DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

February 23, 2007

TO: James R. Farris, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services

FROM: Regional Inspector General for Audit Services, Region VI

SUBJECT: Office of Inspector General's Partnership Plan--Oklahoma Health Care Authority's Report on Hospice Covered Drugs for Dually Eligible Beneficiaries (06-06-00102)

Attached is a copy of the final report on an audit of Medicaid payments to Reavis Super Drug in Pauls Valley, Oklahoma, during the period January 1 through December 31, 2003. As part of our partnership efforts with State audit organizations, we conducted this review in partnership with the Oklahoma Health Care Authority Management & Audit Services Division, an internal audit organization of the Oklahoma Health Care Authority (OHCA).

The objective of the review was to determine whether OHCA made inappropriate Medicaid payments to Reavis Super Drug for prescription drugs that Valley Hospice identified as prescriptions that it should cover for dually eligible beneficiaries.

As part of the review, the Office of Audit Services assisted in planning the audit and conducting the onsite audit work at Reavis Super Drug. We believe that the attached audit report is reliable and can be used by the Centers for Medicare & Medicaid Services in meeting its program oversight responsibilities.

For four dually eligible beneficiaries, Reavis Super Drug billed Medicaid and received payment for 60 prescription drug claims that Valley Hospice should have paid for because the drugs were related to the beneficiaries' terminal illness.

OHCA recommended that it reimburse the Federal share of the identified overpayments of $3,680 to the Centers for Medicare & Medicaid Services within 60 days of the closure of this review and that Reavis Super Drug (1) reimburse OHCA the $3,680,(2) perform an internal review on amounts billed and Medicaid payments received subsequent to the end of our review period and return any self-identified overpayments to OHCA, and (3) bill the hospice provider for the overpayment amount reimbursed to OHCA.

We would appreciate your views on this report and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or Warren Lundy, Audit Manager, at 405-605-6183. Please refer to report number 06-06-00102 in all correspondence.

Gordon L. Sato

Attachment

cc: John D. Hagg, Director of Medicaid Audits, Office of Audit Services
Craig Briggs, Director of Medicare Part A, Part C, and Part D Audits

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PARTNERSHIP REVIEW – OKLAHOMA HEALTH CARE AUTHORITY'S REPORT ON HOSPICE COVERED DRUGS FOR DUALLY ELIGIBLE BENEFICIARIES

Daniel R. Levinson
Inspector General

February 2007
A-06-06-00102

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

PROGRAM / PAYMENT INTEGRITY REVIEW

Oklahoma Health Care Authority

Review of Medicaid Payments – Valley Hospice/Reavis Super Drug

January 2003 – December 2003

(December 2006)

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

February 2, 2007

Warren Lundy
Audit Manager
Department of Health and Human Services, Office of Inspector General, Office of Audit Services
#5 Corporate Plaza Bldg., Rm 101
3625 N.W. 56th Street
Oklahoma City, OK 73112

Dear Mr. Lundy:

Enclosed are two copies of the Oklahoma Health Care Authority (OHCA) final report entitled "Review of Medicaid Payments – Valley Hospice/Reavis Super Drug for Dates of Service January 2003 to December 2003."

If you have any comments or additional information, please contact the OHCA within 30 days of receipt of this letter.

Sincerely,

Kelly Shropshire

Kelly Shropshire, C.P.A.
Audit Project Manager

Enclosures

Section 1

Background

In 2004 and 2005 Oklahoma Health Care Authority and Office of Inspector General joined in a partnership to review medications provided to dual eligible beneficiaries. These beneficiaries were both in a long term care facility, and qualified for Medicaid and Hospice benefits at the time of service.

A Hospice provider is paid a daily per diem rate; this rate includes coverage of prescription drugs that are related to the beneficiary's terminal illness. Therefore Medicaid is not responsible for covering the drugs that relate to the beneficiary's terminal illness. There is no set list a Hospice follows; it is up to the individual Hospice to decide which drugs they will cover for each beneficiary. Typically the Hospice would notify the nursing home and pharmacy the drugs that they will cover; therefore the pharmacy will know who to bill.

Purpose

In July of 2006, the Program Integrity & Planning Division, Audit Management Unit initiated a review of the Medicaid claims of Reavis Super Drug to see if they were the responsibility of Valley Hospice (Hospice).

The review looked at dual eligible beneficiaries; these beneficiaries were eligible for Medicaid and Hospice and were also in a long term care facility. In the review it was found that Medicaid paid for prescriptions that the Hospice provider should have covered.

Objectives

- To determine whether the OHCA has made inappropriate Medicaid payments to Reavis Super Drug for prescriptions that Valley Hospice identified as prescriptions they will cover for the beneficiaries.

Scope and Methodology

The scope of this review was limited to claims submitted for reimbursement with dates of service between January 1, 2003 and December 31, 2003 on four dual eligible beneficiaries who were beneficiaries of Valley Hospice and Medicaid for the twelve month period. The Medicaid claims looked at were prescription drugs paid to Reavis Super Drug.

The methodology, procedures and activities performed to accomplish our objectives included, but were not necessarily limited to, the following:

- Review of applicable policies, procedures, laws and regulations;
- Interviews with providers to obtain an understanding of hospice prescription benefits and hospice covered drugs; and
- Review of Medicaid paid prescription claims.

This review was performed according to Generally Accepted Governmental Auditing Standards.

Section 2

Executive Summary

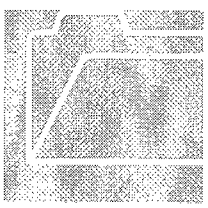
Reavis Super Drug's Medicaid prescription claims were reviewed on four recipients for the period of January 2003 through December 2003. For services rendered during the twelve month period, on the four recipients, the provider was paid $5,812.56.

Summary of Findings

Finding #1: The Provider billed Medicaid for Hospice covered Prescriptions – Overpayment $3,680

Based upon testwork performed, the pharmacy billed Medicaid for sixty prescription drugs that Valley Hospice stated they would cover during the twelve month period.

Effect(s)



- State and Federal dollars inappropriately expended.
- Could be potential audit point for OHCA from Centers for Medicare and Medicaid Service (CMS), Department of Health and Human Services' – Office of Inspector General (DHHS-OIG), and / or the State Auditor and Inspector's Office.

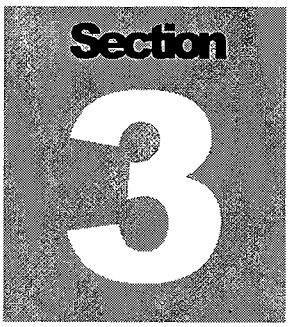
Recommendation(s)

1. The Provider should reimburse OHCA the amounts of the identified overpayments;

2. The Provider should perform internal review on amounts billed and Medicaid payments received subsequent to the end of the review period (December 31, 2003) and return any self-identified overpayments to OHCA;

3. The Provider should bill Valley Hospice for the overpayment amount taken back from them by OHCA;

4. OHCA should reimburse the federal share of the identified overpayments to the Centers for Medicare and Medicaid Services (CMS) within sixty days of closure of this review.



Specific Findings

Finding #1: Reavis Super Drug Medicaid Billed for Hospice Covered Medications – Identified Overpayment $3,680*

*(*Overpayment based on actual claims reviewed; extrapolation was not used.)*

Condition: Based upon testwork performed, the provider billed Medicaid for prescriptions the Hospice provider stated they would cover; resulting in overpayments sixty times during the twelve month review period, for the four recipients.

The identified overpayment has already been recovered by OHCA and federal share reimbursed to CMS.

Criteria:

The Medicare Hospice Manual
Chapter 4, Subsection 401

> ". . . Medicare reimbursement for hospice care is made at one of four predetermined rates for each day in which a Medicare beneficiary is under the care of the hospice."

The Medicare Hospice Manual
Chapter 4, Subsection 411

> " . . . Medicare is the primary payer for all covered benefits and another insurer [e.g. Medicaid] should not be billed for these items or services."

The Medicare Benefit Policy Manual
Chapter 9, Section 40.1.6

> "Only drugs . . . which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered."

Effects:

- Estimated total of $3,680 State and Federal dollars inappropriately expended for services inappropriately billed by the provider.
- Could be potential audit point for OHCA from CMS, DHHS-OIG, and / or the State Auditor and Inspector's Office.