FINAL AUDIT REPORT

Shield Denver Health Care Center, Inc.
Valencia, CA

NPI NUMBER: 1043512116
TPI NUMBER: 219242901 and 219242902

AUDIT/CASE TRACKING NUMBER
2017-TXIG012-DME-09-07

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I. AUDIT SUMMARY

On November 8, 2017, an on-site audit was initiated by Health Management Systems, Inc. (HMS), contracted by the Texas Health and Human Services Commission – Inspector General (IG). The audit was for services provided to medical assistance recipients by:

Name:	Shield Denver Health Care Center, Inc.
NPI Number:	1043512116
TPI Numbers:	219242901 and 219242902
Address:	2941 Trade Center, Suite 120 Carrollton, TX 75007
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Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited durable medical equipment (DME) records to verify services provided to recipients, paid by the Texas Medical Assistance (Medicaid) Program. Detailed audit findings for individual claim lines are contained in the Appendices.

This report reflects only the findings of this audit and is not intended to discover all possible errors in billing or recordkeeping. Any omission of other errors from this report does not mean such practice is acceptable. Because of the limited nature of this audit, no inferences as to the overall level of provider performance should be drawn solely from this report.

II. AUDIT AUTHORITY & REFERENCES

The IG is responsible for maintaining an ongoing program to audit providers participating in the State medical assistance programs.

This audit was carried out consistent with the *Texas Administrative Code* (TAC), *Title 1*, *Part 15*, *Chapter 371*, *et seq.*; and *Generally Accepted Governmental Auditing Standards*, as issued by the United States Government Accountability Office.[1]

Refer to Appendix B for the State Regulations and Policy Provider Manual provisions which were used to support the audit. The regulations and guidelines used were in effect at the time the service was provided. These include:

[1] 1 Tex. Admin. Code § 371.1719(b)(1)(A) (effective May 1, 2016).

- *Government Auditing Standards* (GAS)
- *Code of Federal Regulations* (CFR)
- *Texas Administrative Code* (TAC)
- *Texas Medicaid Provider Procedures Manual* (TMPPM)
- Applicable coding references (CPT, HCPCS, ICD-9-CM, ICD-10-CM)

III. AUDIT PROCESS

This provider audit was conducted in the following manner:

Case Selection

For the audit of DME claims, a universe of paid claims with service dates ranging from January 1, 2015 through March 31, 2017 was developed. Only claims with a paid amount greater than zero were included in this universe. The universe included 40,525 claim lines with a total Medicaid payment of $4,170,743.72. From this universe, a total of 556 claim lines totaling $73,759.54 were selected for review.

Claims previously identified as overpayments in prior audits or through post payment reviews performed by the Payment Review Program are removed from the audit universe. This prevents the same claim from being recovered twice.

Documentation Reviewed

The Entrance Conference was held at the Provider's call center facility in Texas on December 8, 2017. Documentation to support services reimbursed by Medicaid was submitted electronically and hardcopy by the Provider on December 14, 2017, as all medical records are kept at the home office in California.

An Exit Conference was held with the Provider on March 2, 2018 to review the Draft Audit Report. In response to the Draft Audit Report, the Provider submitted additional documentation to support the claims under review on March 16, 2018.

The documents were analyzed to identify any billing irregularities or deviations from program rules, regulations, and the Medicaid Provider Agreement. The results are contained in Sections IV and V of this report.

Statistical Sampling

A sample was drawn from the universe of claims paid by Medicaid program. The sample was produced using the RAT-STATS 2010-v4 random number generator. Overpayments, if any, are determined for the claims within the probability sample. These overpayments are then extrapolated to the audit universe to determine an overpayment amount. The extrapolation detail file contains the (a) population of

claims, (b) sample frame, including sample size determination, (c) seed value for random number generation, (d) extrapolation validation, and (e) results printout from the RAT – STATS software.

The audit population consisted of 2,027 recipients. The probability sample consisted of 30 randomly selected recipients totaling $73,759.54. All claims were itemized on the Medical Assistance Remittance Advices to the Provider. Overpayments identified in the probability sample will be extrapolated to the audit universe in accordance with *TAC, Title 1, Part 15, Chapter 371, Subchapter B, Rule 371.35 Use of Statistical Sampling and Extrapolation (effective 05/01/2016).* See Appendix C Sampling Plan for more information.

In some instances, more than one audit finding relates to an individual service provided. This is referred to as "overlap" of findings. When more than one finding requires repayment on an individual service, the amount asserted for recoupment is limited to the amount paid by the Medicaid.

IV. FINDINGS

Of the 556 claim lines reviewed, there were 27 claim lines with recoupable monetary findings. See Appendix A for the Audit Finding Index.

Finding 1: Billed Prior to Delivery (BPD)

There was one instance of the Provider submitting a claim to Medicaid prior to the supplies being shipped or delivered to the recipient.

Example: Sample SN-1328-C-004-A– The carrier's delivery confirmation shows the product was picked up on 07/21/2015. The claim was billed on 07/20/2015. Per TMPPM DME 2.2.3 Medical Supplies, (effective July 2015), the date of service (DOS) is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The Provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery.

> *Rebuttal Medical Record Review*: Tracking numbers SK379748, SK379749 and SK379750 were picked up on 7/21/2015. The corrected delivery slip says they were picked up on 7/20/2015 for SK379748 and SK379749. There is no rebuttal documentation for SK379750 but a search on the carrier's website says it was picked up on 07/21/2015. The sample remains discrepant.

Basis for Finding:

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.3 Medical Supplies (effective August 2014, July 2015, March 2016, and February 2017) provides, "… The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. There records are subject to retrospective review. …"

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 2: <u>Improper Procedure Code (IPC)</u>

There were five instances where the documentation in the medical record did not support the procedure code billed and paid.

Example: Sample SN-1032-C-019-A – The Title XIX Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form which covers DOS 12/31/2015 prescribes HCPCS code T4534. The Provider billed HCPCS codes T4522 and T4534. Per TAC 371.1653 Claims and Billing, (effective May 2014), A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, a claim for payment by the Medicaid or other HHS program: (5) based on a code that would result in greater payment than the code applicable to the item or service that was actually provided.

> <u>*Rebuttal Medical Record Review*</u>: The Provider rebuttal comment stated that this should be an administrative finding. However, the comment confirmed that they were unable to locate the prescription for the product. The sample remains discrepant.

Basis for Findings:

TAC, Title 1, Part 15, Chapter 371, Subchapter G, Division 2, Rule 371.1653 Claims and Billing (effective 05/01/2016) provides, "A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, a claim for payment by the Medicaid or other HHS program: …
(5) based on a code that would result in greater payment than the code applicable to the item or service that was actually provided;
(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; …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.13 Incontinence Supplies (effective August 2014, July 2015, March 2016, and February 2017) provides, "Incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. ..."

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 3: Invalid Prescription (IP)

There were fourteen instances of the prescription not having accurate or complete required information, or the prescription did not have the appropriate physician signature.

Example: Sample SN-1970-C-001-A– The recipient was not seen by a physician within one year of the DOS 01/23/2015. The date last seen by physician on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form is 06/11/2013. Per TMPPM DME 2.2.2 Durable Medical Equipment (DME) and Supplies, the client must be seen by a physician within one year of the DOS.

> *Rebuttal Medical Record Review*: The Provider rebuttal comment stated this should be an administrative finding. No additional documentation was submitted. The sample remains discrepant.

Example: Sample SN-1970-C-014-A – The Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form is signed by a physician assistant. The prescribing physician's signature is missing. Per TMPPM DME 2.2.3 Medical Supplies, the representative of the DME/medical supply provider and a physician who is familiar with the client must sign and date a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME or supplies. Per TMPPM DME 5 Forms, Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form instructions, signatures from nurse practitioners, physician assistants, and chiropractors are not be accepted.

> *Rebuttal Medical Record Review*: The Provider submitted a copy of a prescription with a note from a nurse in the office that the co-signature was that of the physician. However, the script for the DOS under review was not co-signed as required. The sample remains discrepant.

Example: Sample SN-1927-C-020-A – The Physician's name does match with the NPI number or license number. Per TMPPM DME 5 Forms, Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form instructions, the prescribing physician's TPI, NPI, and license number must be indicated.

> *Rebuttal Medical Record Review*: License number E4838 is invalid and does not match with the NPI is associated with the physician. The sample remains discrepant.

Example: Sample SN-778-C-012-A – The Title XIX Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for DOS 09/02/2016 expired on 08/17/2016. Per TMPPM DME 2.2.1 Home Health Services, (effective March 2016), For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but not more than, 6 months from the date of the physician's signature on the form.

> *Rebuttal Medical Record Review*: The Provider rebuttal comment stated that this should be an administrative finding. However, the comment confirmed that they were unable to locate the prescription for the product billed. The sample remains discrepant.

Basis for Findings:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 2.

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.1 Home Health Services (effective August 2014 and July 2015) provides, "The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME) Medical Supplies Physician Order Form … In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician's signature on the form, unless otherwise noted in this handbook. … Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and invoices for all supplies provided to a client and must disclose them to HHSC or its designee upon request. …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.1 Home Health Services (effective March 2016 and

February 2017) provides, "The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME) Medical Supplies Physician Order Form … In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician's signature on the form, unless otherwise noted in this handbook. … Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and corresponding invoices for all supplies provided to a client and must disclose them to HHSC or its designee upon request. …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.1.1 Client Eligibility (effective August 2014, July 2015, March 2016, and February 2017) provides, "… Unless otherwise noted in this handbook, certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has been reviewed, signed, and dated by the treating physician for these clients. …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 5. Forms, DM.3 Medical Supplies (effective August 2014, July 2015, March 2016, and February 2017) provides, "This form becomes a prescription when the physician has signed section B. With the exception of the DME provider's signature, this form may not be altered or amended once it is signed by the prescribing physician. … All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid Provider), NPI and license number must be indicated. …"

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 4: Missing Documentation (MD)

There were three instances of the medical record missing documentation to support the services that were rendered, billed, and paid.

Example: Sample SN-1032-C-013-A – There is no proof of delivery for DOS 07/30/2015. Per TMPPM DME 2.3 Medical Supplies, providers must retain individual delivery slips or invoices for each DOS that documents the date of delivery for all supplies provided to a client. Documentation of delivery must include one of the following: Delivery slip or invoice signed and dated by client or caregiver. A dated carried tracking document with shipping date and delivery date

must be printed from the carrier's website as confirmation that the supplies were shipped and delivered.

Rebuttal Medical Record Review: The Provider rebuttal comment stated that this should be an administrative finding. However, the comment confirmed that they were unable to locate the proof of delivery documentation. The sample remains discrepant.

Basis for Findings:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 2.

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.1.1 Client Eligibility (effective August 2014, July 2015, March 2016, and February 2017) provides, "… To qualify for home health services, the Medicaid client must be eligible on the DOS and must:

- Have medical need for home health professional services, DME, or supplies that is documented in the client's POC and considered a benefit under home health services. …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.3 Medical Supplies (effective August 2014 and July 2015) provides, "… Providers must retain individual delivery slips or invoices for each DOS that documents the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:

  - Delivery slip or invoice signed and dated by client or caregiver.
  - A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or invoice.
- The dated delivery slip or invoice must include the client's full name, the address to which supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. …

The DOS is the date on which supplies are delivered to the client or shipped to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review. …"

TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.3 Medical Supplies (effective March 2016 and February 2017) provides, "… Providers must retain individual delivery slips or invoices for

each DOS that documents the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:

- Delivery slip or corresponding invoice signed and dated by client or caregiver, or
- A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or corresponding invoice.

- The dated delivery slip or invoice must include the client's full name, the address to which supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client and the corresponding tracking number from the carrier. …

The DOS is the date on which supplies are delivered to the client or shipped to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review. …"

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 5: Over Billed Quantity (OBQ)

There were four instances of the Provider delivering and billing for more supplies than were prescribed by the physician.

Example: Sample SN-1792-C-001-A – The Title XIX Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form which covers DOS 01/21/2015 prescribes the quantity as 96/month. The Provider billed the quantity as 112/month. Per TMPPM DME 2.2.13 Incontinence Supplies, incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Rebuttal Medical Record Review: The Provider rebuttal comment stated that this should be an administrative finding. However, the comment confirmed that they were unable to locate the prescription for the quantity of the product billed. The sample remains discrepant.

Basis for Findings:

Refer to *TMPPM, Volume 2, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, 2.2.13 Incontinence Supplies (effective August 2014, July 2015, March 2016, and February 2017)*; under Finding 2.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

V. SUMMARY OF OVERPAYMENTS

The identified overpayments for the discrepant sampled claims totaled $3,485.51. See Appendix A for detailed information. When extrapolated to the universe of claims from which the sample was selected, the calculated overpayment at the lower limit of 80% confidence interval is $39,159.00. See Appendix D for the extrapolation summary. The total amount due to the Texas Health and Human Services Commission is $39,159.00.

NOTE: Actions resulting from this report and its directives do not take into consideration any subsequent program recoveries, Provider repayments, or Medicaid and Medical Assistance reimbursements, which relate to the period covered by this report.