Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Braden Medical Services

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December XX, 2004

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

Re: Audit of Braden Medical Services
(Provider # 0808960)

Dear Director Hayes:

Attached is our report on Medicaid reimbursement made to Braden Medical Services for the period April 1, 2001 through March 31, 2004. We identified $11,541.11 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 scope and methodology section of this report describes the procedures followed during our audit.

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 Braden Medical Services 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 Braden Medical Services, the Ohio Attorney General, the Ohio State Medical Board, and other interested parties. 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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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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Braden Medical Services (hereafter called the Provider), Provider # 0808960, doing business at 44510 SR 821, Caldwell, OH 43724. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Section 117.10. As a result of this audit, we identified findings amounting to $11,541.11, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code. In situations involving medical necessity, we are also recommending that the Provider seek prior authorization from Medicaid before filing claims for supplies that are shipped in excess of Medicaid maximums.

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 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 due to non-compliance. Within the Medicaid program, the Provider is listed as a supplier of pharmacy services.

Following a letter of notification, we held an entrance conference at the Provider's place of business on August 10, 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 $560,126.52 for 11,773 services rendered during the audit period. A total of 2,083 services, for which the Provider was paid $78,487.50, were excluded from our audit because they involved Medicare co-payments.

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 Providers 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. Inappropriate service code combinations identified by these tests were pulled for separate 100 percent review. These analyses included tests for:

- 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.*

- 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.)
- Bills for Medicaid non-covered services to recipients residing in a nursing home.
- Bills for incontinence garment services to recipients less than 36 months of age.
- Services for supplies potentially dispensed, billed, and paid in amounts greater than the Medicaid maximum allowed.

All exception tests were negative except for two. We found two pairs of duplicate billed services and 18 different HCPCS codes where supplies were dispensed, billed and paid in excess of Medicaid maximum amounts. When performing our audit field work, we reviewed the Provider's supporting documentation for all potential billing exceptions identified by our analyses.

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 recipient dates of service not already identified by our exception analysis for 100 percent review. A recipient date of service was defined as all services that occurred on a specific date for an individual recipient. Our statistical sample consisted of 141 recipient dates of service with a total of 368 services.

Our work was performed between May 2004 and September 2004.

FINDINGS

We identified $11,541.11 in total findings (summarized in Table 1 below) resulting from our 100 percent review of items billed in excess of the Medicaid maximum and duplicate claims. No deficiencies were identified from our review of 141 statistically sampled recipient dates of service. The bases for our findings are discussed below.

Table 1: Summary of Findings
Audit Period: April 1, 2001 through March 31, 2004

Reason for Finding	Findings
Items Exceeding "Rent to Purchase" Price	$ 5,101.00
Items Dispensed in Excess of the Medicaid Maximum	$ 6,316.81
Duplicate Claims	$ 123.30
TOTAL	***$11,541.11***

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

Supplies Exceeding the Medicaid Maximum

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…
>
> ***

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 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 ($)
B9002	Enternal Nutrition Infusion Pump-Without Alarm	$700.00	54	$ 3,780.00
E0570	Nebulizer, W/Compressor, (Pulmo-Aid)	$133.00	11	$ 317.00
E0776	IV Pole (if pump is authorized, payment for pole is included in pump rental)	$75.00	54	$ 405.00
E0910	Trapeze Bar, bed mounted with grab bar	$101.00	30	$ 599.00
		TOTAL	***180***	***$ 5,101.00***

Source of Medicaid maximum: 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 275 exceptions, involving 14 HCPCS codes where the Provider 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. Table 3 summarizes our results.

Table 3: Listing of Supplies Dispensed in Excess of the Medicaid Maximum

HCPCS Code	Item	Medicaid Maximum	Number of Exceptions	Repayable Findings ($)
A4213	Syringe without needle	50 per year	2	$ 15.60
A4221	Supplies for maintenance of a drug infusion catheter	4 per month	1	$ 41.10
A4222	Supplies for external drug infusion pump	60 per month	4	$ 704.00
A4253	Blood Glucose test strips	50 per month	7	$ 910.00
A4374	Ostomy skin barrier with flange, any size	5 per month	29	$ 1,112.15
A4385	Ostomy skin barrier, solid, 4 x 4	5 per month	2	$ 40.00
A4402	Lubricant	8 per month	11	$ 14.30
A4407	Ostomy skin barrier with flange, 4 x 4 or smaller	5 per month	1	$ 76.70
A4616	Tubing, aerosol	50 feet per 3 months	2	$ 25.00
A4927	Surgical gloves, non-sterile	1 box of 100 per month	196	$ 2,946.76
A5063	Pouch, drainable; for use on barrier with flange	10 per month	14	$ 296.20
A5073	Ostomy pouch urinary; for use on barrier with flange	10 per month	3	$ 89.40
A6405	Gauze, sterile	30 per month	1	$ 12.00
XX001	Sterile saline solution	120 per month	2	$ 33.60
		Total	***275***	***$ 6,316.81***

Source of Medicaid maximum: 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.

Duplicate Claims

Ohio Adm.Code 5101:3-1-19.8(F) states:

> Overpayments are recoverable by the department at the time of discovery…

Our computer analysis identified two pairs (4 services) of potential duplicate billings where the Provider billed more than once for the same procedure code for the same patient, on the same day, and for the same amount. Our examination of records determined that only one service was rendered. Therefore, we disallowed the second services billed. This resulted in a finding of $123.30.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent a draft report to the Provider on September 30, 2004. During an October 12, 2004 exit conference, the Provider stated that they agreed with our findings and planned to make restitution to the Ohio Department of Job and Family Services.

We also asked the Provider to prepare a corrective action plan addressing how the deficiencies identified in our report would be corrected. On October 7, 2004, the Provider submitted a corrective action plan to prevent recurrences of the exceptions noted in the report. We are referring the attached corrective action plan to ODJFS' Surveillance and Utilization Review Section for its review and follow up. The attached plan also includes several suggestions from the Provider for ODJFS. We have not assessed the merits of the suggestions, but are including them for ODJFS' consideration.

BRADEN MED SERVICES, INC
44510 SR 821
CALDWELL, OH 43724
740-732-7201

October 7, 2004

Auditor of State
35 N. Fourth St.
First Floor
Columbus, OH 43215

Dear Auditor Betty Montgomery:

After concluding the audit that your staff performed at our facility for the period April 1, 2001 through March 31, 2004, we have implemented a corrective action plan which is attached for you to review. There are several suggestions that I have attached for the Ohio Department of Job and Family Services System to review that will help providers like Braden Med Services better serve our patients and your customers.

I will be contacting Jeffrey Corzine, Chief of ODJFS' Surveillance and Utilization Review Section on October 7, 2004 to arrange repayment. If you need any further information please feel free to contact me.

Sincerely,

Diane Braden

Diane Braden
General Manager

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OCT 12 2004
BETTY MONTGOMERY
AUDITOR OF STATE

BRADEN MED SERVICES, INC.
COMPLIANCE REPORT

Upon completion of our ODJFS Audit, Braden Med Services implemented the following policy changes:

- Health Care Computer Corporation, our software vendor, has been contacted in regards to placing quantity limits on each product. Quantities will only be able to be overridden with a PA#. We have also asked HCC to put limits on the dollar amount that can be billed out on rental items to the ODJFS. Estimated completion date has not been given to us.

- Internal Audits that have been put in place until our software vendor can complete our request.

    1. The billing department is printing a weekly report for all items that are going to bill out to ODJFS and manually checking each product to make sure we are not billing over the max. If over the max quantities are given to a patient a Prior Authorization number must be attached to the claim before it bills.

    2. The billing department is printing a monthly report on all rented items so that we can make sure we are not billing over the maximum dollar amount set forth by the ODJFS.

    3. A copy of all findings on the above issues will be given to the General Manager on a weekly basis for review and action. These findings will also become part of our Performance Improvement Quarterly Meetings.

BRADEN MED SERVICES, INC.
SUGGESTIONS FOR ODJFS

The following are suggestions for the ODJFS:

1. ODJFS computer system should reject anything that is over the maximum quantity or dollar amount for an item if there is not a PA # attached. This would be determined from the maximum allowable quantities or $ amounts that you provide us on the Medicaid Supply List.

2. We take responsibility for making sure we bill correctly, but ODJFS should take some responsibility for making sure you enforce your policies and allowables as well.

3. ODJFS wouldn't need an audit team that our tax dollars pay for if your audits were in place up front, such as the quantity limits and allowable limits.

4. More education needs done to help us understand policy. Most seminars that we have been to, the ODJFS staff can't answer the questions presented to them.

    - I sent two staff members last week to a seminar put on by OAMES. I paid over $300.00 and the ODJFS couldn't explain the policy changes because they "Weren't familiar with what the equipment was used for", therefore they couldn't answer policy questions related to the equipment.

5. We have to produce a note every time a patient gets a product. The delivery ticket signed by the patient and the order signed by the doctor should be enough proof that the patient wants and needs the product. The reimbursement is low, half of the products we have to deliver or mail d/t our patients aren't able to physically walk in and get them. There is not reimbursement for delivery, but on top of everything else we do, you want us to make a note every time the patient's request a product that gets billed to ODJFS.

    - Example: A diabetic patient comes in every month to get their strips and we have to produce a note for the patient's chart stating: who requested the strips (including first and last name), who is taking the request that the patient needs product (including first and last name), the number of times per day the patient is checking their sugar level and how many strips they have left. This is all in addition to the signed delivery ticket and signed order.

6. The manufacturer should be consulted on their package size and reimbursement made accordingly. Some of our ostomy supplies come in sealed packages of 10, but ODJFS only allow 5 per month. There isn't anyway for us to split a package.

7. ODJFS Prior Authorization Department should be able to approve medical necessity for services regardless of a spend down. We are required to resubmit a PA every month then wait 6 weeks to get approval. We cannot bill for the PA unless the patient is eligible, therefore ODJFS is not out any money by giving us the approval. This is costing the state more money by processing the PA every month vs. every 6 months.

8. Don't do an audit over such a long period of time. If you know we're doing something wrong let us know immediately. If your system can't put stoppers in place on quantities and allowables then at least produce reports that could be sent to the providers.

9. Reimbursement on respiratory assist devices such as CPAP and BiPAP supplies need evaluated. Reimbursement on supplies such as masks, tubing and headgear usually don't cover our cost. Allowable on headgear is only 1 per year, which the average patient needs 2 per year. With the cost being so low on masks the patient doesn't always get the best suited mask with the correct fit.

10. Most reimbursement for suction supplies such as canisters, tubing and filters do not cover our cost.

Auditor of State
Betty Montgomery

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BRADEN MEDICAL SERVICES

NOBLE 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