Dave Yost · Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Michael Linville, Sr., LPN

A Compliance Audit by the:

Medicaid/Contract Audit Section

September 2011 ***AOS/MCA-12-005C***

Dave Yost • Auditor of State

September 29, 2011

Michael Linville, LPN
4932 Lebanon Rd.
South Lebanon, OH 45065

Dear Mr. Linville:

We enclose our audit report on Medicaid reimbursements made to Michael Linville, Sr., LPN, Medicaid provider number 2675412, for the period July 1, 2006 to June 30, 2009. Our audit was performed according to our authority in Ohio Rev. Code § 117.10 and our Letter of Arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $86,989.99 in findings for improper charges to Ohio Medicaid plus $15,233.96 in interest totaling $102,223.96 that is due and payable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After September 29, 2011, additional interest will accrue at $19.07 per day until repayment occurs. Interest is calculated pursuant to Ohio Administrative Code § 5101:3-1-25.

We are forwarding this report to ODJFS because it is the state agency charged with administering Ohio's Medicaid program, ODJFS is responsible for making a final determination regarding recovery of our findings and any accrued interest. However, if you agree with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are being sent to the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Board of Nursing. In addition, copies are available on the Auditor of State website at www.auditor.state.oh.us.

Questions regarding this report should be directed to Charles H. Brown, III, Chief Auditor, Medicaid Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Dave Yost
Auditor of State

cc: Ohio Attorney General, Medicaid Fraud Control Unit
Ohio Department of Job and Family Services
U. S. Department of Health and Human Services/Office of Inspector General
Ohio Board of Nursing

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ACRONYMS

AOS	Auditor of State
ASP	All Service Plan
CMN	Certification of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
LPN	Licensed Practical Nurse
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
PDN	Private Duty Nursing
POC	Plan of Care
RN	Registered Nurse

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SUMMARY OF RESULTS

The Auditor of State (AOS) performed an audit of Michael Linville, Sr., LPN, provider number 2675412, doing business at 4932 Lebanon Rd., South Lebanon, OH 45065 (the "Provider"). The Provider furnishes private duty nursing services and waiver nursing services to Ohio Medicaid patients.

We performed our audit of Medicaid reimbursements to the Provider for nursing services between July 1, 2006 and June 30, 2009, according to Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $86,989.99 in findings for improper charges based on reimbursements that did not meet the rules of the Ohio Administrative Code in effect at the time the services were provided. Additionally, we assessed interest of $15,233.97 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $102,223.96, which is due and payable to ODJFS as of the release of this audit report. Additional interest of $19.07 per day will accrue after September 29, 2011, until repayment.

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 Ohio Medicaid Provider Handbook. A fundamental concept underlying 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. *See* Ohio Admin. Code § 5101:3-1-01 (A).

The Auditor of State performs audits to assess providers' compliance with reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, medical necessity, and sound fiscal, business, or medical practices. According to Ohio Admin. Code § 5101:3-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated within the six year period is completed. When the AOS identifies fraud, waste or abuse by a provider in its audits,[1] "any amount in excess of that legitimately due to the provider will be

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "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 result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5101:3-1-29(A)(2)

recouped by ODJFS through its office of fiscal and monitoring services, the state auditor, or the office of the attorney general." Ohio Admin. Code § 5101:3-1-29(B)

Some Ohio Medicaid patients may be eligible to receive home care (HC) nursing services provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Ohio Admin. Code §§ 5101:3-12-02 (A) and 5101:3-46-04 (A)(1). Qualifying HC nursing services must be medically necessary. *Id*. HC nursing services may include private duty nursing (PDN) services, waiver nursing services, or both. *See, e.g.,* Ohio Admin. Code §§ 5101:3-12-02 and 5101:3-46-04. PDN services must be greater than four but no more than twelve hours in length, unless an authorized exception applies. Ohio Admin. Code § 5101:3-12-02 (A). Waiver nursing services are limited to the hours authorized in an all services plan (ASP). Ohio Admin. Code § 5101:3-46-04 (A)(3)(d). Nurses providing both PDN services and waiver nursing services to the same patient must comply with the rules for the waiver program. Ohio Admin. Code § 5101:3-12-03.1 (C). They must also maintain a clinical record for each patient indicating the date, time span, and type of services provided. *See* Ohio Admin. Code §§ 5101:3-12-03.1 (A)(2), 5101:3-12-03 (C)(3), 5101:3-12-03 (B)(2), and 5101:3-45-10 (A)(11).

LPNs providing HC nursing services, such as the Provider here, must be supervised by a RN. For waiver nursing, the supervising RN must hold a supervisory meeting every 60 days with the LPN, and every 120 days with the LPN and the patient. Ohio Admin. Code § 5101:3-46-04 (A)(5). During those visits, the RN must evaluate the LPN's performance and assure that waiver nursing services are provided according to a physician's plan of care (POC). *Id*. The LPN must be identified by name as the provider on the ASP and skilled nursing services must be specified in the POC. Ohio Admin. Code § 5101:3-46-04 (A)(4)(d).

LPNs providing HC nursing services at the direction of an RN must maintain records for each patient containing all of the information listed in Ohio Admin. Code § 5101:3-46-4 (A)(6) including:

- Certification for treatment plans at least every 60 days (§ 5101:3-46-04 (A)(6)(e));
- POCs covering each service and describing the type, frequency, scope and duration of nursing services provided (§ 5101:3-46-04 (A)(6)(e)); and
- Clinical nursing notes documenting the details of each visit (§ 5101:3-46-04 (A)(6)(i)).

Ohio Medicaid does not pay the LPN for services not specified by the POC. Ohio Admin. Code § 5101:3-12-02 (C)(2).

When a patient is on an ODJFS administered Home and Community Based Service waiver, an ASP is required in addition to the POC. *See* Ohio Admin. Code § 5101:3-45-10 (A)(7). The ASP lists all services approved for the patient under the waiver program, including the type, frequency and duration; and it specifies which providers can render services and subsequently bill Ohio Medicaid for them. *See* Ohio Admin Code § 5101:3-45-01(D).

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of nursing services complied with regulations and to identify, if appropriate, any findings resulting from non-compliance.

An entrance conference was held with the Provider on December 14, 2010, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for which the Provider rendered services to Ohio Medicaid patients and received payment during the period of July 1, 2006 to June 30, 2009. The Provider was reimbursed $224,435.04 for 776 services covering both traditional and waiver program PDN services.

We reviewed the Provider's paid claims history from the ODJFS Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. This claims data included: patient name, patient identification number, date of service, service rendered and reimbursement per service billed. Providers bill services to the Medicaid program using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS). We also reviewed the Provider's supporting documentation for the services identified by our exception tests and the sampled PDN services.

Prior to beginning fieldwork, we performed a series of computerized, or exception tests on the Provider's Medicaid claims data to determine if potentially inappropriate reimbursements occurred. Our exception tests analyzed:

- Dates where the Provider billed for 16 or more hours of service for a single patient;
- Dates where the Provider billed for multiple patients on the same date of service without using the 'HQ' group modifier;
- Dates where the Provider billed both personal aide and PDN services for the same patient; and
- Whether there were claims billed for the same patient, for the same procedure, for the same date, without using a modifier to show that a second visit occurred on that date.

Our results did not indicate any potential duplicate services. However, we identified potentially unallowable services in the other categories. In order to avoid duplicate findings, we separated all services identified by our exception tests from the rest of the Provider's claims population. From the remainder of the population, we selected a statistical random sample as permitted by Ohio Admin. Code § 5101:3-1-27 (B)(1). We performed our fieldwork between June, 2010 and April, 2011.

RESULTS

As a result of our audit, we identified findings that projected $81,865 in Medicaid overcharges from our statistical sample. Additionally, we identified findings of $5,124.99 from our exception tests. The bases for our total findings of $86,989.99 are discussed below in more detail.

A. Exception Testing on Private Duty Nursing Services

While reviewing the Provider's documentation for services in our exception tests, we found issues with plans of care and missing reviews by a supervising RN. We also found issues with ASPs that did not list the Provider as an approved practitioner, and/or the ASPs did not cover the dates of service which the Provider billed to Ohio Medicaid.

1. Excessive Hours Billed Per Day

We identified 12 dates of service (a total of 24 services) where it appeared the Provider billed for 16, or more, hours of HC nursing services in a calendar day. We reviewed the patients' records to determine how many hours of service were documented and whether the services were supported by substantive documentation and rendered in accordance the approved ASPs and POCs. *See* Ohio Admin. Code § 5101:3-46-04(A)(6).

Our analysis disallowed the reimbursement for 13 services where the services were not supported by required documentation resulting in a finding of $3,653.99. We identified the following 22 errors:

- 5 services where no POC was found to cover the date of service;
- 4 services where we did not receive a clinical nursing note documenting the visits.
- 4 services where documentation was not found to indicate they were covered under a 120 day supervisory RN review period;
- 3 services whose corresponding POC did not contain the required scope, duration, and frequency elements;
- 3 services where documentation failed to indicate they were covered under a 60 day supervisory RN review period;
- 2 occurrences of two HC nursing visits billed for the same date; however, there was only clinical documentation to support one visit; and
- 1 services beyond the 60 day certification period where the corresponding POCs had certification periods greater than the allowed 60 days.

There were services that had more than one error; however only one finding was made per service. All but one of the services missing documentation of an RN supervisory review also had other errors. The reimbursement for the one service missing only evidence of a supervisory RN review was not disallowed (see Matters for Attention).

2. Billing Multiple Patients On Same Day without HQ Modifier

When providing services in a group setting (*i.e.*, up to three patients at one time), the "HQ" billing modifier must be used so the Medicaid reimbursement is adjusted accordingly. Ohio Admin. Code § 5101:3-12-06 (C) We reviewed the Provider's documentation to determine if the Provider failed to use the HQ modifier when providing group services and further, to determine if the services were authorized and documented as required by Ohio Admin. Code §§ 5101:3-12-06 (C) and 5101:3-46-04 (A)(6). We identified six services where the Provider billed for

multiple patients on the same date of service; however none were for patients in a group setting so a 'HQ' modifier was not required.

Our review of the patients' records identified 10 errors as outlined below. While certain services had more than one error, only one finding was made per service. We found:

- 5 services where the corresponding POCs did not contain the required scope, duration, and frequency elements;
- 3 services where clinical documentation was not found to support the visit;
- 1 service where no POC was found to cover the date of service; and
- 1 service where the corresponding POC was not signed by the treating physician approving the services.

The total reimbursement for these services was denied and a finding was made for $1,150.80.

3. Unauthorized Personal Care Aide Services

We identified one instance where the Provider billed both PDN services (HCPCS T1000) and Personal Care Services (HCPCS T1019) for the same patient on the same date of service. We examined the Provider's documentation to determine if the services were authorized and documented as required by Ohio Admin. Code §§ 5101:3-12-03 (C)(3), 5101:3-12-3.1 (A)(2) and 5101:3-46-04 (B)(2).

Our analysis revealed the Provider was not approved by the ASP to render the personal care aide service to the patient. In addition, our review found the following errors for the PDN service:

- The service was beyond the 60 certification period where the corresponding POC certification period was greater than the allowed 60 days; and
- The POC did not include the required scope, duration, and frequency elements.

The total reimbursement for these two services was denied and a finding was made for **$**320.20.

4. Summary of Exception Tests

Findings from our exception tests totaled $5,124.99. The findings resulted because of POCs with certification periods greater than 60 days and that did not contain the require scope, frequency and duration elements; POCs and ASPs that did not cover the reviewed date of service; and failure to substantiate clinical documentation, including nursing notes and RN supervisory visits.

B. Statistical Sampling of Home Care Nursing Services

After removing the 34 services in our exception tests we selected a statistical random sample of 133 HC nursing services from the remaining population of 742 paid services. We reviewed patient records to determine if the services were supported by substantive documentation and

whether they were rendered in accordance with approved ASPs and POCs. We identified 63 errors and the reimbursement for those services was disallowed. In addition, we used these errors to calculate a projected finding of $81,865 across the entire remaining population. While certain services had more than one error, only one finding was made per service. The bases for these findings are presented below.

1. Incomplete or Missing Plans of Care and All Service Plans

As stated above, Ohio Medicaid rules require that HC nursing services be rendered according to an approved POC and ASP. *See* Ohio Admin. Code §§ 5101:3-12-02 (B)(2) and 5101:3-46-04 (A)(6).

We found 101 errors as follows:

- 38 services where the corresponding POCs which did not contain the required scope, duration, and frequency elements;
- 24 services where the corresponding POC did not list the Provider as authorized to render PDN services or otherwise specify skilled nursing services;
- 22 services where no POC was furnished that covered the date of service;
- 13 services beyond the 60 day certification period where the corresponding POCs certification periods were greater than the allowed 60 days; and
- 4 services where no ASP was furnished which authorized the service.

We disallowed the reimbursements for these services and used them in calculating the projected finding.

2. Lack of Documentation for Supervisory Visits and PDN Services; Overbilled PDN Services

Only HC nursing services provided and properly documented can be billed. As this Provider also renders waiver nursing services he is subject to RN supervisory reviews. *See* Ohio Admin. Code § 5101:3-46-04(A)(5). Our review identified 23 errors as follows:

- 11 services where documentation failed to indicate the Provider was covered under a 60 day supervisory RN review period;
- 6 instances where the units of PDN services billed were greater than the units of PDN services documented as provided;
- 5 instances where we did not receive a clinical nursing note documenting the visit; and
- 1 service where documentation failed to indicate it was covered under a 120 day supervisory RN review period.

We disallowed the reimbursements for these services and used them in calculating the projected findings. The reimbursement for 10 services missing only documentation of an RN supervisory review were not included in calculating the projected findings (see Matters for Attention).

3. Summary of Statistical Sample Results

The overpayments identified for 63 of 133 nursing services from our random sample were projected across the Provider's paid population of nursing services, excluding those already selected for 100 percent exception testing. This resulted in a projected overpayment amount of $95,270 with a precision of plus or minus $16,008 (16.80 percent) at the 95 percent confidence level. However, since the obtained precision range was greater than our procedures require for use of a point estimate, the results were restated as a single tailed lower-limit estimate using the lower limit of a 90 percent confidence interval (equivalent to method used in Medicare audits). This allows us to say we are 95 percent certain the population overpayment amount is at least $81,865. A detailed summary of our statistical sample and projection results is presented in Appendix I.

C. Matters For Attention

1. Supervisory RN Visits

ODJFS advised us that the 60 day and 120 day rule for supervisory RN reviews of an LPN is a quality issue rather than a monetary issue. As a result, the reimbursement for services missing only documentation of an RN supervisory review was not included in calculating our findings. However, we note that Ohio Admin. Code § 5101:3-46-04 (A)(5) does not state that this is merely a check of the quality of care provided. More importantly, we believe the supervisory visits help verify that the nursing services are actually being provided as claimed and thereby serve to verify in part the integrity of Ohio's Medicaid home nursing program. Consequently, we noted in our findings all instances of missed supervisory visits.

2. CareStar Oversight

ODJFS contracts with CareStar to provide case management services for Ohio's Home Health Care waiver program. CareStar is committed to meeting "with providers at least annually to review education requirements, compliance, documentation, and assure that services are being provided as authorized." *Carestar.com/provider-monitoring/ohio-home-care-program.* Web Sept. 19, 2011. According to CareStar's website, "CareStar is proficient in the development and implementation of successful provider management and monitoring systems. [CareStar] has the ability to monitor and manage thousands of providers and assure services are delivered according to a service plan, thus providing HCBS systems confidence in the safety and cost-effectiveness of their programs." *Carestar.com/provider-services/ohio-home-care-provider monitoring* Web Sept. 19, 2011. These case management services help ODJFS ensure the overall quality of services provided to consumers in Ohio's Home Care Program, and the integrity of program.

Through the course of our audit and during our exit conference with the Provider, we found two significant deficiencies outlined in this report which we believe are easy for the Provider to remedy going forward. More importantly, we believe these problems could be reduced and/or prevented for home care nurses through more comprehensive provider training and case

management oversight. Specifically, we believe the following would be valuable for all nursing providers:

- Additional training for RNs and LPNs regarding supervisory reviews of LPNs under direction of an RN, and the consequence of incomplete or missing Plans of Care and All Service Plans.
- Monitoring individual compliance of supervising RNs and LPNs at least annually to ensure that they are meeting these requirements.

We believe that ODJFS and CareStar are well positioned to educate providers concerning this issue and monitor compliance.

CONCLUSION

We found the Provider was overpaid by Ohio Medicaid for private duty nursing services between July 1, 2006 and June 30, 2009 in the amount of $86,989.99. This finding is the sum of $5,124.99 from exception testing and $81,865.00 from statistical sampling of the Provider's records. This finding plus interest in the amount of $15,233.97 through September 29, 2011 totaling $102,223.26, is immediately due and payable to ODJFS as of the date of release of this audit report. After September 29, 2011, additional interest will accrue at the rate of $19.07 per day until the finding and interest is paid in full.

PROVIDER'S RESPONSE

A draft report along with a detailed list of services which resulted in findings was mailed to the Provider on July 25, 2011. The Provider was afforded ten business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. We discussed the report with the Provider and his legal counsel during an exit conference on August 31, 2011. Although the Provider requested and received an extension to submit a written response and supply additional documentation, no response or additional documents were supplied to us. Consequently, a final determination of findings was made after consideration of the Provider's comments at the exit conference.

APPENDIX I

Summary of Sample Record Analysis for Michael Linville, Sr., LPN
For the period July 1, 2006 through June 30, 2009
Nursing Sample Population – Provider Number 2675412

Description	**Audit Period [July 1, 2006 – June 30, 2009]**
Type of Examination	Simple Random Sample of Services
Description of Population Sampled	All paid nursing services excluding services selected for exception tests
Total Medicaid Amount Paid For Population Sampled	**$**217,069.52
Number of Population Services Provided	742
Amount Paid for Services Sampled	$38,884.47
Number of Services Sampled	*133*
Estimated Overpayment using Point Estimate	$95,270
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	*$16,008 (+/- 16.80%)*
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	*$13,405 (+/- 14.07%)*
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	**$81,865**

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

Dave Yost • Auditor of State

MICHAEL LINVILLE, SR., LPN

WARREN 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
SEPTEMBER 29, 2011

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