Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Personal Care Products, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

April 5, 2005

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

Re: Audit of Personal Care Products, Inc.
Provider Number: 2359522

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Personal Care Products, Inc. for the period April 1, 2001 through March 31, 2004. We identified $48,252.85 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 Personal Care Products, Inc. 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 Personal Care Products, Inc., 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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ACRONYMS

AMA	American Medical Association
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Personal Care Products, Inc. (hereafter called the Provider), Provider # 2359522, doing business at 624 Trade Center Blvd., #C; Chesterfield, MO 63005. 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 $48,252.85 in repayable findings, based on reimbursements that did not meet the rules of 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.

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 over utilization of medicaid covered services and result in an unnecessary cost to the Medicaid program."

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

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, if appropriate, 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 a telephone entrance conference on July 28, 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 April 1, 2001 through March 31, 2004. The Provider was reimbursed $386,823.97 for 6,747 services during the audit period.

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 paid 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. Potential inappropriate services identified by our computer analyses were selected for 100 percent review. These tests checked for the following:

- Services billed for recipients who died prior to the date of service.
- Medical supplies billed in excess of price or quantity limits set by ODJFS.
- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and the same procedure code modifier with different quantity amounts.

The test for services for recipients who died prior to the date of service was negative, but the other exceptions tests identified potential inappropriate billings. When performing our audit work, we requested the Provider's supporting documentation for all reimbursements with identified exceptions.

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.

To facilitate an accurate and timely audit of the Provider's remaining medical services; we also extracted and analyzed a stratified statistically random sample from the subpopulations of services not already identified with potential exceptions. This sample consisted of 150 services and our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between May 2004 and January 2005.

RESULTS

We identified findings of $8,878.72 from our 100 percent audit exception tests and $39,374.13 from the projected results of our statistical sample; for a total finding amount of $48,252.85. The circumstances leading to these findings are discussed below:

Results of Exception Tests

Duplicate Billings

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

We identified 74 duplicate billings involving the same patient, the same procedure code, and the same date of services. Our examination of the medical records supported that only one service was rendered, therefore we took exception with the 74 duplicate billings resulting in findings totaling $4,228.40.

Supplies Exceeding the Medicaid Maximum

Ohio Adm.Code 5101:3-10-03 states:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule…
>
> ***

Appendix A establishes maximum dollar amounts and quantities that Medicaid will cover for specific items. Our computer analysis identified 131 services, involving six different HCPCS service codes, where the Provider billed and was reimbursed for supplies over the maximum allowed. We subtracted the maximum allowed Medicaid reimbursement from the amount billed by and paid to the Provider. The difference resulted in findings totaling $3,806.08. The bases for these findings are detailed below in Table 1.

Table 1: Supplies Exceeding the Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Repayable Finding	Number of Exceptions
A4521, A4526, A4527, A4528, and A4535	Incontinence Garments and Related Supplies	Combination of 300 incontinence garments per month	$3,302.08	119
A4554	Incontinence Garments and Related Supplies	Combination of 300 incontinence garments per 2 months	$504.00	12
		Totals	**$3,806.08**	131

Source of Medicaid Maximum Allowed: Ohio Adm.Code 5101:3-10-03, Appendix A – Medicaid Supply List

Source of Estimated overpayments and Exceptions: AOS analysis of the Provider's paid claims in MMIS and provider patient records for April 1, 2001 through March 31, 2004.

Billing for Items Not Shipped

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

We identified 16 services where the Provider billed for items that were not shipped to the recipient. For these services, the item billed was not listed on the shipping documentation. Therefore, we disallowed the 16 services that were not shipped, resulting in a finding of $844.24.

Summary of Exception Tests

Of the 435 services segregated from the sample population for special examination, we took exception with 221 services. Table 2 summarizes the exceptions found by reason and the overpayment amount.

Table 2: Summary of Billing Exceptions
For the Period of April 1, 2001 – March 31, 2004

Basis for Exception	Number of Services with Exceptions	Repayable Findings.
Duplicate Billings	74	$4,228.40
Items Dispensed in Excess of the Medicaid Maximum	131	$3,806.08
Billing for Items Not Shipped	16	$844.24
Total Services with Exceptions	**221**	**$8,878.72**

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

Results of Sample Analysis

Missing Prescriptions and Prescriptions Lacking a Qualifying Diagnosis

Ohio Adm.Code 5101:3-10-05(A) 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.
>
> ***

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.
>
> ***

Within our random sample of 150 services, we identified eight services that were missing prescriptions. In addition, we identified five services with prescriptions that did not specify an applicable diagnostic reason for incontinence. Because the Provider did not maintain the required documentation in the recipients' medical records, we took exception with all 13 services.

Duplicate Billings

Ohio Adm.Code 5101:3-1-19.8(F) states "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 within the 150 services in our sample. Because the medical records only supported that one service was rendered, we took exception with the two duplicate billings.

Projected Sample Findings

Overall we identified 15 exceptions in our stratified sample of 150 services. Table 3 summarizes the basis for our exceptions.

Table 3: Summary of Sample Findings
For the Period of April 1, 2001 – March 31, 2004

Basis for Exception	Number of Services
Missing Prescription and Prescription Lacking a Qualifying Diagnosis	13
Duplicate Billings	2
Total Services with Exceptions	15

Source: AOS analysis of a sample of 150 services.

We took exception with 15 of 150 statistically sampled recipient services from a stratified random sample of the Provider's population of paid services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $321,243.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $342,334.00 to $300,153.00 (+/- 6.57 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population amount ($321,243.00) from the amount paid to the Provider for this population ($360,617.13), which resulted in a finding of $39,374.13. 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 warrant the attention of the Provider and ODJFS.

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.
>
> ***

As a supplier of incontinence garments and related supplies to consumers, the Provider was responsible for contacting consumers (or their caregiver) monthly to ascertain supply needs. The majority of services in our sample (106 of 150) lacked evidence of contact for the tested service month. However, for the 106 services, we also saw evidence of contacts either prior to or subsequent to the month in question. Moreover, the Provider had implemented procedures subsequent to our audit period but prior to our audit visit that appeared to have corrected the problem.

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 a 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 documentation to verify that supplies were sent, we believe good business practice warrants maintaining this information as a means of verifying that items were shipped. Shipping documentation was missing for two of the 150 services in our sample.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on February 1, 2005. The current owner[3] of Personal Care Products sent us a corrective action plan, dated February 11, 2004 (sic), to address the deficiencies identified in the report. The corrective action is attached (see page 11) for the review and consideration of ODJFS' Surveillance and Utilization Review Section.

In a letter dated February 15, 2005, the prior owner's legal representative stated that he was holding the $48,252.85 due and owed to the state until such time as the final report was completed. Because ODJFS is responsible for recovery of findings identified herein, we are forwarding a copy of the February 15 letter to the Surveillance and Utilization Review Section for follow up action. A copy of this report is also being sent to the prior owner's legal representative.

3 Ownership of Personal Care Products changed hands on July 1, 2004, and according to the sales agreement, the sale did not include assumption of prior liabilities. The current owner accepted responsibility for preparing a corrective action plan to address the deficiencies identified in our report. However, in as much as our audit period covered April 1, 2001 through March 31, 2004, repayment of our audit findings is the responsibility of the previous owner.

APPENDIX I

Summary of Statistical Sample Analysis of Personal Care Products, Inc.
For Sub-Population of Services Not Excepted for 100 Percent Review
Audit Period: April 1, 2001 – March 31, 2004

Description	Audit Period April 1, 2001 – March 31, 2004
Type of Examination	**Stratified Random Sample of Services**
Number of Population Service	**6,307**
Number of Population of Services Sampled	**150**
Total Medicaid Amount Paid for Population	**360,617.13**
Actual Amount Paid for Population Services Sampled	**$8,516.64**
Projected Correct Population Payment Amount	**$321,243.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$342,334.00**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$300,153.00**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$39,374.13**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$21,091.00 (+/- 6.57%)**

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

APPENDIX II

Summary of Audit Findings for Personal Care Products, Inc.
Audit Period: April 1, 2001 to March 31, 2004

Basis for Exceptions	Amount of Overpayment
Projected Overpayment from Sampled Medicaid Services	**$39,374.13**
Duplicate Billings	**$4,228.40**
Supplies Exceeding the Medicaid Maximum	**$3,806.08**
Billing for Items Not Shipped	**$844.24**
Total Services with Exceptions	**$48,252.85**

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

FROM :PERSONAL CARE PRODUCTS FAX NO. :877 531 1854 Feb. 15 2005 02:59PM P2

PERSONAL CARE
Caring for you & others!
PRODUCTS, INC.

TOLL-FREE (800) 575-0302

Local (636) 536-4152
Toll-Free Fax (877) 531-1854

02/11/04

Tracie Thompson
Program Manager, Health Care and Contract Audit Section
35 N Fourth St. First Floor
Columbus, OH 54215

RE: Corrective Action Plan / Medicaid Provider Audit / Provider #2359522

Dear Ms. Thompson,

In response to your letter dated February 1, 2005, I would like to thank your department's ongoing cooperation and assistance in bringing this Medicaid Audit to a satisfactory conclusion.

In accordance with the Ohio Department of Job and Family Services guidelines, we have instituted the following procedure and policy changes to avoid future billing errors and product shipments to Ohio Medicaid recipients.

1. All Ohio Medicaid recipient files have been placed on a "Hold" status to avoid inaccurate or unauthorized shipments.
2. The number of monthly units needed by the recipient and the maximum number of units allowed by Ohio Medicaid are documented in the recipient's file and our company's new operations software. This new software has been developed to avoid any unauthorized or duplication of product shipments to the recipient and duplication or inaccurate billing of services to the State of Ohio.
3. No products are to be shipped to recipients until either phone or mail contact has been made and documented in the recipient's file. The Personal Care Product employee must document in the recipient's file, the first and last name of the person who authorized the need and quantity of the product to be shipped.
4. Any phone contact or correspondence with a recipient must be documented in the recipient's file and noted with the Personal Care Products employee's first and last name.

Personal Care Products, Inc. • 624 Trade Center Blvd. • Suite C • Chesterfield, MO 63005

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FROM :PERSONAL CARE PRODUCTS FAX NO. :877 531 1854 Feb. 15 2005 02:59PM P3

All of our employees have been instructed and understand the above procedure and policy changes.
Should there be any other guideline recommendations regarding the above matter, I would appreciate your input.

I would also like to take this opportunity to recognize the assistance of your department's employees, David Grimm and Patricia Severs. Their professional attitude and dialog has made this audit flow as smooth and quickly as possible.

Very Truly Yours,

Brad Statler
President

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PERSONAL CARE PRODUCTS, INC.

OUT-OF-STATE
(MISSOURI)

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 5, 2005