Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Hamilton's Health Aid Services – Dayton, Ohio

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

March 28, 2006

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

Re: Audit of Hamilton's Health Aid Services – Dayton, Ohio; Provider Number: 0779199

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Hamilton's Health Aid Services for the period April 1, 2001 through March 31, 2004. We identified $7,398.17 in findings that are repayable to the State of Ohio. 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 a final determination regarding recovery of the findings and any interest accruals.

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.

Copies of this report are also being sent to Hamilton's Health Aid Services and the Ohio Attorney General. In addition, copies are 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
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Hamilton's Health Aid Services (hereafter called the Provider), Provider #0779199, doing business at 2231 Embury Park, Dayton, OH 45414. 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 $7,398.17 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook.

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 a final determination regarding recovery of the findings[1] and any interest accruals.[2]

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.[3] 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."

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

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

[2] *Ohio Adm.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was March 31, 2004, the latest payment date in the random sample used for analysis.*

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

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 pertinent 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 Medicaid claims 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 notification letter, we held an entrance conference at the Provider's place of business on January 11, 2005 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. During this audit period, the Provider was reimbursed $2,677,660.65 for 5,430 services rendered on 1,979 recipient dates of service. 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 Ohio Medicaid Provider Handbook 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, which contains an electronic file of services billed to and paid by the Medicaid program. This 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).[4]

[4]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.

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. These included tests for:

- Services to deceased recipients for dates of service after their 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.)
- Recipients receiving incontinence garments with a living arrangement of other than a personal residence for the time span of the billed service.
- Infants under the age of thirty-six months receiving incontinence garments without a prior authorization.
- Supplies dispensed in excess of Medicaid maximum allowable prices or quantities.

All tests were negative except for supplies dispensed in excess of Medicaid maximum allowable prices or quantities, which identified potentially inappropriate services. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed three statistically random samples: 1) a stratified random sample of major and minor wheelchair repairs, containing a total of 128 services; 2) a simple random sample of incontinence garments, containing a total of 80 services; and 3) a stratified random sample of wheelchairs and wheelchair parts, containing a total of 100 recipient dates of service (690 services).

Our work was performed between May 2004 and February 2006.

RESULTS

We identified $174.96 in findings from our exception analyses, $6,403.06 in projected findings from our statistical sample of major/minor wheelchair repairs, and $820.15 in actual findings from our statistical sample of wheelchairs and wheelchair parts. No findings were identified in our statistically random sample of incontinence garments.

The total findings of $7,398.17 are repayable to ODJFS and are discussed in more detail below.

Exception Test Results

Our field review of services that appeared to have exceeded Medicaid maximums did not identify any violations of the maximums. However, in the course of our review, we identified other billing errors.

Twice-Billed Services

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

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

The Provider billed and was paid for two pieces of durable medical equipment: a $952 hoyer lift (E0630) and a $104 commode chair (E0165), which the Provider delivered and picked back up a month later. A year later, the Provider billed and was paid for another hoyer lift and commode chair delivered to the same recipient. The Provider said that Medicaid took back the first payment, thus negating a duplicate payment; however, the credit remittance supporting the take-back was for a hospital bed for which the Provider was paid $989. We verified that the recipient still possessed all of the equipment (hoyer lift, commode chair, and hospital bed). Therefore, because the Provider was entitled to only one reimbursement for a lift and commode, and the take back for the bed was erroneous, we identified a net $67.00 finding ($952 + $104 - $989) for the original two items.

The Provider also, on one occasion, transposed the number of units billed for a catheter (HCPCS A4351 – intermittent urinary catheter) with the number of units provided for a diaper code. This error resulted in a $12.00 overpayment.

Labor Billed in Excess of the Maximum

Ohio Adm.Code 5101:3-10-08(A)(5) states in pertinent part:

> …labor will be reimbursed at the lesser of the billed hourly rate or thirty-six dollars per hour, prorated for periods of less than one hour.

The Provider was reimbursed for two minor wheelchair repairs (HCPCS Y2098). While the repairs were eligible for Medicaid reimbursement, the labor had been billed at hourly rates of $99.96 and $100, respectively, both of which were in excess of the $36 per hour maximum (or $18 per half hour). The Provider billed one hour at the $99.96 rate and one half hour at the $100 rate. Therefore, we identified $95.96 in findings ($99.96 - $36 plus $50 - $18) based on the difference between what was paid for labor and what should have been paid.

Major and Minor Wheelchair Repair Sample

Our sample was a stratified random sample of 128 services. This statistical sample was taken from a subpopulation of 621 services that excluded all Medicare co-payments and all services already identified by our exception tests for 100 percent review. This sample identified 19 services that were overpaid and which resulted in projected findings of $6,403.06. The bases for these findings are presented below.

Labor Billed in Excess of the Maximum

Ohio Adm.Code 5101:3-10-08(A)(5) states in pertinent part:

> …labor will be reimbursed at the lesser of the billed hourly rate or thirty-six dollars per hour, prorated for periods of less than one hour.

We identified 16 sample services where the Provider incorrectly billed for labor at an hourly rate in excess of the Medicaid maximum. The Provider billed for labor on the repairs at a rate of $25 per quarter hour, or $100 per hour. According to Ohio Adm.Code 5101:3-10-08(A)(5), labor should have been billed at $9 per quarter hour, or $36 per hour. Therefore, we took the difference between what the Provider billed and was paid for labor and what should have been paid. This calculation identified $717.96 in actual findings which were used in projecting the overall overpayment amount for wheelchair repairs.

Billing for Repair Labor on a Warranty Item

Ohio Adm.Code 5101:3-10-08(A)(4) states:

> "Labor" is defined as the time required by a technician to repair, refurbish, or provide nonroutine service on medical equipment more than ninety days after the dispensing date of that equipment and after the expiration of any applicable warranty.

Ohio Adm. Code 5101:3-10-16(I) states in pertinent part:

> Provider responsibility
> (1) The cost of any changes or modification…which are found to be necessary within the first ninety days following dispensing, must be borne in full by the provider.
>
> ***

We took exception with the payment for one sampled service where the Provider inappropriately billed and was paid for labor when the service was covered by an applicable warranty; it was performed within the first ninety days of dispensing the product. We identified a $75.00 finding for the overpayment and used the finding in projecting the overall overpayment for wheelchair repairs.

Reimbursement Greater than Invoice Price

Ohio Adm.Code 5101:3-10-16(I)(2) states in pertinent part:

> … Providers may only bill the department for the specific wheelchair and manufacturer/make and model, parts, accessories, adaptive positioning devices and custom-molded seating that are authorized and subsequently dispensed to the consumer.

When ODJFS pre-approves a service, the form sent to a provider states that the approval is "…not a guarantee of payment; it is an approval of the medical necessity for the service requested."

We took exception with the payment for two sampled services where the Provider billed Medicaid for an amount listed on the approved prior authorization form, although subsequent

adjustments had reduced the amount invoiced to the consumer (recipient). For these services, the Provider adjusted the final invoice to reflect an item that was either no longer needed by the consumer or was not available at the time of delivery. Therefore, we took the difference between what the Provider was paid and what should have been reimbursed according to the services delivered and the final invoice price. This resulted in a $317.00 finding that was used in projecting the overall overpayment for wheelchair repairs.

Wheelchair Repair Sample Projection

In total, we took exception with 19 of 128 statistically sampled recipient services from a stratified random sample of the Provider's 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 $307,186.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $295,006.00 to $312,479.10 (+/- 3.97 percent.) We then calculated audit findings repayable to ODJFS by subtracting the projected correct population payment amount ($307,186.00) from the amount paid to the Provider for this population ($313,589.06), which resulted in a finding of $6,403.06. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Wheelchairs and Wheelchair Parts Sample

No Evidence of Delivery

Ohio Adm.Code 5101:3-10-16(I)(2) states in pertinent part:

> …Providers may only bill the department for the specific wheelchair manufacturer/make and model, parts, accessories, adaptive positioning devices and custom-molded seating that are authorized and subsequently dispensed to the consumer.

Our sample was a stratified random sample of 100 recipient dates of service (RDOS), containing 690 services. This statistical sample was taken from a subpopulation of the Providers claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review. Supporting documentation for one RDOS (six services) lacked evidence that the item was dispensed to the consumer. Therefore, we took exception with the actual reimbursement of $820.15 for these services. This exception represented only one percent (1 of 100) of the RDOS sampled and less than one percent of the services sampled (6 of 690 = 0.87 percent).

Since both the error rate of services tested and the dollar amount of the overpayment found were below our criteria for materiality, we did not project the wheelchair and wheelchair parts sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the actual $820.15 overpayment found in the sample.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on October 17, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. On November 11, 2005, the Provider replied and supplied additional documentation that was used to adjust our findings. In their response, the Provider stated, "in a concerted effort to minimize the type of billing errors cited above in the future, Hamilton's is establishing a training program for members of our staff who are involved in the Ohio Medicaid billing process." At the Provider's request, an exit conference was also held with the Provider on January 19, 2006, at which time the Provider indicated that they were submitting additional documentation in regards to two matters. A final determination of findings was made after receipt and review of the additional documentation.

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APPENDIX I
Summary of Statistical Sample Analysis of Hamilton's Health Aid Services
Wheelchair Repair Sample
Audit Period: April 1, 2001 – March 31, 2004

Description	Audit Period Apr. 1, 2001 – Mar. 31, 2004
Type of Examination	**Stratified Random Sample of Services**
Number of Population Services Provided	**621**
Number of Population Services Sampled	**128**
Total Medicaid Amount Paid for Population	**$313,589.06**
Actual Amount Paid for Population Services Sampled	**$134,056.30**
Projected Correct Population Payment Amount	**$307,186.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$312,479.10**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$295,006.00**
Projected Overpayment Amount = Total Medicaid Amount Paid for Population – Projected Correct Population Payment Amount	**$6,403.06**
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	**$12,180 (+/- 3.97%)**

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

Appendix II
Summary of Overpayment Results for:
Hamilton's Health Aid Services
For the period April 1, 2001 to March 31, 2004

Description	Audit Period April 1, 2001 to March 31, 2004
Dispensed Supplies in Excess of the Medicaid Maximum	$174.96
Projected Findings for Statistical Sample of Major/Minor Wheelchair Repairs	$6,403.06
Actual Findings for Statistical Sample of Wheelchairs and Wheelchair Parts	$820.15
TOTAL	**$7,398.17**

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

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HAMILTON'S HEALTH AID SERVICE

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
MARCH 28, 2006