Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Excel Medical Supplies

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 7, 2004

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

Re: Audit of Excel Medical Supplies
Provider Number: 0154630

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Excel Medical Supplies for the period October 1, 2000 through June 30, 2003. We identified $55,301.82 in findings that are repayable to the State of Ohio. 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 specific procedures employed during this audit are described in the scope and methodology section of this report.

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 Excel Medical Supplies that if our findings are not repaid to ODJFS within 45 days of the date of this report, 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.

As a matter of courtesy, a copy of this report is being sent to Excel Medical Supplies, the Ohio Attorney General, and the Ohio State Medical Board. 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

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TABLE OF CONTENTS

SUMMARY OF RESULTS 1

BACKGROUND 1

PURPOSE, SCOPE, AND METHODOLOGY 2

FINDINGS 4
- Results of Exception Tests 4
  - Billing Medical Supplies Over the Maximum Allowable Charge 4
  - Billing for Non-Prescribed Medical Supplies 5
  - Summary of Exception Tests 5
- Results of the Sample Analysis 5
  - Invalid Prescriptions and Supplies Shipped without Prescriptions 6
  - Missing Prescriptions and Prescriptions Lacking a Qualifying Diagnosis 6
  - Billing Incontinence Supplies for a Nursing Facility Resident 7
  - Duplicate Billings 8
  - Billing for an Item Not Shipped 8
  - Projected Findings from the Sample 8
- Other Reportable Matters 9
  - Missing Required Documentation for Monthly Contact Calls 9
  - Missing Shipping Documentation 10

PROVIDER'S RESPONSE 10

APPENDIX I: Summary of Sample Analysis 11
APPENDIX II: Summary of Findings 12

PROVIDER'S CORRECTIVE ACTION PLAN 13

ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
ODMRDD	Ohio Department of Mental Retardation and Developmental Disabilities
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Excel Medical Supplies (hereafter called the Provider), provider #0154630 doing business at 137 Commerce Blvd., Loveland, OH 45140. 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 and our interagency agreement to perform audits of Medicaid providers. As a result of this audit, we identified $55,301.82 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Revised Code, the Ohio Administrative Code, and the Medicaid Provider Handbook (OMPH).

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 requirements for reimbursement of 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.

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

- 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.
- 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 constitutes an over utilization of Medicaid covered services and results 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 to identify any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a medical equipment supplier.

Following a letter of notification, we held an entrance conference at the Provider's place of business on February 18, 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 $161,105.68 for 2,745 services rendered on 1,184 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 on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. Potentially inappropriate services identified by our computer analysis were selected for 100 percent review. These computerized tests included:

- Testing for incontinence garment services billed and paid for recipients less than 36 months of age.
- Checking for services billed and paid for dates of service after the date of death of a recipient.
- Testing for duplicate billed and paid services, where the same service was billed more than once for the same patient, date of service, item, quantity, and dollar amount.
- Determining if medical supplies were dispensed, billed, and paid over the dollar or quantity limits set by ODJFS.

All of our computerized tests were negative except our tests for supplies dispensed, billed and paid in excess of the Medicaid dollar or quantify limits. When performing our audit field work, we reviewed the Provider's supporting documentation for all supplies potentially dispensed, billed and paid in excess of the Medicaid dollar or quantity limits. In the process of reviewing documentation, we identified supplies that were billed to Medicaid without a required prescription.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed a stratified statistically random sample of 129 recipient dates of services, containing a total of 344 services. Our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between December 2003 and May 2004.

[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.*

FINDINGS

We identified findings of $890.64 from our 100 percent audit of supplies dispensed, billed and paid in excess of the Medicaid dollar or quantity limits and $54,411.18 from the projected results of our statistical sample. The circumstances leading to the findings are discussed below:

Results of Exception Tests

The following presents the results of our exception tests.

Billing Medical Supplies Over the Maximum Allowable Charge

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) "Max Units" indicator.
> 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.
>
> ***

Appendix A of Ohio Adm.Code 5101:3-10-03 stipulates that the maximum allowed quantity for surgical gloves, non-sterile per 100, billed as code A-4927, is one box per month.

Effective April 1, 2003, ODJFS changed the billing unit and price of non-sterile surgical gloves (billed as HCPCS code A4927) from $0.22 per glove to $8.69 per box of 100 gloves.

We identified 73 recipients with 129 A4927 services rendered on or after April 1, 2003 that were billed and paid at a rate in excess of that allowed by Medicaid. In each case, the Provider billed for 50 gloves (half box) at $9.50, but incorrectly entered 50 units of service (boxes) rather than one-half of a unit on the bill to Medicaid. The MMIS system paid the Provider the full $9.50 for each service because the system pays what the Provider bills ($9.50 in this case), or the Medicaid maximum ($8.69 times 50), whichever is less. We took exception with these 129 services and reduced the allowed reimbursement to $4.34 (one-half the price of a box of 100 gloves) and took the difference between the amount paid and the correct payment amount. This reduction for the 129 services resulted in a finding of $665.64

Billing for Non-Prescribed Medical Supplies

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

> (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 incontinence garments and related supplies, a legible written or typed physician prescription, signed and dated not more than thirty days prior to the first date of service must be maintained on file by the provider; prescriptions for incontinence garments and related supplies must include all information required in accordance with rule 5101:3-10-21 of the Administrative Code…
>
> ***

We identified two recipients with 11 incontinence services where the physicians' prescriptions contained in the patients' records did not include all of the items that were shipped and billed. For example, one of the recipient's prescriptions was written for disposable underpants and wipes; however, the Provider also shipped underpads and gloves. We disallowed the seven services that were not ordered on the prescriptions, resulting in $225.00 in findings.

Summary of Exception Tests

We took exception with 136 of the 140 services segregated from the sample population for special examination. Table 1 summarizes the exceptions found by reason and overpayment amounts.

Table 1: Summary of Service Billing Exceptions Found
For the Period of October 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions	Amount of Findings
Billing Medical Supplies Over the Maximum Allowable Charge	**129**	**$665.64**
Billing for Non-Prescribed Medical Supplies	**7**	**$225.00**
Total Services with Exceptions	**136**	**$890.64**

Source: AOS analysis of the Provider's MMIS claims history.

Results of the Sample Analysis

We identified deficiencies in several areas as result of our analysis of 344 statistically sampled patient services, some of which led to monetary findings. The rationale for our sample findings and the methodology used to project the sample results to the subpopulation of the Provider's paid services for incontinence garments and supplies are presented below.

Invalid Prescriptions and Supplies Shipped without Prescriptions

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…
>
> ***

Of the 344 services in our stratified sample, we found problems with reimbursements for 102 services that lacked valid prescriptions.

- For 38 of the services, patient medical records did not contain a valid prescription written by a physician. Instead, a photo copy of an original prescription had been inserted in patient files with dates changed to reflect the current year. We contacted the physician offices who wrote the original prescription and they verified that only the original prescription had been written. Although representatives in the physicians' offices told us that many of the patients in question had chronic conditions that could necessitate a continuing need for incontinence supplies, the Provider was not entitled to make this determination and thus was not eligible to be reimbursed for these services.

- For 12 of the services, we found prescriptions had been written one to nine months after the services were rendered.

- For 36 of the services, medical supplies shipped and billed had not been ordered by the physician on the prescription.

- For 16 of the services, the supplies shipped exceeded the prescription refill quantity amount prescribed by the physician.

As a result, we took exception with all 102 services.

Missing Prescriptions and Prescriptions Lacking a Qualifying Diagnosis

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…
>
> ***

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
>
> ***

Of the 344 services in our stratified sample, we identified nine services that were missing prescriptions. In addition, we identified another seven services with prescriptions that did not state an applicable diagnosis. Because the Provider did not maintain the required documentation in the recipients' medical records we took exceptions with all 16 services.

Billing Incontinence Supplies for a Nursing Facility Resident

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

> (A) Incontinence garments and related supplies, including disposable underpads, are covered by the Medicaid program under the following conditions:
>
> ***
>
> (2) The consumer is not a resident of a nursing facility or intermediate-care facility for the mentally retarded. Coverage of incontinence garments and related supplies is provided as part of the per diem payment to the facility.

We identified four services where the Provider billed for incontinence garments and related supplies to a recipient residing in a nursing facility. Because these services are provided as part of the per diem payment to the facility, we disallowed the services billed directly to the Medicaid program.

Duplicate Billings

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified two duplicate billings involving the same patient, the same procedure code, and the same date of service. Because the medical records supported that only one service was rendered, we took exception with the two duplicative billings.

Billing for an Item Not Shipped

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified one service where the Provider billed for an item that was not shipped to the recipient. For this service, the item billed was not listed on the shipping documentation that was signed by the recipient as being received.

Projected Findings from the Sample

Overall, we identified 125 exceptions in our stratified sample of 344 services, Table 2 summaries the basis for our exceptions.

Table 2: Summary of Findings from the Sample
For the Period of October 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions
Invalid Prescriptions and Supplies Shipped without Prescriptions	102
Missing Prescriptions and Prescriptions Lacking a Qualifying Diagnosis	16
Billing Incontinence Supplies for a Nursing Facility Resident	4
Duplicate Billings	2
Billing for an Item Not Shipped	1
Total Services with Exceptions	125

Source: AOS analysis of a sample of 129 recipient dates of service.

We took exception with 125 of 344 stratified statistically sampled recipient services (49 of 129 recipient dates of service) from the Provider's sub-population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review). We then calculated audit findings repayable to ODJFS by projecting the sample error rate to the Provider's sub-population of paid services. Our projected audit findings were $54,411.18 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $34,917.18 to $61,917.18 (+/- 12.91 percent.) A detailed summary of our statistical sample and projection results is presented in Appendix I.

Other Reportable Matters

We did not associate monetary findings with the following matters, but we believe they provide further evidence of the Provider's need to improve compliance with Medicaid rules.

Missing Required Documentation for Monthly Contact Calls

Ohio Adm.Code 5101:3-10-21(D) states:

> Providers must ascertain from the consumer or the consumer's caregiver on a monthly basis the required type and amount of incontinence garments and/or related supplies.
>
> (1) The provider 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…
>
> (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.
>
> ***

The Provider primarily provides medical supplies to Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) group homes. Our sample of 78 recipients involved residents in six group homes. To meet the requirements of Ohio Adm.Code 5101:3-10-21(D) the Provider told us that if a home has not contacted them, they call each group home by the 10th of each month to confirm orders to be sent.

We found that the Provider partially documented monthly contacts, but the documentation lacked many required elements. Specifically, contact sheets typically contained a "check mark" by a recipient's name if supplies were to be shipped but did not include the name of the person contacted; the type and amount of supplies to be shipped; or the date of contact. In some cases, "per caregiver" or "per standard order of home manager" was added to the check mark.

We also spoke with five group homes that received incontinence supplies from the Provider to inquire about the Provider's monthly contact procedures. While most of the homes said they had been contacted, two of the homes said they received supplies over and above what was needed and had difficulty returning them.

Missing Shipping Documentation

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."

While this rule does not specifically require that durable medical equipment suppliers maintain shipping documents to verify that supplies were sent, we believe good business practices warrant maintenance of this information. Of the 344 services in our sample, we were unable to confirm shipment for 18 services.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on July 22, 2004. The Provider sent us a written response on August 31, 2004, along with additional documentation to support some 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 accordingly.

As noted above, both Ohio Adm.Code 5101:3-10-21(B) and Ohio Adm.Code 5101:3-10-05(A) require that providers maintain certain information to verify the medical necessity of incontinence supplies. The Provider's files were missing much of this information, which resulted in monetary findings for the more egregious violations. 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 type of incontinence. In response to our audit results, the Provider created and is using a certificate of medical necessity. The Provider also committed to (1) use a monthly order form to document recipient contacts when verifying the need for medical supplies, and (2) maintain shipping and delivery records. The Provider's corrective action plan is attached to this report for ODJFS' review and consideration.

APPENDIX I

Summary of Statistical Sample Analysis for Excel Medical Supplies
Audit Period: October 1, 2000 – June 30, 2003

Description	Audit Period October 1, 2000 – June 30, 2003
Type of Examination	**Stratified Random Sample**
Number of Sub-Population Recipient Dates of Service	**1,116**
Number of Sub-Population Recipient Dates of Service Sampled	**129**
Number of Sub-Population Services Provided	**2,604**
Number of Sub-Population Services Sampled	**344**
Total Medicaid Amount Paid For Sub-Population	**$159,003.18**
Amount Paid for Sub-Population Services Sampled	**$22,508.01**
Point Estimate of Projected Findings at 95 % Confidence Level	**$54,411.18**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$61,917.18**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$34,917.18**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$13,507.00 (+/- 12.91%)**

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

APPENDIX II

Summary of Audit Findings for Excel Medical Supplies
Audit Period: October 1, 2000 to June 30, 2003

Description of Audit Findings	Amount of Overpayment
Medicaid Services Sample Excluding Exceptions	**$54,411.18**
Billing Medical Supplies Over the Maximum Allowable Charge	**$665.64**
Billing for Non-Prescribed Medical Supplies	**$225.00**
Total Audit Findings	**$55,301.82**

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

EXCEL MEDICAL SUPPLIES, INC.
137 COMMERCE BLVD.
LOVELAND, OHIO 45140
PHONE (513) 683-3390
FAX (513) 697-4925

RE: PROCEDURAL/POLICY CHANGES – CORRECTION OF COMPLIANCE

To Whom It May Concern:

I'm writing to confirm our correction of compliance with Medicaid. I created a Certificate of Medical Necessity (CMN) in which all of our present clients' have in file. All new clients will have original prescriptions on initial set-up and yearly follow-up with the approved CMN. I compiled a monthly order form for each client in which amounts of each product is documented as well as the person ordering for the client. Our compliance on shipment to client is handled three ways, we deliver to the client and get signed delivery ticket, Invacare Supply Group drop ships products and we have the tracking in each clients file. The third way is via Fed-ex and we have tracking documentation on the delivery ticket for each client. If there are any other compliance issues, please inform me and I will correct. I greatly appreciate your time.

Warm Regards,

Beth A Gilmore

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EXCEL MEDICAL SUPPLIES

HAMILTON COUNTY

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

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
DECEMBER 7, 2004