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

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Medi-Wise Health Mart Inc.

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

April 2002 *AOS/FWAP-02-020C*

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

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Mr. Greg Donaldson, Owner
Medi-Wise Health Mart Inc.
1325 Monroe Avenue NW
P.O. Box #1005
New Philadelphia, Ohio 44663

Re: Medicaid Review of Provider Number #0496468

Dear Mr. Donaldson:

We have completed our review of selected medical services rendered to Medicaid recipients by the Medi-Wise Health Mart, Inc. for the period October 1, 1998 through September 30, 2001. We identified findings in the amount of $85,530.24, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "provider remittance form" is located at the back of this report for remitting payment. We also identified questioned costs of $150,877.64 for services that we believe were billed in excess of the Provider's usual and customary fee for oxygen services. We are recommending that ODJFS as the program administrator make the final determination on these questioned costs and pursue the appropriate recovery action.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if repayment of the findings 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 feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

April 11, 2002

cc: Barbara Edwards, Director of Ohio Department of Job and Family Services

TABLE OF CONTENTS

ABBREVIATIONS

AMA	American Medical Association
AOS	Auditor of State
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
HCPCS	HCFA Common Procedure Coding System
LPM	Liters Per Minute
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed a review of Medi-Wise Health Mart Inc., Provider Number 0496468, doing business at 1325 Monroe Avenue NW, New Philadelphia, Ohio 44663. During this audit, findings amounting to $85,911.36 were identified for recovery, of which the Provider has already remitted $381.12. The remaining amount ($85,530.24) is recoverable as it resulted from Medicaid claims submitted by Medi-Wise Health Mart Inc. for services incorrectly billed under the Durable Medical Equipment Manual and the Ohio Administrative Code. We also identified questioned costs of $150,877.64 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, 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. The Ohio Department of Job and Family Services (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.

ODJFS' Medicaid Provider Handbook, Chapter 3334, General Information, Section II, Subsection (B) states, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must authorize medical services within the scope of his/her licensure and based on their professional judgement of those services needed by an individual. Medically necessary services are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice."

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 Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio

Administrative Code 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 based upon those records or until any initiated audit is completed, whichever is longer".

Pursuant 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.

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 that they were selected for a compliance review. An Entrance Conference was held on November 30, 2001 at the provider's facility with Mr. Gregory Donaldson, Owner.

We utilized ODJFS' Medicaid Durable Equipment Manual and the Ohio Administrative Code (OAC) as guidance in determining the extent of service and applicable reimbursement rates. We obtained the provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to Medicaid and paid to providers. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],

[1]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

- Health Care Financing Administration's[2] (HCFA) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period October 1, 1998 through September 30, 2001. During this audit period, the Provider was reimbursed $525,528.75 for 4,480 durable medical equipment services provided to 819 Medicaid recipients. Of the $525,528.75, the provider was reimbursed $360,322.02 for oxygen concentrators for patients residing in their personal residence and patients residing in LTCF facilities.

To facilitate an accurate and timely review of paid claims, we analyzed statistical random samples of oxygen services. During our random samples, we did not find any missing documentation that would render services ineligible for reimbursement under the rules of the Ohio Department of Job and Family Services (ODJFS) Medicaid Provider Handbook. However, we identified other findings that are discussed below.

Our work was performed between November 2001 and February 2002 in accordance with government auditing standards.

FINDINGS

Our finding of $85,911.36 resulted from overpayments caused by billing for services to deceased recipients and an erroneous payment. We also identified questioned costs of $150,877.64 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services. The basis for the finding and questioned cost are detailed below.

Billing for Services to Deceased Recipients

Pursuant to 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.

During our review of the Provider's paid claims for the audit period, we determined that the Provider billed Medicaid for three services that involved two recipients subsequent to the recipients' date of death. Therefore, a finding was made for $381.12, which represents the amount reimbursed to the Provider for services billed in months subsequent to the month of the recipients' deaths.

The Provider responded in a letter dated December 7, 2001 stating that one recipient was paid under the wrong recipient number; and the other recipient's flow sheet showed an error of six hours on the concentrator reading for December. This error occurred due to the November meter reading

[2]The Center for Medicare and Medicaid Services (formerly known as HCFA) has federal oversight of the Medicaid program. HCFA has federal oversight of the Medicaid program.

which was incorrectly copied. According to the Provider, this information was not communicated to the billing clerk in a timely manner, making her unaware of the recipient's death.

Based on documentation received from the Provider on December 7, 2001, a payment of $381.12 was remitted during the audit by the Provider to ODJFS for the billing of services to deceased recipients.

Erroneous Payment

Pursuant to OAC Section 5101:3-1-198, "errors in payment, caused either by the provider or the department, must be corrected by advising the department by completing the appropriate request form (ODHS 6766 for hospitals or ODHS 6767 for all other provider types) as identified in the billing instructions. These forms are to be used for line items or entire claims having an erroneous payment or which are in paid status with a zero payment".

During our review of the Provider's billed claims, we identified a claim for oxygen service in which the provider had billed ODJFS for $592.00, but had been erroneously reimbursed $85,708.80. The Provider acknowledged the overpayment and told us he had contacted ODJFS several times about returning it, but had been unsuccessful in reaching someone who could assist him. As a result, we contacted the Division Chief for Plan Operations in the Office of Ohio Health Plans, who oversees Medicaid claims processing. The Division Chief confirmed that an error had occurred during the processing of the Provider's claim.

Several things appear to have gone wrong in the submission and processing of this claim. First, the processing system erroneously multiplied the billed amount by a number in the "units of service" field of the claim. Second, the Provider used an incorrect procedure code modifier (QG). According to 5101:3-10-13 (D)(2)(b) of the OAC, the QG modifier code increases a payment amount by 50 percent when the prescribed amount of oxygen is greater than 4 liters per minute continuous (twenty-four hours per day). In this instance, the Provider's documentation supported a billing for oxygen without the modifier code because the patient's prescription only called for 2 liters per minute of oxygen, and the oxygen meter reading measured 720 hours of usage for the month.

The Provider's documentation supported a reimbursement of $178.56 – the Medicaid maximum for this amount of oxygen usage. Therefore, we are making a finding for $85,530.24, which represents the difference between $85,708.80 and $178.56, to which the Provider was entitled.

Questioned Costs Regarding Usual and Customary Fee

In order to supply medical services to Medicaid recipients, providers sign a provider agreement. The Ohio Administrative Code § 5101:3-1-172 states, in part:

A "Provider Agreement" is a contract between the Ohio department of job and family services and a provider of medical ASSISTANCE services in which the provider agrees to comply with the terms of the "Provider Agreement," state statutes and ODJFS Administrative Code rules, and federal statutes and rules, and agrees to:

> (B) Bill the Ohio department of job and family services for no more than the usual and customary fee charged other patients for the same service.

In addition, the Ohio Administrative Code § 5101:3-10-13 C(5), Oxygen: covered services and limitations, states "...billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient...".

During the entrance conference the Provider stated that he supplied concentrators to other nursing home patients for $60.00 per month. Our subsequent review of contracts that the Provider held with 15 nursing home supported this statement. We found that the Provider charged nine of the facilities $60.00 per month for oxygen services and a lessor amount to two other facilities. We were not able to verify the Provider's charges at four other facilities.

We are questioning $150,877.64 of Medicaid's costs for concentrator services because they appear to exceed the Provider's usual and customary charges. The Provider charged Medicaid $178.56 per concentrator per month of service almost 70 percent of the time, while charging nursing homes $60 per concentrator per month. Our questioned costs are conservative because we took a weighted average of all Medicaid claims paid to the Provider, thus likely including some partial months of service. We calculated the difference between the Medicaid average monthly claim amount paid to the Provider for oxygen concentrator services ($135.59) and the $60 monthly rate typically charged by the Provider to nursing homes, and then multiplied the difference ($75.59) by the number of claims (1,996) paid to the Provider during the audit period. This resulted in a $150,877.64 difference between what the Provider was reimbursed by Medicaid, and what the Provider would typically be reimbursed under the monthly rate paid by nursing homes.

The Provider asserted that higher charges to Medicaid are justified because Medicaid has additional administrative requirements (periodic meter readings and maintenance of patient files to support billings). In contrast, when oxygen concentrators are provided to nursing homes for private pay customers the Provider is not required to perform meter readings or keep any patient files.

We did not gather detailed information on what services are required for non Medicaid oxygen concentrators. However, due to the large disparity of $75.59 per month/per concentrator between what the Provider charged Medicaid and what was charged for patients in a same setting, we question whether the amounts billed Medicaid were a "usual and customary" charge. In addition, Medicaid, like a nursing home, is a volume purchaser and should expect to benefit from reductions

or discounting of fees and charges. Therefore, we recommend that the Ohio Department of Job and Family Services review the questioned claims to verify whether the amounts billed for oxygen concentrators are appropriate under Ohio Administrative Code § 5101:3-1-172 and Ohio Administrative Code § 5101:3-10-13 C(5).

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent the Provider a draft copy of the report on March 8, 2002. The Provider's legal representative responded in a March 21, 2002 letter, in which the Provider agreed with the $381.12 finding for deceased recipient billings and the $85,530.24 finding for an erroneous payment.

However, the Provider disagreed with our questioning of whether usual and customary charges were billed to Medicaid for oxygen concentrator services. The following is an excerpt from the Provider's response.

> In conclusion, the Provider disagrees with the classification of $164,968.80[3] as a questioned amount because (1) there is no usable definition of the term "usual and customary" in Ohio law, rules, or manuals, and it does not comport with notions of due process or fair dealing for Medicaid providers to be subject to rules which may be applied in an arbitrary manner in different circumstances; (2) the Provider's usual and customary charges for services at issue are above Medicaid fee schedule amounts; (3) the Auditor of State only considered a distinct subset of the Provider's customers when the entire spectrum of the Provider's customers should have been analyzed; and (4) the Medicare regulations regarding this issue are persuasive in the absence of any useful guidance from ODJFS, and the provisions of such regulations the reimbursement received by the Provider from Medicaid would be below its usual and customary charge.[4]

Auditor's Note: While we would agree that Ohio Medicaid rules lack a formula for quantifying a provider's usual and customary fee, we question the basis for the Provider's assertion that his usual and customary charges were above Medicaid fee schedule amounts. None of the data supplied by the Provider supports this assertion. Moreover, we believe our calculation of the questioned costs

[3]The questioned costs in the final report are less than the amount in the draft report reviewed by the Provider because we reduced the questioned amount to give credit for Medicaid charges made by the Provider that were less than the maximum Medicaid allowance.

[4]In support of point (4), the Provider cited 42 CFR 405.503 in which Medicare defines customary charges as the uniform amount the individual physician or other person charges in the majority of cases for a specific medical procedure or service.

is conservative, in that we based it on the highest contract rate charged to nursing homes under contract with the Provider. We also based our calculation on payments for services to patients in the same setting as Medicaid patients.

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APPENDIX I

**Table 1: Recap of Findings and Questioned Costs for Medi-Wise Health Mart, Inc.
For the period October 1, 1998 through September 30, 2001**

Description	Number of Instances	Audit Period October 1, 1998 through September 30, 2001
Number of Oxygen Services, Procedure Code Y2076, Y2081, Y2082, and Y2083 (questioned cost)	1,996	$150,877.64
Billing for Services to Deceased Recipients (repaid finding)	3	$381.12
Erroneous Billing (finding)	1	$85,530.24
TOTAL FINDINGS	2,000	$236,789.00

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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 Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Medi-Wise Health Mart Inc. 1325 Monroe Avenue NW P.O. Box #1005 New Philadelphia, Ohio 44663
Provider Number:	0496468
Audit Period:	October 1, 1998 through September 30, 2001
AOS Finding Amount:	$85,911.36
Payment Received on 12/7/01:	$381.12
Balance of AOS Finding Amount:	$85,530.24
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.

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Facsimile 614-466-4490

MEDI-WISE HEALTH MART, INC

TUSCARAWAS 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
APRIL 11, 2002