

**Texas Health and Human Services Commission  
Office of the Inspector General  
and Aeroflow Inc.**

Performance Audit Report

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



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August 24, 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 Aeroflow Inc. (“Aeroflow” 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 and 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 Aeroflow.

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 Aeroflow 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 Aeroflow’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 Aeroflow. 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 10 for details):

- Breast pumps shipped during pre-natal period
- Multiple breast pumps shipped at one time
- Amount billed and quantity shipped in excess of prescribed amount
- Amount billed in excess of quantity shipped
- DME claims not priced correctly in accordance with underlying contracts
- Insufficient documentation provided to support amounts billed

### Conclusions

We identified multiple findings in our sample of 40 claims, totaling \$867.69 in overpayments to Aeroflow, 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.

### Recommendations

See report section "Findings and Recommendations" beginning on page 10.

Sincerely,

DK PARTNERS, PC

Austin, Texas  
August 24, 2022

cc: Aeroflow Inc.

## Methodology

## Methodology

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### 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.

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
<b>Total Providers</b>	<b>96</b>	<b>27</b>	<b>20</b>	<b>143</b>

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 Aeroflow.

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

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**Analytical Procedures**

The following analytical procedures were performed over the DME encounters during the period of our scope for Aeroflow, 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, the ten claims with the highest total paid amount, and the ten most common detail procedure code descriptions.

**Summarized Results:**

We identified two procedure codes, for breast pumps and gradient compression stockings, that were the most expensive, generated substantial revenue for the provider, or were commonly offered by the provider, and noted an increase in risk. In response we judgmentally selected samples to cover this area.

**Analytical Procedure 3:**

Review the detail procedure code descriptions field for encounters related to breast pumps, which comprise 14,827 out of the 23,769 encounters (62%). For these encounters, we grouped by the Detailed Diagnostic Code and the member age to identify unusual relationships.

**Summarized Results:**

No significant results found.

**Analytical Procedure 4:**

Filter for youth and pediatric incontinence products and scan the ages of members to confirm they were under 21.

**Summarized Results:**

No significant results found.

**Analytical Procedure 5:**

Filter for adult incontinence products and scan the ages of members to confirm they were adults.

**Summarized Results:**

No significant results found.

**Analytical Procedure 6:**

Scan to determine whether the maximum limitation related to procedure code A4927 was exceeded. The maximum limitation for this procedure code is one per month.

Procedures and Summarized Results of Audit

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**Summarized Results:**

Identified members who exceed the maximum limitation related to procedure code A4927. However, the total amount paid for all claims related to this procedure code is only \$1,112.52. As such, we will pass on further investigation as this is unlikely to be significant to audit objectives.

**Analytical Procedure 7:**

Review for members receiving more than one breast pump within one year.

**Summarized Results:**

We found five claims where multiple breast pumps were received within a year; we selected samples based on this result.

**Analytical Procedure 8:**

Review for unbundling related to breast pumps: claims for breast pump support items (bottles, tubes, etc.) on same day as pump.

**Summarized Results:**

We noted that support products (whether properly ordered or unbundled) only totaled approximately \$14,000 over the test period and discontinued further analysis, as this is unlikely to be significant to audit objectives.

**Analytical Procedure 9:**

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

**Summarized Results:**

Identified some substantial increases over time related to breast pump support products. We noted that total support products only totaled approximately \$14,000 over the test period and discontinued further analysis, as this is unlikely to be significant to audit objectives.

**Analytical Procedure 10:**

Review the members with the highest spending in the period.

**Summarized Results:**

No significant results found.

**Analytical Procedure 11:**

Review for use of the "KX" modifier, which indicates that the supplier has ensured coverage criteria for the billed is met and that documentation does exist to support the medical necessity of the item.

**Summarized Results:**

We found claims without this modifier and selected samples based on this result.

**Analytical Procedure 12:**

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

Procedures and Summarized Results of Audit

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**Summarized Results:**

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

**Analytical Procedure 13:**

Review data for instances where billed quantity exceeds allowed quantity.

**Summarized Results:**

No significant results found within our analytical procedures. We did find evidence of this within our detailed testing, see Detailed Testing Procedures below.

**Analytical Procedure 14:**

Review for members with claims from multiple insurance vendors.

**Summarized Results:**

No significant results found.

**Analytical Procedure 15:**

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:**

No significant results found.

Procedures and Summarized Results of Audit

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**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:**

In 4 of our 40 samples, the amount of DME billed to MCOs and shipped to the Medicaid member were for quantities in excess of quantities prescribed by a physician.

***See Finding 2 - Multiple breast pumps shipped at one time***

***See Finding 3 - Amount billed and quantity shipped in excess of prescribed amount***

In 2 of our 40 samples, the amount of DME billed to MCOs did not agree to the amount shipped and delivered to Medicaid member.

***See Finding 4 - Amount billed in excess of quantity shipped***

***See Finding 6 - Insufficient documentation provided to support amounts billed***

**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 1 of our 40 samples, the Provider was not paid in accordance with rates and terms in the underlying contract between the Provider and the MCO.

***See Finding 5 - DME claims not priced correctly in accordance with underlying contracts***

**Procedure 3:**

When applicable, determine whether breast pumps were only delivered to mothers after the baby's date of birth.

**Summarized Results:**

In 10 of our 20 applicable samples, breast pumps were shipped to Medicaid members during the pre-natal period prior to birth.

***See Finding 1 – Breast pumps shipped during pre-natal period***

Procedures and Summarized Results of Audit

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**Procedure 4:**

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 Aeroflow'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: Breast pumps shipped during pre-natal period**

Criteria:

Supporting Policy	Policy Description/Details
Texas Medicaid Providers Procedures Manual Vol 2, Provider Handbooks, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook, Section 3.8.	Services that are not a Benefit: Breastfeeding support services in the preconception or prenatal period.

Condition: We determined that in 10 instances out of 20, in our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, breast pumps were shipped to Medicaid members during the pre-natal period prior to birth.

Sample Line Number	Claim Number	Paid Amount
2		147.45
4		147.45
6		173.47
10		173.47
17		147.45
23		121.43
27		173.47
32		173.47
33		173.47
39		173.47
<b>Total</b>		<b>\$ 1,604.60</b>

Cause: "Aeroflow Inc's previous interpretation of TMHP's guidelines was that the breast pump equipment could be delivered anytime within 12 months of the date of the birth event. Mothers often request the equipment prior to the birth event so that the pump is available immediately upon the birth of the child."

Effect: Aeroflow was paid \$1,604.60 from the MCOs for DME that was shipped to Medicaid members during the pre-natal period, and by doing so, Aeroflow did not comply with the criteria above.

Of the 10 instances above in which breast pumps were shipped during the pre-natal period prior to birth, only sample numbers 2 and 6, in the amounts of \$147.45 and \$173.47 respectively, totaling \$320.92, were delivered more than 30 days prior to birth.

Recommendation: Aeroflow should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that breast pumps are not shipped during the pre-natal period. In addition, AeroFlow should repay the State of Texas \$320.92.

Management Response: "After clarifying communication from the MCOs, Aeroflow stopped shipping the breast pump and supplies prior to the birth of the child. Aeroflow now requires that the mother must confirm the birth of the child by either call, text, or email. Upon receipt of this confirmation from the patient, Aeroflow will then ship the equipment to ensure compliance with provider guidelines."

Findings and Recommendations

**Finding 2 – Multiple breast pumps shipped at one time**

Criteria:

Supporting Policy	Policy Description/Details
Texas Medicaid Providers Procedures Manual Vol 2, Provider Handbooks, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook, Section 3.	Purchase of a personal-use, electric breast pump (procedure code E0603) is limited to once within 12 months from the date of birth.

Condition: We identified 2 instances in our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, where multiple breast pumps were shipped to a Medicaid member within a 12 month period. While certain exceptions are allowable, the multiple shipments were not supported by a valid exception to the criteria.

Sample Line Number	Claim Number	Overpayment Amount
14		173.47
31		147.45
<b>Total</b>		<b>\$ 320.92</b>

Cause: “The two instances described in finding 2 were a result of automation failures due to simultaneous order entry.”

Effect: Aeroflow billed MCOs \$320.92 in excess of amounts allowable under the contract. As a result, Aeroflow did not comply with the criteria above.

Recommendation: Aeroflow should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that multiple breast pumps are not shipped to Medicaid members in a 12-month period unless appropriate criteria are met. In addition, AeroFlow should repay the State of Texas \$320.92.

Management Response: “Aeroflow’s systems automatically and unintentionally billed TMHP for two units of E0603 as the patient updated their order preferences on the date that the shipment was queued to be sent. The result is that these patients received two pumps thus causing automatic billing for two units. Aeroflow has done and will continue to do internal data review to ensure that if this occurs in the future, it will be discovered quickly so that two claims will not be generated or submitted.”



Findings and Recommendations

**Finding 3 – Amount billed and quantity shipped in excess of prescribed amount**

Criteria:

Supporting Policy	Policy Description/Details
Texas Medicaid Providers Procedures Manual Vol 2, Provider Handbooks, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, Section 2.2.4 Medical Supplies	All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Condition: We identified 2 instances in our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, in which the amounts of DME billed to MCOs and shipped to the Medicaid member were for quantities in excess of quantities prescribed by a physician.

Sample Line Number	Claim Number	Overpayment Amount
15		27.62
40		37.26
<b>Total</b>		<b>\$ 64.88</b>

Cause: "Aeroflow uses supplier generated order templates to provide swift and efficient patient care. These two order templates had a generic "100" entered in the quantity field instead of being updated to reflect the standard quantity of 238."

Effect: Aeroflow billed MCOs and shipped to Medicaid members \$64.88 in DME that exceeded the quantities prescribed by a physician. As a result, Aeroflow did not comply with the criteria above.

Recommendation: Aeroflow should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that DME quantities billed to MCOs and shipped to Medicaid members are not in excess of quantities prescribed by a physician. In addition, AeroFlow should repay the State of Texas \$64.88.

Management Response: "Aeroflow has corrected the order templates moving forward to reflect the correct quantity of 238 as allowed by TMHP guidelines."

Findings and Recommendations

**Finding 4 – Amount billed in excess of quantity shipped**

Criteria:

Supporting Policy	Policy Description/Details
Amerigroup Texas, Inc. d/b/a Amerigroup Community Care Participating Provider Agreement for Ancillary Providers (Aeroflow Inc.) effective as of the date set forth immediately below Amerigroup's signature (the "Effective Date"), or 3/13/2017, Article III Provider Obligations 3.10 Representations and Warranties (b) Provider Information and Documentation	[REDACTED]

Condition: We identified 1 instance in our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, in which the quantity of DME billed to MCOs exceeded the quantity of DME shipped to a Medicaid member.

Sample Line Number	Claim Number	Overpayment Amount
20	[REDACTED]	56.87
<b>Total</b>		<b>\$ 56.87</b>

Cause: "Aeroflow was working a data clean up project to correct quantities billed for other claims and this claim was inadvertently included in the cleanup. This caused Aeroflow to void the correct claim and submit a new claim which billed a quantity in excess of what was actually supplied."

Effect: Aeroflow billed MCOs \$56.87 for DME in excess of the quantities shipped to the Medicaid member. As a result, Aeroflow did not comply with the criteria above.

Recommendation: Aeroflow should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that DME quantities billed are consistent with the quantities of DME shipped. In addition, AeroFlow should repay the State of Texas \$56.87.

Management Response: "Aeroflow performs regular internal audits in order to find and correct billing errors such as the instance described here. Regular review of TMHP claims will be added to the internal audit plan to ensure that any future overpayments are returned in a timely manner."

Findings and Recommendations

**Finding 5 – DME claims not priced correctly in accordance with underlying contracts**

Criteria:

Supporting Policy	Policy Description/Details
Amerigroup Texas, Inc. d/b/a Amerigroup Community Care Participating Provider Agreement for Ancillary Providers (Aeroflow Inc.) effective as of the date set forth immediately below Amerigroup's signature (the "Effective Date"), or 3/13/2017, Attachment A Reimbursement, Section IV: Compensation	[REDACTED]

Condition: In 1 instance out of our sample of 40 DME claims, which were selected from the DME claims data provided by OIG, Aeroflow billed MCOs in excess of 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 MCO and Aeroflow. Specifically, Aeroflow did not apply an appropriate discount rate.

Sample Line Number	Claim Number	Overpayment Amount
28	[REDACTED]	24.37
<b>Total</b>		<b>\$ 24.37</b>

Cause: "Aeroflow's automation did not identify the overpayment from normal operations."

Effect: Aeroflow billed an MCO for DME prescribed and shipped to Medicaid members that was \$24.37 in excess of underlying contractual rates and terms. By doing so, Aeroflow did not comply with the criteria above.

Recommendation: Aeroflow 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 specified in their underlying contracts with MCOs. In addition, AeroFlow should repay the State of Texas \$24.37.

Management Response: "Aeroflow reviews all payor correspondence and updates quote files as needed in order to bill and receive the correct amounts per contracts. In the normal course of business Aeroflow identifies and returns overpayments as required by regulations."

Findings and Recommendations

**Finding 6 – Insufficient documentation provided to support amounts billed**

Criteria:

Supporting Policy	Policy Description/Details
1) Medicaid Ancillary Services Agreement by and between Aetna Better Health of Texas, Inc. and AeroFlow Inc. effective 9/1/2016: Section 5.3.1 Maintenance of Information and Records  2) Texas Medicaid Providers Procedure Manual Volume 1, Section 1.7.3 Retention of Records and Access to Records and Premises	

Condition: In 1 instance out of our sample of 40 DME claims, which were selected from the DME claims data provided by HHSC OIG, AeroFlow was unable to provide sufficient documentation supporting the amount billed to MCOs. Specifically, AeroFlow was unable to validate the accuracy of quantity billed and shipped to Medicaid members information within the claims data to underlying accounting records.

Sample Line Number	Claim Number	Overpayment Amount
8		79.73
<b>Total</b>		<b>\$ 79.73</b>

Cause: "AeroFlow's internal inventory record description was incorrect for this item. This caused the delivery documentation to show that 10 units were received by the patients, however 20 units were actually shipped and received."

Effect: AeroFlow billed MCOs for \$79.73 of DME that was not supported by accounting records. As a result of not having sufficient accounting records, AeroFlow did not comply with the criteria above.

Recommendation: AeroFlow should ensure that internal controls are designed and operating effectively, sufficient to provide a high level of confidence that accounting records supporting the amounts billed and shipped to Medicaid members are retained. In addition, AeroFlow should repay the State of Texas \$79.73.

Management Response: "AeroFlow's internal inventory record has been corrected to reflect the correct quantity on shipping documentation."