Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Tip Top Drugs, Inc., d.b.a. Advance Medical Equipment

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

September 20, 2005

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

Re: Audit of Tip Top Drugs, Inc. d.b.a. Advanced Medical Equipment
Provider Number: 0494371

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Tip Top Drugs, Inc., d.b.a. Advanced Medical Equipment for the period October 1, 2001 through September 30, 2004. We identified $23,786.68 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 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 being sent to Tip Top Drugs, Inc. d.b.a. Advanced Medical Equipment, and the Ohio Attorney General. 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
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

SUMMARY OF RESULTS

The Auditor of State performed an audit of Tip Top Drugs, Inc., d.b.a. Advance Medical Equipment (hereafter called the Provider), Provider # 0494371, doing business at 2655 S. Dixie Dr., Kettering, OH 45409. 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 $23,786.68 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code Ohio and the Medicaid Provider Handbook (OMPH).

We are issuing this report to ODJFS 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 identified herein, and any interest accruals.[1]

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.[2] 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 that 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 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

[1] *See Ohio Adm.Codes 5101:3-1-19.8(F) and 5101:3-1-25*
[2] *See Ohio Adm.Code 5101:3-1-01(A) and (A)(6)*

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."

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 durable medical equipment supplier. Primary items supplied by the Provider during our audit period included wheelchairs, wheelchair repairs and accessories, and incontinence supplies.

Following a letter of notification, we held an entrance conference at the Provider's place of business on March 23, 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 October 1, 2001 through September 30, 2004. The Provider, excluding Medicare co-payments, was reimbursed $2,112,247.22 for 12,961 services rendered on 5,589 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's 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).[3]

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:

[3] 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.

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

All of the exception tests identified potentially erroneous reimbursements. Therefore, when performing our audit field work, we reviewed the Provider's supporting documentation for all potentially erroneous reimbursement claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical supply services, we also analyzed three statistical samples of the Provider's services rendered during the audit period.

- The first sample was a census (100 percent review) of all services for HCPCS codes E1350 ~Repair, non-routine services, DME major repair and E1399 ~ Durable medical equipment, non-specific rendered by the Provider which consisted of 51 services. An examination of these two procedure codes was performed because of the non specific nature of the service, the relatively high cost ($764.49) per service, and the few recipients (44 of 1,920) for which these services were performed.
- The second sample was a stratified random sample of all recipients who had wheelchair and wheelchair repair services rendered by the Provider during the audit period. The sample consisted of 88 recipients and a total of 380 services.
- The third sample of 152 recipient dates of service (comprising 428 services) was drawn from all other Medicaid services not already identified for review. A RDOS was defined as all services received by a particular recipient on a specific date.

Our work was performed between November 2004 and June 2005.

RESULTS

We identified $15,929.18 in findings from our exception tests and $7,857.50 in findings ($1,024.50 actual and $6,833.00 projected) from our samples. The circumstances leading to these findings are discussed below:

Results of Exception Tests

Medical supplies billed in excess of price or quantity limits set by ODJFS

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

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

Appendix A of Ohio Adm.Code 5101:3-10-03 establishes maximum dollar amounts and quantities that Medicaid will cover for specific items. Appendix A also defines some items supplied by Medicaid as "rent to purchase" items.

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."

Our computer analysis identified 284 services, involving 25 different HCPCS service codes, where the Provider appeared to have billed and been reimbursed for supplies over the maximum Medicaid price or quantity allowed. We subtracted the maximum allowed Medicaid reimbursement from the amount billed by and paid to the Provider. The differences resulted in findings totaling $12,335.24. The bases for these findings are detailed below.

Items Dispensed in Excess of the Medicaid Maximum

Our computer analysis identified 254 services, where the Provider billed and was reimbursed for supplies that exceeded the allowed Medicaid maximums. After subtracting the allowed maximum from the amount paid to the Provider, we identified findings totaling $10,761.44 for the items shown in Table 1.

Table 1: Listing of Supplies Exceeding Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Repayable Findings ($)	Number of Exceptions
A4351	Intermittent urinary catheter	200 per month	$78.21	1
A4554	Disposable underpads	300 per 2 months	$170.32	7
A4595	Tens supplies, for 2 or 4 leads	1 per month	$25.00	1
A6402, A6403, and A6404	Non-Impregnated gauze	The combined maximum payment is $50 per month	$543.50	26
A6222	Impregnated gauze	The combined maximum is 30 units per month	$33.00	1
A6251 – A6253	Specialty absorptive dressing	The combined maximum is 30 units per month	$6,973.35	176
A6406	Non-Elastic gauze sterile	30 rolls per month	$1,755.31	21
E0192	Low pressure equal pad with cover	1 every 2 years	$330.00	1
E0244	Raised toilet seat	1 every 5 years	$24.55	1
E0245	Tub stool or bench	1 every 5 years	$90.00	2
Y2010	Transfer bench	1 every 5 years	$80.00	1
A4522, A4524, A4525, A4527, and A4529	Incontinence items	300 incontinence garments per month	$658.20	16
		Totals	***$10,761.44***	***254***

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 October 1, 2001 through September 30, 2004.

Items Exceeding "Rent to Purchase" Price

We also identified five rental HCPCS codes where the Provider's cumulative rental billings exceeded the purchase price. We subtracted the Medicaid purchase price from the actual payments made to calculate findings of $1,573.80. Table 2 lists these items and the corresponding overpayment.

Table 2: Listing of Supplies that Exceeded the "Rent to Purchase" Price

HCPCS Code	Item	"Rent to Purchase" Price	Number of Rental Months Over Purchase Price	Repayable Findings ($)
B9002	Enteral Nutrition Infusion Pump	$700.00	5	$350.00
E0180	Pressure Pad	$138.00	5	$177.60
E0600	Suction Pump/Home Model	$217.00	11	$693.00
E0910	Trapeze Bar, Bed Mounted	$101.00	2	$20.20
E0940	Trapeze Bar, Freestanding	$130.00	7	$333.00
		Totals	***30***	***$1,573.80***

Source of Medicaid maximum: 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 October 1, 2001 through September 30, 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 gloves (HCPCS code A4927) 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." We identified 382 services where the Provider improperly billed and was overpaid for HCPCS code A4927. After adjusting the amount paid to the Provider to correspond to the actual units supplied, we identified findings totaling $3,359.90.

Billing for Items Not Shipped

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

> …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…submit claims only for service actually performed…
>
> ***

We identified seven services where the Provider billed for items that were not shipped to the recipient. Therefore, we disallowed the reimbursement for these seven services resulting in a finding of $129.84.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states:

> …all medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to medicaid consumers, and to document significant business transactions…
>
> ***

We identified two billed services that were not supportable because the patient's medical records did not contain the required documentation to support billing to ODJFS. Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these two services resulting in findings totaling $79.20.

Billing for Services to Deceased Recipients

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

> …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…submit claims only for service actually performed…
>
> ***

During our review of the Provider's paid claims for the audit period, we identified one occasion where the Provider billed Medicaid for a service supposedly performed subsequent to the recipient's date of death. Therefore, we disallowed the payment for this service and made a finding of $25.00.

Summary of Exception Tests

We took exception with 676 of the 1,269 services segregated from the sample population for special examination. Table 3 summarizes the exceptions found by reason and overpayment amount.

Table 3: Summary of Billing Exceptions
For the Period of October 1, 2001 – September 30, 2004

Basis for Exceptions	Number of Services with Exceptions	Repayable Findings ($)
Items Dispensed in Excess of the Medicaid Maximum	254	$10,761.44
Items Exceeding the "Rent-to-Purchase" Price	30	$1,573.80
Surgical Gloves Billed with Erroneous Units of Service	382	$3,359.90
Billing for Items Not Shipped	7	$129.84
Missing Documentation	2	$79.20
Billing Services for Deceased Recipients	1	$25.00
Total Services with Exceptions	**676**	**$15,929.18**

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

Results of Statistical Samples

Results of E1350 and E1399 Census Analysis

We reviewed at 100 percent all services rendered by the Provider for HCPCS codes E1350 ~Repair, non-routine services, DME major repair; and E1399 ~ Durable medical equipment, non-specific, which consisted of 51 services. We identified findings for two of the 51 services reviewed which resulted in actual findings totaling $238.50. The findings resulted from the two deficiencies listed below:

Billing Over the Medicaid Maximum Hourly Rate for Repairs

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

> Request for prior authorization of repairs (both minor repairs in excess if one per one hundred twenty days and major repairs) must itemize parts and labor separately. Prior-authorization 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 one repair service that had been billed at an hourly rate greater than the amount specified by Ohio Adm.Code 5101:3-10-08(A)(5). Specifically, the patient record indicated the Provider billed $240.00 in labor for eight 15-minutes units, (i.e. an effective wage rate of $120

per hour.). The Medicaid maximum reimbursement for two hours of labor would have been $72.00 ($36 per hour x two hours.) We reduced the amount paid for labor for this repair service to the Medicaid maximum. This resulted in findings totaling $168.00.

Billing for Warranty Repair Item

Ohio Adm.Code 5101:3-10-08(A)(7)(a) states "No reimbursement may be made for any repair covered under manufacturer or dealer warranty…"

We identified one repair service that had been billed but which was under warranty. We disallowed the payment for this service and took a finding of $70.50 because this repair should have been covered under the dealer warranty.

Findings from E1350 and E1399 Census Analysis

Overall, we identified two exceptions in our census sample of 51 services. Table 4 summarizes the bases for our exceptions.

Table 4: Summary of Findings from E1350 and E1399 Census Sample
For the Period of October 1, 2001 – September 30, 2004

Basis for Exception	Number of Services with Exceptions	Repayable Findings
Billing Over the Medicaid Maximum Hourly Rate for Repairs	**1**	**$168.00**
Billing for Warranty Repair Item	**1**	**$70.50**
Total Services with Exceptions	**2**	**$238.50**

Source: AOS analysis of the Provider's HCPCS codes E1350 and E1399 consisting of 51 services.

Analysis of Wheelchair and Wheelchair Repair Services Sample

Improper Billing for Third-Party Payer Covered Services

Ohio Adm.Code 5101:3-1-08 states in pertinent part:

> (A) The medicaid program reimburses for covered services only after all available third-party benefits are exhausted. Payment for services provided under the medicaid program must be reduced to the extent that they are offset by an insurance policy, workers' compensation, or other third-party resource. The provider may not bill the medicaid consumer for any difference between the medicaid payment and the provider's charge, or request the consumer to share in the cost through a co-payment or other similar charge.
>
> (B) Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party.

> In such instances, the department will not reimburse for the cost of services which are or would be covered by a third-party payer…
>
> ***

We identified one service where the Provider did not identify a third-party payment had been received for a dual eligible recipient. Because the Provider did not offset the payment amount received by the third-party payer we took exception with the reimbursement for this service and identified $234.00 in findings.

Billing Over the Medicaid Maximum Hourly Rate for Repair Services

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

> Request for prior authorization of repairs (both minor repairs in excess if one per one hundred twenty days and major repairs) must itemize parts and labor separately. Prior-authorization 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 12 repair services that had been billed at an hourly rate greater than the amount specified by Ohio Adm.Code 5101:3-10-08(A)(5). Specifically, the patient records indicated the Provider billed either $60 or $120 per hour for these 12 repair services instead of the Medicaid maximum of $36 per hour. Therefore, we reduced the amount paid for these 12 repair services to adjust for the billing error. This resulted in findings totaling $552.00.

Findings for Wheelchair and Wheelchair Repair Services Sample

Overall, we identified 13 exceptions out of the 380 wheelchair and wheelchair repair services from our sample. A projection of the sample error rate to the population of 653 recipients with 2,630 wheelchair or wheelchair repairs is not being used in this report since the achieved precision of our sample was too great (+/- 161 percent) to use in any projection. Findings for this sample were therefore limited to just actual observed overpayments. Table 5 summarizes the amount and basis for our actual exceptions taken.

Table 5: Summary of Findings from Wheelchair and Wheelchair Repair Services Sample For the Period of October 1, 2001 – September 30, 2004

Basis for Exception	Number of Services with Exceptions	Repayable Findings
Improper Billing for Third-Party Payer Covered Services	**1**	**$234.00**
Billing Over the Medicaid Maximum Hourly Rate for Repairs	**12**	**$552.00**
Total Services with Exceptions	**13**	**$786.00**

Source: AOS analysis of a sample of 380 wheelchair and wheelchair repair services.

Results of All Other Medicaid Services Sample Analyses

Our sample of services not included in other analyses consisted of 152 recipient dates of services and 428 services. Our analysis of the supporting documentation for these services identified the following issues:

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 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, 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 428 services in our sample, we identified seven services where the provider did not maintain prescriptions for the services billed. Because the Provider did not maintain the required documentation in the recipients' medical records, a determination could not be made if the service rendered was Medicaid eligible. We therefore took exception with the reimbursement for all seven services.

Missing Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states that providers are required "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is complete."

We were unable to confirm from the Provider's records that one of the 428 paid services in our sample was actually supplied. Consequently, we took exception with the payment for this one service.

Improper Billing for Third-Party Payer Covered Service

Ohio Adm.Code 5101:3-1-08 states in pertinent part:

> (A) The medicaid program reimburses for covered services only after all available third-party benefits are exhausted. Payment for services provided under the medicaid program must be reduced to the extent that they are offset by an

> insurance policy, workers' compensation, or other third-party resource. The provider may not bill the medicaid consumer for any difference between the medicaid payment and the provider's charge, or request the consumer to share in the cost through a co-payment or other similar charge.
>
> (B) Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party. In such instances, the department will not reimburse for the cost of services which are or would be covered by a third-party payer…
>
> ***

We identified one service out of our 428 sampled services where the Provider did not submit a claim to the third-party payer for a covered item. Because the Provider did not take reasonable measures to file a claim with the third-party payer we took exception with the payment for this service.

Service Prescribed by an Unlicensed Physician

Ohio Adm.Code 5101:3-4-01(A)(1) states in pertinent part a "Physician" means an individual currently licensed under state of Ohio law or under another state's law to practice medicine and surgery or osteopathic medicine and surgery."

We identified one service out of our 428 sampled services where the attending physician who prescribed the service had an inactive medical license. Because the attending physician was not currently licensed under state of Ohio law we took exception with this one service.

Supplies Exceeding Medicaid Maximum

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

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

Appendix A of Ohio Adm. Code 5101:3-10-03 establishes maximum dollar amounts and/or quantities that medicaid will cover for specific items.

Of the 428 services in our sample, we identified one service where the Provider billed and was reimbursed for supplies that exceeded the allowed maximum quantity. Therefore, we took exception with the payment for this service.

Billing for an Item Not Shipped

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

> …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…submit claims only for service actually performed…
>
> ***

Of the 428 services in our sample, we identified one service where the Provider billed for item that was not shipped to the recipient. Therefore, we took exception with the payment for this service.

Projected Findings from the "All Other" Sample

Overall, we identified 12 exceptions in our random sample of 152 RDOS and 428 services. Table 6 summarizes the bases for our exceptions.

Table 6: Summary of Findings from the All Other Services Sampled For the Period of October 1, 2001 – September 30, 2004

Basis for Exception	Number of Services with Exceptions
Missing Prescription	**7**
Missing Documentation	**1**
Improper Billing For Third-Party Payer Covered Services	**1**
Service Prescribed by an Unlicensed Physician	**1**
Supplies Exceeding Medicaid Maximum	**1**
Billing for an Item Not Shipped	**1**
Total Services with Exceptions	**12**

Source: AOS analysis of all other service sample of 428 medical supply services.

The overpayments identified for 12 of 152 statistically sampled RDOS (12 of 428 services) from our simple random sample of the Provider's subpopulation of paid services (which excluded services associated with Medicare co-payments, services extracted for 100 percent review, E1350 and E1399 services, and wheelchair and wheelchair repair services) were projected across the Provider's total sub-population of paid recipient dates of service. This resulted in a projected overpayment amount of $15,591 with a 95 percent certainty that the true subpopulation overpayment fell within the confidence interval of $5,156 to $26,026. Since the confidence interval was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment amount is at least $6,833. A detailed summary of our statistical sample and projection results is presented in Appendix I.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on August 9, 2005. The Provider sent us a written response on August 23, 2005, along with additional documentation to support some of the claims for services we initially took exception with. As a result of the additional supporting information supplied by the Provider, we reduced our findings to $23,786.68, which are repayable to the Ohio Department of Job and Family Services.

In addition, the Provider committed to correcting the deficiencies identified by our audit. We are attaching the Provider's corrective actions (see page 17) for the consideration and review of ODJFS' Surveillance and Utilization Review Section.

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APPENDIX I

**Summary Table of Sample Record Analysis for
Tip Top Drugs, Inc, d.b.a. Advanced Medical Equipment
Subpopulation of Non Exceptions, Non E1350 and E1399 Services, and Non Wheelchair and Wheelchair Repair Services
For the period October 1, 2001 to September 30, 2004**

Description	Audit Period October 1, 2001 – September 30, 2004
Type of Examination	**Statistical Simple Random Sample**
Description of Population	**All paid services net of adjustments and excluding Medicare Co-payments, 100% Exception tests, E1350 and E1399 services, and Wheelchair and wheelchair repair services**
Number of Population Recipient Date of Services	**4,246**
Number of Population Services Provided	**8,315**
Total Medicaid Amount Paid For Population	**$361,198.08**
Number of Recipient Date of Services Sampled	**152**
Number of Services Sampled	**428**
Amount Paid for Services Sampled	**$29,994.78**
Estimated Overpayment using Point Estimate	**$15,591**
Lower Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$5,156**
Upper Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$26,026**
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	**$6,833**

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

APPENDIX II

Summary of Audit Findings for
Tip Top Drugs, Inc., d.b.a Advanced Medical Equipment
Audit Period: October 1, 2001 to September 30, 2004

Basis for Exception	Amount of Overpayment
Billing Items in Excess of the Medicaid Maximum	**$10,761.44**
Items Exceeding "Rent to Purchase" Price	**$1,573.80**
Surgical Gloves Billed with Erroneous Units of Service	**$3,359.90**
Billing for Items Not Shipped	**$129.84**
Missing Documentation	**$79.20**
Billing for Services to Deceased Recipients	**$25.00**
Actual Findings for E1350 and E1399 Census Sample	**$238.50**
Actual Findings for Wheelchair and Wheelchair Repair Services Sample	**$786.00**
Projected Findings for All Other Services Sample (See Appendix I)	**$6,833.00**
Total Findings	**$23,786.68**

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

PROVIDER'S CORRECTIVE ACTION PLAN

ADVANCED MEDICAL EQUIPMENT

(937) 534-1080
1-800-543-1249
Fax: (937) 534-1081

2655 S. Dixie Drive • Kettering, Ohio 45409
Your Complete Home Care Equipment Dealer

Plan of Action

August 24, 2005

Re: Medicaid Provider Audit 2005
Provider # 0494371

Limits in our computer system have been set and reviewed. This will allow the computer system to flag any order that is over maximum and /or limits.

Maximum allowable have been corrected in our computer system to prevent billing past the purchase price.

Warranty repairs will have serial numbers verified to assure warranty work is not billed to Medicaid.

All Customer Service and Order Entry personnel have been in serviced and will be informed of any future policy changes.

All maximum and/or limits will be reviewed at least yearly.

Sincerely:
William W. Willhelm

William W. Willhelm
President
TipTop Drugs Inc.

WE BRING GOOD HEALTH CARE HOME.

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TIP TOP DRUGS., INC. dba ADVANCE MEDICAL EQUIPMENT

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
SEPTEMBER 20, 2005