Auditor of State
Betty Montgomery

Ohio Medicaid Program

Independent Auditor's Report on Medicaid Reimbursements Made to Crosby Drugs, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

October 12, 2004

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

Re: Audit of Crosby Drugs Inc.
Provider Number: 1884420

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Crosby Drugs, Inc. for the period October 1, 2000 through June 30, 2003. We identified $19,501.66 in findings that are repayable to the State of Ohio. We are also recommending that Crosby Drugs, Inc. improve its record keeping in certain areas to reduce the risk of future audit findings. 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 Crosby Drugs, Inc. 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.

Copies of this report are being sent to Crosby Drugs, 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 questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Crosby Drugs Inc. (hereafter called the Provider), Provider #1884420, doing business at 2609 N. High St., Columbus, Oh 43202. 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 $19,501.66 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code. We are also recommending that Crosby Drugs, Inc. improve its record keeping in certain areas to reduce the risk of future audit findings.

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" [See Ohio Adm.Code 5101:3-10-02(A)(2)]. Requirements for providers of durable medical equipment services are covered in ODJFS' Durable Medical Equipment Manual, which is a part of the Ohio Medicaid Provider Handbook.

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

In addition, Ohio Adm.Code 5101:3-1-29(A) states in part: "…In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the 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 constitute an overutilization 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 pharmacy. The Provider also supplies durable medical equipment to Medicaid recipients.

Following a letter of notification, we held an entrance conference at the Provider's place of business on March 4, 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 durable medical equipment and supply services to Medicaid patients and received payment during the period of October 1, 2000 through June 30, 2003. The Provider was reimbursed $676,968.43 for 18,271 services rendered on 9,783 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. The tests that identified potential problems included:

- Billing services for recipients who died prior to the date of service.
- Billing medical supplies over the limits set by ODJFS.
- 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.

[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.*

When performing our audit field work, we requested the Provider's supporting documentation for all potentially inappropriate service code combinations identified by our analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we analyzed a stratified statistically random sample of 190 recipient dates of services, containing a total of 460 services, after removal of those services with identified potential exceptions. Our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between December 2003 and March 2004.

RESULTS

We identified findings of $7,130.66 from our 100 percent audit exception tests and $12,371.00 from the projected results of our statistical sample. The circumstances leading to the findings are discussed below:

Results of Exception Tests

The following presents the results of our exception tests.

Billing Medical Supplies Over the Maximum Allowable

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…
>
> ***
>
> (F) "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.
>
> ***
> Note for foam dressing codes A6209, A6210, A6211, A6212, and A6214, the combined maximum allowable units is 12 per month.
>
> ***
> Note for non-impregnated gauze codes A6216 – A6221 and A6402 – A6404, the combined allowable payment is $50 per month and charges are not to exceed manufacturer's suggested list price.
>
> ***
> Note for impregnated gauze codes A6222 – A6224, the combined maximum allowable units is 30 per month.
>
> ***
> Note for hydrocolloid codes A6231 – A6238, the combined maximum allowable units is 12 per month.

> ***
> Note for hydrogel codes A6242, A6243, and A6244 the combined maximum allowable unit is 30 per month. For hydrogel codes A6245, A6246, and A6247 the combined maximum allowable units is 12 per month.
>
> ***
> Note for transparent film codes A6257 – A6259, the combined maximum allowable units is 12 per month.
>
> ***
> A4660 ~ Sphygmomanometer/blood pressure apparatus w/cuff & stethoscope, one unit every eight years.
>
> A4927 ~ Surgical gloves, non-sterile per 100, one box per month.
>
> ***
> A4670 ~ Automatic blood pressure monitor, one unit every eight years.
>
> Note: coverage is limited to either code A4660 or A4670. Both codes are not reimbursable.
>
> ***
> A4627 Spacer (e.g. aerochamber) w/o mask, bag or reservoir (e.g. inspireez) w/ or w/o mask, for use with metered dose, one per year.

We identified 167 services where the Provider billed for medical/surgical supplies over the maximum allowable charge/units resulting in findings amounting of $6,606.46 that are repayable to ODJFS. The following is a breakdown of the exceptions noted:

- We identified three recipients with eight services for procedure codes A6209 ~ foam dressing; where the combined number of units within a given month exceeds the maximum allowable 12 units per month. We took exception with five services resulting in findings of $213.75.

- We identified 45 recipients with 232 services for non-impregnated gauze procedure codes A6216 – A6221 and A6402 – A6404; where the combined allowable charge within a given month exceeds the maximum allowable $50.00 per month. We took exception with 108 services resulting in findings of $1,954.79.

- We identified four recipients with 18 services for impregnated gauze procedure codes A6222 – A6224, where the combined number of units within a given month exceeds the maximum allowable 30 units per month. We took exception with nine services resulting in findings of $278.90.

- We identified eight recipients with 16 services for hydrocolloid procedure codes A6231 – A6238, where the combined number of units within a given month exceeded the maximum allowable 12 units per month. We took exception with nine services resulting in findings of $378.85.

- We identified one recipient with three services for hydrogel procedure codes A6242, where the combined number of units within a given month exceeds the maximum allowable 30 units per month. We took exception with two services resulting in findings of $113.80.

- We identified five recipients with 19 services for transparent film codes A6257 – A6259, where the combined number of units within a given month exceeds the maximum allowable 12 units per month. We took exception with 10 services resulting in findings of $212.00.

- We identified six recipients with 13 services for procedure codes A4660 ~ sphygmomanometer blood pressure set; and 4670 ~ automatic blood pressure monitor; where the Provider billed both A4660 and A4670 within an eight year period. We took exception with seven services resulting in findings of $287.95.

- We identified eight recipients with 12 services for A4927 ~ Surgical gloves, non-sterile per 100, where the combined number of units within a given month exceeds the maximum allowable one unit (100 gloves) per month. We took exception with these 12 services and reduced the services to the maximum allowed one unit. The reduction of these 12 services resulted in findings of $3,090.72.

- We identified five recipients with 10 services for A4627 Spacer, where the combined number of units within a given year exceeds the maximum allowable one unit. We took exception with five services resulting in findings of $75.70.

Billing for Services to Deceased Recipients

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

During our review of the Provider's paid claims for the audit period, we determined that the Provider billed Medicaid for six services to two recipients subsequent to the recipients' dates of death. Therefore, we identified findings of $452.20 for the amount reimbursed to the Provider for services billed in months subsequent to the recipients' dates of death.

Duplicate Billings

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified four potentially duplicate billings involving the same patient, the same procedure code, and the same date of service. Because the medical records supported that only one service was rendered, we took exception with two duplicative billings, which amounted to $72.00 in findings.

Summary of Exception Tests

Of the 331 services segregated from the sample population for special examination, we took exception with 175 services. Table 1 summarizes the exceptions found by reason and overpayment amount.

Table1: Summary of Service Billing Exceptions Found
For the Period of October 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions	Amount of Findings
Billing Medical Supplies Over the Maximum Allowable	**167**	**$6,606.46**
Billing for Services to Deceased Recipients	**6**	**$452.20**
Duplicate Billings	**2**	**$72.00**
Total Services with Exceptions	**175**	**$7,130.66**

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

Results of Sample Analysis

Missing Prescriptions

Ohio Adm.Code 5101:3-10-05 states:

> (A) For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. For incontinence garments and related supplies, a legible written or typed physician prescription, signed and dated not more than thirty days prior to the first date of service must be maintained on file by the provider; prescriptions for incontinence garments and related supplies must include all information required in accordance with rule 5101:3-10-21 of the Administrative Code. For medical supplies only, other than incontinence garments and related supplies, an oral prescription with all of the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code…
>
> ***

Pharmacies that participate in the Ohio Medicaid program may bill for medical supplies and durable medical equipment. One of the stipulations of participation in the program on the Providers part is that "all products require a prescription written by a practitioner authorized to prescribe which must be obtained and kept on file at the pharmacy."

Of the 460 services in our sample, we identified 19 services where the Provider did not maintain prescriptions for the services billed. Because the Provider did not maintain the required documentation in the recipient's medical records, a determination could not be made if the service rendered was Medicaid eligible. We therefore took exceptions with all 19 services.

Missing Shipping Documentation

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

While this rule does not specifically require that durable medical equipment suppliers maintain shipping documents to verify that supplies were sent, we believe good business practices warrant maintenance of this information. Of the 460 services in our sample, shipping documentation was missing for 79 services. While we did not associate any monetary findings with this matter, we are recommending that the Provider ensure that patient files contain sufficient information to verify that services were provided, such as the inclusion of shipping documents but we

Projected Findings from the Sample

Our projected findings were based exclusively on the services with missing prescriptions. Overall, we took exception with 19 of 460 statistically sampled recipient services (15 of 190 recipient dates of service) from a stratified random sample of the Provider's population of paid services. We calculated the findings by projecting the error rate to the Provider's population of paid services excluding (1) services identified as potential exceptions and (2) Medicare deductible and co-insurance payments. This resulted in projected findings of $34,676 with a 95 percent certainty that the true population amount fell within the range of $12,371 to $56,982, a precision of plus or minus $22,305 (64.32 percent). Since the precision percentage achieved is greater than our procedures require for use of a point estimate, the findings repayable to ODJFS were set at $12,371, the lower limit estimate. This allows us to say with 97.5 percent certainty that the findings for the population are at least $12,371. Appendix I further details the methodology used for our projection.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on July 27, 2004. The Provider sent us a written response on August 9, 2004, along with additional documentation to support many of the claims for services we initially took exception with. As a result of the additional supporting information supplied by the Provider, we reduced our findings to $19,501.66, which are repayable to the Ohio Department of Job and Family Services.

In addition, the Provider committed to correcting the deficiencies identified by our audit, and in the attached letter, the Provider outlines corrective actions taken to prevent recurrences of the exceptions mentioned in the report.

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APPENDIX I

Summary of Sample Analysis for Crosby Drugs Inc.
Audit Period: October 1, 2000 – June 30, 2003

Description	Audit Period October 1, 2000 – June 30, 2003
Type of Examination	**Stratified Random Sample of Sub-population of Non Exception Services**
Number of Sub-Population Recipient Dates of Services	**9,684**
Number of Sub-Population Services Provided	**17,884**
Number of Recipient Dates of Service Sampled	**190**
Number of Services Sampled	**460**
Amount Paid for Services Sampled	**$26,099.95**
Total Medicaid Amount Paid For Sub-Population	**$664,243.57**
Point Estimate of Projected Overpayment at 95% Confidence Level	**$34,676**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$56,982**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$12,371**
Precision of Estimated Correct Population Payment at the 95% Confidence Level	**$ 22,305 (+/- 64.32%)**

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

APPENDIX II

Summary of Findings for Crosby Drugs Inc.
For the Period: October 1, 2000 to June 30, 2003

Description	Amount of Findings
Medicaid Services Sample Excluding Exceptions	**$12,371.00**
Billing Medical Supplies Over the Maximum Allowable	**$6,606.46**
Billing for Services to Deceased Recipients	**$452.20**
Duplicate Billings	**$72.00**
Total Findings	**$19,501.66**

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

August 7, 2004

Crosby's Drugs, Inc.
2609 North High Street
Columbus, Ohio 43202
614-263-9424

Patricia Severs
State of Ohio Office of the Auditor
35 North Fourth Street
First Floor
Columbus, Ohio 43215

Dear Patricia:

The following report is a corrective action plan for Crosby's Drugs, Inc. Thank you to Christina Helm and yourself for the patience and guidance you have given Crosby's Drugs throughout this audit. Your suggestions and conversations have helped our Durable Medical Division better organize our record keeping and billing procedures.

All filing, billing and selling will now be centralized in one physical location. We now have a separate file for every patient receiving any type of Durable Medical Equipment or Supply. We are requiring all physicians who phone in prescriptions for Durable Medical Equipment or Supplies to follow up with a hard copy immediately upon calling. All incontinence or wound care will not be shipped until a signed certificate of medical necessity is in our office.

All of our employees have or are being trained as to allowables for Durable Medical Equipment and Supplies. They have been instructed what action to take if one of our homecare experts are not available. We are working closer with our third party billing company as to making sure the allowables are in tact with state regulations. They have had several problems in the past, but with their new management, we are much more comfortable working with them.

All deliveries must be signed for or will not be left at the patient's residence. We will make two attempts and then the patient will be required to pick up their order.

As you can see, we have learned from this audit and it has helped or company enhance our procedures in our homecare division. Thank you again for your special assistance with the audit for Crosby's Drugs, Inc.

Sincerely,

Sherrie L. Cohen-Merchant

Sherrie L. Cohen-Merchant
President
Crosby's Drugs, Inc.

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CROSBY DRUGS, INC.

FRANKLIN 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
OCTOBER 12, 2004