Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Hamilton's Health Aid Services, Inc. – Cincinnati, Ohio

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

June 29, 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, Inc. - Cincinnati, Ohio; Provider Number: 0252962

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Hamilton's Health Aid Services, Inc. for the period April 1, 2001 through March 31, 2004. We identified $35,937.09 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 any final determinations 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, Inc. 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, Inc. (hereafter called the Provider), Provider # 0252962, doing business at 6225 Colerain Ave., Cincinnati, OH 45239. 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 $35,937.09 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 Ohio Medicaid Provider Handbook. 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 population 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 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 period (the audit period), excluding Medicare co-payments, the Provider was reimbursed $3,077,503.79 for 6,753 services rendered on 2,684 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 Providers 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:

- Payments for services to deceased recipients 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 potential overpayments. When performing our audit field work, we reviewed the Provider's supporting documentation for all of the potential overpayments.

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/minor wheelchair repairs, containing a total of 139 services; 2) a stratified random sample of incontinence garments, containing a total of 130 services; and 3) a stratified random sample of wheelchairs and wheelchair parts, containing a total of 90 recipient dates of service (514 services).

Our work was performed between January 2005 and April 2006.

RESULTS

We identified $314.44 in findings from our exception analyses, $24,422.50 in projected findings from our statistical sample of major/minor wheelchair repairs, $9,447.00 in projected findings from our statistical sample of incontinence garments, and $1,753.15 in actual findings from our statistical sample of wheelchairs and wheelchair parts. The total findings of $35,937.09 are repayable to ODJFS and discussed in more detail below.

Exception Test Results

Supplies Exceeding the Medicaid Maximum

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

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

Appendix A establishes maximum dollar amounts and/or quantities that Medicaid will cover for specific items. This appendix also defines some items supplied by Medicaid as "rent to purchase" items.

Billings Exceeded "Rent to Purchase" Price

Ohio Adm.Code 5101:3-10-03(G) states in pertinent part: "'R/P' means item may be purchased or rented until purchase price is reached." We identified one item billed by the Provider where the cumulative rental billing exceeded the purchase price. The Provider was reimbursed over the purchase price for HCPCS E0180 (pressure pad, alternating, with pump, complete), which has an allowable quantity of one pump every four years with a purchase price of $138.00. After subtracting the purchase price from the amount paid to the Provider, we identified findings totaling $55.20.

Items Dispensed in Excess of the Medicaid Maximum

Our computer analysis identified four services, where the Provider billed and was reimbursed for supplies that exceeded the maximum allowed. After subtracting the maximum allowed from the amount paid to the Provider, we identified findings totaling $49.17 for the items shown in Table 1.

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

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Number of Exceptions	Overpayment
Y0021	Standard mechanical wheelchair, short term	Rent per month, up to 3 months; 3 per 5 years	1	$45.00
A4331	Extension draining tubing with connector	2 per month	3	$4.17
		Total	***4***	***$49.17***

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 (HCPCS A4927) changed from $0.22 *per glove* 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 claims, we identified overpayments that appeared to result from the Provider continuing to bill "per glove," instead of "per box," which resulted in overpayments. We identified 27 services, where the Provider improperly 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 $210.07.

Sample Results

Major/Minor Wheelchair Repair Sample

Our sample was a stratified random sample of 139 services 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. This sample identified 21 services that were overpaid resulting in projected findings of $24,422.50. A few services had more than one error; however, only one monetary finding was made per service. 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:

> …prior authorized 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 11 sample services for minor wheelchair repairs, where the Provider incorrectly billed for labor at an hourly rate in excess of the Medicaid maximum. The Provider billed for labor on the repair at $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 $416.00 in findings that were used in projecting the overall overpayment amount for wheelchair repairs.

Billing for Repair During Warranty Period

Ohio Adm.Code 5101:3-10-08(A)(7) states:

> No reimbursement may be made for: (a) Any repairs covered under manufacturer or dealer warranty.
>
> ***

Ohio Adm.Code 5101:3-10-16(I)(1) states:

> The cost of any changes or modifications…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 reimbursement for two sampled services where the Provider inappropriately billed and was paid for the repair when the services were covered by an applicable warranty or within the ninety days following dispensing. We identified a finding of $2,224.50 and used that finding in projecting the overall overpayment for wheelchair repairs.

Prior-Authorized Repair Billed In Excess of Medicaid Allowable Amount

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 took exception with the reimbursement for one sample repair service where the Provider billed and was reimbursed by Medicaid for more than the total cost of the repair. The Provider initially obtained a prior authorization for repair services based on an estimate that included wheelchair batteries. Later, the Provider billed and was reimbursed for the prior-authorized amount plus a separate battery service. We calculated what the Provider should have been paid for the non-battery items plus the separate battery service, and determined that a $204.10 overpayment had occurred. This overpayment was used in projecting the overall overpayment for wheelchair repairs.

Missing Prescription and Other Required Documentation

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

> ***
> (1) Separate codes have been established for major and minor repairs to…durable medical equipment.
>
> (a) "Major repairs" are defined as those repairs for which the combined charges for materials and labor exceed one hundred dollars. Prior authorization is required for major repairs to durable medical equipment.
>
> ***
>
> (2) A written prescription is required if the item requiring repair:
>
> (a) Was not paid for by the department; or,
>
> (b) Was originally approved through the department's prior authorization procedure and the repair would substantially change the appearance or function of the item; or,

> (c) Did not require prior authorization but was paid for by the department and is a major repair.
>
> (3) A verbal or written prescription is required if the item requiring repair did not require prior authorization but was paid for by the department and is a minor repair.
>
> ***

Ohio Adm.Code 5101:3-10-16(J)(6) states in pertinent part:

> A description, model number, manufacturer serial number, date of purchase, and the condition of a consumer's current equipment must be specified on a request for authorization of additional or replacement equipment…

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…for a period of six years from the date of receipt of payment based upon those records…

We took exception with the reimbursement for eight sample services because the Provider billed for repair services without a prescription on file. Without a prescription, we were unable to verify a physician had determined the repairs were medically necessary. In addition, one of the eight services was a duplicate payment because both Medicaid and a third insurer paid for the service. Furthermore, in all eight cases, patient files and the preauthorization requests lacked information about the condition of the consumer's current equipment, as required by Ohio Adm.Code 5101:3-10-16(J)(6).

In one example, a wheelchair was dispensed to a recipient in January 1998. In October 2001, the Provider billed and was reimbursed for a major repair including a new frame and other items. There was no prescription on file by a physician requesting the wheelchair repair , and the record lacked an explanation of the patient's current equipment condition.

In the absence of both a prescription and documentation of the wheelchair condition necessitating the repair, we took exception with the eight services, leading to $5,134.18 in findings that were used in projecting the overall overpayment for wheelchair repairs.

Provider Patient Records Sometimes Lacked Supporting Documentation

Ohio Adm.Code 5101:3-10-08(A)(6) states:

> Requests for prior authorization of major repairs for durable medical equipment must specify who owns the equipment, the date of purchase or the approximate age of the equipment, and the applicable warranty period.

Ohio Adm.Code 5101:3-10-16(J)(6) states in pertinent part:

> A description, model number, manufacturer serial number, date of purchase, and the condition of a consumer's current equipment must be specified on a request for authorization of additional or replacement equipment…

While we are not asserting any monetary findings for this issue because the services were prior authorized, we identified three services where the original wheelchair purchase information was not in the Provider's patient files. To support the billing of any subsequent repairs, we believe the Provider should maintain the original wheelchair information to avoid potential billings of items under warranty.

We also observed many of the Provider's patient records lacked descriptions of the condition of the consumer's current equipment as support for replacement equipment. ODJFS officials told us that while providers requesting prior authorization of a repair may not always be required to submit every piece of supporting documentation (e.g. prescription, description of wheelchair, wheelchair condition, and parts to be replaced), they are expected to maintain this supporting documentation in patient files. We did not assert monetary findings in these cases, except those also missing a required prescription, but we are recommending that the Provider maintain all required documentation to avoid future audit findings.

Sample Projection of Major/Minor Wheelchair Repair Overpayments

We took exception with 21 of 139 statistically sampled 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 $188,165.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $176,233.00 to $200,098.00 (+/- 6.34 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($188,165.00) from the amount paid to the Provider for this population ($212,587.50), which resulted in a finding of $24,422.50. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Incontinence Garments Sample

Our sample was a stratified random sample of 130 services taken from a subpopulation of the Provider's claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review. This sample identified 21 services that were overpaid resulting in projected findings of $9,447.00. One service had more than one error; however, we only issued a monetary finding once. The bases for these findings are presented below.

Invalid Diagnosis

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:

***

(3) Incontinence is:
(a) Secondary to disease which results in irreversible loss of control of the urinary bladder and/or anal sphincter; or
(b) Secondary to injury of the brain or the spinal cord which results in irreversible loss of control of the urinary bladder and/or anal sphincter; or
(c) Attributed to developmental delay or developmental disability.
(B) A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months…and must specify:
(1) The applicable diagnosis of the specific disease or injury causing the incontinence.…

***

(3) Type of Incontinence
(a) Stress incontinence is considered a type of incontinence and does not meet the definition of disease or injury as specified in paragraph (A) of this rule.
(b) Consumers with stress incontinence that is secondary to other disease or injury causing irreversible loss of control of the urinary bladder and/or anal sphincter may be eligible for incontinence garments and related supplies providing all requirements of this rule are met.
(C) A prescription that only lists incontinence or incontinence supplies and does not specify the reason for the incontinence in accordance with paragraph (B) of this rule does not meet the requirements of this rule.

***

We took exception with the reimbursement of 17 sample services. During our review, we noted that the prescriptions for these services did not list a valid diagnosis specifying the disease or injury causing the incontinence. Either there was no diagnosis provided or the type of incontinence listed on the prescription was stress incontinence, which does not meet the definition of disease or injury in order to be reimbursable under Medicaid. For 16 of the services, a diagnosis was added to the prescription; however, upon review of the physician's records, we could not confirm the diagnosis was present during the time frame in question. Therefore, we took exception with the reimbursement of these services. We identified a $1,422.00 finding for the overpayment and used the finding in projecting the overall overpayment for incontinence garments.

Missing Required Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…for a period of six years from the date of receipt of payment based upon those records…

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

> A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months…

We took exception with the reimbursement of four sample services. During our review, we identified two services where there either was no chart to review or no documentation to support services were performed on the date in question. In addition, we identified two services where the prescription was missing for the date of service. We identified a $644.04 finding for the overpayment and used the finding in projecting the overall overpayment for incontinence garments.

Sample Projection of Incontinence Garment Overpayments

The overpayments identified for 21 of 130 services from our stratified random sample were projected across the Provider's total population of paid services. This resulted in a projected overpayment amount of $15,569.00 with a precision of plus or minus $7,294.00 at the 95 percent confidence level. Since the precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate (equivalent to method used in Medicare audits), and a finding was made for $9,447.00. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $9,447.00. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Wheelchair and Wheelchair Parts Sample

Our sample was a stratified random sample of 90 recipient dates of service (containing 621 services) taken from a subpopulation of the Provider's claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review. This sample identified 14 services that were overpaid, resulting in a finding of $1,753.15. The bases for these findings are presented below.

Missing Required Documentation

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

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

We took exception with the reimbursement of 13 sample services. For 10 of the 13 services, the part provided was not included on the letter of medical necessity or a separate order; therefore, the part was not authorized by a physician. For the remaining three services, a prior authorization was received by the department; however, no physician order prior to that date or evidence of shipment was on file. Therefore, we could not verify that the part was ordered and/or subsequently dispensed to the consumer. We identified a $1,621.90 finding for the overpayment.

Reimbursement Greater than Prior Authorized Amount

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

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

When ODJFS pre-approves a service, the form sent to the Provider shows the maximum ODJFS is willing to reimburse for the requested service.

We took exception with the reimbursement for one sample service where the Provider billed Medicaid for an amount greater than the pre-approved amount. Therefore, we took the difference been what the Provider billed and what should have been reimbursed according to the final invoice price. We identified a $131.25 finding for the overpayment.

Total sample findings were $1,753.15 of which $1,289.50, consisting of four errors, came from two census (100 percent review) strata. The additional sampled stratum had two errors, out of 47 sampling units (4.26 percent error rate), and $463.65 in findings.

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 wheelchairs and wheelchair parts sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the actual $1,753.15 overpayment found in the wheelchairs and wheelchair parts sample.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on January 3, 2006 to afford an opportunity to provide additional documentation or otherwise respond in writing. On February 9, 2006, 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 billing errors in the future, Hamilton's is establishing a training program for members of our staff who are involved in the Ohio Medicaid billing process." Several additional telephone conferences were held with the Provider to discuss the audit findings and provide an opportunity to supply clarifying documentation. 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, Inc.
Major/Minor Repair Sample
Audit Period: April 1, 2001 – March 31, 2004

Description	Audit Period Apr. 1, 2001 – Mar. 31, 2004
Type of Examination	Stratified Statistical Random Sample
Number of Population Services Provided	607
Number of Population Services Sampled	139
Total Actual Medicaid Amount Paid for Population	$212,587.50
Actual Amount Paid for Population Services Sampled	$116,443.55
Projected Correct Population Payment Amount	$188,165.00
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$200,098.00
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$176,233.00
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	$11,933.00 (+/- 6.34%)
Projected Overpayment Amount = Actual Medicaid Amount Paid for Population – Projected Correct Population Payment Amount	$24,422.50

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

APPENDIX II
Summary of Statistical Sample Analysis for Hamilton's Health Aid Services, Inc.
Incontinence Garments Sample
Audit Period: April 1, 2001 – March 31, 2004

Description	Audit Period April 1, 2001 – March 31, 2004
Type of Examination	Stratified Statistical Random Sample
Description of Population	All paid services less 100% examined exception cases
Number of Population Services Provided	966
Total Medicaid Amount Paid For Population	$111,911.48
Number of Services Sampled	130
Amount Paid for Services Sampled	$14,879
Estimated Overpayment using Point Estimate	$15,569
Precision of Overpayment Estimate at 95% Confidence Level	$7,294
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	$9,447

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

APPENDIX III
Summary of Overpayment Results for:
Hamilton's Health Aid Services, Inc.
For the period April 1, 2001 to March 31, 2004

Description	Audit Period April 1, 2001 to March 31, 2004
Items Exceeding "Rent to Purchase" Price	$55.20
Items Dispensed in Excess of the Medicaid Maximum	$49.17
Surgical Gloves Billed with Erroneous Units of Service	$210.07
Major/Minor Wheelchair Repair Sample	$24,422.50
Incontinence Garment Sample	$9,447.00
Wheelchair and Wheelchair Parts Sample (actual findings)	$1,753.15
TOTAL	**$35,937.09**

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

Auditor of State
Betty Montgomery

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HAMILTON'S HEALTH AID SERVICES

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
JUNE 29, 2006