Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to United Patient Care, 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 E. Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, OH 43266-0423

Re: Audit of United Patient Care, Inc.
Provider Number: 0865596

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to United Patient Care, Inc. for the period April 1, 2001 through March 31, 2004. We identified $36,484.80 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 United Patient Care, 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 United Patient Care, 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
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 United Patient Care, Inc. (hereafter called the Provider), Provider #0865596, doing business at 753 A Milford Ave., Marysville, OH 43040. 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 $36,484.80 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 durable medical equipment supplier.

Following a letter of notification, we held an entrance conference at the Provider's place of business on September 9, 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 $375,963.18 for 2,459 services, not involving Medicare co-payments, rendered on 941 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 of service.

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. Potentially inappropriate services identified by our computer analysis were selected for 100 percent review. These tests checked for the following:

- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and the same payment amount.
- 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.
- Oxygen services billed in excess of price or quantity limits set by ODJFS.

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.

The duplicate billings and services billed for recipients who died prior to the date of service were negative, but the other exception tests identified potential inappropriate billings. When performing our audit field work, we requested the Provider's supporting documentation for all reimbursement claims with identified exceptions.

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 subpopulation of services not already identified with potential exceptions. This sample consisted of 130 recipient dates of service, containing a total of 522 services. A recipient date of service is defined as all services received by a specific recipient on a particular date of service. 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 $18,425.95 in findings from our exception tests and $18,058.85 in projected findings from our statistical sample. The circumstances leading to the findings are discussed below:

Results of Exception Tests

Billing for Oxygen Services after a Physician's Disconnect Order

Providers may not submit claims for Medicaid services prior to delivery of the services. Ohio Adm.Code 5101:3-1-17.2 states:

> ***
>
> A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To render medical services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap; **submit claims only for services actually performed;***[emphasis added]* and, bill the department for no more than the usual and customary fee charged other patients for the same service.
>
> ***

During our review of the Provider's paid claims, we determined that the Provider incorrectly billed Medicaid up to 12 months in advance for oxygen services [CPT code(s) E0424, Q0036, and Q0046]. It appeared the Provider submitted these reimbursement claims upon receiving

prior authorization for the services. We advised the Provider to cease billing for services prior to their delivery. We also identified 30 oxygen services, where the Provider's records showed that the physician had subsequently ordered the oxygen services to be disconnected prior to the end of the period billed. Because the Provider did not return the resulting overpayment to ODJFS, we took exception with these 30 services. When calculating our finding, we reduced the allowable payment to the service level provided up to the point of the disconnect order. The reduced payments were then subtracted from the payments actually received to arrive at a finding amount of $8,920.58.

Billing Oxygen Services Without the Required Modifier

Ohio Adm.Code 5101:3-10-13(C) states in pertinent part:

> To receive a payment adjustment, one of the following modifiers must be used with stationary oxygen systems codes when appropriate. This applies to oxygen used with concentrators, liquid and gaseous systems.
>
> (1)Modifier code QE shall be used and the payment amount reduced by fifty percent when:
> (a) The prescribed amount of oxygen is one liter per minute or less….

During our review of the Provider's paid claims for the audit period, we determined that the Provider incorrectly billed Medicaid for five oxygen services without the required modifier. The prescribed amount of oxygen noted in the patient records were one liter per minute or less, and therefore, the QE modifier should have been used and the reimbursement amount reduced by 50 percent. When calculating our finding, we reduced the allowable payment for these five services to a level supported by documentation in the patient medical record and the reduction resulted in findings amounting to $2,901.60.

Supplies Exceeding Medicaid Maximums

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 stipulates the maximum number of items that Medicaid will allow and reimburse.

Our computer analysis identified 153 services, involving 13 different HCPCS service codes, where the Provider appeared to have billed and been 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 $6,137.92. The bases for these findings are detailed below in Table 1.

Table 1: Listing of Supplies Dispensed in Excess of the Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Estimated Overpayment	Number of Exceptions
A6217, A6402, and A6403	Non-Impregnated Gauze	The combined maximum payment is $50 per month	$770.10	17
A4213	Syringe w/o needle, sterile 20 cc or greater	50 per year	$108.60	24
A4523	Incontinence items	300 incontinence garments per month	$139.04	2
A4319	Sterile Water Irrigation Solution	12 per month	$63.00	9
Y2040	Gastrostomy button (replacement only)	3 per year	$1,940.00	16
A4622	Tracheostomy/laryngectomy tube	2 per month	$206.60	5
A7003	Administrative set, disposable	4 per month	$2.15	1
A7005	Administrative set, non-disposable	2 per year	$591.95	52
Y9174	Nebulizer w/air heater adapter	4 per month	$25.50	4
A4628	Oropharyngeal suction catheter	4 per month	$223.48	13
A7000	Canister, disposable	3 per month	$60.00	6
A7002	Tubing, used with suction pump	4 per month	$7.50	2
E0619	Apnea monitor (prior authorization not required for first four months of rental)	4 months	$2,000.00	2
		Totals	**$6,137.92**	***153***

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.

Surgical Gloves Billed with Erroneous Units of Service

Ohio Adm.Code 5101:3-10-03(F) defines the "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. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.
>
> ***

On April 1, 2003, the reimbursement rate for non-sterile surgical gloves changed in price from $22 per 100 gloves to $8.69 *per box* of 100 gloves. Concurrently, the definition of a "unit of service" changed from "per individual glove" to "per box of 100 gloves." During our review of the Provider's patient records, we identified overpayments that appeared to result from the Provider continuing to bill "per glove," instead of "per box," which resulted in overpayments. In particular, we identified 35 services where the Provider billed and was overpaid for HCPCS A4927. After adjusting the amount paid to the Provider to account for the actual units supplied, we identified findings totaling $465.85.

Summary of Exception Tests

Of the 326 services segregated from the sample population for special examination, we took exception with 223 services. Table 2 summarizes the exceptions found by reason and overpayment amount.

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

Basis for Exceptions	Number of Services with Exceptions	Repayable Findings
Billing for Oxygen Services After a Physician's Disconnect Order	30	$8,920.58
Items Dispensed in Excess of the Medicaid Maximum	153	$6,137.92
Billing for Oxygen Services Without the Required Modifier	5	$2,901.60
Surgical Gloves Billed with Erroneous Units of Service	35	$465.85
Total Services with Exceptions	223	$18,425.95

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

Results of Sample Analysis

Missing Prescriptions

Ohio Adm.Code 5101:3-10-05 states:

> (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. For medical supplies only, other than incontinence garments and related supplies, 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. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-17.2 and 5101:3-1-17.3 of the Administrative Code.

***

Of the 522 services in our sample, we identified four services where the Provider did not maintain prescriptions for the services billed. Because the Provider did not maintain the required documentation in the recipient medical records, a determination could not be made if the service rendered was Medicaid eligible. We therefore took exception with all four services.

Billing for Apnea Monitors after a Physician's Disconnect Order

As noted above Ohio Adm.Code 5101:3-1-17.2(A) precludes providers from billing in advance for services.

During our review of the Provider's paid claims we determined that the Provider incorrectly billed Medicaid in advance (after receipt of the doctor's order) for apnea monitors (CPT code E0608). After further review of the 522 services in our sample, we identified nine apnea monitor services where the Provider had been paid for services after the physician had ordered the monitors disconnected. Because the Provider had not returned the resulting overpayment to ODJFS, we took exception with all nine services.

Projected Sample Findings

Overall, we identified 13 exceptions in our stratified sample of 522 services. Table 3 summarizes the bases for our exceptions.

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

Basis for Exceptions	Number of Services with Exceptions
Missing Prescriptions	4
Billing for Apnea Monitors After Physician's Disconnect Order	9
Total Services with Exceptions	13

Source: AOS analysis of a sample of 140 recipient dates of service.

We took exception with 13 of 522 statistically sampled recipient services (12 of 130 recipient dates of service) from a stratified random sample of the Provider's sub-population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review.) Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $237,986.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $224,079.00 to $251,893.00 (+/- 5.84 percent.)

We then calculated audit findings repayable to ODJFS by subtracting the correct population amount ($237,986.00) from the amount paid to the Provider for this population ($256,044.85), which resulted in a finding of $18,058.85. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Prescriptions Missing Specific Information

We did not associate monetary findings with the following matter, but we believe the Provider could reduce the risk of future audit findings by better supporting the medical necessity of supplies provided to Medicaid recipients.
Ohio Adm.Code 5101:3-1-01(A) states in pertinent part

> 'Medical necessity' is a fundamental concept underlying the medicaid program, Physicians, dentists, and limited practitioners render, authorize, or prescribe medical services within the scope of their licensure and based on their professional judgment regarding services needed by an individual…

A physician's prescription is a primary determinant of medical necessity. 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 ongoing services or supplies, a new prescription must be obtained at least every twelve months...

Several of the prescriptions in our sample listed specific items (e.g., a pulse oximeter with cable), and included a more general statement calling for other supplies as needed. Of the 522 supply items (services) in our sample, we identified 254 items that were supported by a general "as needed" statement, and in some cases involved supplies not directly related to specifically prescribed items. For example, the patient receiving the pulse oximeter was also provided with tracheostomy supplies, based on requests from the recipients' caseworkers or family members. While Ohio Adm.Code 5101:3-10-02(C)(4)[3] allows family members and caseworkers to request medical supplies, Ohio Adm.Code 5101:3-1-01(A) indicates that "physicians dentists, and limited practitioners" are to make determinations of medical necessity[see above].

Accordingly, we recommended that the Provider, as part of the annual requirement to obtain physician prescriptions and before billing for Medicaid supplier services, have physicians complete and sign a "supplemental certificate of medical necessity" form. This form should identify both the type and quantity of needed items. Although ODJFS does not require medical services suppliers to use such a form, unless required for prior authorization, we believe doing so

3 Ohio Adm.Code 5101:3-10-02(C)(4) states: "Requests for medical supplier services must originate with the recipient, recipient's physician, family, or caseworker, and must proceed with the recipient's full knowledge and consent."

minimizes the potential for unallowable services. The Provider agreed to implement our recommendation.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on January 20, 2005. The Provider supplied additional information on February 4, 2005 that resolved some of the deficiencies addressed in the draft and resulted in a reduction in our audit findings. We subsequently discussed the audit findings in a February 23, 2005 phone conference with the President and Vice President of United Patient Care, Inc. After we answered questions regarding our audit methodology, the President agreed with the audit findings and inquired about repayment. We advised the Provider to contact ODJFS' Surveillance and Utilization Review Section to discuss repayment arrangements.

Following the phone conference, on February 25, 2005, the Provider submitted a corrective action to address the deficiencies identified in the report. We are attaching the Provider's February 25 response for the review and consideration of the Surveillance and Utilization Review Section.

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APPENDIX I

Summary of Statistical Sample Analysis for Sub-Population of United Patient Care, Inc. Audit Period: April 1, 2001 – March 31, 2004

Description	Audit Period April 1, 2001 – March 31, 2004
Type of Examination	**Stratified Random Sample**
Number of Population Recipient Dates of Service (RDOS)	**893**
Number of Population RDOS Sampled	**130**
Number of Population Services Provided	**2,122**
Number of Population Services Sampled	**522**
Total Medicaid Amount Paid for Population	**$256,044.85**
Actual Amount Paid for Population Services Sampled	**$68,697.55**
Projected Correct Population Payment Amount	**$237,986.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$251,893.00**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$224,079.00**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$18,058.85**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$13,907.00 (+/- 5.84%)**

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

APPENDIX II

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

Basis for Exceptions	Amount of Overpayment
Projected Overpayment from Sampled Medicaid Services	**$18,058.85**
Billing for Oxygen Services After a Physician Disconnect Order	**$8,920.58**
Items Dispensed in Excess of the Medicaid Maximum	**$6,137.92**
Billing for Oxygen Services Without the Required Modifier	**$2,901.60**
Surgical Gloves Billed with Erroneous Units of Service	**$465.85**
Total Services with Exceptions	**$36,484.80**

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

753A Milford Avenue
Marysville, Ohio 43040
937-644-8554
937-644-8656 Fax

UNITED PATIENT CARE, INC.

February 25, 2005

Auditor of State
Patricia Severs, Assistant Auditor
35 North Fourth Street
First Floor
Columbus, Ohio 43215

Dear Patricia Severs:

Please find enclosed the audit response from United Patient Care, Inc. I hope that this satisfies your requirements. If not, please let me know.

I would like a letter from the Auditor's office stating the finality of the audit investigation. Along with any other documentation needed to allow United Patient Care, Inc the ability to recoup any money remitted back to Medicaid through the prior authorization process.

I also need the name of the individual at OJFS responsible for our refund payments and setting up additional payment terms.

I thank you for your time and assistance.

Sincerely,

Mahlon A. Buller III
Vice President

Mab

Enclosure

United Patient Care...The Way Home

800-805-5885

UNITED PATIENT CARE, INC.

AUDIT RESPONSE

The following is a written response to the Medicaid audit conducted by the office of Betty Montgomery, Auditor of State. United Patient Care, Inc appreciates the Auditor of State with their assistance in helping to identify the Medicaid billing oversights outlined in the draft report. United Patient Care has implemented the following procedural changes to correct and avoid future billing oversights.

With respect to continued billing cycles for apnea monitors and oxygen therapy services after discontinued order, United Patient Care, Inc shall institute computer tracking systems which will enable us to accurately review all posted billing cycles prior to invoicing. A recurring order report will be processed and all orders reviewed for accuracy prior to posting.

All sale products requiring a onetime invoice shall be billed with no recurring billing cycles. Rental products requiring monthly invoicing, shall be set for monthly recurring billing cycles and will be based upon prior authorization length of need. A recurring order report will be processed and reviewed for accuracy prior to posting.

Establish new oxygen code(s) to reflect QE modifier for all Medicaid clients whose oxygen flow rates are less than one liter per minute. Review all prior authorizations and current pediatric oxygen clients to ensure compliance. Process and review recurring order report prior to posting and invoicing.

Establish and implement Medicaid supply list. Review authorization and monthly limits prior to delivery and invoicing. Products exceeding monthly limits will require physician prescription and prior authorization to Medicaid. Generate and review order report for accuracy and compliance prior to posting.

Perform client chart review every 90 days to ensure proper and adequate documentation. Ensure all prescriptions and required prior authorizations are current. Implement computer tracking of all essential documentation required for billing. Review CMN, P/A's and documentation reports monthly to ensure compliance.

The policy and procedural changes listed above have been implemented and will help to eliminate the oversights associated with the audit exceptions. United Patient Care will continue to monitor and implement any procedural changes required for compliance.

ACTION PLAN
BILLING ERROR OVERSIGHTS

Exceptions	Corrective Action Plan	Date Implemented	Task Assigned To	Approved by
Billing for apnea and oxygen Services after discontinue order	Computer tracking. Input discontinue order and stop billing cycle	01/01/05	Customer Service Billing Department	
Billing PA prior to delivery	Set billing cycle to one month recurring. Monthly Cycle based on PA length	01/01/05	Customer Service Billing Department	
Billing for oxygen without required QE modifier	Set up new oxygen code to reflect QE modifier for oxygen rate less than one liter	01/01/05	Billing Department Customer Service	
Billing supplies exceeding Medicaid Limits	Review Medicaid supply limits prior to delivery. PA submitted for all overages. Computer tracking	01/01/05	Customer Service Billing Department	
Documentation, Rx missing/renewals	Computer tracking of all Rx's. Chart review every 90 days	01/01/05	Customer Service Billing Department	
Medicaid supply listing/referral form	Develop supply listing	01/01/05	Customer Service	

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UNITED PATIENT CARE., INC.

MADISON COUNTY

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

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
APRIL 5, 2005