STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to RCS Subacute, Inc. and RCS Management, Corp.

A Compliance Review prepared by the:

Fraud, Waste and Abuse Prevention Division

January 2003 *AOS/FWAP-03-002C*

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

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Kevin Merritt, Owner
RCS Management Corp.
341 Gradle Drive
Carmel, IN 46032

Dear Mr. Merritt:

We have completed our audit of selected medical services rendered to Medicaid recipients by RCS Subacute, Inc. and RCS Management, Corp. for the period April 1, 1999 through March 31, 2002. We identified findings in the amount of $506,907.28, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "Provider Remittance Form" is included at the back of this report for remitting payment.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if repayment of the findings is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

Additionally, we identified questioned costs of $322,290.28 for services that we believe were billed in excess of the Provider's usual and customary fee for oxygen concentrator services. We are recommending that the Ohio Department of Job and Family Services determine whether or not these questioned costs are recoverable. However, because these questioned costs are already included in the findings referenced above, any action taken by the Department should not result in recoveries exceeding $506,907.28.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

January 7, 2003

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ABBREVIATIONS

AOS	Auditor of State
CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of RCS Subacute, Inc. and RCS Management, Corp., Provider Numbers 0253989 and 2212617, doing business at 341 Gradle Drive, Carmel, Indiana 46032. Our review encompassed RCS Subacute, Inc. and RCS Management, Corp. (hereafter called the Provider) because the same entity was providing services, although the Provider changed names and provider numbers during our review period. We identified $506,907.28 in findings for services that did not meet reimbursement rules of the Durable Medical Equipment Manual and the Ohio Administrative Code.

Additionally, we identified questioned costs of $322,290.28 for services that we believe were billed in excess of the Provider's usual and customary fee for oxygen concentrator services. We are recommending that the Ohio Department of Job and Family Services determine whether or not these questioned costs are recoverable. However, because these questioned costs are already included in the findings referenced above, any action taken by the Department should not result in recovering more than $506,907.28.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews to assess Medicaid providers' compliance with Federal and State claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a Federal/State financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The Ohio Department of Job and Family Services (ODJFS) administer the Medicaid program. The rules and regulations that providers must follow are issued by ODJFS in the form of an Ohio Medicaid Provider Handbook.

ODJFS' Medicaid Provider Handbook, Chapter 3334, General Information, Section II, Subsection (B) states, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must authorize medical services within the scope of his/her licensure and based on their professional judgment of those services needed by an individual. Medically necessary services are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

Durable medical equipment services are among the services reimbursed by the Medicaid program when delivered by eligible providers to eligible recipients. Durable medical equipment encompasses equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. Requirements for providers of durable medical equipment services are covered in ODJFS' Durable Medical Equipment Manual, which is a part of the Ohio Medicaid Provider Handbook.

All durable medical equipment services that are reimbursed by Medicaid must be prescribed by a physician. For ongoing services or supplies, a new prescription must be obtained at least every

twelve months. Providers must keep copies of prescriptions which include a diagnosis in their files.

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172, (E), 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 date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud 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."

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the Medicaid program."

PURPOSE, SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter that they were selected for a compliance review. An Entrance Conference was held on July 8, 2002 at the provider's facility with Kevin Greisl, CEO, Deb Griffith, Vice President of Operations, and Michael Bayler, Controller.

During the review period, the Provider submitted claims for reimbursement to the Department of Job and Family Services using the provider numbers for RCS Subacute, Inc. and RCS Management, Corp. Our review scope included reimbursements made to both entities.

We utilized ODJFS' Medicaid Durable Equipment Manual and the Ohio Administrative Code (OAC) as guidance in determining the extent of service and applicable reimbursement rates. We obtained the provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to Medicaid and paid to providers. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service.

Services are billed using the five (5) digit Current Procedural Terminology (CPT)[2] coding system or ODJFS local level codes[3].

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period April 1, 1999 through March 31, 2002. During this review period, the Provider was reimbursed $506,907.28 for oxygen concentrators for patients residing in long term care facilities, including $369,083.52 paid to RCS Subacute, Inc for 1,854 claims for services to 539 Medicaid recipients and $137,823.76 paid to RCS Management, Corp for 708 claims for services to 261 Medicaid recipients.

To facilitate an accurate and timely review of paid claims, we analyzed a statistically random sample of oxygen recipient dates of service. A recipient date of service is generally a charge for one recipient for one month's oxygen service. The review involved comparing the Provider's records for oxygen services with the claims payment history from MMIS. In addition, we looked for "duplicate" payments – payments in which two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We also checked for other types of overpayments, such as payments for services to recipients who were deceased at the time of service and whether the Provider charged Medicaid more than their usual and customary fee for oxygen concentrator services.

A draft report was mailed to the Provider on October 23, 2002 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider submitted a written response on November 15, 2002. In addition, we met with the Provider and their legal representative on December 2, 2002. In addition, the Provider's position regarding our findings and questioned costs have been incorporated into the report.

Our work was performed between June 2002 and December 2002 in accordance with government auditing standards.

FINDINGS

Our findings of $506,907.28 are based on overpayments caused by claims that were not backed by documentation showing the amount of oxygen used each month. We also took exception with other claims that (1) did not have sufficient documentation to validate a physician order and/or physician signature, (2) were for services to deceased recipients, (3) were duplicate payments, (4) did not document equipment deliveries, and (5) were missing required oximetry readings. In addition, we also identified questioned costs for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services.

[2]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[3] Local level codes are published in the Ohio Medicaid Providers Handbook.

[4] OAC 5101:3-10-13 (C)(5) was amended by the ODJFS effective 10/11/2001. OAC 5101:3-10-13 (H)(1) states "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." This rule change did not affect our audit finding.

Missing Oxygen Usage Readings

Section 5101:3-10-13 (C) (5)[4] of the Ohio Administrative Code states:

All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient. The amount of oxygen actually used each month (as determined from a meter reading), must be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of the amount of oxygen used each month must be maintained in the provider's file.

Provider maintenance and documentation of the amount of oxygen used does not meet the requirements of this rule when such documentation is created, or collected, from sources other than the provider, after the service has been billed.

All oxygen services are billed in cubic feet according to the amount of oxygen used. Providers must use meter readings to calculate the cubic feet of oxygen used for the month's services. Therefore, a meter reading is essential in determining the correct code to bill for oxygen services.

In our entrance conference, the Provider's management team informed us that they did not obtain or keep oxygen usage readings (typically obtained by reading meters on concentrators) for patients they serviced. They explained that they supplied oxygen concentrator services to Medicaid patients in a number of different states, and had not been aware of Ohio's unique requirement for meter readings. They further explained that most other states pay a flat fee for oxygen concentrator services, instead of basing reimbursement on the amount of oxygen used.

The lack of documentation on oxygen use was confirmed by our review of the Provider's oxygen records: 118 of the 118 sampled recipient dates of service for RCS Subacute, Inc. and 106 of the 106 sampled recipient dates of service for RCS Management, Corp**.** did not contain meter readings to document the amounts of oxygen used. We also noted that in 2,556 of the 2,562 claims in our review period, the Provider billed and was reimbursed for a full unmodified oxygen concentrator service. Without the meter reading, however, neither we nor the Provider could determine the correct level of oxygen to claim for reimbursement.

Other Concurrent Findings

We identified other deficiencies that would normally be subject to monetary findings; however, but we are not seeking recovery of these findings since the lack of oxygen meter readings made all of the Provider's Medicaid claims ineligible for reimbursement.

No Physician Orders and/or No Physician Signature

Section 5101:3-10-05 (A) of the Ohio Administrative Code states:

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . . For medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code:

In addition, Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code states:

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. The prescription, or certification of medical necessity, must specify: (a) diagnosis; (b) oxygen flow rate; and (c) duration (hours per day); or (d) indications for usage.

In our sample review of oxygen services provided to residents of long term care facilities we found that 11 of the 118 sampled recipient dates of service for RCS Subacute, Inc. and 19 of the 106 sampled recipient dates of service for RCS Management, Corp., were not supported by a prescription. The lack of valid physician orders would have resulted in projected findings of $50,654.86, including $25,953.48 for RCS Subacute, Inc. and $24,701.38 for RCS Management, Corp.

Duplicate Payments

Section 5101:3-1-198 (E) (Payment errors and overpayments) of the Ohio Administrative Code states:

> Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery . . .

During our field review, we checked for instances where two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We identified two types of duplicate payments:

- 214 duplicate claims which resulted from the same claims submitted by RCS Subacute, Inc. and RCS Management, Corp.,
- 31 duplicate claims which resulted from the same claims submitted by either RCS Subacute, Inc. or RCS Management, Corp. and a third provider.

The total amount paid to RCS Subacute, Inc. and RCS Management, Corp. for these duplicated claims were $43,747.20, of which we estimate $24,641.28 was the duplicated amount.

Services Billed for Deceased Recipients

In our deceased recipient test, we found that the Provider had received reimbursements for deceased recipients. OAC Section 5101:3-1-198 (E) (Payment errors and overpayments) prohibits payments for these services.

We determined that the Provider billed Medicaid for 5 services rendered subsequent to the recipients' date of death. The amount reimbursed to the Provider was $892.80.

Other Reportable Conditions

Although we did not calculate monetary findings in the following two areas, we are recommending that the Provider correct these deficiencies.

Equipment Delivery Not Documented

According to OAC 5101:3-10-13 (F)(1) and (H)(1)...

> For recipients receiving gaseous or liquid oxygen, documentation of the amount of oxygen actually used each month (as determined from a meter reading or documented refill amount and delivery information) must be maintained in the provider's file.

For oxygen services provided to recipients residing in long term care facilities, we identified 11 of the 118 sampled recipient dates of service for RCS Subacute, Inc. and 36 of the 106 sampled recipient dates of service for RCS Management, Corp. that did not contain delivery tickets. Delivery tickets are necessary to verify that equipment was delivered to the patient for oxygen services.

Pulse Oximetry Results Not Documented

According to OAC 5101:3-10-13 (G)(4)… For each resident who receives oxygen services for six months or more, the resident's PO2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter. The provider shall keep on file a copy of a laboratory report of an arterial blood gas (ABG) study that has been ordered and evaluated by the prescribing physician. Documentation of pulse oximetry may be kept on file in lieu of an ABG, when ordered and evaluated by the prescribing physician. A copy of the dated oximetry print-out or a dated form used to document the oximetry results, signed and dated by the prescribing physician, shall be kept in the provider's file. All tests for oxygen saturation shall be performed while the resident is in stable condition, at rest.

We identified 29 of the 118 sampled recipient dates of service for RCS Subacute, Inc. and 18 of the 106 sampled recipient dates of service for RCS Management Corp. that did not have patients' PO2 levels documented.

Need to Reduce Double Billing Risk

During the course of our review, the Provider supplied additional documentation to support its claims for oxygen concentrator services. Included in the documentation were invoices sent to nursing homes by the Provider that included line items for concentrator services to Medicaid recipients. We also noted that the Provider had billed Medicaid directly and been reimbursed for the same services to these recipients. The Provider explained that duplicate billings sometimes occur because of confusion as to whether recipients are Medicaid eligible. The Administrator of the nursing home that received the invoices acknowledged the potential for confusion, which their facilities attempt to mitigate by sending oxygen services providers a list each month that designates the service payer for each recipient. She added that finance staffs at each nursing facility also review invoices to ensure that the facility does not pay for services that are the responsibility of other payers (e.g. Medicaid).

We did not pursue this line of inquiry further because technically, the Provider did not submit duplicate billings to Medicaid. However, to the extent that nursing homes might make erroneous payments because of an erroneous invoice, the payments would inflate costs in a facility's cost report. Ultimately, the inflated costs could increase the Medicaid per diem payment that nursing facilities receive, since the per diem rate is derived from cost reports. Therefore, the situation we identified can potentially cause Medicaid overpayments. Because providers are responsible for billing correctly, we believe this Provider should develop controls to prevent future duplicate billing situations.

Follow up Test for Services

The lack of oxygen meter readings, physician orders, and other items prevented us from determining whether or not the Provider's claims for reimbursement were consistent with the amount of oxygen delivered and in some cases, whether the services had been ordered by physician. We also tested whether or not any services had been provided. To perform this test, we randomly selected 30 recipient dates of services from our sample of 224 dates of service and contacted the long term care (nursing home) facilities where the recipients resided. For each service, we asked the facility to verify whether or not the recipient(s) received oxygen services from the Provider for the dates of service in question. Our results indicated the Provider had supplied oxygen concentrator services to all 30 recipients. The only discrepancy with the Provider's claims involved two instances where the recipients were in the Hospice Program. Hospice providers are paid a per diem rate by Medicaid for providing services to hospice recipients, including oxygen. Therefore, in these two instances, the Provider should have billed the hospice provider for oxygen services, instead of Medicaid directly.

Provider's Response to our Findings

In general, the Provider agreed with our findings stemming from duplicate payments and payments for services to deceased recipients. The Provider also told us that new forms have been developed and implemented to remedy the documentation deficiencies noted in our report.

However, the Provider disagreed with the findings stemming from missing oxygen meter readings. While acknowledging that meter readings had not been kept, the Provider does not believe that the missing meter readings justifies asking for repayment of all Medicaid reimbursements. The Provider's legal representative argued that state regulations regarding oxygen meter readings are inapplicable to oxygen concentrators because oxygen filtered and delivered by a concentrator is not a consumable product (unlike liquid or gaseous oxygen). Therefore, the representative argued, whether a patient uses oxygen at two liters a minute or five liters per minute is immaterial when it comes to billing. The Provider's legal representative further argued that the Provider "substantially complied" with other requirements regarding physician orders, delivery tickets and pulse oximetry readings and therefore should not be required to repay Medicaid reimbursements.

We agree that Ohio's rules regarding Medicaid reimbursement for oxygen concentrator services need to be reviewed. For example, in response to questions we are raising about the application of "usual and customary" fees (see below), we believe ODJFS may need to reconsider its reimbursement method. In the meantime, however, we believe that the requirement for oxygen meter readings is clearly spelled out in Section 5101:3-10-13 (C) (5) of the Ohio Administrative Code (see page 3 above). Given this fact, we do not believe that a Provider can arbitrarily choose to disregard a rule because it disagrees with the rule. Moreover, noncompliance without penalty is not equitable to other oxygen services providers who are being held accountable for and are complying with the rule.

QUESTIONED COSTS REGARDING USUAL AND CUSTOMARY FEES

In order to supply medical services to Medicaid recipients, providers sign a provider agreement. The Ohio Administrative Code § 5101:3-1-172 states in part:

> A 'Provider Agreement' is a contract between the Ohio department of job and family services and a provider of medical ASSISTANCE services in which the provider agrees to comply with the terms of the 'Provider Agreement,' state statutes and ODJFS Administrative Code rules, and federal statutes and rules, and agrees to:
>
> (B) Bill the Ohio department of job and family services for no more than the usual and customary fee charged other patients for the same service.

In addition, the Ohio Administrative Code § 5101:3-10-13 (A)(6), Oxygen: covered services and limitations, states billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient.

During our review period, and based on information supplied by the Provider, the Provider normally charged long term care facilities $65.00 a month for the rental of oxygen concentrators used by non-Medicaid patients. Therefore, we are questioning $322,290.28 of Medicaid's costs paid to the Provider for concentrator services, because they appear to exceed the Provider's usual and customary charges. We calculated the difference between what was paid to the Provider by Medicaid (a median average of $178.56 per service) and the $65.00 rate charged by the Provider to long term care facilities for the period of April 1, 1999 through March 31, 2002; which amounted to $322,290.28 for 2,824 dates of service. The total amount of the questioned cost comprised $234.728.52 from RCS Subacute, Inc. and $87,561.76 from RCS Management, Corp.

In responding to our draft report, the Provider disagreed with our questioning whether the Provider's Medicaid charges for oxygen concentrator services represented the Provider's "usual and customary" fee. The Provider's legal representative offered data to support a position that the Provider incurred additional expenses in servicing Medicaid recipients that were not incurred in concentrator rental fees to nursing homes.

We did not gather detailed information on what additional expenses were incurred in supplying oxygen concentrators to Medicaid recipients, nor did we attempt to verify the expense data given to us by the Provider. We would agree that Medicaid documentation requirements could increase a Provider's administrative expenses. However, due to the large disparity of $113.56 per month/per concentrator between what the Provider charged Medicaid and the rate charged for patients in a same setting, we question whether the amounts billed to Medicaid were a "usual and customary" charge. Medicaid, like a nursing home, is a volume purchaser and should expect to benefit from reductions or discounting of fees and charges. Therefore, we are bringing this matter to the attention of the ODJFS' Office of Ohio Health Plans for their consideration and resolution.

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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
Post Office Box 182367
Columbus, Ohio 43218-2367

Auditee Name & Address:	Kevin Merritt, Owner RCS Management, Corp. 341 Gradle Drive Carmel, IN 46032
Auditee Number if needed:	0253989 and 2212617
Review Period:	4/1/99 through 3/31/02
AOS Finding Amount:	$506,907.28
Date Payment Mailed:	
Check Number:	

IMPORTANT:
To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Thomas Tedeschi at (614) 728-7398.

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RCS SUBACUTE/MANAGEMENT

CARMEL, INDIANA

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
JANUARY 7, 2003