STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Care Medical, Incorporated

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

November 2001 ***AOS/FWAP-02-006C***

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OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Mr. Mark Thornberry, President
Care Medical, Incorporated
8340 Reading Road
Cincinnati, Ohio 45237

Re: Medicaid Review of Provider Number #0526818

Dear Mr. Thornberry:

We have completed our review of selected medical services rendered to Medicaid recipients by Care Medical for the period January 1, 1997 through December 31, 2000. We identified findings in the amount of $4,928.49, which have been paid in full to the Ohio Department of Job and Family Services. The attached report details the basis for the findings.

We appreciate your cooperation in resolving the matters identified by our audit. As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

November 8, 2001

TABLE OF CONTENTS

ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of Care Medical, Provider #0526818, doing business at 8340 Reading Road, Cincinnati, Ohio 45237. We identified $4,928.49 in findings relating to duplicate Medicaid payments. The cited funds are recoverable as they resulted from Medicaid claims submitted by Care Medical Inc. for services that did not meet reimbursement rules under the Ohio Medicaid Durable Medical Equipment Manual and the Ohio Administrative Code (OAC).

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services (ODJFS), performs reviews designed to assess Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. ODJFS administers the Medicaid program. The rules and regulations that providers must follow are issued by ODJFS in the form of an Ohio Medicaid Provider Handbook.

Durable medical equipment services are among the services reimbursed by the Medicaid program when delivered by eligible providers to eligible recipients. Durable medical equipment encompasses equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. Requirements for providers of durable medical equipment services are covered in ODJFS' Durable Medical Equipment Manual, which is a part of the Ohio Medicaid Provider Handbook. All durable medical equipment services that are reimbursed by Medicaid must be prescribed by a physician. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Providers must keep copies of prescriptions which include a diagnosis in their files.

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172, providers are required to "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general.

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and

result in an unnecessary cost to the medicaid program.."

PURPOSE SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter they had been selected for a compliance review. An Entrance Conference was held on June 27, 2001 with Mark Thornberry, President, Todd Wirtz, Vice President, and Kathy Neal, Customer Service Coordinator.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period January 1, 1997 though December 31, 2000. We used computer programs to analyze the Provider's paid claims history for that audit period. We specifically looked for "duplicate" payments – payments made twice for the same service to the same recipient. We also checked for other types of overpayments, such as payments for services to recipients who were hospital inpatients at the time of service (and which should have been covered by payments made to their hospital), and payments for services to recipients who were deceased at the time of service.

In addition, we reviewed two statistical random samples of the Provider's records, which were used to support Medicaid claims paid by ODJFS. The samples comprised 155 transaction control numbers (TCNs), which is the identifier for a durable medical equipment service bill for one recipient. The first sample, totaling 75 TCNs, was for claims that contained wheelchair services; the second sample, totaling 80 TCNs, was for those claims which did not include wheelchair services. These claims represented 435 different durable medical equipment services, of which 316 services were in the wheelchair sample and 119 services were in the sample that did not have wheelchair services. We examined the amounts reimbursed by ODJFS and conducted an on-site review of durable medical equipment records.

For the January 1, 1997, through December 31, 2000, review period, the Provider was reimbursed $2,541,239.59 for 13,077 Medicaid durable medical equipment services, including $310,381.71 for the 435 services in our sample.

Work performed on this audit was done in accordance with government auditing standards. Detailed below are the results of this review.

FINDINGS

We identified overpayments and questioned costs in one area during our review: Duplicate Payments. None of our other tests, including our samples, revealed any material deficiencies or weaknesses in the Provider's records.

Duplicate Payments

According to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

We reviewed the Provider's data for the period of January 1, 1997 through December 31, 2000, to determine if the Provider received two reimbursements for the same recipient on the same date of service for the same billed procedure. We identified $103,054.33 in potential duplicate payments. We then sent a list of these payments to the Provider for their review. The Provider submitted documentation to show that most of these duplicates had either been repaid to the Medicaid program or were for different items, as the procedure code used was a miscellaneous item code. After making the appropriate adjustments to our calculation, the duplicate payment totaled $4,928.49 in Medicaid funds, comprising 147 services.

CONCLUSION

A draft of this report was sent to the Provider on September 7, 2001, and the Provider was contacted by telephone on September 28, 2001, to discuss their response to the draft report. The Provider subsequently sent in additional documentation to verify that some of the claims were not duplicated. We made changes to the report where appropriate and the Provider paid the adjusted overpayment amount.

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CARE MEDICAL, INCORPORATED

HAMILTON COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
NOVEMBER 8, 2001