STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Fidelity Orthopedic, Incorporated

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

October 2001 ***AOS/FWAP-02-004C***

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Paul Murka, President
Fidelity Orthopedic, Incorporated
1222 South Patterson Boulevard, Suite #370
Dayton, Ohio 45402

Re: Medicaid Review of Provider Number #2728347

Dear Mr. Murka:

We have completed our review of selected medical services rendered to Medicaid recipients by Fidelity Orthopedic for the period January 1, 1997 through December 31, 2000. We identified Medicaid findings in the amount of $7,723.26, which must be repaid to the Ohio Department of Job and Family Services. A "provider remittance form" is located at the back of this report for remitting payment. We also identified $14,697.98 in questioned Medicare payments that would be repaid to Medicare.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment for the Medicaid findings is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, the U.S. Department of Health and Human Services, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

October 16, 2001

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ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of Fidelity Orthopedic Inc., Provider #2728347, doing business at 1222 South Patterson Boulevard, Suite #370, Dayton, Ohio 45402. We identified findings of $7,723.26 in Medicaid funds, which are recoverable because they resulted from Medicaid claims submitted by Fidelity Orthopedic for services that did not meet reimbursement rules under the Ohio Medicaid Durable Medical Equipment Manual and the Ohio Administrative Code (OAC).

In addition, we identified $14,697.98 in Medicare questioned costs, which should be repaid to the Medicare program.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services (ODJFS), performs reviews designed to assess Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. ODJFS administers the Medicaid program. The rules and regulations that providers must follow are issued by ODJFS in the form of an Ohio Medicaid Provider Handbook.

ODJFS' Medicaid Provider Handbook, General Information, Section II, Subsection (B),Chapter 3334, (OAC Section 5101:3-1-01), states in part, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must render or authorize medical services within the scope of their licensure and based on their professional judgement of those services needed by an individual. "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice."

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172, 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 form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud 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.

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with

professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program.."

PURPOSE SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter they had been selected for a compliance review. An Entrance Conference was held on April 25, 2001 with Paul Murka, President, and Linda Debord, Office Manager.

We utilized ODJFS' Ohio Medicaid Provider Handbook and the OAC 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 Medicaid. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],
- Center for Medicare and Medicaid Services [2] (CMS) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

We also referred to Medicare claims payment regulations in analyzing our results. These regulations are determined by the individual Medicare insurance carriers, and in the case of the Provider, is AdminaStar Federal. AdminaStar Federal's regulations for Durable Medical Equipment suppliers, including requirements for reimbursing claims for services, are spelled out in its Region B Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during the period January 1, 1997 though December 31, 2001. The Provider also received reimbursement from Medicare during this time as well, so in conjunction with our review of the Provider's Medicaid claims, we also reviewed Medicare claims that involved Medicaid "crossover" payments. This occurred when a recipient in our review had eligibility in both programs. In these situations, the

[1]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[2]Center for Medicare and Medicaid Services (formally known as HCFA) has federal oversight of the Medicaid program.

Provider submits claims to the primary insurance carrier, which happens to be Medicare. Medicare then determines the amount to pay the Provider for the services rendered, and also the amount that any third-party insurances will pay. When Medicaid is the third-party insurer, it pays the remaining portion of the claim.

We reviewed 100 percent of paid claims during the audit period due to the small amount of claims for which the Provider received payment. For the January 1, 1997 through December 31, 2000 review period, the Provider was reimbursed $457,252.82 for the 2,037 Medicaid services that were billed to Medicaid on 789 claims (called TCN's). The review involved comparing durable medical equipment records with the claims payment history from MMIS. We examined the amounts reimbursed by ODJFS and conducted an on-site review of durable medical equipment records.

Work performed on this audit was done in accordance with government auditing standards. Detailed below are the results of this review.

FINDINGS

We identified findings in four areas: No Documentation, No Prescriptions, No Physician Signature, and Duplicate Payments. The total findings for these categories amounted to $22,421.24, $7,723.26 of which should be repaid to the Medicaid program, and $14,697.98 of which are questioned costs that should be repaid to the Medicare program. A discussion of each deficiency, the number of instances found, the basis for the overpayment, and the amount overpaid follows:

No Documentation

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection B (OAC Section 5101:3-1-172), the provider must maintain records for a period of six years from the date of receipt of payment or until any initiated audit is completed, whichever is longer, to fully describe the extent of services rendered.

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

Furthermore, the Provider's Medicare insurance carrier, AdminaStar Federal, requires the Provider, in its Region B Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual, Chapter 2, Supplier Enrollment, to provide "to CMS [formerly HCFA], upon request, any information required by the Medicare statute and implementing regulations."

Our review identified 71 TCNs, comprising 82 services, where the Provider billed and was reimbursed by ODJFS for durable medical equipment services but was unable to provide documentation to support the service. Therefore, we were unable to verify that services were

performed.

This deficiency amounted to $5,214.75 in recoverable Medicaid funds and $9,814.62 in questioned Medicare costs.

No Prescriptions

According to the Ohio Administrative Code, Section 5101:3-10-05 (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 medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all 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.

As the Provider is an orthotic/prosthetic supplier, the required documentation for Medicare services is located in Chapter 17 of the DMERC manual issued by AdminaStar, the Provider's Medicare insurance carrier. According to that chapter, the Provider must maintain for all orthotic devices "An order for a new or full replacement orthosis which has been signed and dated by the treating physician. . ." The order must contain all the additions to the device, and the medical records must contain information to support that such a device is necessary.

For prosthetic devices, Chapter 17 states, "An order for the prosthesis including all components which is signed and dated by the ordering physician must be kept on file by the prosthetist. Adjustments and repairs of prostheses and prosthetic components are covered under this original order. . . ."

Prescriptions for durable medical equipment services are a physician's tool to verify that a patient truly needs medical goods. By retaining prescriptions, the durable medical equipment supplier verifies the need to provide all necessary medical equipment for a patient. In our review we found that 28 TCNs, comprising 39 services, were not supported by a prescription. Therefore, we were unable to verify that the medical services provided were medically necessary.

This deficiency in the Provider's records led to $2,206.77 in recoverable Medicaid funds and $3,922.57 in questioned Medicare costs.

Missing Physician Signatures

According to the Ohio Administrative Code, Section 5101:3-10-05 (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 medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all 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.

Furthermore, the Medicare regulations listed in the previous section indicate that all prescriptions must be signed and dated by the Provider.

In our review of the Provider's paid claims, we found that 3 TCNs, comprising 6 services, did not have a prescription with a physician's signature. Prescriptions without a physician's signature do not validate that services rendered are medically necessary at the time they were given, and therefore, are not eligible for reimbursement under Medicaid guidelines.

This deficiency in the Provider's records led to $196.85 in recoverable Medicaid funds and $541.22 in questioned cost Medicare funds.

Duplicate Payments

According to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

We reviewed the Provider's data for the period of January 1, 1997 through December 31, 2000, to determine if the Provider received two reimbursements for the same recipient on the same date of service for the same billed procedure. We then gave a list of these payments to the Provider for their review. The Provider agreed that some claims were duplicate payments, totaling $104.89 in Medicaid funds and $419.57 in questioned cost Medicare funds, and had been received in error.

Questioned Medicare Costs

As the Auditor of State's Office only audits Medicaid reimbursements, we will refer this report to the proper Medicare authority for review and recovery of the Medicare funds we determined in our

review to have been received in error. The Medicare funds we determined to have been received in error totaled $14,697.98.

PROVIDER'S RESPONSE

We sent a draft of this report to the Provider on June 19, 2001. The Provider responded in writing on June 28, 2001, and included additional information for us to consider. We made the appropriate changes to the report in light of this new information. The Provider understood the reasons for the findings in this report, except for findings based on the need for prescription for stump socks and stump shrinkers, items used to provide proper fit and comfort of a prosthesis. The Provider disagreed with the need for prescriptions for these items because Medicare allows billing for these items without prescriptions. According to policy staff from Ohio's Office of Health Plans, which oversees the Medicaid program in Ohio, prescriptions for these items are required when reimbursed by Medicaid funds.

The lack of prescriptions for stump stocks and stump shrinkers accounted for $760.37 of the $7,723.26 in Medicaid findings. Our Medicare questioned costs do not include findings on this matter.

APPENDIX I

Table 1: Summary of Record Analysis of Fidelity Orthopedic For the period January 1, 1997 to December 31, 2000

Description	Audit Period January 1, 1997 - December 31, 2000
Total Medicaid DME Services Paid	**$457,252.82**
Number of DME Services	**2,037**
Type of Examination	**Total Review of Provider's 789 TCNs**
Amount Paid for Services Reviewed	**$457,252.82**
Questioned Medicare Payments	**$14,697.98**
Overpayment of Medicaid Funds	**$7,723.26**

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PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Fidelity Orthopedic, Incorporated 1222 South Patterson Boulevard, Suite #370 Dayton, Ohio 45402
Provider Number:	2728347
Review Period:	January 1, 1997 through December 31, 2000
AOS Finding Amount:	$7,723.26
Date Payment Mailed:	
Check Number:	

IMPORTANT: To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Charles T. Carle at (614) 728-7398.

STATE OF OHIO
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FIDELITY ORTHOPEDIC, INC.

MONTGOMERY 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 16, 2001