Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Bettman Miracle Lane Pharmacy

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

October 14, 2004

Tom Hayes, Director
Ohio Department of Job and Family Services
30 E. Broad St., 32nd Floor
Columbus, OH 43266-0423

Re: Audit of Bettman Miracle Lane Pharmacy
Provider Number: 0686753

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Bettman Miracle Lane Pharmacy for the period October 1, 2000 through June 30, 2003. We identified $1,881.60 in findings that are repayable to the State of Ohio. We are also recommending that Bettman Miracle Lane Pharmacy improve its record keeping; thus reducing the risk of future audit findings. Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers, and Section 117.10 of the Ohio Revised Code. The scope and methodology section of this report describes the procedures followed during our audit.

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make any final determinations regarding recovery of the findings identified herein. We have advised Bettman Miracle Lane Pharmacy that if our findings are not repaid to ODJFS within 45 days, this matter can be referred to the Ohio Attorney General's office for collection in accordance with Section 131.02 of the Ohio Revised Code.

Copies of this report are being sent to Bettman Miracle Lane Pharmacy, the Ohio Attorney General, the Ohio State Medical Board, and other interested parties. Copies are also available on the Auditor's web site (www.auditor.state.oh.us). If you have questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

TABLE OF CONTENTS

ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Ohio Auditor of State performed an audit of Bettman Miracle Lane Pharmacy (hereafter called the Provider), Provider #0686753, doing business at 2350 Catalpa Dr., Dayton, OH 45406. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified $1,881.60 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code. We are also recommending that Bettman Miracle Lane Pharmacy create a detailed form to improve its record keeping, thus reducing the risk of future audit findings.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet general principles regarding reimbursement for Medicaid covered services.[1] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

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. It also includes certain medical supplies which are "consumable, disposable, or have a limited life expectancy" [See Ohio Adm.Code 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. Ohio Adm.Code 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 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.

[1] *See Ohio Adm.Code 5101:3-1-01 (A) and (A)(6)*

- 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 lists 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 caregiver on a monthly basis the required type and amount of incontinence garments and/or related supplies.

Ohio Adm.Code 5101:3-1-17.2(D) states that 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 audit initiated within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in part: "…In all instances of fraud, waste, 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."

Ohio Adm.Code 5101:3-1-29(B)(2) states: " 'Waste and abuse' are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and, if warranted, calculate the amount of any recoverable overpayments. Within the Medicaid program, the Provider is listed as a pharmacy that provides supplies and medical equipment.

Following a letter of notification, we held an entrance conference at the Provider's place of business on February 3, 2004 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2000 through June 30, 2003. The Provider was reimbursed $739,370.59 for 17,661 services rendered on 9,413 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH 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 the Medicaid program. This computerized claims data

included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2.]

Prior to beginning our field work, we performed a series of computerized tests of the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for:

- Services to deceased recipients for dates of service after the date of death.
- Potentially duplicate billed and paid services. Defined as more than one bill for the same recipient, same date of service, same procedure, same procedure modifier, and same payment amount occurring on different claims.
- Bills for non-covered services to recipients residing in nursing homes.
- Bills for incontinence garment services to recipients less than 36 months of age.
- Services for supplies dispensed, billed, and paid in amounts greater than the Medicaid maximum allowed.

The tests for services rendered the nursing home residents after their date of death and to recipients less than 36 months of age were negative, but the tests for duplicate payments and payments in excess of the Medicaid maximum identified potentially inappropriate service code combinations. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed two statistically random samples from the subpopulation of claims not identified for 100 percent review. The first sample of 173 recipient dates of service (comprising 243 services) was drawn for incontinence garments and related supplies. The second sample of 197 recipient dates of service (comprising 571 services) was drawn for all other services. In extracting these samples, we defined a recipient date of service (RDOS) as all services performed for a specific recipient on a particular date.

Our work was performed between December 2003 and July 2004.

RESULTS

We identified findings of $697.24 from our exception tests and projected findings of $1,184.36 from the results of our two statistical samples. The circumstances leading to our total findings of $1,881.60 are discussed below.

[2] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

Results of Exception Tests

Our exception tests identified findings of $118.65 from duplicate claims for service and $578.59 from dispensed supplies greater than the Medicaid allowed maximum.

Duplicate Claims

Ohio Adm.Code 5101:3-1-19.8(F) states:

> Overpayments are recoverable by the department at the time of discovery…

Our computer analysis identified five occasions of potential duplicate billing where the Provider billed more than once for the same procedure code for the same patient, on the same day, and for the same amount. Our examination of records determined that on two of these occasions only one service was rendered. Therefore, we disallowed the second billed service. This resulted in findings of $118.65.

Dispensed Supplies Greater than Medicaid Allowed Maximum

Ohio Adm.Code 5101:3-10-03 states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule. This list includes the following information as described in paragraphs (A) to (G) of this rule…
>
> ***

Our computer analysis identified 69 services in five areas where the Provider potentially dispensed supplies over the maximum allowed. These five areas included: blood glucose test strips; syringes without needles; non-impregnated gauze pads; automatic blood pressure monitors; and surgical gloves, non-sterile. After reviewing our analysis, the Provider, acknowledged that 60 services had been incorrectly billed, resulting in an overpayment by Medicaid. We took the difference between the allowed amount for what should have been billed and the amount actually paid and identified a finding for the difference, or $578.59.

Results of Statistical Sample: Incontinence Garments and Related Supplies

We identified and projected findings of $1,032.56 for erroneously billed services from the results of our statistical sample. These findings resulted from bills for 17 services that had missing and invalid prescriptions. The rationale for our findings and the methodology used to project the sample results are presented below.

Missing and Invalid Prescriptions for- Incontinence Supplies and Related Services

Ohio Adm.Code 5101:3-10-21 states in pertinent part:

> ***
>
> (B) 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 diagnosis; and,
>
> (3) Type of incontinence
>
> ***
>
> (C) A prescription that only lists incontinence or incontinence supplies and does not specify the reason for the incontinence in accordance with paragraph (B) of this rule does not meet the requirements of this rule.
>
> ***

We conducted a field review of 173 recipient dates of service containing 243 services. As a result of our review, we found that 6 services were not supported by prescriptions that were written, signed, or dated within twelve months of the service was rendered. In addition, we found 11 services that were missing diagnoses or had diagnoses that did not apply to incontinence. Thus, we were unable to verify that these services were requested by a physician and/or that the patients' condition qualified them for incontinence supplies. Therefore, we took exception with reimbursements for these 17 services.

We also determined that a number of other prescriptions did not identify the "type" of incontinence, e.g. incontinence of urine, nocturnal enuresis, incontinence without sensory awareness, in accordance with Ohio Adm.Code 5101:3-10-21(B)(3). We did not associate findings with this deficiency; however, we believe it supports the need for improved record keeping. Other providers of incontinence supplies have physicians complete a "certificate of medical necessity" to capture such information as a doctor's order for supplies, the qualifying diagnoses, and incontinence type. To minimize the risk of future overpayments, we are recommending that the Provider develop and use a certificate. Page 8 further elaborates on our recommendation.

Sample Projection

We took exception with 17 of 243 statistically sampled services from a stratified random sample (11 of 173 recipient dates of service) from the Provider's sub-population of paid incontinence garment and related supply services not identified for 100 percent review. We then calculated findings by projecting the sample error rate to the Provider's sub-population of paid incontinence related services. This resulted in projected findings of $15,832.00 with a 95 percent certainty that the true sub-population overpayment fell within the range of $1,032.56 to $27,485.00, a precision of plus or minus $11,654.00 (73.61 percent). Since the precision percentage achieved was greater than our procedures require for use of the point estimate, the audit findings determined to be repayable to ODJFS was set at $1,032.56, the lower limit overpayment estimate amount. This allows us to say that we are 97.5 percent certain that the incontinence related services sub-population audit finding amount is at least $1,032.56. Appendix II further details the basis for our projection.

Results of Statistical Sample: All Other Services

We identified and projected findings of $151.80 for erroneously billed services from the results of our statistical sample of non-incontinence related services. These findings were identified in three categories:

- Bills for services that had missing and invalid prescriptions.
- Services that were duplicately billed.
- Supplies dispensed in excess of the Medicaid prior authorized amount.

The rationale for our sample findings and the methodology used in projecting the sample results to the subpopulation of the Provider's other paid services are presented below.

Missing and Invalid Prescriptions for All Other Services

Ohio Adm.Code 5101:3-10-05(A) states in pertinent part:

> 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…an oral prescription with all of 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…

In our review of patient medical records for 197 recipient dates of service (571 services), we found that one service did not contain a prescription that was written, signed, or dated within twelve months of the service rendered. Thus, we were unable to verify that this service was requested by a physician. It also had no documentation to show that the service was rendered. Therefore, we disallowed this service.

We also noted that a significant number of prescriptions failed to specify a diagnosis. In addition, we identified several verbal orders for refills that lacked dates and/or did not clearly identify the ordering physician. We did not associate findings with these deficiencies. However, we believe they further support the need for the Provider to use a standard form, such as certificate of medical necessity, to capture annual prescription information. Additionally, we believe the Provider needs a better process for documenting refill orders.

Duplicate Claims for All Other Services

Ohio Adm.Code 5101:3-10-05(G) states in pertinent part:

> Duplicate equipment, supplies, or services, or conflicting equipment prescribed for a recipient, are not reimbursable.
>
> ***

In our review of patient medical records, we found one service that did not meet Medicaid requirements for reimbursement. For this service, the Provider submitted duplicate billed services. Our examination of Provider records determined that on this occasion only one service occurred. Therefore, we disallowed the second billed service.

Dispensed Supplies Greater than the Medicaid Prior Authorization

Ohio Adm.Code 5101:3-10-03 states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule. This list includes the following information as described in paragraphs (A) to (G) of this rule…
>
> ***
>
> (F) A maximum allowable (MAX) indicator means the maximum quantity of the item which may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.

During our review of the 571 other services, we found that one service was billed for units of service that exceeded the prior authorized amount by Medicaid. Therefore, we took exception with the difference between the prior authorized amount and the amount that was actually billed.

Sample Projection

We took exception with 3 of 571 statistically sampled recipient services (3 of 197 recipient dates of service) from a stratified sample of the Provider's sub-population of other paid services not identified for 100 percent review. This resulted in projected findings of $10,465.11 with a 95 percent certainty that the true sub-population overpayment fell within the range of $151.80 to $30,219.11, a precision of plus or minus $667 (121.25 percent). Since the precision percentage achieved was greater than our procedures require for use of the point estimate, the audit findings determined to be repayable to ODJFS was set at $151.80, the lower limit overpayment estimate amount. This allows us to say that we are 97.5 percent certain that the incontinence related services sub-population audit finding amount is at least $151.80. Appendix III further details the basis for our projection.

Provider Should Create a Detailed Form to Obtain Information

As noted above, both Ohio Adm.Code 5101:3-10-21(B) and Ohio Adm.Code 5101:3-10-05(A) require that providers capture certain information about a durable equipment supply order, such as the doctor's authorization that supplies are needed, a qualifying diagnosis, and other required pieces of information. The Provider's files were missing much of this information, required extensive searching to find the information, and resulted in findings for the more egregious violations. To minimize the risk of future findings, we are recommending that, as part of the annual requirement to obtain physician prescriptions, the Provider send and have physicians complete a supplemental certificate of medical necessity form before billing for Medicaid services. Although ODJFS does not require durable medical equipment suppliers to use such forms, unless required for prior authorization, we believe doing so avoids the potential for unallowable services. In addition, the Provider needs to develop a better process for recording verbal orders for refills, such as the date of the order and the ordering physician.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on July 6, 2004. The Provider sent us a written response on July 29, 2004, along with additional documentation to support many of the claims for services we initially took exception with. As a result of the additional supporting information supplied by the Provider, we adjusted our findings to $1,881.60, which are repayable to the Ohio Department of Job and Family Services.

We also asked the Provider to prepare a corrective action plan addressing how the deficiencies identified in our report would be corrected. On July 20, 2004, the Provider sent a corrective action plan to address recurrences of some of the exceptions noted in the report. We are referring the attached corrective action plan to ODJFS' Surveillance and Utilization Review Section for their review and follow up.

APPENDIX I

Summary of Findings from Bettman Miracle Lane Pharmacy For the period October 1, 2000 to June 30, 2003

Description	Audit Period October 1, 2000 to June 30, 2003
Findings from census review: • Duplicate Claims Exception Test • Dispensed Supplies Greater than Medicaid Maximum Allowed Exception Test	$118.65 $578.59 $697.24
Projected findings from sample of Incontinence Garments and Related Supplies dates of service not involved with census review.	$1,032.56
Projected findings from sample of All Other dates of service not involved with census review.	$151.80
TOTAL FINDINGS	**$1,881.60**

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

APPENDIX II

Summary of Sample Record Analysis for: Bettman Miracle Lane Pharmacy
Incontinence Garments and Related Supplies Services
For the period October 1, 2000 to June 30, 2003

Description	Audit Period October 1, 2000 – June 30, 2003
Type of Examination	**Stratified Statistical Random Sample**
Description of Sub-Population	Sub-population of Incontinence Garments and Related Supplies Recipient Dates of Service excluding services selected for Other sample and services for census review.
Number of Recipient Dates of Service in Sub-Population	2,345
Number of Services in Sub-Population	3,570
Total Medicaid Amount Paid for Sub-population of Incontinence Garment and Related Supplies	$304,571.22
Number of Recipient Dates of Service Sampled	173
Number of Services Sampled	243
Amount Paid for Services Sampled	$20,130.56
Estimated Overpayment (Point Estimate)	$15,832.00
Upper Limit Overpayment Estimate at 95% Confidence Level	$27,485.00
Lower Limit Overpayment Estimate at 95% Confidence Level	$1,032.56
Precision of Correct Population Payment Estimate at 95 % Confidence Level	$11,654.00 (73.61%)

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

APPENDIX III

Summary of Sample Record Analysis for: Bettman Miracle Lane Pharmacy
All Other Services
For the period October 1, 2000 to June 30, 2003

Description	Audit Period October 1, 2000 – June 30, 2003
Type of Examination	**Stratified Statistical Random Sample**
Description of Population Sample	Sub-population of Other recipient dates of service excluding services selected for Incontinence Garments and Related Supplies sample and services for census review
Number of Sub-population Recipient Date of Services	7,932
Number of Sub-population Services Provided	13,931
Total Medicaid Amount Paid For Sub-population of Other Recipient Dates of Service	$429,160.11
Number of Recipient Date of Services Sampled	197
Number of Services Sampled	571
Amount Paid for Services Sampled	$33,105.22
Estimated Overpayment (Point Estimate)	$10,465.11
Upper Limit Overpayment Estimate at 95% Confidence Level	$30,219.11
Lower Limit Overpayment Estimate at 95% Confidence Level	$151.80
Precision of Correct Population Payment Estimate at 95 % Confidence Level	$667.00 (121.25%)

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

This Page Intentionally Left Blank.

Bettman's
YOUR GOOD NEIGHBOR PHARMACY...SINCE 1956

July 20, 2004 937-274-2101 • 2350 Catalpa Drive • Dayton, OH 45406

Auditor of State Betty Montgomery
35 N. Fourth St. First Floor
Columbus, OH 43215
Attn: Tracie Thompson, Kathryn Dyer

Re: Medicaid Provider Audit
Provider # 0686753

Dear Tracie and Kathryn:

In response to your findings regarding the Medicaid audit you conducted here in February, 2004, we will address your findings in the order you presented them in your letter of July 6, 2004.

Duplicate Services Billed

[redacted]– these were for 2 different types of syringes. One was a 1cc syringe and the other was a 3cc syringe.
[redacted]– we were paid twice for this service. The Medicaid system should have caught this error and rejected the duplicate billing.

Dispensed Supplies Greater than the Medicaid Maximum Allowed

Blood Glucose test Strips – we were paid more than the allotted amount on these strips.

Syringes without Needles – this Rx was run as a refill by a pharmacy technician who would not have had the knowledge of the maximum quantity of the syringes. Again, the Medicaid system should have adjusted for this at the time we billed it.

Gauze Pads – we were paid more than the allotted amount for the gauze. Again, the adjustment should have been done at the time it was billed.

Blood Pressure Monitors – we were paid for these blood pressure monitors. The technicians who filled them inadvertently overlooked the earlier fill and the fact that they were only to have received one in 8 years. Medicaid should have rejected the 2nd blood pressure monitor at the time it was billed.

Gloves, non sterile – on April 1, 2003, Medicaid changed their reimbursement of non-sterile gloves from 100 pairs per month at $.22 per pair to one box at $8.69. There were several instances in the month of April where we continued to be reimbursed for two boxes and several instances where we were paid for the amount we billed for one box instead of Medicaid making the adjustment for their new reimbursement amount. In addition, in some instances, we billed for 100 (pairs) instead of for (1) box.

1

On the fill for [redacted] she received one box of gloves containing 50 pairs. With the new reimbursement schedule, it should have been billed as 1 instead of 50, but she did receive one full box of gloves. It would seem that this overpayment should be for $1.31, not $5.65.

Again, it seems clear in these instances that Medicaid was not prepared in their system to adjust for reimbursement changes that they had made. Their system should have been ready on April 1, 2003 when the last round of coding and reimbursement changes were made to make adjustments.

The employee who reconciles our payments does not have extensive knowledge about maximum quantities and reimbursement amounts. She reconciles the payments as they come in and reports any reimbursements that are considerably over or under the billed amount. Some of the duplicate billing occurred because one of her duties of reconciling is to periodically rebill old claims that still remain in the Accounts Receivable file which would indicate to us that they have not yet been paid. On many occasions, this has proven to be the case. In some instances, claims that have actually already been paid have been missed when being reconciled the first time. It would seem to me that the Medicaid system should be set up in a way to know when a claim has already been paid and reject it as a duplicate the second time.

In all of the above instances, we question why the Medicaid system is not set up to reject these duplicate services. While we would acknowledge the oversight on our part that allowed the billing in the first place, the Medicaid system should be set up to reject the claim altogether or, in the case of a maximum billing amount, to cut the reimbursement at that maximum monthly amount.

Incontinent Garments and Related Supplies

[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – never received incontinence items from us. He did receive trach supplies on that date. Among these were 4 trach tube holders with a HCPCS code of Y9188. I believe there was an error of coding when it went into the Medicaid system. Please check your records. Rx attached for the trach tube holders.
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – we were unable to locate the Rx
[redacted] – diagnosis included
[redacted] – Rx attached to cover 2/9/01 and 11/26/01 fill. Unable to locate Rx for 6/11/01 and 9/22/01.
[redacted] – underpads on separate work order
[redacted] – Rx attached
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – diagnosis included
[redacted] – diagnosis included

2

All Other Services

[redacted] - Rx attached

Regarding the prescriptions that appear to be billed before ordered, we have a long-established policy of never sending out supplies until ordered by the customer. It is just not something that we do. What happened in this instance is our pharmacy computer system is set up so that if a computer screen is not brought each day (as an example if a computer is brought up on Monday and not brought down until Friday), whatever the date is on Monday would hold for the entire week. I am sure that is what happened with [redacted]. The billing person at that time did not clear her screen on a daily basis and so it appears that we billed for supplies before they were ordered.
Again, we do not bill for supplies before they are ordered.

[redacted] – Rx attached
[redacted] – Rx attached
[redacted] – these Rxs were actually for two different types of syringes.
[redacted] – we were paid twice for this service. Again, I question why the Medicaid system wasn't able to determine this this was a duplicate billing. We were actually paid twice for it on 2/28/01 and 7/24/02. We also got a reject for it 8/8/01 when we did a resubmission as it was showing as unpaid in our system.
[redacted] Rx attached
[redacted] we were overpaid 4 units on the prior. Again, the Medicaid system should have flagged this at the time.
[redacted] see explanation under [redacted] above. This would be the same case.

In a perfect world, no mistakes would ever be made by anyone. The certainty of human error and logic would tell us that this will never be the case. We bill a lot of supplies and try to be as careful and accurate as possible to avoid billing and reimbursement problems. Obviously, this audit has brought to our attention some deficiencies in this process. As a result, we have put some changes in place that will hopefully alleviate most of these problems in the future, including dispensing no supplies unless we have a prescription that is dated and includes a diagnosis. In the case of incontinent items the type of incontinence will also be listed. Prescriptions will be time-stamped when we receive them. Employees are bringing down their computers at the end of every day, so the date in the system will always be accurate. We are developing a certificate of medical necessity for the physicians to complete to record the required information before billing supplies to Medicaid, so that we are assured of having the doctor's order for supplies, a proper diagnosis and the date. In addition, verbal orders for refills will be recorded with the physician name and name of person calling in the refill and time stamped.

We are also hopeful that the findings of this audit will also bring to light some problems in the Medicaid system that might be addressed to alleviate some of these problems not only for us, but for other providers as well in the future. The problem of recognizing

duplicates at the time of fill and rejecting them rather than paying them again needs to be addressed. The billed amount of the supply should be adjusted to Medicaid's current reimbursement rate at the time it is billed, rather than to pay the full billed amount on some items. If an item is coded with a monthly maximum dollar amount, Medicaid's system should be set up not pay over that allotted monthly maximum.

It would also be helpful for Medicaid to consider a point of sale system much like the way we bill our prescriptions for drugs, so that the supplies could be billed on-line through First Health (or a similar carrier) instead of on 1500 forms. This way, we would know immediately if a claim was good, if a duplicate item was being billed, if maximum quantities had been reached, etc.

We hope that the documentation provided with this letter will take care of some of the exceptions. Please call me if you have any questions.

Sincerely,

RANDI FUCHSMAN
Manager

4

Auditor of State
Betty Montgomery

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

BETTMAN MIRACLE LANE PHARMACY

MONTGOMERY 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
OCTOBER 14, 2004