

**Texas Health and Human Services Commission
Office of the Inspector General
and One Source Medical Group**

Performance Audit Report

Medicaid and CHIP Programs:
September 2019 to August 2021 (SFY 2020 and 2021)



Table of Contents

Cover Letter	1
Methodology	3
Procedures and Summarized Results of Audit	5
Findings and Recommendations:	
1. DME claims not priced correctly in accordance with regulatory guidance or underlying contracts	9



August 26, 2022

Texas Health and Human Services Commission
Office of the Inspector General
11501 Burnet Road, Building 902
Austin, Texas 78758

We have conducted our performance audit over One Source Medical Group (“One Source” or the “Provider”), for State Fiscal Years (SFYs) 2020 (September 1, 2019 through August 31, 2020) and 2021 (September 1, 2020 through August 31, 2021).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This report includes the performance audit objectives, scope, methodology, findings, conclusions, and recommendations, as well as the related responses from One Source.

This performance audit report is intended solely for the purpose of addressing the scope and objective set forth below and is not suitable for any other purpose.

Objective

To determine whether delivery of Durable Medical Equipment (DME) and submissions of Medicaid and CHIP managed care claims by the Provider were in accordance with applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements.

Scope

The performance audit scope was dictated by the Office of the Inspector General (OIG) of the Texas Health and Human Services Commission (HHSC) and focused primarily on determining One Source’s compliance with applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements related to delivery of DME and submissions of Medicaid and CHIP managed care claims.

The audit scope was limited to DME encounters occurring during SFYs 2020 and 2021 and the associated DME claims.

Methodology

We established multiple risk factors and reviewed all DME providers with encounters during SFYs 2020 and 2021 for the existence of those multiple risk factors. Based on such analysis, we identified nine providers who appeared to present higher risk relative to our audit objectives and we submitted those nine providers to OIG for consideration. OIG selected three of the nine providers for detailed testing, including One Source. See report section “Methodology” on page 3 for a detailed walk through of our risk assessment process.

Findings

A finding results from a significant variance or non-compliance with criteria, including applicable Federal and State Medicaid laws, regulations, rules, policies, and contractual requirements. The findings stemming from our performance audit relate to the following topics (see report section “Findings and Recommendations” beginning on page 8 for details):

- DME claims not priced correctly in accordance with regulatory guidance or underlying contracts

Conclusions

We initially identified multiple findings in our sample of 40 claims, totaling \$5,789.85 in overpayments to the One Source, which appeared to stem from weaknesses in the design or operating effectiveness of internal controls. Our selection methodology was judgmental and not representative of the population of claims, as such, it would not be appropriate to project our findings to the population of claims.

After submitting the draft report, One Source provided their management response with additional support. We took the information provided by the MCO in the management response into consideration and have updated our testing accordingly. We have concluded One Source should repay the State of Texas \$4,580.25. Please see Auditor’s Comments on page 12 for additional information.

Recommendations

See report section “Findings and Recommendations” beginning on page 8.

Sincerely,

DK PARTNERS, PC

Austin, Texas

August 26, 2022

cc: One Source Medical Group

Methodology

Methodology

Methodology:

We received files from OIG of DME encounters during SFY 2020 and 2021 and the associated DME claims. The initial population included 1,040 providers and \$1,063,280,309 in encounters. We first reduced the population to only providers with \$1 million or more in encounters for the time period, which left a population of 143 possible providers. We also received a file of top providers for the time period that included the total paid for DME encounters and what was labeled as "total risk"; total risk was explained as dollars paid to the DME provider for members who had not had a physician encounter in the six months preceding the DME encounter. We found that on average total risk dollars paid accounted for 21% of total dollars paid to DME providers. We created a ratio for comparing total risk among providers by calculating risk amounts paid/total paid for each provider, and then used that ratio to divide all providers into three categories and used this as a field in our risk assessment:

- Risk to total dollars of 25% or less;
- Risk to total dollars of 25% to 35%;
- Risk to total dollars of 35% or more.

We next considered the impact of COVID on DME providers and determined that a large increase in claims after March of 2020 could be a red flag for non-compliant behavior due to potential provider expectations of less monitoring and oversight. We reviewed the DME encounter data and compared total encounters from the period of 9/1/19 to 2/29/20 to the total encounters for the three following six-month periods of 3/1/20 to 8/31/20, 9/1/20 to 2/28/21, and 3/1/21 to 8/31/21.

Based on the three periods above, we found average growth from before COVID to during COVID to be 9%, and divided all providers into the following three categories based on growth and used this as a field in our risk assessment:

- Growth of 15% or less;
- Growth of 16% to 50%;
- Growth of 51% or more.

We were also provided with a file of complaints to OIG about DME providers. We divided all providers in our encounters file into the following three groups from this file and used this as a field in our risk assessment:

- No complaints;
- One complaint;
- Two or more complaints.

We analyzed the 143 possible providers using the three criteria mentioned above and focused on providers with risk to total encounters of 25% and higher, or COVID growth of 51% or more, as well as one provider who did not fit in either category but had complaints to OIG we believed should be considered in more detail for our test work. This resulted in a population of 42 providers for additional analysis.

See table on the following page for an illustration of the results of our analysis and refinement of our population of 143 providers down to 42.

Texas Health and Human Services Commission Office of the Inspector General
and One Source Medical Group

Methodology

	COVID growth of 15% or less	COVID growth of 16% to 50%	COVID growth of 51% or more	Total Providers
Risk to total dollars of 35% or more				
Two or more complaints to OIG	1			1
One complaint to OIG	1			1
No complaints	1	1		2
Risk to total dollars of 25% to 35%				
Two or more complaints to OIG	1	1		2
One complaint to OIG	2	1		3
No complaints	9	3	1	13
Risk to total dollars of 25% or less				
Two or more complaints to OIG	9	1	2	12
One complaint to OIG	18	4	5	27
No complaints	54	16	12	82
Total Providers	96	27	20	143

41 Testing population
1 One provider judgementally added from this group
101 Not included for further testing

We researched the 42 providers for additional risk factors such as:

- Lack of an obvious website or other sales platform;
- Complaints of fraudulent behavior;
- Other red flags.

We then added this information to our assessment and risk weighted the 42 providers to come up with a reduced population of nine DME providers that we sent to OIG for review. OIG selected three providers for additional test work, including One Source.

Once a provider was selected, we performed multiple analytical procedures over the provider. Details of our procedures and the results can be seen in report section “Procedures and Summarized Results of Audit” beginning on page 5. Analytical procedures varied for each provider, based on both information acquired from our risk assessment process and the results of the analytical procedures as they were performed. Analytical procedures were customized to each provider based on our professional judgement.

From our conclusions on our analytical procedures, we picked a sample of 40 members for detailed testing. Our sample size was based on OMB Circular A-133 Audits of States, Local Governments, and Non-Profit Organizations. We made judgmental, risk-based samples and felt the control testing sample size was appropriate to our audit objective.

We performed detailed testing on DME claims associated with our sample of 40 members. Details of our procedures can be seen in report section “Procedures and Summarized Results of Audit” beginning on page 5.

Procedures and Summarized Results of Audit

Procedures and Summarized Results of Audit

Analytical Procedures

The following analytical procedures were performed over the DME encounters during the period of our scope for One Source, and/or the claims associated with those DME encounters.

Analytical Procedure 1:

Review for members who have died and scan for DME charges more than 30 days after death.

Summarized Results:

No members with DME related activity more than 30 days after death found.

Analytical Procedure 2:

Identify the ten procedure codes with the highest average paid amount and the ten most common detail procedure code descriptions.

Summarized Results:

We identified two procedure codes related to insulin monitoring systems that were the most expensive, generate substantial revenue for the Provider, or are commonly offered by the Provider, and noted an increase in risk. In response we judgmentally selected samples to cover this area.

Analytical Procedure 3:

Perform a trend analysis on the count of procedure codes by month.

Summarized Results:

We identified some substantial increases over time related to insulin monitoring systems and in response we judgmentally selected samples to cover this area.

Analytical Procedure 4:

Scan to determine whether the maximum limitation related to procedure code A9274 was exceeded. The maximum limitation for this procedure code is 15 per month.

Summarized Results:

One member was found who exceeded 15 units per month and they were included in our sample.

Analytical Procedure 5:

Review encounters for the members with the highest number of procedure codes by month to identify trends or unusual activity.

Summarized Results:

No significant results found.

Procedures and Summarized Results of Audit

Analytical Procedure 6:

Per the Texas Medicaid Provider Procedure Manual, procedure codes A4233, A4236, A4245, A4250, A4253, A4256, A4258, A4259, A9275, E2100, and E2101 should not be submitted in the same month as K0553 or K0554. Scan to determine if this occurred.

Summarized Results:

Nine members were found where this occurred; we selected samples from the nine members.

Analytical Procedure 7:

Review for the ten procedure codes with the highest average paid amount and look for trends by month.

Summarized Results:

No significant results found.

Analytical Procedure 8:

Scan activity in procedure codes K0553 and K0554 for unusual trends or outliers.

Summarized Results:

We identified some unexpected correlations between the two codes in claims for seven members; we selected samples from the seven members.

Analytical Procedure 9:

Per the TMPPM, procedure code K0554 requires prior authorization. Scan for claims for this procedure code without a prior authorization number.

Summarized Results:

We found 26 claims for procedure code K0554 without a prior authorization number. We selected samples from the 26 claims.

Analytical Procedure 10:

Review for modifiers NU or RR, which indicate the items can be either rented or purchased and scan for claims where rental prices were higher than purchase prices.

Summarized Results:

We found one claim with an unexpected amount paid and selected it as a sample.

Analytical Procedure 11:

Review data for claims where the amount paid exceeds the amount billed.

Summarized Results:

No significant results found.

Procedures and Summarized Results of Audit

Analytical Procedure 12:

Review data for large differences in the price-per-unit of procedure codes.

Summarized Results:

We identified procedure codes with large variances between per-unit prices and selected samples based on this result.

Procedures and Summarized Results of Audit

Detailed Testing Procedures

The following procedures were performed over the 40 claims selected for detail testing.

Procedure 1:

Agreed physician prescribed quantities of DME to the amount of DME shipped and delivered to Medicaid members and billed to managed care organization(s) (MCOs).

Summarized Results:

No exceptions noted.

Procedure 2:

Verify claims paid to Provider were paid in accordance with rates and terms in the underlying contract between the Provider and MCO(s).

Summarized Results:

In 21 of our 40 samples the Provider was not paid in accordance with rates and terms in the underlying contracts between the Provider and the MCOs.

See Finding 1 - DME claims not priced correctly in accordance with regulatory guidance or underlying contracts

Procedure 3:

Obtain an understanding of and assess the MCO's internal controls to the extent necessary to address the audit objectives.

Summarized Results:

We determined that the components of internal control most significant to our audit objectives were information and communication, monitoring, and control activities. In addition, we believe that the information systems control considerations are significant to the audit objectives.

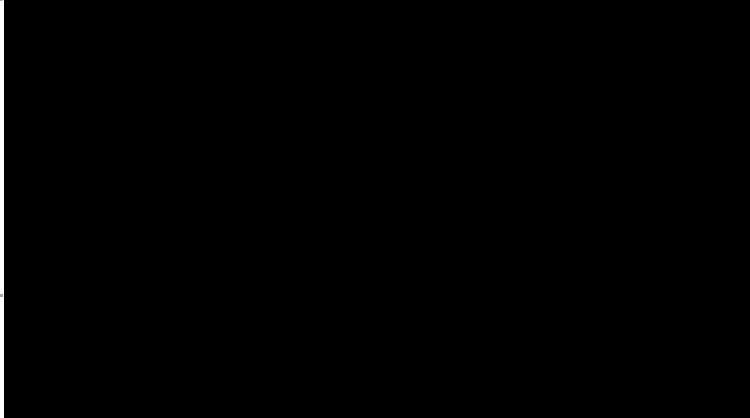
Based on Provider communication and support received related to our gaining an understanding of One Source's internal controls, we determined that testing internal controls appeared unlikely to provide superior audit evidence with regard to the achievement of our audit objectives. Specifically, we determined that the majority of internal controls either operated at high, rather than transactional level, or were likely not designed and operating sufficiently effective to place reliance on. Given that information, instead of testing internal controls we opted to test specific claims for the Provider.

Findings and Recommendations

Findings and Recommendations

Finding 1 – DME claims not priced correctly in accordance with regulatory guidance or underlying contracts

Criteria:

Supporting Policy	Policy Description/Details
<p>Letter of Agreement - El Paso First Health Plans, Inc. & One Source Medical Group, LLC, Page 1 (May 2020)</p>	
<p>Provider Agreement – Superior Health Plan, Inc. & One Source Medical Group, LLC, Page 30 (Nov. 2009)</p>	
<p>Texas Medicaid Provider Procedures Manual, Vol. 2, “Durable Medical Equipment, Medical Supplies, and Nutritional Products” (Oct. 2020)</p>	<p>DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8023.</p> <p>DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost.</p>
<p>1 Tex. Admin. Code § 371.1653(6) (2016)</p>	<p>(6) for an item or service that was not coded, bundled, or billed in accordance with standards required by statute, regulation, contract, Medicaid or other HHS program policy or provider manual, and that, if used, has the potential of increasing any individual or state provider payment rate or fee;</p>

Texas Health and Human Services Commission Office of the Inspector General
and One Source Medical Group

Findings and Recommendations

Condition: In 21 instances out of our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, One Source billed the MCOs in excess of regulatory guidance and contractual rates and terms for the DME prescribed and shipped to Medicaid members, based on the claims pricing guidance included in the underlying contract between the MCOs and One Source.

Sample Line Number	Claim Number	Overpayment Amount
3		7.25
8		767.42
11		68.74
12		789.31
13		307.88
16		231.52
17		309.18
18		65.25
20		65.25
23		566.58
24		273.18
26		65.25
28		301.16
30		642.46
31		67.44
32		308.83
33		342.58
34		224.26
35		303.26
37		75.39
39		7.66
Total		\$ 5,789.85

Cause:

"After reviewing all claims One Source Medical finds one claim that should not have billed for test strips A4253 Claim Number [REDACTED]. All other errors were by the payor side in which One Source was overpaid. In these cases, One Source had no control over the error as it correctly billed the claims. One Source has made many requests through phone conversations and emails with the payors to have the overpayments corrected."

Effect:

One Source billed and received \$5,789.85 from the MCOs for DME prescribed and shipped to Medicaid members that was in excess of regulatory guidance and underlying contractual rates and terms. By doing so, One Source did not comply with the criteria above.

Recommendation:

One Source should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that amounts billed are in accordance with the rates and terms

Findings and Recommendations

specified in their underlying contracts with MCOs and regulatory guidance. In addition, One Source should repay the State of Texas \$5,789.85.

Management Response:

"After further review, One Source Medical ("One Source") respectfully disagrees with the findings of 12 of the 21 claims. For these claims, One Source firmly believes the claims were billed and paid correctly in accordance with its contract.

If a product is not listed on the Medicaid fee schedule, in accordance with the contract, the item is paid as a percentage of the Manufacturer's Suggested Retail Price ("MSRP"). So, in the case of Code A9276/K0553 for Dexcom Sensors, the Manufacturer's Invoice Price ("MIP") is 82% of the MSRP. The MSRP for Code A9276/K0553 is \$578.25. The MIP is, therefore, calculated at 82% of \$578.25. This amount is then reduced by One Source's contracted rate. In the case of Superior, the contracted rate is 85%. For Sample Line Number 8, this payment was billed correctly by One Source but not paid correctly by Superior. Superior should have paid as follows: MSRP of \$578.25 x 82% for the MIP of \$474.17. This number is then reduced by 15% to be 85% of MIP which equals \$403.04. In this case, Superior paid \$836.40, resulting in One Source being overpaid in the amount \$433.36. We agree that One Source was overpaid in this amount and will agree to recoupment in the amount of \$433.36. Also, in Sample Line Number 8, Code A9274 for Omni Pods used with the Omni Pod insulin pump was incorrectly paid. Code A9274 is a covered product on the Texas Medicaid fee schedule and should have been paid at One Source's contracted rate which is 85% of the fee schedule amount. The Medicaid fee scheduled amount is \$43.50/unit/each. The correct payment amount is 85% of 43.50/unit/each or \$36.98/unit/each. One Source was overpaid \$334.13. The resulting total overpayment for this claim is \$767.49.

One Source believes that rather than using the MSRP in calculating the reimbursement, the distributor invoice pricing was used. Using the distributor invoice results in an incorrect amount and is not consistent with the parties' agreement.

Using the logic as set forth above, One Source believes it was paid correctly by the plan and disagrees with your determination that it was overpaid on the following Sample Lines:

Numbers: 3, 11, 13, 16, 17, 18, 20, 24, 26, 31, 32, 35, and 39.

For the remaining claims, One Source correctly billed the claims by the plan overpaid One Source. One Source was overpaid in the following samples:

- 8 - \$767.49 – Explained above
- 12 - \$1041.71 – One Source was paid twice for the K0553 and K0554 on the same DOS.
- 16 - \$224.24 – One Source agrees it was overpaid for K0553.
- 23 - \$257.40 – One Source agrees it was overpaid for K0553.
- 28 - \$301.16 – One Source agrees it was overpaid for K0553.
- 30 - \$642.46 – One Source agrees it was overpaid for K0553.
- 33 - \$342.58 – One Source agrees it was overpaid for K0553.
- 34 - \$224.26 – One Source agrees it was overpaid for K0553.
- 37 - \$159.96 – One Source agrees it was overpaid for test strips A4253.

Based on the above explanations, the total over payment for the sample is \$3,961.26.

In closing, One Source firmly believes it has billed the claims properly but, in some cases, through no fault of its own, it was overpaid by the plan. Attached is a summation of its findings and explanation of benefits to support its response to your Draft Performance Audit Report. One Source has contacted both Superior and El Paso many times through phone conversations and emails asking them to correct overpayments and late payments.

If you agree with our determination, One Source will take steps to submit the \$3,961.26 overpayment directly to the respective plan."

Findings and Recommendations

Auditor's Comments:

We took the information provided by the MCO in the management response into consideration and have updated our testing accordingly. We removed findings related to samples 11, 18, 20, 26, and 31, and adjusted some of the other samples based on the information received. We did not find evidence that One Source had overpaid for test strips related to sample 37, as mentioned in the management response, so this sample's overpayment amount did not change. Our updated condition is that in 16 instances out of our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, One Source was paid by the MCOs in excess of regulatory guidance and contractual rates and terms for the DME prescribed and shipped to Medicaid members, based on the claims pricing guidance included in the underlying contract between the MCOs and One Source.

Sample Line Number	Claim Number	Overpayment Amount
3		7.25
8		767.42
12		1,259.53
13		83.27
16		231.52
17		83.27
23		340.67
24		47.27
28		301.16
30		642.46
32		83.27
33		342.58
34		224.26
35		83.27
37		75.39
39		7.66
Total		\$ 4,580.25

One Source should repay the State of Texas \$4,580.25.