MISTY ANN NEWMAN, LPN
BUTLER COUNTY

MEDICAID PROVIDER AUDIT

FOR THE PERIOD JULY 1, 2006 TO JUNE 30, 2009

Dave Yost · Auditor of State

MISTY ANN NEWMAN, LPN
BUTLER COUNTY

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ACRONYMS

AOS	Auditor of State
ASP	All Services Plan
HC	Home Care
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
RDOS	Recipient Date of Service
RN	Registered Nurse

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Independent Accountant's Report on Medicaid Provider Reimbursements

Misty Ann Newman, LPN
6383 Redmont Court
Liberty Township, Ohio 45044

RE: *Medicaid Provider Number 2763764*

Dear Ms. Newman:

The Auditor of State performed an audit of Medicaid reimbursements made to Misty Ann Newman, LPN, Ohio Medicaid Provider No. 2763764 (the "Provider"), during the period of July 1, 2006 to June 30, 2009. The Provider furnishes private duty nursing services and waiver nursing services to Ohio Medicaid patients. The audit was performed according to our authority in Section 117.10 of the Ohio Revised Code and our Letter of Arrangement with the Ohio Department of Job and Family Services (ODJFS).

We identified $5,564.87 in findings for improper charges to Ohio Medicaid based on reimbursements that did not meet the Medicaid rules in effect at the time the services were provided. We also assessed interest in the amount of $1,185.55 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $6,750.42. The total amount of the findings and interest is repayable to ODJFS as of the release of this audit report. Additional interest of $1.22 per day will accrue after March 13, 2012, until repaid.

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 (collectively referred to as "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 (AOS) audits Medicaid providers to assess compliance with the Medicaid 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 an audit,[1] "any amount in excess of that legitimately due to the provider will be recouped by ODJFS

[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

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 an 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 §§ 5101:3-45-10(A)(11) and 5101:3-46-04(A)(6).

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 supervised visits, the RN must evaluate the LPN's performance and assure that waiver nursing services are being 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 nursing services at the direction of an RN must maintain records for each patient containing all of the information listed in Ohio Admin. Code § 5101:3-12-03 (B) and (C)(4)[2] including:

- Signed and dated certification by the treating physician of the treatment plans at least every 60 days (§ 5101:3-12-03(B)(3)(b));
- Contents of plans of care (POC) specifying the services to be performed, the identity of the professionals performing them, and the nature, frequency, scope, and duration of each service to be provided (§ 5101:3-12-03(B)(3)(b)); and
- Clinical records (including all signed orders) and time keeping records documenting the details of each visit including the date, type and time span of services provided (§ 5101:3-12-03(C)(4)(a) and (b)[2]).

Ohio Medicaid will only pay the LPN for services provided to the patient as specified by the POC, and which services are properly documented. Ohio Admin. Code § 5101:3-12-02(C)(2)

When a patient is on an ODJFS administered Home and Community Based Service waiver, an all services plan 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).

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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] Section number changed from (C)(3) to (C)(4) on November 8, 2007 with no change to content.

Purpose, Scope, and Methodology

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

An entrance conference was held with the Provider on September 22, 2010, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for HC nursing services which the Provider rendered to Medicaid patients and received payment during the period of July 1, 2006 to June 30, 2009 (excluding waivered services between September 2007 and April 2008 previously reviewed by CareStar – ODJFS' contracted case manager for the Ohio Home Care and Transitions Waiver programs). The Provider was reimbursed $116,711.06 for 566 services covering both private duty and waiver program nursing services during the audit period.

We reviewed the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. The claims data included: patient name, patient identification number, date of service, service rendered, and reimbursement per service billed.

Prior to beginning our audit fieldwork, we performed a series of computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for potentially inappropriate services or service code combinations as follows:

- Potentially duplicate billed services where the same procedure was billed for the same patient, for the same date multiple times without a modifier showing that a second visit occurred (exact duplicates).
- Potentially duplicate billed services where the Provider billed both PDN (T1000) and waiver nursing services (T1003) for the same recipient on the same date of service (overlapping services).

The test for exact duplicates was negative. The test for overlapping waiver nursing and PDN services billed for the same patient on the same day identified four suspect services. These services were separated from the rest of the Provider's population of services to prevent overstatement of any potential findings. We reviewed the documentation provided to us by the Provider for the four services identified by the exception test.

To facilitate a timely and accurate review of the remainder of the Provider's population of HC nursing services, we selected a pilot statistical random sample of the provider's PDN services and waivered nursing services as permitted by Ohio Admin. Code § 5101:3-1-27(B)(1). A very high error rate was found in the pilot sample of waiver nursing services. Consequently, this sample was expanded into a 100 percent comparison of the type and amount of waiver services billed to those authorized on the corresponding plans of care (POC) and all services plans (ASP) to determine if services had been billed in excess of the amount authorized, resulting in inappropriate reimbursements. However, due to the low error amount found for PDN services, the pilot sample of PDN services was not expanded and was not projected to the Provider's sub-population of PDN services.

We performed our fieldwork between September 2010 and April 2011.

Results

We identified findings of $5,564.87 in Medicaid overcharges from the 100 percent review of the plans of care and all services plans. We identified no additional findings from our exception test of

potentially overlapping PDN and waiver nursing services. The bases for our findings are discussed below in more detail.

A. Testing of Home Care Nursing Services

We found that the Provider's documentation for both private duty nursing and waiver nursing services, involving the POC and the ASP, did not always support the services billed to Ohio Medicaid. The issues with the Provider's documentation are outlined and discussed in more detail below.

1. Private Duty Nursing Services

The Provider rendered 448 PDN services during the audit period. We selected a statistical random sample of 50 recipient dates of service (RDOS) containing 67 PDN services. An RDOS consists of all services received by a recipient on a certain date. We examined the documentation including clinical notes and authorizing POCs and ASPs for the PDN services billed to Ohio Medicaid.

Our analysis of the 67 sampled PDN services found three services with errors that resulted in the reimbursements for the services being disallowed. These errors included:

- 1 services where the Provider billed more hours than worked;
- 1 service where the corresponding POC did not include the required scope, frequency, and duration elements (note: there were 17 additional services covered by this POC that are addressed in the waiver nursing services analysis below); and
- 1 service where the Provider billed while the patient was under the care of a hospital ER unit;

The overpayment for these three services was denied and a finding was made for $244.49. No projection of the sample findings was made because of the low dollar amount of errors found in the sample.

2. Waiver Nursing Services

The Provider rendered 114 waiver nursing services during the audit period. A complete review of the documentation supporting all 114 services was conducted because of the high error rate observed in an initial pilot sample of 30 RDOS containing 34 services. We reviewed the clinical documentation, including nursing notes, and the approved POCs and ASPs covering the audit period to determine if services billed were properly authorized and documented. Our review found 54 errors covering 45 of the 114 services billed. The errors included the following issues:

- 44 services where the corresponding POC did not include the required scope, frequency, and duration elements;
- 9 services where documentation failed to indicate they were covered under a supervisory RN review; and
- 1 service that did not have a nursing note.

Where services had more than one error, only one finding was made per service. All but one of the services missing a supervisory RN review also had other errors to support a finding. The reimbursement for the one service missing only evidence of a supervisory RN review was not disallowed. We disallowed the reimbursement for 45 services resulting in a finding for $5,320.38.

We also note that there were an additional 52 services where the Provider billed for waiver nursing services but the ASP authorized only PDN services. We did not take a finding for these services

since the services were rendered, the services were prescribed in the POC, and reimbursement was the same for PDN and waiver nursing services. The Provider should ensure that she correctly bills for services as authorized in the ASP in the future.

3. Summary of Home Care Nursing Services

Findings from our review of PDN and waiver nursing services totaled $5,564.87. The findings were predominantly due to POCs that did not contain the required frequency, scope, and duration of service elements; and ASPs that did not authorize waiver services.

B. Exception Testing of Potential Duplicate Services

Our exception test identified two dates of service where the Provider billed for both PDN and waiver nursing services for the same patient on the same day – a total of four services. After reviewing the Provider's records we confirmed that the Provider indeed billed Ohio Medicaid for both PDN and waiver nursing services for the same two dates of service. In each case the ASP only authorized waiver nursing services; however the nursing notes documented that two separate nursing visits occurred on those days. Therefore, since PDN and waivered nursing services reimburse at the same rate we made no finding. We caution the Provider to ensure that she bills for services in the future using the correct code.

Conclusion

We found the Provider was overpaid by Ohio Medicaid for home care nursing services between July 1, 2006 and June 30, 2009 in the amount of $5,564.87. This finding is the sum of $244.49 from our sample of PDN services and $5,320.38 from our census of waiver PDN services. These findings plus interest in the amount of $1,185.55 through March 13, 2012, totaling $7,174.36 is immediately due and payable to ODJFS as of the date of release of this audit. After March 13, 2012, additional interest will accrue at the rate of $1.22 per day until the finding and interest is paid in full.

Provider Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on January 3, 2012, and the Provider was afforded an opportunity to respond to this audit report. A written response was received from the Provider on January 13, 2012. The Provider furnished additional documentation to support the services billed. In addition, AOS contacted ODJFS and CareStar to obtain the missing plans of care or other equivalent document that contained the requisite scope, frequency, and duration of services. Neither ODJFS nor CareStar had any additional documentation to be considered. We reviewed the additional documentation obtained from the Provider and adjusted our findings as appropriate.

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. 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 also 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 to the public on the Auditor of State website at www.auditor.state.oh.us.

Sincerely,

Dave Yost
Auditor of State

March 13, 2012

cc: Ohio Attorney General, Medicaid Fraud Control Unit
Ohio Department of Job and Family Services, Surveillance and Utilization Review Section
Ohio Department of Job and Family Services, Ohio Health Plans, Program Integrity Unit
U. S. Department of Health and Human Services, Office of Inspector General
Ohio Board of Nursing

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MISTY ANN NEWMAN, LPN

BUTLER 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
MARCH 13, 2012

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