Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Advanced Medical Concepts, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

March 2008 ***AOS/MCA-08-003C***

Mary Taylor, CPA
Auditor of State

March 11, 2008

Ms. Kathy Bolin
Treasurer
Advanced Medical Concepts, Inc.
8730 Ohio River Rd.
Wheelersburg, OH 45694

Dear Ms. Bolin:

Attached is our audit report on Medicaid reimbursements made to Advanced Medical Concepts, Inc., Medicaid provider number 0101802, for the period October 1, 2002 through September 30, 2005. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). We identified $419,654.54 in findings plus $82,321.27 in interest accruals 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 March 11, 2008, additional interest will accrue at $91.98 per day until repayment occurs. Interest is calculated pursuant to Ohio Administrative Code 5101:3-1-25(A).

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. 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" has been attached to this report.

Copies of this report are being sent to Advanced Medical Concepts, Inc., the Ohio Attorney General, the Director and Legal Division of ODJFS, and the Ohio Respiratory Care Board. In addition, copies are available on the Auditor of State website (www.auditor.state.oh.us).

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

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Advanced Medical Concepts, Inc.
Ohio Attorney General
Ohio Respiratory Care Board
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services

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PROVIDER REMITTANCE FORM 30

ACRONYMS

AOS	Auditor of State
AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
LTCF	Long-Term Care Facility
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Admin.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code

SUMMARY OF RESULTS

The Auditor of State performed an audit of Advanced Medical Concepts, Inc. (hereafter called the Provider), provider #0101802, doing business at 8730 Ohio River Rd., Wheelersburg, Ohio 45694. Within the Medicaid program, the Provider is listed as a medical equipment supplier.

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 $419,654.54 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest of $82,321.27 are repayable to ODJFS. After March 11, 2008, additional interest will accrue at $91.98 per day[1] 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

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 income, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Handbook. 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.[2] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Durable medical equipment services are among the services reimbursed by the Medicaid program when delivered by an eligible provider to eligible recipients. Durable medical equipment encompasses equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. It also includes certain medical supplies, such as oxygen, which are "consumable, disposable, or have a limited life expectancy."

Ohio Admin.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant

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[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 Admin.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was September28, 2005, as the latest payment date in the random sample used for analysis.*
[2] *See Ohio Adm.Code 5101:3-1-01(A) and (A)(6).*

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 audit initiated within the six year period is completed."

In addition, 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."

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."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance.

Following a notification letter, we held an entrance conference at the Provider's place of business on March 9, 2006 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2002 through September 30, 2005. During this period, the Provider was reimbursed $2,874,251.28 for 14,364 services, not involving Medicare co-payments, billed on 12,614 claims.

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. Services are billed using codes from the Healthcare Common Procedural Coding System (HCPCS) issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[3]

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:

[3] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

- Supplies dispensed in excess of the Medicaid maximum allowable price or quantity.
- Potential duplicate oxygen services billed by the Provider. (Defined as more than one oxygen service billed by the Provider for the same recipient, for the same month of service.)
- Potential duplicate oxygen services billed by the Provider and another provider. (Defined as more than one oxygen service billed by the Provider and different provider for the same recipient, for the same month of service.)
- Services billed to deceased recipients for service dates after their date of death.
- Oxygen service codes billed with a place of service that is not covered by the procedure code billed.
- Portable oxygen services billed for residents in a Long-Term Care Facility (LTCF).

All of our exception tests identified potentially incorrect reimbursements. When performing our field work, we reviewed the supporting documentation supplied by the Provider for all claims in our exception tests.

To facilitate an accurate and timely review of the Provider's remaining medical services, we also analyzed four statistically random samples and one census review as follows:

- Simple random sample of 100 volume ventilator claims (100 services).

- Stratified random sample of a total of 135 oxygen claims (135 services) billed as:

  Y2081 Oxygen, ltcf residents only, 501-750 cu ft or 41-60 lbs liq or equiv,
  Y2082 Oxygen, ltcf residents only, 251-500 cu ft or 21-40 lbs liq or equiv, or
  Y2083 Oxygen, ltcf residents only, 0-250 cu ft or 0-20 lbs liq or equiv.

- Statistically random sample of 100 total oxygen claims without a modifier (100 services) billed as:

  Y2076 Oxygen concentrator for ltcf residents, does not include supplies, or
  Y2079 Oxygen contents, liquid, for ltcf residents only, no supplies.

- Statistically random sample of 100 total oxygen claims (100 services), with modifier "QG," billed as:

  Y2076 Oxygen concentrator for ltcf residents, does not include supplies, or
  Y2079 Oxygen contents, liquid, for ltcf residents only, no supplies.

  The "QG" modifier is billed when the oxygen liter flow is greater than four liters continuous and portable oxygen is not used.

- Census review of 84 incontinence garment and related supplies services which listed the type of incontinence as the primary diagnosis.

Our work was performed between December 2005 and January 2007.

RESULTS

We identified findings that projected to $383,251.60 for the services in the sampled population. Additionally, we identified findings of $36,402.94 for services in our exception tests. Together, our findings repayable to ODJFS totaled $419,654.54 and are discussed in more detail below.

Results of Exception Testing

Items Dispensed in Excess of the Medicaid Maximum

Ohio Admin.Code 5101:3-10-03 states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule…
>
> ***

Appendix A of Ohio Admin.Code 5101:3-10-03 establishes maximum dollar amounts and/or maximum quantities that Medicaid will cover for medical supply items. Our computer analysis identified 99 services, where the Provider billed and was reimbursed either for more than the maximum allowed units; or more than the maximum allowed reimbursement for the supplies.

After subtracting the allowed maximum from the amount paid to the Provider, we identified findings totaling $14,732.56 for the items shown in Table 1.

Table 1: Items Dispensed in Excess of the Medicaid Maximum

HCPCS Code	HCPCS Description	Maximum Allowed Units	Number of Exceptions	Findings[4]
A4216	Sterile water/saline, 10mL	30 per month	2	$30.00
A4245	Alcohol wipes or swabs, per box	2 per month	2	$9.00
A4385	Ostomy skin barrier, solid, 4x4 or equivalent extended wear, without built-in convexity	5 per month	1	$60.00
A4386	Ostomy skin barrier with flange, extended wear without built-in convexity, any size	5 per month	4	$113.60
A4629	Tracheostomy care kit for established tracheostomy	30 per month	14	$502.35
A5063	Pouch, drainable; for use on barrier with flange (2pc)	10 per month	2	$42.60
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16sq.in. or less	30 per month	1	$24.00
A6216	Gauze, non-impregnated, pad siz 16 sq.in. or less, without adhesive border	$50 per month	14	$525.00
A7000	Canister, disposable, used with suction pump	3 per month	3	$52.50
A7003	Administration set, with small volume nonfiltered pneumonia nebulizer, disposable	4 per month	7	$34.40
A7015	Aerosol mask, used with DME nebulizer	4 per month	2	$4.89
A7018	Water, distilled, 1000mL	16 per month	7	$194.74
A7034	Nasal interface used with positive airway pressure device	One per year	1	$66.71

A7035	Headgear, used with positive airway pressure device	One per year	1	$34.95
B4035	Enteral feeding supply kit; pump fed (per day, includes bags/containers)	One per day	5	$658.00
E0450	Positive pressure volume ventilator, stationary or portable included	1 per month, always rented	15	$11,250.00
E0570	Nebulizer with compressor	One per 5 years R/P	3	$150.00
A4523, A4527, A4532, and T4527	Incontinence garments and related supplies	300 per month	5	$307.82
A4554 and T4541	Underpads (chux)	300 per 2 months	11	$672.00
		Total	***100***	***$14,732.56***

[4]Source of Findings: AOS analysis of the Provider's paid claims and provider's patients' records for October 1, 2002 through September 30, 2005.

Duplicate Payments

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for services actually performed…
>
> ***

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

> ***
>
> (H) …Payment for oxygen services for recipients in an LTCF is as follows:
>
> (1) …The amount of oxygen actually used each month…must be determined and documented by the provider prior to submitting the monthly claim for reimbursement…
>
> ***
>
> (3) Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.
>
> ***

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

Our analysis identified two different types of duplicately billed services: 1) claims filed solely by the Provider and, 2) duplicate or overlapping claims submitted by the Provider and another oxygen provider for the same patient for the same service.

We identified 124 services (62 pairs of duplicates) where the Provider billed for more than one oxygen service for the same recipient in the same month. Our 100 percent review identified 71 errors, totaling $8,066.70 in findings, as follows:

- 54 services were billed twice in the same monthly cycle causing an oxygen reimbursement duplicate for the month.
- 10 services were billed with overstated levels; therefore, we recoded the oxygen code to a lower code based on the liter flow and meter reading.
- Seven services did not have all the required documentation in the patients' medical records.

Our computer analysis also identified 304 duplicate combinations (128 combinations of duplicates) where the Provider and another oxygen provider billed for more than one oxygen service for the same recipient in the same month. Our 100 percent review identified 27 errors, totaling $3,529.20 in findings, as follows:

- The levels for 13 services were overstated; therefore, we recoded the oxygen service to a lower code based on the liter flow and meter reading.
- The Provider did not retain all required documentation for 14 services. For 14 of the services, the Provider did not submit documentation for review; seven services did not have a liter flow listed on the documentation; and two services did not have the oxygen consumption documented.

The total finding made for duplicate payments was $11,595.90.

Services Billed for Deceased Recipients

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for services actually performed…
>
> ***

During our computer analysis testing, we determined that the Provider billed Medicaid for four services rendered after the recipient's date of death. One recipient was billed once after the date of death and one recipient was billed three times after the date of death. Therefore, a finding was made for the $3,000.00 in reimbursement received for these services.

Oxygen Services Billed as if Patient was LTCF Resident

Ohio Admin.Code 5101:3-10-03, states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A to this rule. This list includes the following information as described in paragraphs (A) to (G) of this rule:
>
> ***
>
> (B) Item description. A brief description of the supply or equipment item.
>
> ***

Appendix A lists the HCPCS codes providers must use when billing for oxygen services. The oxygen codes are grouped by the location of the patient's residence. The oxygen codes used to bill for services rendered to patients residing in a long-term care facility (LTCF) are different from those codes used to bill for services rendered to patients residing in a personal residence.

Additionally, Ohio Admin.Code 5101:3-10-13 (D) through (F) describe the rules for oxygen services in a personal residence while Ohio Admin.Code 5101:3-10-13 (G) and (H) describe the rules for oxygen services rendered to patients residing in a LTCF.

Our computer analysis identified 17 oxygen services, dispensed to 17 recipients, where the HCPCS code billed indicated that the recipient was a LTCF resident, however, the place of

service on the reimbursement claim indicated the patient did not live at a LTCF. The Provider submitted additional clarifying documentation for 15 of these services which we accepted. However, one recipient was determined to not reside in a LTCF and the Provider did not furnish any additional supporting documentation. The remaining recipient was determined to reside in a LTCF but no valid physician order was furnished by the provider for service rendered. Therefore, we disallowed the reimbursement for these two services, resulting in a finding of $357.12.

Portable Oxygen Services Billed for LTCF Residents

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

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

Furthermore, the chart in Appendix B of the rule shows that portable contents are not allowed to be billed directly to the department unless the recipient owns the stationary oxygen concentrator and/or owns the portable system.

Our computer analysis identified eight oxygen services where the Provider billed for portable oxygen services for recipients who resided in a LTCF. These services should not have been billed directly to Medicaid, but rather should have been included in the LTCF's cost report. Therefore, we disallowed the reimbursement of these eight services, resulting in a finding of $80.00.

Incontinence Garments and Related Supplies with Incomplete Prescriptions

Ohio Admin.Code 5101:3-10-21 states in pertinent part:

> ***
>
> (B) A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months. The prescription must be obtained by the provider prior to the first date of service in the applicable twelve-month period and must specify:
> (1) The applicable diagnosis of the specific disease and injury causing the incontinence; or
> (2) The developmental delay or disability, including applicable diagnoses; and
> (3) The type of incontinence

> ***
>
> (C) A prescription that only lists incontinence or incontinence supplies and does not specify the disease or injury that had resulted in the incontinence in accordance with paragraph (B) of this rule does not meet the requirements of this rule…
>
> ***

Our computer analysis identified 84 services where a type of incontinence was listed in the claims' primary diagnosis field; however, a qualifying diagnosis was not listed in the claims' secondary diagnosis field. Therefore, we reviewed these 84 services to determine if they were in compliance with the above rule. We determined that 83 services had at least one error.

- Documentation for 21 services did not contain a prescription, or the prescription was invalid. Furthermore, one of the prescriptions, covering two services, had a date added to the prescription after our initial field review.
- Documentation for 51 services lacked a diagnosis specifying the disease or injury which caused the patient's incontinence.
- Documentation for 52 services did not state the patient's type of incontinence.
- Documentation for 41 services, did not list neither the diagnosis nor the patient's type of incontinence.

We disallowed the reimbursement for services billed with incomplete prescriptions resulting in findings of $6,637.36.

Summary of Exception Testing

Total combined findings of $36,402.94 resulted from our 100 percent exception testing, which included $14,732.56 for items dispensed in excess of the Medicaid maximum, $11,595.90 for duplicate payments, $6,637.36 for incontinence garments and related supplies lacking complete prescription information, $3,000.00 for services billed for deceased recipients, $357.12 for oxygen services billed erroneously for non-LTCF residents, and $80.00 for portable oxygen billed for LTCF residents.

Results of Sample Testing

We selected four statistical samples for review. All samples were chosen from corresponding subpopulations that excluded all Medicare co-payments and all services already identified by our exception tests for 100 percent review. All four subpopulations sampled were composed of single service claims.

During our review, we identified the following findings: lack of documentation for volume ventilator claims, and lack of documentation and overstated levels of service for oxygen rendered to patients residing in long-term care facilities. The projected finding from our field reviews total $383,251.60. The bases for our findings are stated below.

Sample of Volume Ventilator Services

Ohio Admin.Code 5101:3-10-05(A) states in pertinent part:

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated…For ongoing services or supplies, a new prescription must be obtained at least every twelve months…

We selected a simple random sample of 100 ventilator services from the Provider's subpopulation of 1,158 ventilator paid service claims. These services excluded those associated with Medicare co-payments and services extracted for 100 percent review.

Eleven services were identified where the Provider's service records were missing part of the required information. Specifically, for 10 services the prescription was either missing or invalid, and 1 service did not have a diagnosis on the prescription.

Furthermore, for 6 of these 11 services, the date on the prescription appeared to be altered to cover services other than those originally designated on the prescription. Therefore, we disallowed the reimbursement for these services, resulting in actual findings, prior to projection, of $8,250.00.

Summary of Sample Findings for Volume Ventilator Services

The overpayments identified for 11 of 100 statistically sampled services were projected across the Provider's total subpopulation of paid volume ventilator services. This resulted in a projected overpayment amount of $95,535 with a precision of plus or minus $51,799 (54.22 percent) at the 95 percent confidence level. Since this projection did not meet criteria that our procedures require for use of a point estimate, the results were restated as a single-tailed lower limit estimate using the lower limit of the 90 percent confidence interval (equivalent to method used in Medicare audits), and a finding was made for $52,190. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $52,190. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Sample of Oxygen HCPCS Codes Y2081, Y2082, and Y2083

We took a stratified random sample of 135 oxygen claims, with 135 services, for long-term care facility (LTCF) patients where the following codes were billed:

- Y2081 Oxygen, ltcf residents only, 501-750 cu ft or 41-60 lbs liq or equiv
- Y2082 Oxygen, ltcf residents only, 251-500 cu ft or 21-40 lbs liq or equiv
- Y2083 Oxygen, ltcf residents only, 0-250 cu ft or 0-20 lbs liq or equiv

Our sample was taken from a subpopulation of 2,114 oxygen service claims. Our review determined that 39 claims sampled had discrepancies in the documentation, and resulted in projected findings of $23,915.00. The bases for these findings are presented below.

Required Documentation Not Received

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

> (A)(1) A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.
>
> ***
>
> (G)(2) …The prescription…must specify: (a) Diagnosis; (b) Oxygen flow rate; and (c) Duration (hours per day); or (d) Indications for usage.
>
> ***
>
> (4) For each resident who receives oxygen services for six months or more, the resident's PO_2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter.
>
> ***
>
> (H)(1) …The amount of oxygen actually used each month (as determined from a meter reading or refill amount and delivery information) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement.
>
> ***

We identified 34 services where the Provider's service records were missing part of the required documentation. Some of the services with a finding contained more than one error; however, only one finding per service was made as follows:

- For 19 services, the Provider's documentation did not contain a physician prescription.
- For nine services, the Provider did not maintain meter readings which made the amount of oxygen used for the month undeterminable.
- For six services, the Provider did not obtain the required pulse oximetry readings.
- For three services, the Provider did not submit documentation for our review.
- For three services, the Provider's prescription did not have a diagnosis listed.

Therefore, we disallowed the reimbursement for these services, resulting in actual overpayments prior to projection of $1,584.00.

Level of Service Not Supported by Documentation

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

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

Additionally, during our field review of oxygen services, we identified five services where the Provider billed for a higher level of service than the documentation supported. The services were recoded to the HCPCS code supported by the liter flow and meter readings of the Provider's documentation.

- Four services billed as HCPCS Y2081 (oxygen, ltcf residents only, 501-750 cu ft or 41-60 lbs liq or equiv) were recoded to HCPCS Y2082 (oxygen, ltcf residents only, 251-500 cu ft or 21-40 lbs liq or equiv).
- One service billed as HCPCS Y2082 (oxygen, ltcf residents only, 251-500 cu ft or 21-40 lbs liq or equiv) was recoded to HCPCS Y2083 (oxygen, ltcf residents only, 0-250 cu ft or 0-20 lbs liq or equiv).

We determined the findings by taking the difference between the amount reimbursed for the billed code and the allowed amount for the code supported by the documentation. The actual overpayments prior to projection totaled $120.00.

Summary of Sample Findings for Oxygen Services Y2081, Y2082, and Y2083

We took exception with 39 of 135 selected services from a stratified random sample of the Provider's population of paid services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $66,535, with a 95 percent certainty that the actual correct payment amount fell within the range of $60,145 to $72,925 (+/- 9.60 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($66,535) from the amount paid to the Provider for this population ($90,450.00), which resulted in a finding of $23,915.00. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Sample of Oxygen HCPCS Codes Y2076 and Y2079 (unmodified)

We selected a statistical random sample of 100 oxygen claims billed without a modifier, with 100 services, for long-term care facility (LTCF) patients where the following codes were billed:

- Y2076 Oxygen concentrator for ltcf residents, does not include supplies
- Y2079 Oxygen contents, liquid, for ltcf residents only, no supplies

Our sample was selected from a subpopulation of 8,466 oxygen service claims. Our review determined that 20 claims were overpaid and resulted in projected findings of $269,719.96. The bases for these findings are presented below.

Required Documentation not Received

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

> (A)(1) A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.
>
> ***
>
> (G)(2) …The prescription…must specify: (a) Diagnosis; (b) Oxygen flow rate; and (c) Duration (hours per day); or (d) Indications for usage.
>
> ***
>
> (4) For each resident who receives oxygen services for six months or more, the resident's PO_2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter.
>
> ***
>
> (H)(1) …The amount of oxygen actually used each month (as determined from a meter reading or refill amount and delivery information) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement.
>
> ***

We identified 14 services where the Provider's service records did not contain all of the required documentation. Some services with a finding contained more than one error; however, only one finding per service was made as follows:

- Five services did not contain a physician prescription.
- Two services did not have a diagnosis listed on the prescription.
- Three services had no documentation submitted for our review.
- Three services were missing other required information.
- Three services did not contain meter readings which made the amount of oxygen used by the patient for the month undeterminable.
- Two services did not obtain required pulse oximetry readings.

Therefore, we disallowed the reimbursement for these services resulting in actual overpayments prior to projection of $2,499.84.

Level of Service Not Supported by Documentation

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

> (C) Billing requirements.
> To receive a payment adjustment, one of the following modifiers must be used with stationary oxygen system codes when appropriate. This applies to oxygen used with concentrators, liquid and gaseous systems.
>
> (1) Modifier code QE shall be used and the payment amount reduced by fifty percent when:
> (a) The prescribed amount of oxygen is one liter per minute or less, or
> (b) The patient has used no more than one thousand cubic feet of gaseous oxygen, or no more than eighty pounds of liquid oxygen.
>
> ***
>
> (H)(3) Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose and listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.
>
> ***

We identified six services where the Provider billed for a higher level of service than supported by the documentation. The services were recoded to the HCPCS code supported by the liter flow and meter readings of the Provider's documentation.

- Two services billed as HCPCS Y2076 (oxygen concentrator, LTCF, 1000+ cubic feet) were recoded to HCPCS Y2083 (oxygen, ltcf residents only, 0-250 cu ft or 0-20 lbs liq or equiv).
- Two services billed as HCPCS Y2076 were recoded to HCPCS Y2076 modified with "QE."
- One service billed as HCPCS Y2076 was recoded to HCPCS Y2082 (oxygen, ltcf residents only, 251-500 cu ft or 21-40 lbs liq or equiv).
- One service billed as HCPCS Y2079 (liquid oxygen, LTCF, 1000+ cubic feet) was recoded as HCPCS Y2079 modified with "QE."

We determined the findings by taking the difference between the amount reimbursed for the billed code and the allowed amount for the code supported by the documentation. The actual overpayments prior to projection totaled $686.10.

Summary of Sample Findings for Y2076 and Y2079 Services (Unmodified)

We took exception with 20 of 100 statistically sampled recipient services (100 claims) from a simple random sample of the Provider's population of paid services. Based on this error rate, we

calculated the Provider's correct payment amount for this population, which was $1,241,967, with a 95 percent certainty that the actual correct payment amount fell within the range of $1,131,922 to $1,352,012 (+/- 8.86 percent.). We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($1,226,850.00) from the amount paid to the Provider for this population ($1,511,686.96), which resulted in a finding of $269,719.96. A detailed summary of our statistical sample and projection results is presented in Appendix III.

Sample of Oxygen HCPCS Codes Y2076 and Y2079 (modified with QG)

We took a simple random sample of 100 oxygen claims, with 100 services, modified with "QG," for long-term care facility (LTCF) patients where the following codes were billed:

- Y2076 Oxygen concentrator for ltcf residents, does not include supplies
- Y2079 Oxygen contents, liquid, for ltcf residents only, no supplies

Our sample was taken from the subpopulation of 746 oxygen service claims. Our review determined that 27 of the 100 sampled claims had discrepancies in the documentation and resulted in projected findings of $37,426.64. The bases for these findings are presented below.

Required Documentation not Received

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

> (A)(1) A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.
>
> ***
>
> (G)(2) …The prescription…must specify: (a) Diagnosis; (b) Oxygen flow rate; and (c) Duration (hours per day); or (d) Indications for usage.
>
> ***
>
> (4) For each resident who receives oxygen services for six months or more, the resident's PO_2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter.
>
> ***
>
> (H)(1) …The amount of oxygen actually used each month (as determined from a meter reading or refill amount and delivery information) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement.
>
> ***

During our field review, we identified 14 services where the Provider's service records did not contain all of required documentation. Some services with a finding contained more than one error; however, only one finding per service was made as follows:

- Documentation for eight services did not contain a physician prescription.
- Documentation for three services did not contain meter readings, which made the amount of oxygen used by the patient for the month undeterminable. Furthermore, we initially received documentation for one of these services that did not contain an ending meter reading; however, when we received additional documentation from the Provider an ending meter reading amount had been added.
- Documentation for four services did not contain pulse oximetry readings.
- Documentation for four services did not list a diagnosis on the prescription.
- Documentation for two services was missing other required information.

Therefore, we disallowed the reimbursement for these services resulting in actual overpayments, prior to projection, of $3,749.76.

Level of Service Not Supported by Documentation

Ohio Admin.Code 5101:3-10-13(C) states in pertinent part:

> ***
>
> (2) Modifier code QG shall be used and the payment amount increased by fifty per cent when:
> (a) The prescribed amount of oxygen is greater than four liter per minute continuous and portable oxygen is not prescribed.
> (b) If the QG modifier is used, the provider must check and record the appropriate meter readings or document the refill amount and delivery information.
>
> ***
>
> (H)(3)Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose and listed in Appendix A of rule 5101:3-10-03 of the Administrative Code.

We identified 13 services where the Provider billed for a higher level of service than supported by the documentation. The services were recoded to the HCPCS code supported by the liter flow and meter readings of the Provider's documentation.

- 12 services billed as HCPCS Y2076, modified with "QG" (oxygen concentrator, LTCF, 1000+ cubic feet, over 4LPM), was recoded to HCPCS Y2076 (unmodified).
- One service billed as HCPCS Y2076, modified with "QG," was recoded to HCPCS Y2081.

We determined the findings by taking the difference between the amount reimbursed for the billed code and the allowed amount for the code supported by the documentation. The actual overpayments, prior to projection, totaled $1,267.20.

Summary of Sample Findings for Y2076 and Y2079 Services (modified with QG)

We took exception with 27 of 100 statistically sampled recipient services from a simple random sample of the Provider's population of paid services. Based on this error rate, we calculated the Provider's correct payment amount for this subpopulation, which was $162,382, with a 95 percent certainty that the actual correct payment amount fell within the range of $149,347 to $175,418 (+/- 8.03 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($162,382.00) from the amount paid to the Provider for this subpopulation ($199,808.64), which resulted in a finding of $37,426.64. A detailed summary of our statistical sample and projection results is presented in Appendix IV.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on September 24, 2007 to afford an opportunity to furnish additional documentation or otherwise respond in writing. The Provider retained legal counsel and asked for an extension to respond to the draft report. An exit conference was held on December 4, 2007, during which the Provider submitted a written response to our report and additional supporting documentation for review. The Provider also requested additional time to furnish supporting documentation for incontinence and related supply items. An extension was granted to January 1, 2008, but on January 2, 2008 the Provider informed us that no additional documentation would be furnished.

Our review of the additional documentation furnished by the Provider on December 4, 2007 resulted in adjustments to the findings in both of our duplicate exception tests and to our place of service exception test. In addition, adjustments were made to the identified findings for all four of the statistical samples. In total, the exception and sample adjustments made resulted in an $89,310.54 reduction in recoverable findings.

A copy of the Provider's December 4, 2007 response, with patient names redacted for privacy reasons, due to the Health Insurance Portability and Accountability Act (HIPAA), is presented in Appendix VI.

APPENDIX I
Summary of Statistical Sample Analysis of Advanced Medical Concepts Inc.
Volume Ventilator Services
Audit Period: October 1, 2002 – September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Simple Random Sample of Claims
Number of Population Claims	1,158
Number of Population Claims Sampled	100
Number of Population Services Provided	1,158
Number of Population Services Sampled	100
Total Medicaid Amount Paid for Population	$868,500.00
Actual Amount Paid for Population Services Sampled	$75,000.00
Estimated Overpayment using Point Estimate	$95,535.00
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	+/-$51,799 (54.22%)
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	+/-$43,345 (45.37%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits).	$52,190

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

APPENDIX II
Summary of Statistical Sample Analysis of Advanced Medical Concepts Inc.
Sample of Oxygen HCPCS Codes Y2081, Y2082, and Y2083
Audit Period: October 1, 2002 – September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Stratified Random Sample of Claims
Number of Population Claims	2,114
Number of Population Claims Sampled	135
Number of Population Services Provided	2,114
Number of Population Services Sampled	135
Total Medicaid Amount Paid for Population	$90,450.00
Actual Amount Paid for Population Services Sampled	$6,810.00
Projected Correct Population Payment Amount	$66,535.00
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$72,925.00
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$60,145.00
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$23,915.00
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	$6,390.00 (+/- 9.60%)

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

APPENDIX III
Summary of Statistical Sample Analysis of Advanced Medical Concepts Inc.
Sample of Oxygen HCPCS Codes Y2076 and Y2079 (unmodified)
Audit Period: October 1, 2002 – September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Simple Random Sample of Claims
Number of Population Claims	8,466
Number of Population Claims Sampled	100
Number of Population Services Provided	8,466
Number of Population Services Sampled	100
Total Medicaid Amount Paid for Population	$1,511,686.96
Actual Amount Paid for Population Services Sampled	$17,856.00
Projected Correct Population Payment Amount	$1,241,967.00
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$1,352,012.00
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$1,131,922.00
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$269,719.96
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	$110,045.00 (+/- 8.86%)

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

APPENDIX IV
Summary of Statistical Sample Analysis of Advanced Medical Concepts Inc.
Sample Oxygen HCPCS Codes Y2076 and Y2079 (modified with QG)
Audit Period: October 1, 2002 – September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Simple Random Sample of Claims
Number of Population Claims	746
Number of Population Claims Sampled	100
Number of Population Services Provided	746
Number of Population Services Sampled	100
Total Medicaid Amount Paid for Population	$199,808.64
Actual Amount Paid for Population Services Sampled	$26,784.00
Projected Correct Population Payment Amount	$162,382.00
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$175,418.00
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$149,347.00
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$37,426.64
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	$13,036.00 (+/- 8.03%)

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

APPENDIX V
Summary of Findings
Advanced Medical Concepts Inc.
For the period October 1, 2002 to September 30, 2005

Description	Audit Period October 1, 2002 to September 30, 2005
Supplies Exceeding the Medicaid Maximum	$14,732.56
Duplicate Payments	$11,595.90
Services Billed for Deceased Recipients	$3,000.00
Place of Service Disagrees with HCPCS Billed	$357.12
Portable Oxygen Services Billed for LTCF Residents	$80.00
Census Results from Incontinence Garments and Related Supplies	$6,637.36
Projected Results from Volume Ventilator Services Sample	$52,190.00
Projected Results from Oxygen Service Sample of HCPCS Y2081, Y2082, and Y2083	$23,915.00
Projected Results from Oxygen Service Sample of HCPCS Y2076 and Y2079 (unmodified)	$269,719.96
Projected Results from Oxygen Service Sample of HCPCS Y2076 QG and Y2079 QG	$37,426.64
Total of Findings	**$419,654.54**
Interest Calculated from Sept. 28, 2005 to March 11, 2008	$82,321.27
Total of Findings and Interest	**$501,975.81**

Source: AOS analysis of MMIS information and the Provider's records. Interest was calculated in accordance with Section 5101:3-1-25 of the Ohio Administrative Code.

J. RANDALL RICHARDS
Attorney at Law
An Associate of Geoffrey E. Webster

Two Miranova Place, Suite 310
Columbus, Ohio 43215
614 / 461-1156
FAX 614 / 461-7168
jrrichards@gewebster.com

December 4, 2007

Norman Hoffman
Healthcare and Contract Audit Section
88 East Broad Street, 5th Floor
Columbus, Ohio 43215

Re: Audit of Advanced Medical Concepts, Inc.

Dear Mr. Hoffman:

On behalf of Advanced Medical Concepts, Inc. ("Advanced Medical"), I am submitting the provider's preliminary response to the draft audit report issued September 24, 2007. As more fully explained below, Advanced Medical has reviewed and been able to favorably address many of the categories of claims. It requires additional time, however, to fully review two remaining categories and thus requests such time. In the event additional time is not granted, Advanced Medical's objections are otherwise stated herein.

Advanced Medical is an Ohio corporation which provides respiratory therapy services and durable medical equipment to Medicaid recipients residing in nursing homes as well as to Medicaid recipients receiving home care services.

The Auditor conducted a stratified audit of claims paid to Advanced Medical for Medicaid services provided between October 1, 2002 and September 30, 2005 (the "Audit Period"). The majority of the audited claims were for respiratory services provided to nursing home residents. Only two categories of claims (items dispensed in excess of Medicaid maximum, and census review of incontinence garments and related supplies) involved claims for services and equipment delivered to home care Medicaid recipients. During the Audit Period, Advanced Medical provided 14,364 services to Medicaid recipients, submitted 12,614 claims, and was reimbursed $2,874,251.28.

According to the audit report, the Auditor conducted "Exception Testing" on several categories of claims where it reviewed 100 percent of the claims in each category. This Exception Testing resulted in an overpayment finding of $34,659.12.

The Auditor's report then indicates that the claims subject to Exception Testing were removed from the universe of claims submitted by Advanced Medical during the Audit Period and the remaining claims in the universe were subjected to a further stratified audit whereby the Auditor reviewed a sampling of claims from five different

sub-categories of claims. The findings from the sampled sub-categories were statistically extrapolated to the universe of claims resulting in an overpayment finding of $474,305.96.

Advanced Medical disagrees with the audit findings as set forth below.

A. EXCEPTION TEST RESULTS

The Exception Testing categories and corresponding sums disallowed are summarized as follows:

Exception Testing Category	Amount Disallowed
Items dispensed in excess of Medicaid maximum	$14,732.56
Duplicate payments – same provider	$8,489.10
Duplicate payments – different provider	$6,214.74
Services billed for deceased recipients	$3,000.00
Oxygen services billed as if patient was LTCF resident	$2,142.72
Portable oxygen services billed for LTCF residents	$80.00
TOTAL	$34,659.12

Advanced Medical does not dispute the findings made with regard to services billed for deceased recipients and for portable oxygen services billed to LTCF residents. These very few claims, totaling $3,080.00, were the result of inadvertent billing errors.

Advanced Medical does dispute the following disallowed claims in the following categories for the reasons stated below. Additional documentation is being provided with this letter. These responses respond only to the specific comments made by auditor as the reason for disallowance, i.e., the record was missing an order, or missing hours, etc. If these claims were disallowed for some other reason, Advanced Medicaid has no knowledge or notice of what that reason may be.

1. <u>Duplicate Payments – Same Provider</u>

– This claim was inadvertently submitted twice and paid. Both claims were disallowed. Advanced Medical has documentation supporting one claim and should be paid for delivering that service.

- This claim also was inadvertently submitted twice. Both claims were disallowed. Advanced Medical has documentation supporting one claim and should be paid for delivering that service.

2. **Duplicate Payments – Different Provider**

These claims were disallowed because two different oxygen providers submitted bills for the period in question. This may occur when the oxygen provider changes in the middle of a month and both providers furnish sufficient services to bill Medicaid. Advanced Medical has no control over the claims submitted by another provider. However, if Advanced Medical provides the service and the resident consumes sufficient oxygen for billing, Advanced Medical should be properly reimbursed, as was the case in the following claims:

- Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

– Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

– Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

- Advanced Medical has documentation supporting the claim, including the liter flow which is on the order.

- Advanced Medical has documentation supporting the claim.

- Advanced Medical has documentation supporting the claim.

- Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

– Advanced Medical has documentation supporting the claim.

– Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

– The dates were inadvertently flip-flopped but Advanced Medical has documentation supporting the claim and the resident has sufficient hours for the amount billed.

– Advanced Medical has documentation supporting the claim. The resident was receiving liquid oxygen so there will be no hour meter reading.

– Advanced Medical has documentation supporting the claim.

3. <u>Oxygen Services Billed as if Patient was LTCF Resident</u>

These claims were all inadvertently coded "12" for home care patients instead of "32" for nursing home residents. However, the supporting documentation provided clearly demonstrates that these services were all provided to residents in a nursing home. The claims for the months both before and after the inadvertently coded claim indicate the recipients' nursing home status. The hours on the log are sequential. The doctors' orders and other medical records show that services were provided in a nursing home. These claims were otherwise billed as nursing home claims and reimbursed as nursing home claims. All of the claims disallowed under category should be allowed.

4. <u>Items dispensed in excess of Medicaid maximum</u>

This is one category of claims that Advanced Medical has not yet had time to review and address. It has worked diligently on the other claims as this preliminary response shows and requests additional time to review and address these particular claims. Advanced Medical believes that with additional time most of the disallowed claims in this category can be favorably resolved like the others.

B. STATISTICAL SAMPLE TESTING AND EXTRAPOLATION

The statistical sampling sub-categories and corresponding sums disallowed are as follows:

Statistical Sampling Sub-Category	Amount Disallowed
Volume Ventilator Services	$112,905.00
Oxygen HCPCS Codes Y2081, Y2082, and Y2083	$24,508.00
Oxygen HCPCS Codes Y2076 and Y2079 (unmodified)	$284,836.96
Oxygen HCPCS Codes Y2076 and Y2079 (modified with QG)	$45,418.64
Census review of incontinence garments and related supplies	$6,637.36
TOTAL	$474,305.96

Advanced Medical disputes the following claims disallowed in the following sub-categories in the statistical sampling portion of the audit for the reasons stated below. Additional documentation is being provided with this letter. These responses respond only to the specific comments made by auditor as the reason for disallowance, i.e., the record was missing an order, or a diagnosis, etc. If these claims were disallowed for some other reason, Advanced Medicaid has no knowledge or notice of what that reason may be.

1. **Volume Ventilator Services**

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the order supporting the claim.

– Advanced Medical has several overlapping orders supporting the claim.

– Advanced Medical has the order supporting the claim and the diagnosis is located in the history and physical section.

2. **Oxygen HCPCS Codes Y2081, Y2082, and Y2083**

– Advanced Medical has the order and diagnosis supporting the claim.

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the order supporting the claim. This date of service is within the first six months and a pulse ox is not required for the first six months. Advanced Medical has orders and pulse ox's supporting the claim after that.

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the order supporting the claim and a clarifying order which contains the diagnosis to "keep sat > 90%."

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the chart and documents supporting the claim. This date of service is within the first six months and a pulse ox is not required for the first six months.

– The diagnosis is stated on the order.

– This claim was disallowed because a faxed copy of the order could not be easily read. A clean copy was re-sent earlier and is again provider here.

3. **Oxygen HCPCS Codes Y2076 and Y2079 (unmodified)**

– Advanced Medical has the order supporting the claim which contains the liter flow. The resident was receiving liquid oxygen so there will be no hour meter reading.

- Advanced Medical has the order supporting the claim.

- Advanced Medical has the order and liter flow supporting the claim.

– The record reflects enough liter flow and hours to support the billing.

– Advanced Medical has the order and diagnosis ("congestion" and "albuterol due to congestion") supporting the claim.

– Advanced Medical has the order and liter flow supporting the claim.

- Advanced Medical has several orders with a diagnosis of COPD. A diagnosis of COPD does not change. You never recover from COPD.

4. Oxygen HCPCS Codes Y2076 and Y2079 (modified with QG)

– The resident was receiving liquid oxygen so there will be no hour meter reading.

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the order supporting the claim, which contains a diagnosis of pneumonia

– The resident was receiving liquid oxygen so there will be no hour meter reading.

– Advanced Medical has the order supporting the claim.

– Advanced Medical has the order supporting the claim, which contains the liter flow of "2 liter bleed in."

5. Census Review of Incontinence Garments and Related Supplies

This is another category of claims that Advanced Medical has not yet been able to fully review and address. It has been able, however, to review and favorable resolve 14 of the 21 claims at issue so far and believes with additional time the other claims will be favorably resolved as well. It therefore asks for additional time to complete its review these claims. Additional documents are being furnished with this response to support the claims already reviewed.

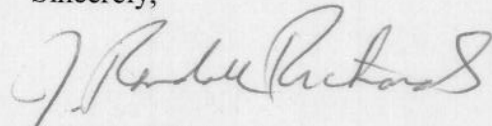
C. STATISTICAL SAMPLING

Advanced Medical strongly objects to the statistical sampling used in this audit. The Exception Testing of 100 percent of the claims in certain categories combined with a stratified audit and statistical sampling of claims in other categories creates a great potential for flawed audit findings. This flaw becomes evident when claims for the same resident are subject to both the Exception Testing and the Statistical Sampling. Furthermore, the sample size of the statistical sample testing was too small to provide adequate assurance that the audit results are accurate or valid, and the overpayment estimate therefore has a very strong potential to be flawed. This conclusion is evident in the great span in the upper and lower limit of the 95% confidence levels of each sub-category. Given such wide limits it was not difficult for the Auditor to place its findings within the calculated range. Under these circumstances the Auditor, at a minimum, should have gone to the upper limit of each range to calculate the finding in the sample testing.

D. ADMINISTRATIVE APPEAL

Finally, as a Medicaid provider Advanced Medical is entitled to an administrative hearing pursuant to R.C. Chapter 119 to contest these findings once they are finalized. The Department of Job and Family Services, and any other agency acting on its behalf, are barred by Ohio law from taking any action against Advanced Medical until certain administrative remedies have been exhausted, including the issuance of a proposed adjudication order and a 30-day notice of the right to request a hearing. Advanced Medical intends to exercise its right to administrative review and accordingly requests such a hearing with this response.

Sincerely,



J. Randall Richards
Attorney at Law

JRR:gl
cc: File
Client

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
PO Box 714856
Columbus, OH 43271-4856

1. **Provider Name and Address:**
   Advanced Medical Concepts, Inc.
   8730 Ohio River Rd.
   Wheelersburg, OH 45694

2. **Provider Number:** **0101802**

3. **Review Period:** **October 1, 2002 through Sept. 30, 2005**

4. **AOS Finding Amount (including accrued interest):** **$501,975.81**

5. **Interest "as of" Date:** **March 11, 2008**

6. **Date Payment Mailed:** ______________________

7. **Additional Interest Owed:**
   (Calculated by multiplying $91.98 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

ADVANCED MEDICAL CONCEPTS, INC.

SCIOTO 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
MARCH 11, 2008