Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Lorraine Surgical Supply Company

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

August 22, 2006

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

Re: Audit of Lorraine Surgical Supply Company
Provider Number: 0276786

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Lorraine Surgical Supply Company for the period April 1, 2003 through March 31, 2005. We identified $80,944.96 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 being sent to Lorraine Surgical Supply Company 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

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

TABLE OF CONTENTS

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
RDOS	Recipient Date of Service
TCN	Transaction Control Number

SUMMARY OF RESULTS

The Auditor of State performed an audit of Lorraine Surgical Supply Company (hereafter called the Provider), Provider #0276786, doing business at 2080 W. 65th St., Cleveland, OH 44102. 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 $80,944.96 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.

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 Providers 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 30, 2005, 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 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."

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 applicable, 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 June 28, 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, 2003 through March 31, 2005. The Provider, excluding Medicare co-payments, was reimbursed $5,752,404.43 for 72,521 services rendered on 36,518 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 and the Ohio Administrative Code 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).[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 billed for recipients who died prior to the date of services.
- 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.
- Medical supplies billed in excess of price or quantity limits set by ODJFS.

The exception tests identified 12,389 services with potentially erroneous reimbursements; and therefore, when performing our audit field work, we reviewed the Provider's supporting documentation for all potentially erroneous reimbursed claims identified by our exception analyses.

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

The first sample was drawn from incontinence services not already identified for review by our exception tests and consisted of 100 recipient dates of service (RDOS) comprising of 183 services. The second sample was drawn from enteral feeding supply services not already identified for review by our exception tests and consisted of 166 recipient dates of service (RDOS) comprising 207 services. Collectively, incontinence and enteral feeding supplies accounted for 80.8 percent of the Provider's total reimbursements during our audit period.

Our work was performed between March 2005 and May 2006.

RESULTS

We identified a total of $80,944.96 in findings that are repayable to the State of Ohio. This total consisted of $57,919.19 in findings identified by our exception tests, $342.72 in actual findings from our sample of incontinence services, and $22,648.05 in projected findings from our sample of enteral feeding supplies. The circumstances leading to these findings are discussed below:

Exception Test Results

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 resulted from the Provider continuing to bill "per glove," instead of "per box". We identified a total of 11,824 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 $27,633.44.

Dispensing Supplies After the Need Passed and/or More Than 14 Days After Obtaining the Consumer Ascertainment of Need

Ohio Adm.Code 5101:3-10-21(D) states:

> Providers must ascertain from the consumer or the consumer's caregiver on a monthly basis the required type and amount of incontinence garments and/or related supplies.
>
> (1) The providers must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider ascertained the required type and amount from the consumer or consumer's care giver. The date that the provider ascertained the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
>
> ***

Ohio Adm.Code 5101:3-10-05(E) states in pertinent part:

> …Providers of medical supplies shall ascertain the quantity of supplies needed and shall not dispense supplies in excess of the amount actually needed by the recipient for the prescribed period…
>
> ***

We identified 58 services for incontinence garments and related medical supplies where the Provider shipped and billed Medicaid for services delivered past the point actually needed by the recipient for the prescribed period. In one example, a physician prescribed 10 diapers and 16 liners per day for a recipient. Because this exceeded the allowed Medicaid maximum of 300 units per month for diapers and liners[5], the Provider requested and ODJFS approved the shipment of an additional 600 units of A4522 (Adult diapers, medium) and 840 units of A4535 (Disposable Incontinence Liner/Shield) over a three-month period of 12/22/2003 to 03/21/2004.

[5] *See pages 5 and 6 in Appendix A of Ohio Adm.Code 5101:3-10-03 "Medicaid Supply List".*

However, the Provider's shipping documentation showed that all 600 units of A4522 and all 840 units of A4535 were not shipped until 3/11/2004. In this particular example, we took exception with the reimbursement for the first two months but accepted the reimbursement for the last month (the period ending March 21).

In 28 of the 58 services, we also determined that the supplies were dispensed more than 14 days after obtaining the consumer ascertainment of need. In a second example, a physician prescribed 18 diapers per day for a recipient. Because this exceeded the allowed Medicaid maximum of 300 units per month for diapers and liners, the Provider requested and ODJFS approved the shipment of an additional 720 units of T4525 (Adult diapers, small) over a three-month period of 01/01/2005 to 03/31/2005. On 01/01/2005, the Provider contacted the consumer's care giver to ascertain the quantity and type needed by the recipient. However, the Provider's shipping documentation showed that all 720 units of T4525 were not shipped until 3/10/2005. In this particular example, we took exception with the entire reimbursement for this service because more than 14 days passed since the Provider contacted the consumer or care giver, and more than two months of the consumer's need had passed.

Therefore, because the Provider dispensed supplies after the need had passed and/or more than 14 days after obtaining the consumer's ascertainment of need, we disallowed payment in part or in full for all 58 services, which resulted in a finding totaling $9,770.11.

Billing for Rent to Purchase Items without Reporting the Discount

Ohio Adm. Code 5101:3-10-05 states in pertinent part:

> ***
>
> (C) Unless prior authorization has been obtained for used equipment, all equipment that is purchased must be new at the time of purchase or have been new at the time of rental for the same recipient…
>
> ***
>
> (I) Purchased or rental of durable medical equipment…
>
> ***
>
> (4) Short term rental and rent to purchase
> (b)…When a decision is made to purchase the equipment, all prior rental payments will apply toward the purchase price. After ten monthly payments the equipment will be considered purchased and becomes the property of the recipient.
>
> ***

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

> Providers must fully and accurately report any discount received (including a rebate check) on a good or service when submitting a claim for reimbursement. A "discount" means a reduction in the amount a seller charges a provider who buys either directly or through a wholesaler or a group purchasing organization. "Fully and accurately reporting a "discount" means deducting the amount of the discount from billed charges when submitting a claim for payment and if prior authorization is required, indicating on the "Prior Authorization" request form (JFS 03142), or attached documentation, the amount of the discount. This policy is implemented in accordance with federal law 42 CFR, section 1001.952(h).
>
> ***

The owner of Lorraine Surgical Supply told us that his supplier of enteral feeding pumps (the manufacturer) supplied pumps at no charge to Lorraine as long as accompanying enteral feeding "sets" were also purchased. Section 1 of the Provider's contractual agreement with the manufacturer of enteral feeding pumps confirms this arrangement:

> Always Lease. Lorraine shall lease the Pump(s) from manufacturer. As consideration for use of the leased Pump(s), Lorraine shall purchase from manufacturer its requirements of disposable pump sets and containers ("Sets") to be used with the Pump(s)…Title of the Pump(s) shall remain with manufacturer. Lorraine may purchase a leased Pump at a purchase price to be determined by manufacturer.

Section 8 of the agreement further states:

> Discounts. Any discount or other form of price reduction received by Lorraine under this agreement is a discount or price reduction within the meaning of 42 U.S.C. Section 1320a-7b(b)(3)(A) of the Social Security Act. Lorraine may have an obligation to report or pass on such discount or price reduction to any state or federal program which provides cost- or charge-based reimbursement to Lorraine for the items to which the discount or price reduction applies.

We identified 125 services for B9002 (Enteral Nutrition Infusion Pump with/Alarm) that the Provider obtained at no charge and subsequently supplied to Medicaid recipients. We have two reasons for taking exception with the 125 services. First, the Provider did not disclose or pass on the no-charge arrangement to the Medicaid program as required by Ohio Adm.Code 5101:3-10-03(I). The Provider billed and was reimbursed the Medicaid maximum allowed amount for each enteral pump. And secondly, although the pumps were billed to Medicaid on a rent to purchase basis, equipment ownership did not pass to the recipient as required by Ohio Adm.Code 5101:3-10-05(I)(4)(b). The Provider's contractual agreement with the manufacturer states the pumps were leased to Lorraine unless purchased. Lacking evidence that the Provider purchased the pumps, the Provider could not and did not pass ownership of the pumps to the Medicaid recipients once the rental maximum was reached. For both reasons, we took exception with the reimbursements for the 125 pumps billed as B9002, which resulted in findings totaling $8,750.00.

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 supplies, 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 dollars amounts and/or quantities that Medicaid will cover for specific items. Our computer analysis identified 197 services, involving 27 different HCPCS service codes, where the Provider billed and was reimbursed for supplies that exceeded the allowed maximum. After subtracting the allowed maximum from the amount paid to the Provider, we identified $6,000.84 in findings 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 Service Exceptions
A4351	Intermittent Urinary Catheter, Straight	200 per month	$15.80	1
A4367	Ostomy Belt	2 per 6 months	$111.09	16
A4450	Tape, Non-Waterproof, Per 18 Sq In	60 per month	$385.92	33
A4452	Tape, Waterproof, Per 18 Square Inches	60 per month	$195.17	10
A5063	Pouch Drainable; Use On Barr. w/Flnge(2 Pc)	10 per month	$42.60	2
B4035	Enteral Feeding Supp Kit, Per Day	1/Day	$210.00	1
B4086	Gastrostomy/Jejunostomy Tube; Any Mat/Type	2 per month	$31.90	1
A4521, A4522, A4523, A4525, A4526, A4527, A4528, A4532, A4533, A4534, A4535, T4521, T4525, T4532, T4534, and T4535	Incontinence Garments	300 per month	$3,044.21	82
A6402	Non-Impregnated Gauze	$50 per month	$593.91	41
A4554 and T4541	Underpads	300 per 2 months	$170.24	6
Y2040	Gastrostomy Button	3 per year	$1,200.00	4
		Totals	***$6,000.84***	***197***

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, 2003 through March 31, 2005.

Supplies Billed Before Being Provided to the Recipient

Ohio Adm.Code 5101:3-10-05(E) states in pertinent part:

> …No supplies shall be billed before they have been provided to the recipient.

We identified 12 services where the Provider billed and was reimbursed for supplies before they had been shipped to the recipient. For example, the Provider billed and was later reimbursed for 23 boxes of A4927 ~ Surgical Gloves, Non-Sterile, per 100 on February 24, 2005. However, the Provider did not ship the 23 boxes of gloves until March 7, 2005. Because the Provider is not allowed to bill for supplies before they have been provided, we disallowed all 12 services, which resulted in findings totaling $3,304.33.

Missing Consumer Request for Incontinence Supplies

Ohio Adm.Code 5101:3-10-21(D) states:

> Providers must ascertain from the consumer or the consumer's caregiver on a monthly basis the required type and number of incontinence garments and/or related supplies.
>
> (1) The providers must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider ascertained the required type and amount from the consumer or consumer's care giver. The date the provider ascertained the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
>
> (2) The type and amount required may be ascertained verbally or in writing. For each month's worth of incontinence garments and supplies, the date of service entered on the Medicaid claim (dispensing date) should not be prior to the date that the provider ascertained the type and amount of incontinence supplies required for the month.
>
> (3) Documentation of the type and amount of incontinence garments and/or related supplies requested must include the first and last name of the provider's employee that took the request and the first and last name of the consumer, or consumer's care giver, making the request.
>
> ***

We identified two services where the Provider's documentation of the consumer's request was missing. Because the Provider lacked documentation of the supplies ordered and who ordered them, we could not verify that the items were needed. We therefore disallowed the payment for these two services resulting in findings of $619.20.

Duplicate Billings

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 agree:
>
> (A) To…submit claims only for service actually performed…
>
> ***

We identified six duplicate billings involving the same patient, the same procedure code, and the same date of service. Our review of patient medical records only supported that one service was rendered. Therefore, we disallowed the six duplicate billings resulting in findings totaling $772.20.

Billing for Services to Deceased Recipients

Ohio Adm.Code 5101:3-1-02(B)(1) states that a service must be medically necessary to be eligible for Medicaid reimbursement.

During our review of the Provider's paid claims for the audit period, we determined that the Provider billed Medicaid for 13 services performed subsequent to the recipients' date of death. Therefore, we identified findings of $834.89 for the amount reimbursed to the Provider for services billed as being performed subsequent to the recipients' dates of death.

Billing Over the Provider's Usual and Customary Charge to Medicaid

Ohio Adm.Code 5101:3-10-05(F) states in pertinent part:

> Payment for durable medical equipment, medical supplies (including enteral nutrition products), orthoses, and prostheses is limited to the lower of the usual and customary charge of the supplier…

During our review of the Provider's paid claims and claims pricing for the audit period, we determined that the Provider billed and was reimbursed more than their usual and customary charge for seven Medicaid services (procedure codes A6216, A6263, and E0168). We identified the overpayments by comparing the Medicaid billings and reimbursements for these seven services with the Provider's price list for other customers. After adjusting the billings for these seven services to the Provider's usual and customary pricing, we identified a $269.18 finding that is repayable to ODJFS.

Summary of Exception Tests

After reviewing the Provider's supporting documentation for 12,389 services identified by our computer exception testing, we took exception with the reimbursement for 12,244 services. Table 2 summarizes the exceptions found by reason and overpayment amount.

Table 2: Summary of Billing Exceptions
For the Period of April 1, 2003 – March 31, 2005

Basis for Exceptions	Number of Services with Exceptions	Repayable Findings ($)
Surgical Gloves Billed with Erroneous Units of Service	11,824	$27,633.44
Dispensing Supplies After the Need Passed and/or More Than 14 Days After Obtaining the Consumer Ascertainment of Need	58	$9,770.11
Billing for Rent to Purchase Items without Reporting the Discount	125	$8,750.00
Medical supplies billed in excess of price or quantity limits set by ODJFS	197	$6,000.84
Supplies Billed Before Being Provided to the Recipient	12	$3,304.33
Missing Consumer Request for Incontinence Supplies	2	$619.20
Duplicate Billings	6	$772.20
Billing for Services to Deceased Recipients	13	$834.89
Billing Over the Provider's Usual and Customary Charge to Medicaid	7	$269.18
Total Services with Exceptions	**12,244**	**$57,954.19**

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

Results of Enteral Services Sample

Our sample of enteral services not included in our exception analysis consisted of 166 recipient dates of service (RDOS) and equated to 207 services. Our analysis of the supporting documentation for these services identified overpayments for 10 of the 166 RDOS (10 of 207 services). The issues causing these overpayments are discussed below.

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 seven services where the Provider did not file a claim for a third-party covered service for a dual eligible recipient, although the Provider's patient records clearly indicated that the patient had third-party insurance. In each instance, we contacted the third-party insurer and verified that the insurer would have covered the service billed to Medicaid. Because the Provider did not take reasonable measures to ascertain available third-party resources and file a reimbursement claim before billing Medicaid, we took exception with all seven services.

Billing for Conflicting Services

Ohio Adm.Code 5101:3-10-05(G) states in pertinent part:

> Duplicate equipment, supplies, or services, or conflicting equipment prescribed for a recipient, are not reimbursable.

We identified one service where the Provider was reimbursed for enteral feeding bags shipped to a patient whose record stated that he received enteral nutrition orally. Because enteral feeding bags are not needed for orally fed patients, we took exception with this one service.

Supplies Billed Before Being Provided to the Recipient

Ohio Adm.Code 5101:3-10-05(E) states in pertinent part:

> …No supplies shall be billed before they have been provided to the recipient.

We identified one service where the Provider billed and was reimbursed for supplies before they had been shipped to the recipient. In this instance, the Provider billed and was later reimbursed for 30 units of B4035 ~ Enteral Feeding Supplies Kit, Per day on July 15, 2003. However, the Provider did not ship 5 of the 30 units until July 25, 2003. Because the Provider is not allowed to bill for supplies before they have been provided, we disallowed 5 of the 30 units billed on July15, 2003.

Billing for Items After the Spenddown Period

Ohio Adm.Code 5101:1-39-10(C) states in pertinent part:

> Definition of terms used in the spenddown process
>
> ***

> (21) "Spenddown amount" or "monthly spenddown amount" means the dollar amount, if any, a SAG must satisfy in order to become eligible for medicaid for all or part of the month as provided in paragraphs (D)(4)(b), (G), and (H) of this rule.
>
> (22) "Spenddown assistance group (SAG)"…
>
> ***

We identified one service where the Provider billed and was reimbursed by Medicaid for supplies during a month when the recipient had not met their spenddown requirement. In this instance, the Provider billed for 90 units of B4152 ~ Enteral Formula, Category II Intact Prot/Prot Isolates with a service date of February 29, 2004. Based on the February service date, the recipient was Medicaid eligible because the February spenddown requirement had been met. However, a review of the Provider's shipping documentation revealed that the item was not shipped to the recipient until March 18, 2004 – a month when the recipient had not met their spenddown requirement. (Typically, the shipment date is the service date.) Because the spenddown requirement was not met in March 2004, the recipient was not Medicaid eligible. Thus, we took exception with the reimbursement for this service because it occurred in a month when the recipient was not eligible for Medicaid benefits.

Projected Findings from the Sample

Overall, we identified 10 exceptions in our random sample of 166 RDOS (10 of the 207 services). Table 3 summarizes the bases for our exceptions.

Table 3: Summary of Exceptions from the Enteral Services Sampled For the Period of April 1, 2003 – March 31, 2005

Exception Category	Number of Services with Exceptions
Improper Billing for Third-Party Payer Covered Services	**7**
Billing for Conflicting Services	**1**
Supplies Billed Before Being Provided to the Recipient	**1**
Billing for Items After the Spenddown Period	**1**
Total Exceptions	**10**

Source: AOS analysis of enteral services sample of 207 services.

We took exception with 10 of 166 statistically sampled recipient dates of service (10 of 207 sampled services) from a stratified random sample of the Provider enteral feeding 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 $1,800,013.00 with a 95 percent certainty that the actual correct payment amount fell with the range of $1,696,731.00 to $1,818,227.21 (+/- 5.74 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct

population amount ($1,800,013.00) from the amount paid to the Provider for this population ($1,818,227.21), which resulted in a finding of $22,648.05. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of Incontinence Services Sample

Our sample of incontinence services not included in our exception analysis consisted of 100 RDOS, which equated to 183 services. Our analysis of the supporting documentation for these services identified overpayments for 4 of the 100 RDOS (4 of 183 services). The issues causing these overpayments are discussed below.

Billing for Supplies Not Provided to the Recipient

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 183 services in our sample, we identified one service where the Provider erroneously billed for incontinence supplies that were not shipped to the recipient. Because the Provider billed and was reimbursed for supplies that were not shipped, we took exception with the payments for this one service, resulting in an overpayment of $126.72.

Dispensing Supplies More than 14 days After Obtaining the Consumer Ascertainment of Need

Ohio Adm.Code 5101:3-10-21(D)(1) that states in pertinent part:

> …The date that the provider ascertained the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
>
> ***

Of the 183 services in our sample, we identified two services where the Provider dispensed incontinence supplies more than 14 days after obtaining the consumer ascertainment of need. For example, in one instance, the Provider contacted the consumer on May 27, 2003 to ascertain the required type and amount of incontinence supplies. The Provider dispensed the incontinence

supplies on June 23, 2003, more than 28 days after obtaining the required type and amount of incontinence supplies. Because the Provider dispensed the incontinence supplies outside the required period of time, we took exception with the payments for these two services, resulting in an overpayment of $132.00.

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. Payments 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 file a claim for a third-party covered service for a dual eligible recipient, although the Provider's patient records clearly indicated that the patient had third-party insurance. In each instance, we contacted the third-party insurer and verified that the insurer would have covered the service billed to Medicaid. Because the Provider did not take reasonable measures to ascertain available third-party resources and file a reimbursement claim before billing Medicaid, we took exception with this one service, resulting in an overpayment of $84.00.

Actual Findings from the Sample

Overall, we identified 4 exceptions in our random sample of 100 RDOS (4 of 183 services). Since both the error rate of services tested and the overpayment amount were below our criteria for materiality, we did not project the incontinence sample results to the Provider's payment subpopulation. Thus, the finding repayable to ODJFS is the actual amount of $342.72 overpayment found in the sample. Table 4 summarizes the bases for our exceptions and the overpayment amounts.

Table 4: Summary of Exceptions from the Incontinence Services Sampled For the Period of April 1, 2003 – March 31, 2005

Exception Category	Number of Services with Exceptions	Overpayment Amount
Billing for Supplies Not Provided to the Recipient	**1**	**$126.72**
Dispensing Supplies More than 14 days after Obtaining the Consumer Ascertainment of Need	**2**	**$132.00**
Improper Billing for Third-Party Payer Covered Services	**1**	**$84.00**
Total Exceptions	**4**	**$342.72**

Source: AOS analysis of incontinence supplies sample of 183 services.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on June 14, 2006 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation that was used to adjust our findings. At the Provider's request, an exit conference was also held with the Provider on June 29, 2006, at which time the Provider indicated that they were submitting additional documentation. A final determination of findings was made after receipt and review of the additional documentation.

This Page Intentionally Left Blank

Lorraine Surgical Supply
2080 West 65th Street
Cleveland, OH 44102
216-281-4777 or 800-541-1416
Medicaid Provider Number: 0276786

July 7, 2006

Robert I. Lidman, CFE, CGFM
Chief Auditor
35 North Fourth Street, First Floor
Columbus, OH 43215

Dear Mr. Lidman:

In response to the State's audit items, we adjusted some of our business practices. These changes will align our business with State requirements, and/or efficiencies suggested for file maintenance. Below is an explanation of our changes.

Medical Necessities:

When we supply our customers with products for which a doctor writes a medical necessesity letter for "above the Medicaid allowable," we now send the request to the prior authorizations department, asking for an approval period of one year, as opposed to our previous requests for three months. In the case of an ongoing need for "above the allowable supplies," we will send prior authorizations in advance of their expiration dates in order to avoid a lapse in services.

Leased Pumps vs. Purchased Pumps:

We will revisit our contract with Ross regarding leased pumps, and turn it into a purchase only contract. Currently, the lease contract requires that the lease payments for the pumps be incorporated into the charges for pump sets. With the change in our contract, all pumps will be purchased through a rent-purchase program. We are also willing to change the leased pumps noted in the audit into purchased pumps.

Billing Errors:

During HIPPA implementation, we billed some products before dispensing them because of the HIPPA problems that ODJFS was having with overrides on their prior authorizations. Some items were billed two or three times before we would be paid. We did not know if we were going to be paid. We now know that this was not the correct procedure, so we no longer follow it.

File Maintenance:

We have always maintained individual, alphabetical files for our customers' CMNs, and will continue to do so. Our filing procedure regarding order and tracking sheets was to place all of a month's orders into the same box(es). We'd write the month/year on the outside of the box, and move that box into storage. We have modified this practice. Beginning with the July, 2006 billing, we will file an order with attached tracking sheets, within individual customer folders. The folders will be alphabetized and maintained in a file cabinet for a period of one year. At the end of the year, they will be placed in storage boxes, labeled with the year and appropriate alphabetical notations, and moved into storage.

Billing Past the 14 Daly Limit:

In the event of a "backorder", we will call the customer when the product arrives, to determine whether the product is still needed. If the need is still there, we will update the billing date to coincide with the shipping date.

General Office Procedures:

We recently instituted an internal tracking procedure which requires that all staff who handle, ship, and bill an order will initial that order sheet. This procedure is in addition to the customer service rep's signature at time of order, and the CSR's initials for IVR verification. We also have staff double-checking customer billing to ensure its accuracy. We believe that these additional procedures provide us with a chain of responsibility, which should ensure more careful order-taking and billing.

Sincerely,

David R. Zake
President

APPENDIX I

Summary of Statistical Sample Analysis of Lorraine Surgical Supply Company
Population: Enteral Feeding Supplies
Audit Period: April 1, 2003 – March 31, 2005

Description	Audit Period April 1, 2003 – March 31, 2005
Type of Examination	**Stratified Random Sample of RDOS**
Number of Population Recipient Dates of Service (RDOS)	**9,921**
Number of Population RDOS Sampled	**166**
Number of Population Services Provided	**10,541**
Number of Population Services Sampled	**207**
Total Medicaid Amount Paid for Population	**$1,822,661.05**
Actual Amount Paid for Population Services Sampled	**$71,731.57**
Projected Correct Population Payment Amount	**$1,800,013.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$1,818,227.21**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$1,696,731.00**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$22,648.05**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$103,282 (+/- 5.74%)**

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

APPENDIX II

Summary of Audit Findings for Lorraine Surgical Supply Company
Audit Period: April 1, 2003 to March 31, 2005

Basis for Exception	Amount of Overpayment
Surgical Gloves Billed with Erroneous Units of Service	**$27,633.44**
Dispensing Supplies After the Need Passed and/or More than 14 Days After Obtaining the Consumer Ascertainment of Need	**$9,770.11**
Billing for Rent to Purchase Items without Reporting the Discount	**$8,750.00**
Medical Supplies Billed in Excess of Price or Quantity Limits Set by ODJFS	**$6,000.84**
Supplies Billed Before Being Provided to the Recipient	**$3,304.33**
Missing Consumer Request for Incontinence Supplies	**$619.20**
Duplicate Billings	**$772.20**
Billing for Services to Deceased Recipients	**$834.89**
Billing Over the Provider's Usual and Customary Charge to Medicaid	**$269.18**
Projected Findings for the Enteral Feeding Sample	**22,648.05**
Actual Findings for Statistical Sample of Incontinence Supplies	**342.72**
Total Amount of Overpayment	**$80,944.96**

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

Auditor of State
Betty Montgomery

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140
Telephone 614-466-4514
800-282-0370
Facsimile 614-466-4490

LORRAINE SURGICAL SUPPLY, COMPANY

CUYAHOGA 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
AUGUST 22, 2006