STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Med Doctors

A Compliance Review by the:

Fraud, Waste and Abuse
Prevention Division

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P. O. Box 1140
Columbus, Ohio 43216-1140
Telephone 614-466-4514
800-282-0370
Facsimile 614-466-4490
www.auditor.state.oh.us

Mr. Darrell Grant, Owner
Med Doctors
1119 Hoover Lake Court
Westerville, OH 43081

Re: Medicaid Review of Provider Number #2111646

Dear Mr. Grant:

We have completed our review of selected medical services rendered to Medicaid recipients by Med Doctors for the period January 14, 2002 through March 31, 2002. We identified findings in the amount of $12,536.19, which must be repaid to the Ohio Department of Job and Family Services. A provider remittance form is located at the back of this report for remitting payment. The attached report details the basis for the findings.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

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

September 24, 2002

TABLE OF CONTENTS

ABBREVIATIONS

AOS	Auditor of State
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HCPCS	Common Procedural Coding System
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OHP	Ohio Health Plans

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Auditor of State performed a review of Med Doctors, Provider #2111646, doing business at 1119 Hoover Lake Court, Westerville, OH 43081. We identified findings in the amount of $12,536.19. The findings are recoverable as they resulted from Medicaid claims submitted by Med Doctors 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 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 includes equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. It also includes certain medical supplies which are "consumable, disposable, or have a limited life expectancy" (OAC 5101:3-10-02(A) (2). 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.

Incontinence supplies are among the eligible services provided to Medicaid recipients by Durable Medical Equipment suppliers. OAC 5101:3-10-21 (effective September 1, 1998) lists the requirements of providing incontinence supplies. The following summarizes these requirements:

- Medicaid consumer must be more than 36 months of age
- The consumer is not a resident of a nursing home or intermediate care facility for the mentally retarded
- Incontinence is secondary to a disease, developmental delay/disability, or injury of the brain or spinal cord which results in irreversible loss of control of the urinary bladder and/or anal sphincter
- A prescription that is written, signed, and dated by the treating physician must be obtained every twelve months. The prescription must be obtained by the provider prior to the first date of service.
- The prescription must specify the applicable diagnosis of the specific disease, injury, developmental delay/disability which causes incontinence. The prescription must also specify the type of incontinence
- A prescription that list only incontinence or incontinence supplies and does not specify the reason for the incontinence does not meet the requirements
- Providers must ascertain from the consumer or their care giver on a monthly basis the required type and amount of incontinence garments and/or related supplies

In addition, Section 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."

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172 (E), 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 from the date of receipt of payment or until any initiated audit is completed, whichever is longer."

"Abuse" is defined in Section 5101:3-1-29 (B) of the OAC 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 incontinence services were in compliance with regulations and to calculate the amount of any overpayment resulting from the noncompliance.

On January 2, 2002 we visited the Provider as part of a case study for an overall review of incontinence supplies. During our visit, we identified that the Provider did not call customers monthly to confirm their need for incontinence supplies and did not maintain proper Certificates of Medical Necessity (used to validate a physician's order for incontinence supplies) for recipients.

We concluded the visit by giving the Provider a copy of the ODJFS guidelines for incontinence supplies (OAC 5101:3-10-21) and advising him to comply with the rules.

On May 13, 2002, we initiated a follow up review to determine whether the Provider had taken corrective action and was now compliant with incontinence rules. An Entrance Conference was held on May 29, 2002 with Darrell Grant, Owner of Med Doctors.

We utilized ODJFS' Ohio Medicaid Provider Handbook and the OAC as guidance in determining the extent of services and applicable reimbursement rates. We obtained the provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by Medicaid. This computerized claims data includes patient names, dates of service, and type of procedure/service.

The scope of our review was limited to claims related to incontinence supplies (Procedure Codes Y9131, Y9132, Y9133, Y9136, Y9138, Y9140, and A4554) for which the Provider was paid by Medicaid during the period January 14, 2002 through March 31, 2002. During the audit period the Provider was paid $12,536.19 for 105 claims. To facilitate an accurate and timely review of paid claims, we selected a haphazard, (i.e. non-biased), sample of 59 claims containing 80 services reimbursed by Medicaid. The Provider was

reimbursed $5,781.00 for the services in our sample. We examined the amounts reimbursed by ODJFS and conducted an on-site review of company records.

Work was performed on this audit from May 2002 to June 2002 in accordance with government auditing standards. Detailed below are the results of this review.

FINDINGS

We identified findings amounting to $12,536.19 stemming from noncompliance in multiple areas. The findings were related to the lack of documentation to support consumer requirements, billing prior to supply delivery, missing and invalid physician prescriptions, unsupported billings, and the lack of documentation for a service. A discussion of the deficiencies, the number of instances found, and the amount overpaid follows.

Lack of Documentation to Support Consumer Requirements

According to the Ohio Administrative Code, Section 5101:3-10-21 (D) (1), (2), (3)

> (D) Providers must ascertain from the consumer or consumer's caregiver on a monthly basis the required type and amount of incontinence garments and/or related supplies.
>
> (1) The providers must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider ascertained the required type and amount from the consumer or consumer's care giver. The date that the provider ascertained the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
>
> (2) The type and amount required may be ascertained verbally or in writing. For each month's worth of incontinence garments and supplies, the date of service entered on the Medicaid claim (dispensing date) should not be prior to the date that the provider ascertained the type and amount of incontinence supplies required for the month.
>
> (3) Documentation of the type and amount of incontinence garments and/or related supplies requested must include the first and last name of the provider's employee that took the request and the first and last name of the consumer, or consumer's care giver, making the request.

We found that the Provider maintained some documentation that monthly contacts were occurring, but the documentation that was maintained did not meet the requirements stated above and was not sufficient to support that a customer contact was made. For example, the Provider typically noted on the reverse side of each recipient's registration form the date of contact and the word "yes" if supplies were to continue in the same quantity and size. In a few cases, the Provider also noted if the contact involved a family member, i.e. "daughter", "mother", etc. What was typically missing, however, was confirmation of the quantity needed and the specific item needed.

We determined that 58 of 59 claims, representing 79 of the 80 services in our sample, did not have adequate documentation to support that a customer contact was made.

Billing Medicaid Prior to Supply Delivery

Section 5101:3-10-05 of the OAC (Reimbursement for Covered Services) states in part:

> (E) Automatic refills of medical supply orders are not eligible for reimbursement. Providers of medical supplies shall ascertain the quantity of supplies needed and shall not dispense supplies in excess of the amount actually needed by the recipient for the prescribed period. *No supplies shall be billed before they have been provided to the recipient*. (Italics added)

We determined that the Provider's general practice was to bill Medicaid before the supplies were delivered to recipients. We compared the Provider's Medicaid billing dates with invoices from the supplier and identified 47 of 59 claims, involving 65 of the 80 sampled services, where the Provider billed ODJFS before supplies were shipped to the Medicaid recipients. In other words, over 80 percent of the time, the Provider billed for services prior to actual shipment. Table 1 shows the number of days services were billed before items were actually shipped.

Table 1: Med Doctor Services Billed to ODJFS Prior to Shipment

Number of Services Pre-Billed to ODJFS	Days Billed Prior to Shipment
6	28
2	27
5	16
13	15
1	14
1	8
3	7
6	3
28	1
Total = 65 Services	Average = 13 Days

Source: Med Doctor provider medical record review, May 2002.

The Provider acknowledged his practice was to bill Medicaid when an order was placed with his supplier. The Provider explained that customer orders are phoned to a supplier who then ships the items directly to Medicaid recipients. The supplier then invoices the Provider. The Provider added that the more lengthy delays between billing and shipment occurred because products are sometimes on back order and are not immediately shipped.

Although we did not find any cases where Medicaid recipients did not receive supplies, the Provider's billing practice was clearly not in compliance with Section 5101:3-10-05(E) of the OAC and therefore, the claims in question were not eligible for reimbursement. We believe the practice of billing before services are delivered not only creates a risk that services will not be delivered, but may also unnecessarily create the need for subsequent billing adjustments if the quantity or type of goods delivered changes.

Missing and Invalid Prescriptions

Section 5101:3-10-21 (B) of the Ohio Administrative Code states that effective September 1, 1998…"A prescription that is written, signed and dated by the treating physician must be obtained at least every twelve months". The prescription must be obtained by the provider prior to the first date of service in the applicable twelve-month period and must specify: (1) The applicable diagnosis of the specific disease or injury causing the incontinence; or (2) developmental delay or disability, including applicable diagnoses; and (3) type of incontinence. A physician's written prescription is the Provider's basis for verifying the medical necessity of incontinence supplies.

During the review, we found 19 claims, comprising 19 services, which were missing a physician's prescription. In these instances, it appeared that supplies had been ordered based on call-in requests from recipients, and the requests were not accompanied by a physician's order.

We found another four (4) claims; comprising six (6) services, which had prescriptions, dated more than 12 months prior to the date of service in our sample. We also found one (1) claim, comprising two (2) services, that had prescriptions dated after the date of service. As the Provider must obtain a prescription within a twelve-month period prior to the date of service, the above claims were not eligible for reimbursement.

Unsupported Billing

During the review, we found three (3) claims, involving three (3) services, in which code Y9140-Medium Adult garments were shipped to recipients, but code Y9131-Large Adult garments were billed and reimbursed. Code Y9131 is reimbursed by ODJFS at the rate of $.90 per garment, while code Y9140 is reimbursed at $.80 per garment.

Missing Documentation

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172 (E), 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 from the date of receipt of payment or until any initiated audit is completed, whichever is longer."

We found that a patient's record for one claim, involving one service, was missing. Therefore, we were unable to verify that a service had been provided.

Summary of Findings

In summary, we took exception with all 80 services included in our sample of 59 claims. For many of these services (See Table 2), we had more than one reason for taking issue with the reimbursement for the services. Given the incidence of exceptions from our sample, no further sampling was deemed necessary, and we are projecting findings of $12,536.19, which represents the Provider's total reimbursements for our review period.

Table 2: Summary of Exceptions from Sample Review of Provider Records for the Period Jan. 14, 2002 – Mar. 31, 2002

Basis for Exception	Number of Services with Exceptions
Lack of Documentation for Customer Requests	79
Billing Prior to Rendered Services	65
Missing and Invalid Prescriptions	27
Unsupported Billing	3
Missing Documentation	1
Total Services with Exceptions	175*

* Total occurrences are greater than the number of services in our sample because some services had more than one deficiency. Source: AOS analysis of the Provider's documentation.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on August 8, 2002, to afford an opportunity to provide additional documentation or otherwise respond in writing. In response to a follow up contact, the Provider telephoned on August 15 stating his intent to repay the audit findings.

APPENDIX I

Table 3: Summary of Record Analysis of Med Doctors For the Period Jan. 14, 2002 – Mar. 31, 2002

Description	Audit Period January 14, 2002–March 31, 2002
Total Medicaid Incontinence Services Paid (population)	**$12,536.19**
Number of Population Incontinence Services Claims	**105**
Number of Incontinence Services (population)	**169**
Type of Examination	**Haphazard Sample of 59 claims**
Total Amount of Medicaid Incontinence Services Reviewed	**$5,781.00**
Number of Incontinence Services Reviewed	**80**
Dollar Amount of Incontinence Services Reviewed in Error	**$5,781.00**
Incontinence Services Reviewed with errors	**80**
Projected Dollar Amount with Errors	**$12,536.19**
Projected Number of Claims with Errors	**105**
Projected Number of Services with Errors	**169**

Source: AOS analysis of MMIS information and the Provider's medical records

This Page Intentionally Left Blank

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Human Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider Name & Address:	Med Doctors
	1119 Hoover Lake Court
	Westerville, OH 43081
Provider Number**:**	#2111646
Review Period:	January 14, 2002 through March 31, 2002
AOS Finding Amount:	$12,536.19
Date Payment Mailed:	
Check Number:	

IMPORTANT: To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Charles T. Carle at (614) 728-7398.

This Page Intentionally Left Blank

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140
Telephone 614-466-4514
800-282-0370
Facsimile 614-466-4490

MED DOCTORS

FRANKLIN 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
SEPTEMBER 24, 2002