**Auditor of State**
**Betty Montgomery**

# Ohio Medicaid Program

***Audit of Medicaid Reimbursements Made to Cardiopulmonary Care, Inc. – DBA Goodcare by CPCI***

*A Compliance Audit by the:*

**Fraud and Investigative Audit Group**
**Health Care and Contract Audit Section**

***December 2004*** ***AOS/HCCA-05-011C***

**Auditor of State**
**Betty Montgomery**

December 16, 2004

Tom Hayes, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Cardiopulmonary Care, Inc.
Provider Number: 0333740

Dear Director Hayes:

Attached is our report on Medicaid reimbursement made to Cardiopulmonary Care, Inc. – doing business as (DBA) Goodcare by CPCI, for April 1, 2001 through March 31, 2004. We identified $12,821.07 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 Cardiopulmonary Care, Inc. – DBA Goodcare by CPCI that if our findings are not repaid to ODJFS within 45 days 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 Cardiopulmonary Care, Inc. - DBA Goodcare by CPCI, 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

SUMMARY OF RESULTS ..... 1

BACKGROUND ..... 1

PURPOSE, SCOPE, AND METHODOLOGY ..... 2

FINDINGS ..... 3
- Supplies Exceeding the Medicaid Maximum ..... 3
  - Items Exceeding "Rent to Purchase" Price ..... 4
    - Table 1: Listing of Supplies that Exceeded the "Rent to Purchase" Price ..... 4
  - Items Dispensed in Excess of the Medicaid Maximum ..... 4
    - Table 2: Listing of Supplies Dispensed in Excess of the Medicaid Maximum ..... 5
- Surgical Gloves Billed with Erroneous Units of Service ..... 6
- Results of Statistical Sample ..... 6

PROVIDER'S RESPONSE ..... 6

APPENDIX I ..... 7

PROVIDER'S CORRECTIVE ACTION PLAN ..... 9

## ACRONYMS

| | |
|---|---|
| AMA | American Medical Association |
| CMS | Centers for Medicare & Medicaid Services |
| CPT | Current Procedural Terminology |
| DBA | Doing Business As |
| 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 |

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## *SUMMARY OF RESULTS*

The Auditor of State performed an audit of Cardiopulmonary Care, Inc – DBA Goodcare by CPCI (hereafter called the Provider), Provider # 0333740, doing business at 450 State Route 664 North; Logan, OH 43138. 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 perform audits of Medicaid providers. As a result of this audit, we identified $12,821.07 in repayable findings based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative 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 August 18, 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 April 1, 2001 through March 31, 2004. The Provider was reimbursed $435,244.08 for 6,472 services, not involving Medicare co-payments, rendered on 4,303 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 services identified by our computer analysis were selected for 100 percent review. These computerized tests included:

- Checking for services to deceased recipients 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 and durable medical equipment were potentially dispensed, billed, and paid at prices or in quantities greater than the Medicaid allowed maximum.

All of our computerized tests were negative except our test for supplies dispensed, billed and paid in excess of the Medicaid allowed maximum price or quantity. 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 allowed maximum price or quantity.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed a stratified statistically random sample from the subpopulation of claims not identified for 100 percent review. Our sample of 152 recipient dates of service (comprised of 237 services) was drawn to test if all remaining HCPCS codes were appropriately billed based on the supporting documentation in the patient charts

Our work was performed between May 2004 and September 2004.

## *FINDINGS*

We identified $12,821.07 in findings as a result of (1) rental items billed in excess of an item's "rent to purchase" price, (2) items billed in quantities greater than the Medicaid maximum, (3) surgical gloves billed with erroneous "units of service", and (4) one service that lacked supporting documentation. The bases for our results are discussed below.

## Supplies Exceeding the Medicaid Maximum

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

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

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

## 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 1 lists these items and the corresponding overpayment.

**Table 1: 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 | 209 | $6,776.80 |
| E0600 | Suction pump home mode; ports/state; cmplt | $217.00 | 16 | $932.78 |
| E0910 | Trapeze bar, bed mounted, w/grab bar | $101.00 | 16 | $398.00 |
| E0940 | Trapeze bar, freestanding, complt w/grab bar | $130.00 | 9 | $350.00 |
| E0180 | Pressure pad alternating w/pump, complete | $138.00 | 6 | $264.00 |
| | | ***Total*** | ***256*** | ***$8,721.58*** |

Source of Medicaid Maximum Allowed: Ohio Adm.Code 5101: 3-10-03, Appendix A – Medicaid Supply List.

Source of Estimated overpayments and Exceptions: AOS analysis of the Provider's paid claims in MMIS and provider patient records for April 1, 2001 through March 31, 2004.

## 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 70 services, where the Provider billed and was reimbursed for supplies that exceeded the maximum allowed. After subtracting the maximum allowed from the amount paid to the Provider, we identified findings totaling $3,559.14 for the items shown in Table 2.

**Table 2: Listing of Supplies Dispensed in Excess of the Medicaid Maximum**

| HCPCS Code | HCPCS Name | Maximum Allowed Amount * | Number of Exceptions | Estimated Overpayment($) |
|---|---|---|---|---|
| A6402 | Gauze, non-impregnated sterile pad w/o adhesive border | $50.00 per month not to exceed manufacturer's price | 22 | $ 1,614.00 |
| A4554 | Disposable underpads, all sizes | 300 per 2 months | 21 | $ 847.90 |
| A6216 | Gauze, non-impreg. 16 sq. in. or less w/o border | $50.00 per month not to exceed manufacturer's price | 4 | $ 302.58 |
| K0183 | Nasal application device used with CPAP | 1 per year | 4 | $ 266.84 |
| A6251 | Specialty absorp. 16 sq. in. or less no bo | 30 per month | 6 | $ 162.00 |
| A6253 | Specialty absrp. 48 sq. in. plus no border | 30 per month | 1 | $ 138.00 |
| K0188 | Filter. Dispos. For use with CPAP dev | 6 every 6 months | 4 | $ 53.94 |
| A4622 | Tracheostomy Tube | 2 per month | 1 | $ 49.73 |
| K0185 | Headgear used with CPAP device | 1 per year | 1 | $ 34.95 |
| K0187 | Tubing used with CPAP, replacement only | 1 per year | 1 | $ 28.75 |
| A7037 | Tubing used w/pos airway pres device | 1 per year | 1 | $ 24.75 |
| A7003 | Admin. set sm. Vol. nonfiltrd pneum. Neb. dis | 4 per month | 2 | $ 17.20 |
| A4616 | Tubing; Aerosol – per foot | 50 feet per 3 months | 1 | $ 12.50 |
| A4245 | Alcohol Wipes, per wipe | 200 per month | 1 | $ 6.00 |
| | | ***Total*** | ***70*** | ***$3,559.14*** |

Source of Medicaid Maximum Allowed: Ohio Adm.Code 5101: 3-10-03, Appendix A – Medicaid Supply List.

Source of Estimated overpayments and Exceptions: AOS analysis of the Provider's paid claims in MMIS and provider patient records for April 1, 2001 through March 31, 2004.

The Provider explained that supplies in excess of the Medicaid maximum sometimes need to be dispensed out of medical necessity. Medicaid rules cover the conditions of reimbursement in these situations. 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." Therefore, in the future when medical necessity requires

dispensing supplies in excess of the Medicaid maximum, we recommend that the Provider seek approval from Medicaid prior to filing claims for reimbursement.

## Surgical Gloves Billed with Erroneous Units of Service

Ohio Adm.Code 5101:3-10-03(F) defines the "Max Units" indicator:

> A maximum allowable (MAX) indicator means the maximum quantity of the item which may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.
>
> ***

On April 1, 2003, the reimbursement rate for non-sterile surgical gloves 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", which resulted in overpayments. In particular, we identified 62 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 $432.35.

## Results of Statistical Sample

We took exception with one of 152 statistically sampled recipient dates of service (or 1 of 237 services) from a stratified random sample of the Provider's population of paid services, excluding claims not identified for 100 percent review. The exception amounted to a $108 overpayment and occurred because documentation in the patient chart did not support the service billed. Since the error rate of services tested and the dollar amount of the overpayment were both below our criteria for materiality, we did not project the sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the $108 overpayment found in the sample.

## *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 30, 2004 response, the President of GoodCare (the Provider) stated that he did not dispute the audit findings. He also included a corrective action plan to address the exceptions identified in our report. In addition, he expressed the opinion that the Medicaid program should have software edits to monitor rental payments made to suppliers. We are attaching the Provider's response for the review and consideration of ODJFS' Surveillance and Utilization Review Section.

## APPENDIX I

### Summary of Overpayment Results for:
### Cardiopulmonary Care, Inc – DBA Goodcare by CPCI
### For the period April 1, 2001 to March 31, 2004

| Description | Audit Period April 1, 2001 to March 31, 2004 |
|---|---|
| Items Exceeding "Rent to Purchase" Price | $8,721.58 |
| Items Dispensed in Excess of the Medicaid Maximum | $3,559.14 |
| Surgical Gloves Billed with Erroneous Units of Service | $432.35 |
| Actual Finding for Statistical Sample | $ 108.00 |
| **TOTAL** | **$12,821.07** |

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

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November 30, 2004

Ms. Tracie Thompson
Program Manager
Health Care and Contract Audit Section
Office of Auditor of State
35 N. Fourth Street
First Floor
Columbus, Ohio 43215

Re: Medicaid Provider Audit
Provider # 0333740

Dear Ms. Thompson,

This is our response to the report of the findings by your office of a Medicaid compliance audit performed at our office in Logan, Ohio on August 18, 2004. We received a written audit report from you dated November 10, 2004. The findings were as follows:

1. A total audit finding of $12,821.07, which is deemed repayable by GOODCARE to the Ohio Department of Job and Family Services. These findings include:

| | | |
|---|---|---|
| a. | Items exceeding the "Rent to Purchase Price - | $8721.58 |
| b. | Items dispensed in Excess of the Medicaid Maximum | $3559.14 |
| c. | Surgical Gloves Billed with Erroneous Units of Service | $ 432.35 |
| d. | Actual Finding of Statistical Sample | $ 108.00 |

We do not dispute the findings of this audit. We do feel that, particularly in the case of billing for items in excess of the Rent to Purchase Price, that there is an obligation for the Medicaid program to also have edits on their software so that they can monitor rental payments made to suppliers. It would more appropriate for Medicaid to monitor payments made than to rely solely on the providers to monitor payments received.

GOODCARE by CPCI has implemented policies and procedures to eliminate, or at least to drastically reduce, the possibility of the errors noted in this audit from occurring again. These procedures are as follows:

1. Re: "Rent to Purchase Issues"; we have implemented a monthly work sheet for all rent to purchase equipment to monitor billings and receipts on account. See attached copy of policy and worksheet.
2. Re: "Supplies Dispensed in Excess of Medicaid Maximum"; Billing department has implemented an audit procedure to monitor all billings for supplies billed to third party payors. If a client requests additional supplies, or supplies prior to the next month's covered quantity, the client is informed that they must either pay privately for these supplies, request prior authorization approval from Medicaid if this seems to be a persistent problem or need, or wait until the next month. See copy of memo attached.

   We also implemented a process of documenting patient requests for supplies by noting the request on a written Transaction Form, documenting the date, time, who called, items requested, and initials of our staff member who took the call/request. See memo and sample transaction form.

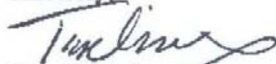
3. Re: "Surgical Gloves Billed with Erroneous Units of Service; We note the change in coverage of quantity for non-sterile gloves, and have in-serviced our intake and billing staff and documented these changes with the memo attached.

4. Re; Results of Statistical Sample; this reflects the very minimal possibility that GOODCARE would not have adequate documentation of equipment or supplies dispensed to a client for which a third party payor is ultimately billed. This was a discontinued client.

We will make arrangements to repay the requested overpayments as documented in the audit report.

I, and our management team, wish to note the courtesies and professionalism exhibited by both Mr Bizzarri and Ms Thompson during their work in our office.

Sincerely,



Tim J. Good, RCP.
President

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**CARDIOPULMONARY CARE, INC., - DBA GOODCARE BY CPCI**

**HOCKING 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 16, 2004**