Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Queen City Med Mart, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 28, 2004

Barbara Riley, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Queen City Med Mart, Inc.
(Provider # 0125877)

Dear Director Riley:

Attached is our report on Medicaid reimbursement made to Queen City Med Mart, Inc. for January 1, 2001through December 31, 2003. We identified $8,594.61 in findings that are repayable to the State of Ohio. Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers, and Section 117.10 of the Ohio Revised Code. The specific procedures employed during this audit are described in the scope and methodology section of this report.

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make any final determinations regarding recovery of the findings identified herein. We have advised Queen City Med Mart, Inc. that if our findings are not repaid to ODJFS within 45 day of the date of this report, this matter can be referred to the Ohio Attorney General's office for collection in accordance with Section 131.02 of the Ohio Revised Code.

As a matter of courtesy, a copy of this report is being sent to Queen City Med Mart, Inc., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also available on the Auditor's web site (www.auditor.state.oh.us). If you have any questions regarding our results, or if we can provider 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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TABLE OF CONTENTS

ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
HCPCS	Healthcare Common Procedural Coding System
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Queen City Med Mart, Inc. (hereafter called the Provider), Provider # 0125877, doing business at 10780 Reading Road, Cincinnati, OH 45241-9542. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement to audit Medicaid providers. As a result of this audit, we identified findings amounting to $8,594.61, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH), the Ohio Administrative Code, and the Ohio Revised Code.

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 general principles regarding reimbursement for Medicaid covered services.[1] 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 date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in pertinent part: "…In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

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

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 constitutes an over utilization of Medicaid covered services and results in an unnecessary cost to the medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and, if warranted, calculate the amount of any recoverable overpayments. Within the Medicaid program, the Provider is listed as a medical equipment supplier.

Following a letter of notification, we held an entrance conference at the Provider's place of business on June 16, 2004 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of January 1, 2001 through December 31, 2003. The Provider was reimbursed $331,501.19 for 2,378 services, not involving Medicare co-payments, rendered on 1,742 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 claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2]

Prior to beginning our field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. Potentially inappropriate service code combinations identified by our computer analysis were selected for 100 percent review. These tests included:

- Checking for paid services to deceased recipients for dates of service after their date of death.

[2] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

- Checking for 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).
- Determining if the Provider had billed for services not covered for recipients residing in a nursing home.
- Determining whether the provider had billed for incontinence garment services to recipients less than 36 months of age.
- Verifying whether supplies were potentially dispensed, billed, and paid in amounts greater than the Medicaid allowed maximum.

All of our computer tests were negative except for our test for supplies dispensed, billed, and paid in excess of the Medicaid Maximum allowed. When performing our audit field work, we reviewed the Provider's supporting documentation for all supplies potentially dispensed, billed and paid in excess of the Medicaid maximum.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed two statistically random samples from the subpopulation of claims not identified for 100 percent review. Our primary sample was a stratified random sample of 156 recipient dates of service (representing 250 services)[3] drawn to test if all remaining non preauthorized HCPCS codes were appropriately billed based on the supporting documentation in the patient charts. A second simple random sample of 30 preauthorized services (occurring on 26 recipient dates of service) was taken to verify that preauthorized services were delivered.

Our work was performed between April 2004 and September 2004.

FINDINGS

Our 100 percent review of supplies potentially dispensed in excess of the Medicaid maximum resulted in findings of $3,547.49. The findings were based on (1) items dispensed and billed in excess of the Medicaid maximum, (2) rental items billed in excess of the items' "rent to purchase" price, and (3) rental items billed in excess of the "capped rental" price.

Additionally, we identified and projected findings of $5,047.12 for errors identified in our review of sampled, non preauthorized recipient dates of service. No findings were identified in our sample of preauthorized services.

The total findings of $8,594.61 are repayable to ODJFS and discussed in more detail below.

Supplies Exceeding Medicaid Maximums

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

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

[3] *A recipient date of service represents all services provided for a unique patient on a specific date.*

***

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

Our computer analysis identified 56 services, involving 13 different HCPCS service codes, where the Provider appeared to have billed and was reimbursed for supplies over the maximum allowed. We subtracted the maximum allowed Medicaid reimbursement from the amount billed by and paid to the Provider. The difference resulted in findings totaling $3,547.49. The bases for these findings are detailed below.

Items Dispensed in Excess of the Medicaid Maximum

Appendix A of Ohio Adm.Code 5101:3-10-03 establishes maximum dollar amounts and/or quantities that Medicaid will cover for specific items. Our computer analysis identified 36 services, 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 findings totaling $2,747.90 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 *	Estimated Overpayment	Number of Exceptions
A4351	(Intermittent Urinary Catheter, Straight)	200 per month	$2,607.00	31
A4253	(Blood Glucose Test Strips, Glucometer, 50)	4 boxes of 50 per month	$ 70.00	1
A6224	(Gauze Impreg. More Than 48 sq. in. No Bond)	30 per month	$ 52.00	1
A6257	(Transparent Film 16 sq. in. or less)	12 per month	$ 11.00	1
A4535 & A4525	(incontinence items)	Combination of 300 incontinence garments per month	$ 7.90	2
Total			**$ 2,747.90**	***36***

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 January 1, 2001 through December 31, 2003.

Items Exceeding "Rent to Purchase" Price

Appendix A 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." We identified several items billed by the Provider where the cumulative rental billings exceeded the purchase price. 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 ($)
E0570	(Nebulizer, w/compressor, e.g. devib pulmo)	$133.00	5	$211.00
E0180	(Pressure Pad, Alternating, w/ Pump, Complete)	$138.00	3	$161.75
E0114	(Crutches, Underarm, Alum. w/ Pads, Tip, & Grips)	$23.85	7	$95.75
E0163	(Commode Char, Stationary w/ Fixed Arms)	$52.80	2	$47.20
E0105	(Canes, Quad or Tri Pronged, All, w/ Tips)	$27.50	1	$27.50
E0112	(Crutch, Underarm, Wood, All, w/ Pads, Tips, & Grip)	$19.25	2	$25.60
Total			**20**	***$568.80***

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 January 1, 2001 through December 31, 2003.

Items Designated "Capped Rental"

Appendix A defines some items supplied by Medicaid as "capped rental" items. Ohio Adm.Code 5101:3-10-03 (G) states in pertinent part: "… 'CR' means item is subject to capped rental as described in rule 5101:3-10-05 of the Administrative Code." Ohio Adm.Code 5101:3-10-05(I)(2) further defines capped rentals:

> (a) For those items of equipment designated "capped rental", rental payments will be made at ten per cent per month of the maximum amount allowable for a maximum of twelve months…
>
> ***

We identified thirteen items billed by the Provider where the cumulative rental billings exceeded the capped rental price for HCPCS code E0604 (Breast Pump, Heavy Duty Electric). We calculated these items to be overpaid by $230.79.

Results of Statistical Sample

We identified a total of 30 exceptions in our sample with 28 deficiencies stemming from the lack of qualifying diagnoses on physician orders (prescriptions) for incontinence supplies and two deficiencies for missing prescriptions.

In general, Ohio Medicaid only pays for incontinence supplies when incontinence is secondary to a disease, injury or developmental disability. [See Ohio Adm.Code 5101:3-10-21(A)(3)]. In addition, Ohio Adm.Code 5101:3-10-21(B) states:

> A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months. The prescription must be obtained by the provider prior to the first date of service in the applicable twelve-month period and must specify:
>
> (1) The applicable diagnosis of the specific disease or injury causing the incontinence; or
>
> (2) Developmental delay or disability, including applicable diagnoses; and,
>
> (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.
>
> ***

Twenty-eight (28) of the physicians' orders maintained by the Provider did not include a diagnosis that qualified applicants for incontinence supplies. Given the opportunity, the Provider was unable to supply supplemental information to support that the patient had a qualifying diagnosis for incontinence supplies. Additionally, we identified 2 exceptions where a valid prescription was not contained in the patient record. Thus, we were unable to verify that these services were requested by a physician. Therefore, we disallowed the 30 services.

Projected Sample Findings

We took exception with 30 of 250 statistically sampled recipient services (24 of 156 recipient dates of service) from a stratified sample of the Provider's population of paid services. Based on the overpayments associated with these exceptions, we calculated the correct amount that each sampled service should have been paid and then projected the result to the Provider's sub-population of other paid services not identified for 100 percent review and not involving

preauthorized services. The projected correct population payment amount was $95,939.28, with a 95 percent certainty that the actual correct payment amount fell within the range of $90,151.44 to $96,856.78, a precision of plus or minus $5,787.84 (6.03 percent). Our audit finding of $5,047.12 repayable to ODJFS was determined by subtracting the projected correct sub-population payment amount ($95,939.28) from the amount actually paid to the Provider for the sub-population ($100,986.40) sampled.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on November 10, 2004. In a November 23, 2004 written response and a December 6, 2004 exit conference, the Provider did not disagree with the basis for our findings but asked that we reconsider some of them.

In one instance, the Provider stated they received verbal permission to supply an item in excess of the Medicaid maximum. Medicaid rules allow supplies in excess of the Medicaid maximum when medical necessity is involved, but only when providers meet certain conditions. Ohio Adm.Code 5101: 3-1-31(F) states: "In situations where the provider considers delay in providing items and/or services requiring prior authorization to be detrimental to the health of the consumer, the services may be rendered or item delivered and approval for reimbursement sought after the fact." However, we believe that such approval should be obtained in writing. Therefore, we did not modify our findings.

In another instance in which required diagnostic information was missing from the Provider's files, we allowed the Provider to seek the information from the prescribing physicians. The Provider stated that miscommunication with audit staff caused them to ask physicians twice for the information, thus hampering the success of that effort. While we regret any miscommunication that might have occurred, we did not modify our finding because it is the Provider's responsibility to maintain this type of information. Unsuccessful efforts to obtain the information after the fact are not a basis for reconsidering our findings.

We also asked the Provider to prepare a corrective action plan addressing how the deficiencies identified in our report would be avoided in the future. The Provider's November 23, 2004 response includes a corrective action plan, which we are attaching for review and consideration by ODJFS' Surveillance and Utilization Review Section.

APPENDIX I

Summary of Overpayment Results for: Queen City Med Mart, Inc
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 to December 31, 2003
Items Dispensed in Excess of the Medicaid Maximum Items	$2,747.90
Exceeding "Rent to Purchase" Price	$568.80
Items Designated "Capped Rental" Price	$230.79
Actual Projection from Statistical Sample of non Exception and non Preauthorized Services	$ 5,047.12
TOTAL	**$ 8,594.61**

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

APPENDIX II

Summary of Sample Record Analysis for: Queen City Med Mart, Inc
RDOS Sample for all Non -Sampled Services
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 – December 31, 2003
Type of Examination	**Stratified Random Sample**
Description of Sub-Population	Sub-population of all other services excluding exceptions and prior authorized services.
Number of Recipient Dates of Service in Sub-Population	1,140
Number of Services in Sub-Population	1,598
Total Medicaid Amount Paid for Sub-Population	$100,986.40
Number of Recipient Dates of Service Sampled	156
Number of Services Sampled	250
Amount Paid for Services Sampled	$20,753.90
Projected Correct Sub-Population Payment	$95,939.28
Upper Limit Correct Sub-Population Payment at 95% Confidence Level[4]	$96,856.78
Lower Limit Correct Sup-Population Payment at 95% Confidence Level	$90,151.44
Estimated Overpayment (Actual Sub-Population Payment – Projected Correct Payment)	$ 5,047.12
Upper Limit Overpayment Estimate at 95% Confidence Level (Actual Sub-Population Payment – Lower Limit Projected Correct Payment)	$10,834.96
Lower Limit Overpayment Estimate at 95% Confidence Level (Actual Sub-Population Payment – Upper Limit Projected Correct Payment)	$4,129.62
Precision of Correct Population Payment Estimate at 95 % Confidence Level	$5,787.84 (6.03 percent)

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

4 Upper Limit set to actual Sub-Population amount paid less actual errors found in sample.

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QUEEN CITY MED MART®

November 18, 2004

Auditor of State
Betty Montgomery
Attn: Tracie Thompson, Program Manager
Health Care and Contract Audit Section
35 N. Fourth St., First Floor
Columbus, OH 43215

Re: Medicaid Provider #0125877 Audit

Dear Ms. Thompson:

We have reviewed your audit identifying findings in the amount of $8,594.61. We would like you to reconsider your findings on HCPCS code A4351 (Table 1) for $2607.00 and Actual Projection from Statistical Sample for $5047.12 (Appendix 1).

HCPCS code A4351- Intermittent Urinary Catheter, Straight
We concur with the overpayment of $237.00 on [redacted] and the duplicate payment of $237.00 on [redacted]. We request reconsideration on the remaining $2133.00 on [redacted]. We had been providing [redacted] 300 catheters since 1998. When Medicaid reduced the allowable from 300 to 200, we called Medicaid customer service to see how we should bill the additional 100 since you require us to submit the total provided. We were told that [redacted] was 'grandfathered in' and Medicaid would continue to pay for 300. Your audit representative, Mr. Bizzarri, said that they shouldn't have said that and furthermore your system wasn't changed to catch the error. I request we split the $2,133.00 ($1,066.50) to allow us to recover our cost on the product since we in good faith relied on your staff's guidance.

Actual Projection from Statistical Sample
Mr. Bizzarri originally asked for a diagnosis on incontinence on forty physician orders involving thirteen patients. One patient and order was dropped because he didn't originally read the order correctly.
The twenty eight physicians orders you state we did not have a diagnosis for involved nine patients. We did supply the primary diagnosis information requested and approved by your representative, Mr. Bizzarri, on ten of the twelve remaining from the thirteen. Several days later, he called back and said there had been a change from prior audits he was unaware of and we also needed additional chart and progress information. We went back to the physicians, apologizing for not asking for the information originally, without much success. Only three responded the second time. If Mr. Bizzarri would have requested everything you wanted the first time, we

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would have probably been able to get it. The information we got the first time did prove we are filing legitimate claims. Since this was a statistical sample our charges are significantly affected by your acceptance of the data we submitted. I request that consideration be given to splitting the $5047.12 ($2523.56) charge.

Corrective action
We will insure physicians include the specific disease or injury causing incontinence and type of incontinence on all orders. On verbal orders, we will send a confirmation of the order with diagnosis for the doctor to sign.

We request a clarification on how we should bill incontinence items when the quantity shipped exceeds the allowable. This can happen when the physician requests more than the allowable or when packaging causes the quantity to run slightly over the allowable. Medicaid guidelines say we are to show the actual quantity issued on our claim. Can we bill Medicaid for the extra units on a separate line and await a duplicate denial? Please provide us some guidance.

Rental equipment is rented by the month no matter how many days are in the month. It is not cost effective or practical to change our system to daily rental. We are looking into ways to catch these in the future. It would seem you would want to modify your system to stop payment at the maximum allowable as you do other items.

Summary
The results of your audit did show us that we are doing a good job at filing good claims within the guidelines. We would ask for your guidance in the issues we've brought up and respectfully request your consideration in reducing the two portions of your audit mentioned above, resulting in an amount of $5004.55 ($8594.61-$1066.50-$2523.56) due ODJFS.

Thank you for your consideration in this matter.

Sincerely,

Paul E. Smith
Vice President
Chief Financial Officer

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QUEEN CITY MED MART, INC.

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
DECEMBER 28, 2004