[Cite as *Omnicare Respiratory Servs. v. Ohio Dept. of Job & Family Servs.*, 2010-Ohio-625.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Omnicare Respiratory Services, dba Respiratory Care Resources,	:	
Appellant-Appellee/ [Cross-Appellant],	:	
v.	:	No. 09AP-547 (C.P.C. No. 08CVF-01-565)
The Ohio Department of Job and Family Services,	:	(REGULAR CALENDAR)
Appellee-Appellant/ [Cross-Appellee].	:	

D E C I S I O N

Rendered on February 23, 2010

Kegler, Brown, Hill & Ritter Co., L.P.A., Ralph E. Breitfeller, R. Kevin Kerns and *Jennifer L. Mackanos*, for Omnicare Respiratory Services dba Respiratory Care Resources.

Richard Cordray, Attorney General, and *Henry G. Appel*, for The Ohio Department of Job and Family Services.

APPEAL from the Franklin County Court of Common Pleas

TYACK, P.J.

{¶1} This appeal stems from an audit of appellee/cross-appellant, Omnicare Respiratory Services ("Omnicare"), a Medicaid provider and a supplier of oxygen services to nursing homes and long-term care facilities ("LTCFs"). During the audit period from April 1, 2003 through March 21, 2005, the Auditor of State determined that Omnicare had

been overpaid by $1,978,108.65. Omnicare disagreed with the auditor's determination and requested an administrative hearing before appellant/cross-appellee, Ohio Department of Job and Family Services ("ODJFS"). The hearing examiner concluded that the Auditor of State correctly identified $1,978,108.65 in overpayments. The director of ODJFS adopted the report by order of December 28, 2007, and Omnicare appealed to the Franklin County Court of Common Pleas.

{¶2} The report indicated that most of the overpayments were from oxygen services provided to persons eligible for Medicaid benefits. Medicaid rules in effect at the time required that payment for oxygen service was to be the lower of either the Medicaid maximum or the "usual and customary" fee charged to non-Medicaid patients for the same service.

{¶3} The overpayments fell into two main classes. In the larger class, Omnicare was charging between $40 and $60 per month for oxygen services if the patients were not receiving Medicaid benefits, but charged higher amounts up to $178.56 per month if the patients' oxygen services were being paid by Medicaid.

{¶4} The smaller class arose from a detailed examination of a sample of 246 claims, in which 44 overpayment errors were found amounting to $6,097.92, which Omnicare agreed to pay. By means of statistical analysis, the auditor then projected the known errors onto a universe of 22,000 claims and came up with an overpayment of $418,730.87. This amount was included in the overall total of $1,978,108.65. Omnicare challenged the validity of the statistical analysis used by the auditor by means of an expert in statistical analysis.

{¶5} On appeal, the common pleas court found that the state had changed its procedure without notice in finding overpayments. The court found no reversible error in the state's statistical methodology used in the audit. Additionally, the court found that the oxygen services provided to Medicaid patients (with monthly billing based on days of use) and the services provided to non-Medicaid patients (billing based on cubic feet of oxygen consumed) were not the same. The common pleas court remanded the matter for further consideration to determine the appropriate Medicaid reimbursement rate.

{¶6} This appeal followed, with ODJFS assigning the following as error:

> [I.] The court below erred in concluding that due process bars an agency from recovering in an audit where there is no evidence that the agency had made affirmative inconsistent statements about how to interpret a rule and there is no evidence that the agency applied rules that were not in effect at the time of the billing.
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> [II.] The court below erred in concluding that the medical services a Medicaid provider billed to ODJFS were not the same as the medical services billed to nursing homes.

{¶7} Omnicare filed a cross-appeal, assigning the following cross-assignments of error:

> 1. The Court of Common Pleas erred when it remanded this matter to ODJFS "to determine the appropriate reimbursement rate".
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> 2. The Court of Common Pleas erred when it failed to reverse and vacate the finding of the Ohio Department of Job and Family Services (ODJFS) that Omnicare Respiratory Services (OCR) was overpaid in the amount of $418,730.87, based on a projection of a review of a sample of claims.
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> 3. The Court of Common Pleas erred when it failed to find that the finding of the Ohio Department of Job and Family Services (ODJFS) that Omnicare Respiratory Services (OCR) was overpaid in the amount of $418,730.87, based

> on a projection of a review of a sample of claims, was not supported by reliable, substantial, and probative evidence.
>
> 4. The Court of Common Pleas erred when it failed to find that the finding of the Ohio Department of Job and Family Services (ODJFS) that Omnicare Respiratory Services (OCR) was overpaid in the amount of $418,730.87, based on a projection of a review of a sample of claims, was contrary to law.
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> 5. It was error for the Court of Common Pleas to hold that ORS "charged the maximum amount allowed for Medicaid patient of $178.56".

{¶8} As the second level of appeal from an administrative decision, our responsibility is to determine if the trial court has abused its discretion. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621. Additionally, a court must give due deference to an agency's reasonable interpretation of the legislative scheme. *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad* (2001), 92 Ohio St.3d 282, 287. Our review is plenary on questions of law. *HCMC, Inc. v. Ohio Dept. of Job & Family Servs.*, 179 Ohio App.3d 707, 2008-Ohio-6223, ¶17.

{¶9} In its first assignment of error, ODJFS contends that the court of common pleas erred in finding a due process violation. Medicaid rules in effect at the time of the audit provided that reimbursement from Medicaid should not exceed the provider's usual and customary charge for the *same* service. Ohio Adm.Code 5101:3-1-17.2(A); and 5101:3-10-13(H)(1) and (4). New rules, effective November 1, 2007, provided that reimbursement for oxygen concentrators was limited to the provider's "usual charge for services provided when compared to *similar* services." [1]

[1] The oxygen concentrators at issue in this case are portable wheeled machines that absorb nitrogen from the ambient air and deliver a continuous supply of oxygen to the patient. The November 2007 rules have since been substantially changed in the way oxygen services are reimbursed.

{¶10} The court of common pleas determined that ODJFS had applied the new administrative rules retroactively by allowing comparison of services with different billing methodologies. Omnicare's non-Medicaid rates were based on rental contracts with LTCFs. The rental fee was usually a per diem rate and normally had a monthly cap. Omnicare billed the LTCFs monthly on one invoice for all equipment, supplies, and services.

{¶11} Billing for Medicaid patients was a more involved process. Medicaid patients were required by rule to be billed for the actual amount of oxygen consumed. There were additional requirements. Omnicare was required to submit a claim for each individual patient. Omnicare was responsible for ensuring that all documentation supporting the claim was in the chart or the patient's file. There had to be a prescription in the patient's file specifying the diagnosis, oxygen flow rate, duration, and indications for usage. If a patient needed oxygen for six months or more, a pulse oximetry reading, signed by a physician, had to be in the file along with a copy of a lab report of an arterial blood gas study. Omnicare had to calculate the amount of oxygen used, convert it from liters to cubic feet, and then assign a proper billing code depending on the amount of cubic feet consumed. Former Ohio Adm.Code 5101:3-10-13 (effective October 11, 2001 through October 31, 2007).

{¶12} In the course of the audit, the auditor sought to compare the average monthly payment that Omnicare charged the non-Medicaid patients to that of the Medicaid patients. The auditor examined Omnicare's contracts with various LTCFs. By means of averaging, the auditor determined that in 2002, Omnicare charged an average of $61.45 per patient per month for oxygen concentrator services, and $52.02 for those

services in 2003; $47.79 in 2004; and $48.08 in 2005. Comparing those charges with the actual Medicaid reimbursement (typically $178.56), the auditor determined the existence of an overpayment.

{¶13} Earlier in 2002, the Auditor of State had conducted an audit of Respiratory Care Resources (subsequently purchased by Omnicare). In that audit, the auditor questioned the predecessor corporation's practice of billing more for oxygen services to Medicaid patients than to its private customers. Although it found an overpayment and the matter was referred for collection to the office of the Ohio Attorney General, that office never took action to collect the money. Based on this failure to collect, Omnicare argues that ODJFS effectively substituted a new law by changing course in its interpretation of the old rule.

{¶14} After reviewing the record, we cannot find any evidence that ODJFS applied the new requirements retroactively. The hearing officer's report and recommendation applied the former rules under which the audit was conducted. The audit itself references the former rules. The real issue appears to be whether ODJFS used a different interpretation of a billing practice in a 2002 audit. If it did, the question is whether such an interpretation was unfair to Omnicare who claimed that it relied on that earlier interpretation to its detriment.

{¶15} Omnicare argues that the failure to collect the overpayment from the 2002 audit shows that ODJFS changed its interpretation of Ohio Adm.Code 5101:3-10-13(H). As a matter of law, we must draw a different conclusion. Omnicare had been on notice since the 2002 audit that the practice of billing Medicaid patients more than non-Medicaid

patients for oxygen services was, at the very least, questionable. The same interpretation of the billing practices continued unabated from the 2002 audit through the 2007 audit.

{¶16} The failure to collect is not relevant to the question of whether ODJFS had changed its interpretation of Medicaid billing rules or had applied a new rule retroactively. Many factors enter into a decision to pursue or not to pursue findings for recovery. The 2002 finding was a smaller amount, and ODJFS was not in charge of collecting the money. The matter had been turned over to the attorney general for recovery. In the present case, the overpayment was substantial, and ODJFS sought to recover the funds from Omnicare.

{¶17} In summary, we cannot find any evidence that ODJFS was applying the new requirements retroactively. The hearing officer's report and recommendation applied the former rules under which the audit was conducted. There is no evidence that ODJFS used a different interpretation of billing practices in the 2002 audit. The first assignment of error is sustained.

{¶18} In considering ODJFS' second assignment of error, we must decide if the different billing method necessitated by Medicaid rules means that the oxygen services provided to private patients were not the same services as those provided to Medicaid patients.

{¶19} Recently, this court considered the same issue in a case decided on nearly identical facts. In *HCMC, Inc.*, the auditor found that HCMC was reimbursed by Medicaid for an amount that exceeded its usual and customary fee for the same service. This court held that oxygen services provided to Medicaid and non-Medicaid patients are not different merely because the provider billed the nursing homes and termed the service a

"rental." Instead, the court looked at how reimbursement of claims for oxygen services to Medicaid recipients in a LTCF were linked to the volume of oxygen used by the patient, while under HCMC's contracts with nursing homes, reimbursement rates were for oxygen concentrators based on daily or monthly fixed rates. Id. at ¶33, 34. The court concluded that the differences in the essential character of the reimbursement methodologies meant that they were not interchangeable and lacked equivalency. Id. at ¶35. The court further found that the auditor had not adjusted for the qualitative differences in billing methodologies and, therefore, the auditor's analysis was lacking. Id. at ¶36.

{¶20} The *HCMC* court specifically referred to the common pleas court's conclusion that the auditor did not compare rates for the same service and that there was no evidence of an analysis or comparison of the difference between billing by volume of oxygen consumed versus billing by device. Id. at ¶30, 39. The court then remanded the matter for recalculation of the proper "usual and customary" rate for provision of services. Id. at ¶69, 70. Finally, the difference in billing did not mean that HCMC could place a surcharge on the Medicaid bills to account for the differences in billing methods. The court found no legal basis by which an oxygen services provider could be reimbursed in the form of a surcharge for overhead necessitated by Medicaid billing requirements. Id. at ¶46, 47.

{¶21} Obviously, if the services being compared are not the same, the analysis stops and there can be no overpayment. But here, as in *HCMC,* we have a situation in which identical oxygen services were provided to patients. Therefore, in one sense the services provided are the same, since the nursing homes furnished oxygen concentrators to every patient needing oxygen services regardless of billing status. But just as in

HCMC, the auditor did not provide an adequate comparison of *rates* for the same service. In other words, Medicaid patients were required by law to be billed by volume of oxygen used per month, while the nursing home was billed for non-Medicaid patients a pre-set charge regardless of the amount of oxygen consumed. *HCMC* holds that we cannot ignore the qualitative differences in billing methodology that make comparison of rates difficult. However, a mere difference in billing arrangements cannot be the basis by which a provider can avoid the "usual and customary" standard for comparing rates.

{¶22} This case is like *HCMC* in that the services provided were the same, but there were qualitative differences in billing that affected the auditor's ability to determine a "usual and customary" fee for the volume of oxygen provided. Thus, in order for ODJFS to recover any overpayments, there must be an analysis, comparison, or adjustment to account for the different billing methodologies. ODJFS claims in its brief that the auditor did a comparison in this case of the difference in billing by volume, versus billing by device, leading to an adjustment of over $100,000 in Omnicare's favor. However, ODJFS has not cited to any portion of the voluminous record as to any specifics or evidence to support that contention.

{¶23} What was lacking in both *HCMC* and the present case, is evidence of an analysis or adjustment for the differences in rates necessitated by billing by volume versus billing by device. See *HCMC* at ¶39 (" '[t]here is no evidence provided by [ODJFS] that comprises an analysis of or a comparison of the difference between billing by volume versus billing by device.' ") (quoting the court of common pleas).

{¶24} In this case, there was evidence that the auditor used averaging to come up with a mean monthly charge per patient, and that she used subtraction to determine the overpayment. The auditor explained as follows:

> [W]e requested that the Provider furnish us with copies of rental contracts to provide oxygen concentrator services to long term care facilities. The Provider furnished 75 rental contracts, which upon review, showed that the Provider charged monthly rental rates well below what was being charged to Medicaid. During our audit period, 64.7 percent of oxygen concentrator service payments and 83.2 percent of the total amount paid by Medicaid were paid at $178.56 per month. (The other 35.3 percent were paid at more or less than 178.56 per month). After removing findings associated with our exception tests, we calculated the difference between what Medicaid paid to the Provider for 22,479 services during our audit period ($3,118,123.03) and the corresponding mean monthly rate charged by the Provider to long term care facilities. A separate mean monthly rate was calculated and used for services provided in calendar years 2002 through 2005 respectively. The final net difference between what Medicaid paid and the Provider's "usual and customary" mean monthly rate was $1,970.140.69. This net difference was then reduced by the projected findings from the oxygen service sample ($418,730.87) to determine the final usual and customary findings of $1,551,409.82.

(Oct. 19, 2006 Medicaid Audit of Omnicare Respiratory Services, at 12.)

{¶25} The problem with this manner of formulating the provider's usual and customary rate is that the former ODJFS rules require something different. The more general rule, Ohio Adm.Code 5101:3-1-17.2(A) provides, in pertinent part, that a provider agrees to "bill ODJFS for no more than the usual and customary fee charged other patients for the same service." However, the more specific rule, former Ohio Adm.Code 5101:3-10-13(H)(1) and (4) provides, in pertinent part, that payment for LTCF claims "shall be the provider's usual and customary charge for the oxygen actually used by the

recipient," and that "[p]ayment will be limited to the lower of the usual and customary charge of the supplier, or the medicaid maximum."

{¶26} Absent from the auditor's report is any adjustment, calculation, or analysis for the ODJFS' requirements that billed charges "shall be the provider's usual and customary charge *for the oxygen actually used by the recipient*," and that "regardless of delivery modality, i.e., gaseous system, liquid system, or concentrator," amounts less than 750 cubic feet must be billed using specific codes. Former Ohio Adm.Code 5101:3-10-13(H)(1),(3). Therefore, under the former regulations, the provider's usual and customary charge had to be based on the provider's charge for volume of oxygen.

{¶27} Here, just as in *HCMC,* Omnicare did not bill LTCFs on the basis of cubic feet of oxygen consumed. The charges to the nursing homes were based on daily or monthly rates for the use of the oxygen concentrator regardless of the amount of oxygen consumed by the patient. The auditor's mean monthly rate per non-Medicaid patient is flawed because there was no analysis or adjustment to account for the volume of oxygen consumed. The auditor calculated a mean monthly charge by averaging days or months of use, not volume of oxygen. In order to determine any overpayment, ODJFS was bound by its own regulations to first establish Omnicare's usual and customary charge for the oxygen actually used by the recipient. ODJFS' failure to perform this function means that the court of common pleas was correct in applying the reasoning of *HCMC* to the facts of this case.

{¶28} ODJFS' second assignment of error is overruled.

{¶29} Turning to the cross appeal, the court of common pleas directed that the matter be remanded for further consideration to determine the appropriate Medicaid

reimbursement rate. Omnicare contends that remand is futile because Omnicare did not have a usual and customary rate for oxygen actually used, other than the charges to ODJFS. Therefore, if this court were to affirm the remand there would be no way to account for the differences in flat rate billing to nursing homes versus billing for specific amounts of oxygen.

{¶30} ODJFS suggests that if this court finds that remand is appropriate, this court should specify that it is reversing the director's decision and permitting additional testimony and evidence pursuant to R.C. 119.09.

{¶31} As discussed in *HCMC*, R.C. 119.09 does not provide for a second hearing on remand. *HCMC* at ¶67, citing *Douglas Bigelow Chevrolet, Inc. v. Gen. Motors Corp.,* 10th Dist. No. 02AP-1156, 2003-Ohio-5942, ¶57. In that case, the court ordered a reconsideration of the evidence based on the factors discussed in its opinion. Our role in reviewing an administrative decision is to determine if the court of common pleas abused its discretion. Omnicare may be correct in its assertion that there is no way that the correct usual and customary rate can be determined. However, this is a matter best left to the agency. We cannot say as a matter of law that there is no possible reason for ODJFS to reconsider the evidence in light of our decision. Accordingly, we find no abuse of discretion in the common pleas court's decision to order a remand. The first cross-assignment of error is overruled.

{¶32} Omnicare's second, third, and fourth cross-assignments of error all relate to the statistical analysis and projection that resulted in a finding of overpayment of $418,730.37. This amount was part of the overall finding of overpayment in the amount of $1,978,108.65.

{¶33} In the course of the hearing, both sides presented experts who were professors at The Ohio State University, and had taught statistics for many years. Omnicare's expert, Dr. Wolfe, challenged the ODJFS expert, Dr. Moeschberger, on a number of points. Omnicare claimed that Dr. Moeschberger did not review the statistical work done in the audit, he merely agreed that the method used by the auditor appeared to work. Dr. Wolfe testified about flaws he detected in the method relied upon by the auditor.

{¶34} The hearing examiner credited the testimony of Dr. Moeschberger over that of Dr. Wolfe. The hearing examiner noted that the projection method used by the auditor is described in elementary statistical textbooks and the calculations were standard in the field. The hearing examiner further found that Dr. Wolfe did not cite to authority other than his own professional opinion in challenging Dr. Moeschberger's approach. The trial court found substantial, reliable, and probative evidence to support the statistical analysis used in the audit. We find no abuse of discretion in this finding.

{¶35} The second, third, and fourth cross-assignments of error are overruled.

{¶36} In its fifth cross-assignment of error, Omnicare challenges a statement made by the court of common pleas that implies that Omnicare charged $178.56 for oxygen services to all the Medicaid patients. This is not true, and the evidence showed that Omnicare requested Medicaid reimbursement for differing amounts based on oxygen consumption.

{¶37} This alleged error has no bearing on the outcome of the trial court's decision or this court's decision. We are well aware that Omnicare did not bill this amount

for every claim because the auditor found that Omnicare charged this rate only 64.62 percent of the time.

{¶38} We overrule the fifth cross-assignment of error as moot.

{¶39} Based on the foregoing, we sustain ODJFS' first assignment of error, and overrule the second assignment of error. We overrule Omnicare's five cross-assignments of error. The judgment of the Franklin County Court of Common Pleas is reversed in part insofar as it found a denial of due process, and affirmed in part, in that it found rates could not be compared without further analysis of differences in billing and that the matter must be remanded to ODJFS.

Judgment affirmed in part and
reversed in part; remanded with instructions.

KLATT and McGRATH, JJ., concur.

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