Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Kaup Pharmacy

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

April 14, 2005

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

Re: Audit of Kaup Pharmacy
Provider Number: 0439243

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Kaup Pharmacy for the period July 1, 2001 through June 30, 2004. We identified $5,137.99 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 Kaup Pharmacy 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 Kaup Pharmacy, 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
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
LTCF	Long Term Care Facility
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook
MMIS	Medicaid Management Information Systems

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Kaup Pharmacy (hereafter called the Provider), Provider # 0439243, doing business at 110 E. Butler St., P.O. Box 605, Fort Recovery, OH 45846. 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 $5,137.99 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook (OMPH).

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services.[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 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

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

medical practices; and that constitute an overutilization 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 claims to Medicaid for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a pharmacy that also furnishes medical equipment supplies.

Following a letter of notification, we held an entrance conference at the Provider's place of business on October 20, 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 July 1, 2001 through June 30, 2004. The Provider was reimbursed a total of $477,808.69 for 8,722 services, not involving Medicare co-payments, during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[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. These included:

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

[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.*

- 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. During our field work, we performed a 100 percent review of these services by reviewing the Provider's supporting documentation for reimbursement claims.

We also reviewed all Y2076 billings for oxygen concentrator services to determine whether these services had been billed and paid correctly.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we analyzed five statistically random samples and one census (100 percent) review from the subpopulation of claims not already identified for 100 percent review. The samples and census review included the following:

- The Group I sample was a simple random sample of service for HCPCS codes A4527 (adult size incontinence product, brief, large), Y9140 (incontinence garment, disposable, medium adult size), and A4523 (adult sized incontinence product, diaper, large size), containing a total of 30 services.
- The Group II sample was a simple random sample of services for HCPCS codes Y9136 (incontinence pads/liners, disposable; for use with reusable pant), A4535 (disposable liner/shield for incontinence), and A4335 (incontinence supplies, miscellaneous), containing a total of 30 services.
- The Group III sample was a simple random sample of recipient dates of service (RDOS) containing all other services not already selected for review. An RDOS was defined as all services received by a specific recipient on a certain date of service. This sample was comprised of 60 RDOS containing a total of 77 services.
- The Y9131 sample was a simple random sample of HCPCS code Y9131 services (incontinence garment, disposable, large adult size) and contained a total of 30 services.
- The A4554 sample was a simple random sample of HCPCS code A4554 services (disposable underpads, all sizes, e.g., chuxs) and contained a total of 30 services.
- The A4528 sample was a census review of all 83 HCPCS A4528 (adult sized incontinence product, brief, extra large size) services.

Our work was performed between August 2004 and February 2005.

FINDINGS

From our exception testing, we identified $4,555.63 in findings for supplies exceeding the Medicaid maximum and $528.96 in findings for overstated levels of service for oxygen supplied to LTCF residents. From three of our statistical samples, we identified $53.40 in findings. No findings were identified in our Group I sample,

A4554 sample, or A4528 census review. The total findings of $5,137.99 are repayable to ODJFS. The circumstances leading to the findings are discussed below:

Exception Test Results

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…
>
> ***

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 151 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 $3,940.57 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	Number of Exceptions	Repayable Finding ($)
A4522, A4523, A4526, A4527, A4528, A4534, and A4535	Incontinence Garments	Combined 300 per month	56	$ 2,199.30
A4554	Chuxs	Combined 300 per 2 months	20	$ 1,022.00
A6253	Specialty absorptive dressing	30 per month	1	$ 9.20
A6402	Gauze, non-impregnated sterile pad w/o adhesive border	$50.00 per month not to exceed manufacturer's price	5	$ 51.15
A7000	Canister	3 per month	8	$ 67.50
K0183	Nasal application device used with CPAP	1 per year	2	$ 133.42
Y9167	Sharps container	1 per 2 months	57	$ 228.00
Y2010	Transfer Bench	1 per 5 years	1	$ 80.00
Y2040	Gastrostomy Button, replacement only	3 per year	1	$ 150.00
Total			**151**	**$ 3,940.57**

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 July 1, 2001 through June 30, 2004.

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 one item, E0600, suction pump, billed by the Provider where the cumulative rental billings exceeded the purchase price of $217.00 for seven months. The findings totaled $178.75.

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 (HCPCS 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 40 HCPCS A4927 billings that had overpayments which appeared to result from the Provider continuing to bill "per glove," instead of "per box." After adjusting the amount paid to the Provider to account for the actual units supplied, we identified findings totaling $436.31.

Level of Oxygen Services Overstated for Long Term Care Facility (LTCF) Recipients

With the following exceptions, Appendix A of Ohio Adm.Code 5101:3-10-03 instructs providers to use HCPCS code Y2076 when billing for oxygen concentrator services provided to LTCF residents.

Ohio Adm.Code 5101:3-10-13 (H)(3) states in pertinent part:

> Regardless of delivery modality…amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose listed in appendix A of rule 5101:3-10-03 of the Administrative Code.
>
> ***

Appendix A shows that the following codes should be billed with the corresponding cubic feet:

- Y2083 for 0 to 250 cubic feet.
- Y2082 for 251 to 500 cubic feet
- Y2081 for 501 to 750 cubic feet

Providers must attach a billing modifier to code Y2076 when patients use less than 1,000 cubic feet of oxygen. Ohio Adm.Code 5101:3-10-13 (C)(1) states in pertinent part:

> Modifier code QE shall be used and the payment amount reduced by fifty percent when:
>
> ***
>
> (b) The patient has used no more than one thousand cubic feet of gaseous oxygen…

Our computer analysis identified 28 services where the Provider billed for oxygen concentrator services provided in a LTCF using HCPCS code Y2076 (oxygen concentrator, not including

supplies). During our review, we identified four Y2076 services that were not supported by the liter flow and meter readings in the patient record. To coincide with the patient record, these services were recoded to Y2076 QE, Y2082, and Y2083 (for two services). Because these three codes are reimbursed at a lesser rate than the unmodified Y2076, we identified findings of $528.96.

Sample Results

Missing Prescriptions or Other Required Documentation

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

> A prescription that is written, signed, and dated by the treating physician must be obtained at least every twelve months…
>
> ***

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

> 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…

Ohio Adm.Code 5101:3-1-17.2(D) requires a provider, in pertinent part:

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…

In Group II, we took exception with one of 30 statistically sampled services from a stratified random sample of the Provider's population of paid services. This exception was for $6.40 and was made because no prescription was found supporting the service.

In Group III, we took exception with two of 77 statistically sampled services from a stratified random sample of the Provider's population of paid services, excluding claims not identified for 100 percent review and other HCPCS codes selected for separate sampling. These exceptions were made because a prescription was not found in a patient chart to support one service billed and another patient chart lacked documentation to support the service billed. Together, these two findings totaled $14.60.

From our sample of HCPCS code Y9131 (incontinence garment, disposable, large adult size), we took exception with one of 30 statistically sampled services from a stratified random sample of the Provider's population of paid services. The exception amounted to a $32.40 overpayment and occurred because a prescription was not found in the patient chart to support the service billed.

Since the error rate of services tested and the dollar amount of the overpayment were 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 actual $53.40 overpayment found in these three samples.

Need to Have Physicians Specify Incontinence Type

Ohio Adm.Code 5101:3-10-21(B) states in pertinent part, "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
> ***

Types of incontinence, according to diagnoses definitions adopted by CMS, include stress incontinence, urinary incontinence, and bowel incontinence.

Although we are not associating monetary findings with this issue, we identified 131 of 217 incontinence services where the prescription or certificate of medical necessity included an applicable diagnosis but did not specifically identify the type of incontinence. To minimize the risk of future audit findings, we are recommending that, as part of the annual requirement to obtain physician prescriptions, the Provider have physicians specify the type of incontinence.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on February 16, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation, on February 23, 2005, that was used to adjust our findings.

The Provider's response has been forwarded to ODJFS' Surveillance and Utilization Section under separate cover. It included the following corrective action plan to prevent recurrence of the matters discussed in this report which stated:

> To address our procedural/policy changes to avoid future billing errors, we are tracking our Medicaid receivables with multiple staff members. Also, on order intake, we have instituted a procedure to double check the Medicaid quantity limits before dispensing. Lastly, we are having the physicians document the type of incontinence as well as the secondary reason for incontinence on our physician orders.

APPENDIX I

Summary of Overpayment Results for:
Kaup Pharmacy
For the period July 1, 2001 to June 30, 2004

Description	Audit Period April 1, 2001 to March 31, 2004
Items Dispensed in Excess of the Medicaid Maximum	$3,940.57
Items Exceeding "Rent to Purchase" Price	$178.75
Surgical Gloves Billed with Erroneous Units of Service	$436.31
Level of Service Overstated for Oxygen Supplied to LTCF Recipients	$528.96
Missing Prescription/Documentation in Group II and Group III Statistical Sample	$21.00
Missing Prescription in Y9131 Statistical Sample	$32.40
TOTAL	**$5,137.99**

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

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KAUP PHARMACY

MERCER 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
APRIL 14, 2005