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

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to RGH Enterprises, Inc.

A Compliance Review by the

Fraud, Waste and Abuse Prevention Division

January 2002 ***AOS/FWAP-02-015C***

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

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Mr. Ronald Harrington, Owner
RGH Enterprises, Inc.
1810 Summit Commerce Park
Twinsburg, Ohio 44087

Re: Medicaid Review of Provider Number 0830757

Dear Mr. Harrington:

We have completed our audit of selected medical services rendered to Medicaid recipients by RGH Enterprises, Inc[1]., for the period January 1, 1996 through June 30, 2000. We identified findings in the amount of $347,507.23, which must be repaid to the Ohio Department of Job and Family Services.

We understand that you plan to contact the Department to arrange repayment of the findings through installments. We appreciate your prompt attention to this matter. Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment arrangements are not made with 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. In the event you choose to repay in full, a "provider remittance form" is located at the back of this report for remitting payment.

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

January 3, 2002

[1]The Provider is registered in the Medicaid Program as Edgepark Surgical, Inc. but is doing business as RGH Enterprises, Inc.

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ABBREVIATIONS

AMA	American Medical Association
AOS	Auditor of State
CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Current Procedural Terminology
FWAP	Fraud, Waste, and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA (CMS) Common Procedure Coding 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 RGH Enterprises, Inc., Provider Number 0830757, at 1810 Summit Commerce Park, Twinsburg, Ohio. During this audit, findings amounting to $347,507.23 were identified for recovery. The cited funds are recoverable as they resulted from Medicaid claims submitted by the Provider for services unallowable under the Ohio Medicaid Durable Medical Equipment Manual and the Ohio Administrative Code.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, 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. 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 and Ohio Administrative Code Section 5101:3.

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 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 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 were selected for a compliance review. An Entrance Conference was held on November 15, 2000 with Mike Leighty, Controller, at the Provider's facility.

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)[2],
- Center for Medicare and Medicaid Services'[3] (CMS) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The Provider is primarily a supplier of ostomy, incontinence, wound care, and diabetic products, and typically ships these products to recipients based on phone orders or mail orders, which are in turn supported by a physicians' prescriptions.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period January 1, 1996 through June 30, 2000. During this audit period, the Provider was reimbursed $3,708,979.15 for 38,597 durable medical equipment services provided to 3,660 Medicaid recipients.

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

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

To facilitate an accurate and timely review of paid claims, a statistical random sample was taken of 172 transaction control numbers (TCN's). A TCN is the identifier for a bill for services for one recipient. The 172 TCN's represented 623 distinct services covering a range of 84 different durable medical equipment procedures. The TCN's sampled accounted for $62,516.82 of the Provider's total reimbursement for the audit period. The review involved comparing the Provider's durable medical equipment records with the claims payment history from MMIS.

We also used computer programs to analyze the Provider's claims history for the audit period to test for such things as payments for services to deceased persons.

Work performed on this audit was done in accordance with government auditing standards.

FINDINGS

Our review of 172 TCN's identified findings in four categories: No Prescriptions, Prescriptions Obtained After Payment Date, Missing Consumer Request for Incontinence Supplies, and Payment for Services to Deceased Recipients. The findings for these categories, which are subject to repayment to ODJFS, totaled $347,507.23. The bases for these findings are detailed in the sections below.

No Prescriptions

According to the Ohio Administrative Code, Section 5101:3-10-05 (A),

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . . For medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code.

A physician's prescription and/or verbal order is the basis for verifying the medical necessity of the DME services or goods. Without the ability to verify medical necessity, the Medicaid program runs the risk of paying for services that are unnecessary and/or not ordered by a physician.

In our review we found that patient records for 13 TCNs, comprising 42 services, did not contain the required prescription or verbal order. Either there was no prescription for the items claimed for reimbursement, or the documented verbal information was insufficient to determine if a physician had requested the items claimed for reimbursement. Therefore, we were unable to support the medical services provided were medically necessary.

In responding to our results, the Provider noted that subsequent to a September 1, 1998 change to OAC 5101:3-10-05, which required that Providers obtain written prescriptions for incontinence supplies, they revised their documentation methods for easier retrieval of prescriptions and documentation of verbal orders. They also pointed out that following the change in procedures only one TCN failed to meet documentation requirements.

Prescriptions Obtained After Payment Date

Under section OAC 5101:3-10-05, a prescription is not valid until the date signed by the attending physician. Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection B (OAC Section 5101:3-1-172), the provider must maintain records for a period of six years from the date of receipt of payment or until any initiated audit is completed, whichever is longer, to fully describe the extent of services rendered. Implicit in the latter requirement is that providers must document the basis for a Medicaid service before receiving payment for it.

We found 6 TCNs, involving 11 services, out of 172 TCNs in our sample that did not meet the above reimbursement criteria because the prescriptions were generated after the Provider had been reimbursed for the services. Under OAC Section 5101:3-1-172, these prescriptions are not acceptable support for the Provider's claims for reimbursement.

Missing Consumer Request for Incontinence Supplies

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

> (D) Providers must ascertain from the consumer or the consumer's care giver 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.
>
> (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.
>
> (4) Documentation of the type and amount required must be obtained and on file prior to dispensing the incontinence garments and/or related supplies.

Because these rules became effective September 1, 1998, we applied these criteria only to instances where the Provider did not present documentation for incontinence items supplied after September 1, 1998. Under Medicaid rules, the provider is not eligible for reimbursement of incontinence supplies without this documentation. Of the 172 TCNs, 1 TCN, involving 2 services, did not contain the proper documentation to receive reimbursement for incontinence supplies.

Findings for Missing/Invalid Prescriptions and Missing Consumer Request

In all, we identified 20 TCNs, involving 55 services, out of the 172 TCNs, in our sample that did not meet Medicaid requirements for reimbursement. We projected the error rate for the 20 TCNs across the total population of durable medical equipment service claims paid to the Provider. This resulted in a projected overpayment of $342,633.43. The overpayment was calculated by projecting the correct population reimbursement amount ($3,366,345.72) and taking the difference between it and the actual amount paid to the provider ($3,708,979.15) during our audit period. The projected correct population reimbursement of $3,366,345.72 has a 95 percent certainty that the true population value would fall within the range of $3,124,011.97 to $3,540,385.00, a precision of +/- 6.25%.

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 119 services to 44 recipients subsequent to the recipients' date of death. Therefore, a finding was made for $4,873.80, which represents the amount reimbursed to the Provider for services billed in months subsequent to the month of the recipients' deaths.[4]

The Provider responded in a letter dated December 7, 2000 that they were unaware that the patients were deceased, and would promptly repay any overpayment. The Provider also stated that they were implementing the following corrective actions:

- When notified by any source that a Medicaid patient is deceased, they will check to see if they received any shipment for which medicaid was billed after the date of death. For those shipments, they will promptly refund the appropriate amount to Medicaid.

- Upon notification to the Provider by medicaid that a payment has been made for a deceased patient, they will promptly refund the appropriate amount to Medicaid.

[4] Note: These services were not included in projections of our sample results.

- The Provider will audit its files in 3 months to insure that refunds are being processed promptly for deceased patients who received a shipment(s) for which Medicaid was billed after the date of death.

- The Provider will periodically audit its files to ensure that refunds are being processed.

We believe these actions are responsive to our findings.

PROVIDER'S RESPONSE

Our initial draft report was sent to the Provider on February 14, 2001. Subsequent to that time, we, the Provider and its legal representative discussed various aspects of the audit methodology and findings. Between February and December 2001, we received both written and oral comments from the Provider, additional documentation to support claims for services, and Medicaid policy clarifications from ODJFS. This report reflects various adjustments resulting from the additional documentation and policy clarifications. The Provider's legal representative advised us they plan to contact ODJFS to arrange repayment of the finding through installments. The Provider also noted that they have implemented procedural controls which should minimize risks of future non compliance with Medicaid requirements.

APPENDIX I

Table 1: Summary of Record Analysis of RGH Enterprises, Inc. For the period January 1, 1996 to June 30, 2000

Description	Audit Period January 1, 1996 - June 30, 2000
Type of Examination	**Stratified Statistical Random Sample of 172 TCNs**
Number of Durable Medical Equipment Services Included in Sampled TCNs	**623**
Amount Paid for Services Sampled	**$62,516.82**
Total Medicaid Amount Paid During Audit Period for Durable Medical Equipment Services	**$3,708,979.15**
Projected Correct Reimbursement for Durable Medical Equipment Services	**$3,366,345.72**
Upper Limit at 95% Confidence Level	**$3,540,385.00**
Lower Limit at 95% Confidence Level	**$3,124,011.97**
Projected Overpayment	**$342,633.43***

*Note: This projected overpayment does not include the $4,873.80 in findings for services to deceased Medicaid recipients. This finding was determined by analyzing the Provider's entire claims history for the audit period, and is not based on a sample projection.

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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:	RGH Enterprises, Inc. 1810 Summit Commerce Park Twinsburg, Ohio 44087
Provider Number:	0830757
Audit Period:	January 1, 1996 through June 30, 2000
AOS Finding Amount:	$347,507.23
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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OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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P.O. Box 1140
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800-282-0370
Facsimile 614-466-4490

RGH ENTERPRISES INC.

SUMMIT 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
JANUARY 3, 2002