Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to THI of Ohio @ Auburn Manor

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

November 15, 2007

Ms Stephanie DeWees
Administrator
THI of Ohio @ Auburn Manor
375 Glenn Avenue
Washington Court House, OH 43160

Dear Ms. DeWees:

Attached is our report on Medicaid reimbursements made to THI of Ohio @ Auburn Manor, Medicaid provider number 2410493, for services rendered for the period July 1, 2004 through June 30, 2005. We identified $95,663.68 in findings plus $33.24 in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After November 15, 2007, additional interest will accrue at $0.06 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).

We are forwarding this report to the 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 order 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 THI of Ohio @ Auburn Manor, 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
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www.auditor.state.oh.us

Questions regarding this report should be directed to Jeffry Castle, Chief of the Medicaid/Contract Audits Section, at (614) 466-7894, or toll free at (800) 282-0370.

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: THI of Ohio @ Auburn Manor
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

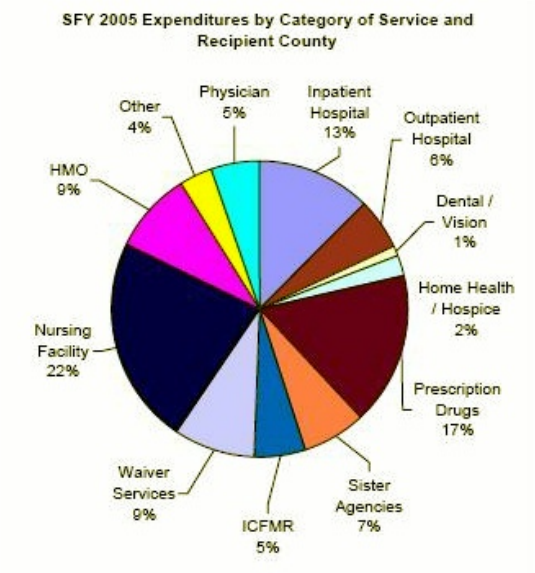
The Auditor of State performed an audit of THI of Ohio @ Auburn Manor (hereafter called the Provider), provider #2410493, doing business at 375 Glenn Avenue, Washington Court House, Ohio 43160. We performed our audit in accordance with Ohio Rev.Code § 117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified $95,663.68 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest[1] of $33.24 are repayable to ODJFS. Additional interest of $0.06 per day will accrue after September 26, 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 Medicaid services. Under that new authority, providers who render services to patients residing in nursing facilities (NF) were selected for audit.

Table 1: Ohio Medicaid Expenditures



Source: Ohio Medicaid Report 2005

[1] *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 June 14, 2006, the latest payment date in the random sample used for analysis.*

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 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 providers' compliance with Medicaid reimbursement rules.

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 an Intermediate Care Facility for 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 nursing facility (NF) and intermediate care facility for the mentally retarded (ICFs-MR) shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, [JFS 02524-appendix A of rule 5101:3-3-202 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 ICFs-MR, must be filed within ninety days after the end of the reporting period.
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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 and the persons rendering the service, the services rendered in nursing facilities (NF) are either directly reimbursable to the rendering provider and the nursing facility; or must be reimbursed through the facility cost report. The following services may be directly 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).
42 U.S.C. § 1395i-3 states in pertinent part:

> ***
>
> … the term "skilled nursing facility" means an institution (or a distinct part of an institution) which –

(1) is primarily engaged in providing to residents –

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) 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 during the period July 1, 2004 through June 30, 2005. During this period, the Provider was reimbursed $2,565,507.76 (excluding Medicare crossovers) for 628 monthly claims, with a total of 17,865 days, for 92 patients. Following a notification letter, we held an entrance conference at the Provider's place of business on July 13, 2006, to discuss the purpose and scope of our audit.

We used the Ohio Revised Code and the Ohio Administrative 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 the date of death.

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

Our work was performed between January 25, 2006 and January 24, 2007.

FINIDNGS

We identified $95,371.44 in findings for incorrectly billed room and board services for patients. An additional $292.24 in findings was identified for incorrectly billed therapy services. The total findings of $95,663.68 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:
>
> ***
> (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 entire audit period.
- Compared each month's 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 claims for the patients.

- Calculated the correct payment amount using the census data and the daily per diem rate for each patient if a discrepancy was found. (Note: leave days are reimbursed at 50 percent of the daily per diem rate).
- Subtracted our calculated amount from the 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 any adjustments were found, the adjustment amount was subtracted from the findings.

We reviewed all 628 monthly claims (with a total of 17,865 days for 92 patients) and found incorrect payments due to the following:

- therapeutic leave days, paid at 100 percent of the per diem instead of 50 percent,
- bed hold days, paid at 100 percent of the per diem instead of 50 percent,
- patient liability not accounted for in reimbursement,
- Medicaid payment for Medicare covered days,
- Medicaid payment for private pay days.

While reviewing the incorrect payments, we found the Provider had previously sent an adjustment to ODJFS for 55 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.

Based upon our review of the Provider's room and board documentation, we identified incorrect payments which resulted in findings of $95,371.44.

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 38 therapy services for which they were reimbursed $1,547.90. They rendered services such as physical and occupational therapy evaluations, neuromuscular re-education, and therapeutic exercises.

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 38 therapy services billed during the audit period and issued findings for eight of them. We did not find documentation for seven (7) of the billed services. Additionally, one therapeutic exercise service was incorrectly billed by one unit.

We issued findings against the reimbursement of therapy services in the amount of $292.24.

Summary of Findings

A total of $95,663.68 in findings was identified. These findings result from the combination of our findings from incorrectly billed room and board services ($95,371.44) and findings from incorrectly billed therapy services ($292.24).

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on September 26, 2007 to afford them an opportunity to provide additional documentation or otherwise respond in writing. We received a letter from the Provider on October 11, 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:
THI of Ohio @ Auburn Manor
375 Glenn Avenue
Washington Court House, OH 45320

2. Provider Number:	**2410493**
3. Review Period:	**July 1, 2004 through June 30, 2005**
4. AOS Finding Amount (including accrued interest):	**$95,696.92**
5. Interest "as of" Date:	**November 15, 2007**
6. Date Payment Mailed:	
7. Additional Interest Owed: (Calculated by multiplying $0.06 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.

In the event that the Provider fails to pay the full amount within 45 days of the report date, the AOS finding amount plus accrued interest will be certified to the Office of Attorney General for collection in accordance with Section 131.02 of the Ohio Revised Code. Upon certification, the Provider will be assessed an additional 10 percent collection fee by the Attorney General.

Mary Taylor, CPA
Auditor of State

THI OF OHIO AT AUBURN MANOR

FAYETTE 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
NOVEMBER 15, 2007

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