reimbursement Manager, Lincare Inc.
Ohio Department of Job and Family Services
Ohio Attorney General, Medicaid Fraud Control Unit
U. S. Department of Health and Human Services/Office of Inspector General
Ohio Respiratory Care Board

TABLE OF CONTENTS

ACRONYMS

ABG	Arterial Blood Gas
AOS	Auditor of State
CMN	Certificates of Medical Necessity
CMS	Centers for Medicare and 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
PO_2	Partial Pressure of Oxygen
SpO2	Peripheral Oxygen Saturation Measured with Pulse Oximeter

SUMMARY OF RESULTS

The Auditor of State performed an audit of Lincare, Inc., provider number 2117159, doing business at 2549 South Ridge East, Ashtabula, Ohio 44004 (Lincare or the Provider). Lincare is a national supplier of durable medical equipment with offices in cities all over the United States and throughout Ohio. Within the Ohio Medicaid program, the Provider is listed as a supplies and medical equipment provider. The Provider was 1 of 34 separate Lincare, Inc. operations in Ohio during the audit period.

We performed the audit in accordance with Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $40,590.00 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code in effect at the time the service was rendered. Additionally, the AOS assessed interest of $4,679.53 according to Ohio Admin. Code § 5101:3-1-25, for a total of $45,269.53. The total amount of the finding is repayable to ODJFS as of the release of this audit report. Additional interest of $8.90 per day will accrue after September 8, 2011 until repayment.

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 Medicaid providers must follow are specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Manuals. A fundamental concept underlying 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. *See* Ohio Admin. Code § 5101:3-1-01(A) and (A)(6).

The Auditor of State performs audits to assess providers' compliance with reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, medical necessity, and sound fiscal, business, or medical practices. According to Ohio Admin. Code § 5101:3-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated within the six year period is completed. When the AOS identifies fraud, waste or abuse by a provider in its audits[1], "any amount in excess of that legitimately due to the provider will be

[1] *Waste and abuse are "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." Ohio Admin. Code § 5101:3-1-29(A)*

recouped by ODJFS through its office of fiscal and monitoring services, the state auditor, or the office of the attorney general." Ohio Admin. Code § 5101:3-1-29(B)

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of oxygen services were in compliance with regulations and if not, to identify findings resulting from non-compliance.

An entrance conference was held with the Provider on July 27, 2010, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of November 1, 2007 through October 29, 2009 (excluding Medicaid co-payments for Medicare or third-party insurance claims; or claims containing services outside of the audit period). The Provider was reimbursed $156,418.57 for 1,345 services during the audit period.

We reviewed the Provider's paid claims history from the ODJFS Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. This claims data included: patient name, patient identification number, date of service, service rendered and reimbursement per service billed. Providers bill services to the Medicaid program using the Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).

Our analyses revealed that two service codes accounted for 82 percent of the Provider's reimbursement during the audit period: oxygen concentrator, single delivery port (HCPCS code E1390) and stationary liquid oxygen, rental (HCPCS code E0439). Oxygen services require that a physician authorize or certify the need for a patient to receive oxygen services by means of a certificate of medical necessity (CMN). We conducted a control test of the Provider's CMNs for oxygen concentrator services to determine if they were present and if they met required criteria as specified by Ohio Admin. Code § 5101:3-10-13 (C)(2)(a) & (b).

Based upon the results of the CMN control test, we selected a statistically random sample of billed oxygen services in order to analyze the provider's substantiative documentation and patients' files for the selected services. The results of both the CMN control test and statistical sample are discussed below.

Our fieldwork was performed between September 2010 and January 2011.

RESULTS

The control test for the selected oxygen CMNs showed a high error rate. Because of the high error rate found in our CMN control test, we performed a more detailed review of the

provider's documentation, and selected a statistical sample of 116 oxygen services. We identified $40,590.00 in findings from our projected sample of oxygen services, the bases of which are discussed below.

A. Control Test of Certificates of Medical Necessity

According to Medicaid rules, an oxygen provider must have a "fully completed form JFS 01909 (rev. 6/2005), 'Certificate of Medical Necessity' " (CMN) on file in order for oxygen services to be billed. Ohio Admin. Code § 5101:3-10-13(C)(2)(b). We therefore conducted a statistical control test of the CMNs on file for the recipients receiving oxygen services during the audit period. According to Ohio Admin. Code § 5101:3-1-27 (B)(1), the AOS may use statistical methods to determine the amount of overpayment.

A sample of 23 of the 85 recipients receiving oxygen services was statistically selected for the control test. A total of 38 CMNs covering all dates of service within the audit period were reviewed for the 23 recipients. The control test analyzed the attributes listed on the CMN, and which are required to be completed by the provider, or the provider must ensure are completed by the attending physician, to indicate the patient has been authorized for oxygen services.

Attributes include: date of last medical examination, prescribing physician's signature and signature date, test results of arterial blood gas (ABG) or partial pressure of oxygen (PO_2), patients' mobility status and oxygen equipment prescribed to patients. Errors were found in a high percentage of CMNs tested. We found 129 errors with the 38 CMNs as follows:

- 27 CMNs where patient's height was blank;
- 26 CMNs where patient's weight was blank;
- 23 CMNs where no "At rest" test results were listed for patients who qualified for oxygen services while sleeping;
- 15 CMNs where the date of the patients' last medical examination was blank;
- 15 CMNs where the Physician's signature was illegible;
- 5 CMNs where no "At rest" test results listed for patients who qualified for oxygen services while exercising;
- 3 CMNs where the question if the patient had dependent edema due to congestive heart failure was not answered;
- 3 CMNs where the question if the patient had Cor pumonale or pulmonary/hypertension was not answered;
- 3 CMNs where the question if the patient had a Hematocrit greater than 56 percent was not answered;
- 2 CMNs where the prescribed oxygen setting/flow rate was not specified;
- 2 CMNs where the prescribed (oxygen) delivery system was not specified;
- 1 CMN where it was not specified whether the oxygen was to be continuous or not;
- 1 CMN where the entire Section B listing duration of oxygen need, date of last medical examination, and all oxygen saturation testing was blank;

- 1 CMN with contradictory information: non-continuous oxygen was written and continuous attribute completed;
- 1 CMN where prescribing physician did not sign CMN; and
- 1 CMN where prescribing physician did not date CMN.

During interviews with Provider representatives we were informed of their documentation review process to ensure CMNs are properly completed. According to the Provider this review process is used to ensure that CMNs are properly completed and meet medical necessity standards. We were told that CMNs not properly completed are identified and sent back to the prescribing physician.

Even though the Provider allegedly has this quality review process in place, most of the CMNs tested still contained errors. Because of the high error rate found in our CMN control test, we discussed our preliminary findings with ODJFS' Office of Ohio Health Plans (OHP). As a result, we decided to perform a more detailed review of the provider's documentation, and selected a statistical sample of 116 oxygen services. An oxygen service was used as the sampling unit because the Provider only billed for one oxygen service per month during the audit period.

B. Results of Oxygen Services Statistical Sample

We selected a statistically random sample of oxygen services from the subpopulation of oxygen concentrator and stationary liquid oxygen services billed by the Provider during the audit period. Our sample consisted of 116 oxygen services for 54 unique recipients. We reviewed patient medical records for the audit period and identified errors with the documentation for 46 services. The reimbursements for these services were disallowed and used in calculating the projected finding of $40,590.00. While certain services had more than one error, only one finding was made per service. The bases for these errors are presented below.

1. Certificates of Medical Necessity

A provider of oxygen services must document that Medicaid coverage has been satisfied by obtaining a CMN prior to submitting a claim for reimbursement. *See* Ohio Admin. Code § 5101:3-10-13 (C)(2). As noted earlier, the Provider told us that a documentation review process was used to ensure that CMNs are properly completed and meet medical necessity standards. Lincare's documentation review process is supposed to reject improperly completed CMNs and return them to the prescribing physician.

However our review of the 54 patient files for documentation supporting the 116 sampled services revealed errors with the CMNs or missing CMNs as follows:

- In 17 instances the CMN was not signed within the required 30 days of the first date of service.

- In 10 instances the document appeared altered, i.e., more than one initial date, values on the CMN changed. Therefore, the CMN was unacceptable to verify authorization.
- In 1 instance there was no CMN which covered the date of the sampled service.

However, before taking a finding for a missing or invalid CMN, we reviewed each patient's file to determine if other documentation could provide the missing information. We found none. Consequently, reimbursement of the sampled services covered by these CMNs was disallowed and used in calculating the projected findings.

2. Medical Evaluations

Patients must be evaluated by their physician in order to qualify for oxygen services. *See* Ohio Admin. Code § 5101:3:10-13 (C)(2)(e).

We reviewed the Provider's patient files for recipients receiving oxygen services to determine whether patients were evaluated by their treating physician when receiving prescriptions for oxygen services. The CMNs which covered the date of the sampled service were reviewed, if present, for the date of "last medical examination" field. If the date of the "last medical examination" was blank or there was no CMN; the patient's entire file was reviewed for evidence of the medical examination.

We identified errors with the medical exams for 25 services as follows:

- In 25 instances where documentation could not be found indicating the patient was evaluated by the prescribing physician.

The reimbursements for these services were disallowed and used in calculating the projected findings.

3. Summary of Oxygen Services Statistical Sample

The overpayments identified for 46 of 116 services (totaling $8,119.30) from our statistical sample were projected to the Provider's subpopulation of paid oxygen services. This resulted in a projected overpayment amount of $49,206 with a precision of plus or minus $10,292 (20.92 percent) at the 95 percent confidence level. However, since the obtained precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate using the lower limit of a 90 percent confidence interval (equivalent to the method used in Medicare audits), and a finding was made for $40,590. This allows us to say that we are 95 percent certain the population overpayment is at least $40,590. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Additionally, the AOS assessed interest of $4,679.53 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $45,269.53 Additional interest of $8.90 per day will accrue after

September 8, 2011 until repayment. The total amount of the finding is repayable to ODJFS as of the release of this audit report.

C. Matter for Attention

Although the following matter did not result in monetary findings during the current audit, we bring it to the attention of the Provider as an area of possible non-compliance that could result in future findings. We also bring this issue to the attention of ODJFS as it is well positioned to educate providers concerning this issue.

1. PRN Plans of Treatment

Some of the patient files reviewed at Lincare contained a document entitled "Lincare Plan of Treatment". Lincare requested that physicians review and sign this Plan of Treatment for their patients serviced by Lincare.

A section on the Lincare Plan of Treatment form states "Lincare's pulmonary assessments may include vital signs, spot and/or overnight pulse oximetry, peak flow monitoring, spirometry and breath sounds/chest assessments. This section contains two selections for the physician to choose from: a checkbox that theses test are to be performed PRN, and an Other fill in the blank option, with suggestions of 3 month, 6 months, etc. below it. None of the forms we reviewed had other than the PRN option selected. According to Dictionary.com, PRN or p.r.n. is Latin for "as needed".

The Lincare Plan of Treatment form contains a box that can be checked by the physician that states "For all my patients admitted to Lincare". This, according to the form, will allow the physician to use the form as "a blanket plan of treatment" for patients. We found only a few Plans of Treatment that contained a particular patient's name or other pertinent patient specific information. Most of the plans we reviewed only stated "For all my patients admitted to Lincare." Indeed, even if the tests were timely performed and the Lincare forms completed as the form requests, the forms would not satisfy the documentation requirement in Ohio Admin. Code § 5101:3-10-13 (C)(3) for the timing of the tests.

This Plan of Treatment form and its use does not specify whether the patient's qualifying test is to be performed "at rest", "at sleep" or "at exercise". Neither does it indicate the specific test, ABG vs. SpO_2, the patient is to undergo. In essence, the 'plan of treatment' form is not based on the individual needs of a patient. Medicaid regulations state that the attending prescriber has to order the test, as well as evaluate and countersign the results. Instead of the prescribing physician making the decision at the time of patient evaluation, this form allows Lincare to determine which tests and testing condition the patient should undergo and when testing should occur. Consequently, the Provider should modify its forms and procedures to comply with Medicaid regulations.

PROVIDER'S RESPONSE

A draft report along with a detailed list of services for which AOS took findings was mailed to the Provider on June 7, 2011. The Provider was afforded ten business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which AOS took findings or otherwise respond in writing. We discussed the report with the Provider on July 5, 2011 during an exit conference. The Provider subsequently supplied documentation that was used to adjust our findings. A final determination of findings was made after receipt and review of the supplied documentation.

APPENDIX I

Summary of Sample Record Analysis for Lincare, Inc
For the period November 1, 2007 through October 29, 2009
Oxygen Sample Population – Provider Number 2117159

Description	Audit Period Nov. 1, 2007 – Oct. 29, 2009
Type of Examination	Simple Random Sample
Description of Population Sampled	Paid Oxygen Concentrator and Stationary Liquid Oxygen Services
Number of Population Services Provided	***703***
Number of Population Services Sampled	***116***
Total Medicaid Amount Paid for Population	***$128,811.18***
Amount Paid for Population Services Sampled	***$21,055.26***
Estimated Overpayment using Point Estimate	***$49,206***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***$10,292(+/-20.92%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***$8,616 (+/-17.517%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare Audits)	***$40,590***

This Page is Intentionally Left Blank.

Dave Yost • Auditor of State

LINCARE INC

ASHTABULA 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
SEPTEMBER 8, 2011

88 East Broad Street, Fifth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.auditor.state.oh.us