Carol S. Sito, LPN
ASHTABULA COUNTY

MEDICAID PROVIDER AUDIT

FOR THE PERIOD JULY 1, 2007 TO APRIL 30, 2011

Dave Yost · Auditor of State

CAROL S. SITO, LPN
ASHTABULA COUNTY

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ACRONYMS

AOS	Auditor of State
ASP	All Service Plan
CAP	Corrective Action Plan
CMS	Centers for Medicare and Medicaid Services
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

Carol S. Sito, LPN
5355 Anderson Road
Pierpont, Ohio 44082

RE: *Medicaid Provider Number 2300218*

Dear Ms. Sito:

The Auditor of State performed an audit of Medicaid reimbursements made to Carol S. Sito, LPN, Ohio Medicaid provider number 2300218 (the "Provider"), during the period July 1, 2007 to April 30, 2011. The Provider furnished private duty nursing and waiver nursing services to Ohio Medicaid patients. 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 $195,153.21 in findings for improper charges to Ohio Medicaid based on Medicaid reimbursement rules in effect at the time services were provided. We also assessed interest in the amount of $19,675.72 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $214,828.93. The finding and interest is repayable to ODJFS as of the release of this audit report. Additional interest of $42.77 per day will accrue after August 20, 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 services to Medicaid recipients. Providers must follow the rules and regulations 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) performs audits of Medicaid providers to assess compliance with Medicaid reimbursement rules and 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 recouped

[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

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 by a licensed practical nurse (LPN) under the supervision of an RN. *See* 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 12 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) prepared by the case manager. Ohio Admin. Code § 5101:3-46-04(A)(3)(d).

LPNs providing HC nursing services, such as the Provider here, must be supervised by an RN and 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 treatment plans at least every 60 days (§ 5101:3-12-03(B)(3)(b));
- Plans of care (POC) approved by the treating physician which specify 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 and time keeping records documenting the details of each visit including the date, time span and type 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 prescribed in the POC. Ohio Admin. Code § 5101:3-12-02(C)(2).

When a patient is in an ODJFS administered waiver program and receives waiver nursing services, an all services plan (ASP) is required in addition to the POC. Ohio Admin. Code § 5101:3-12-03.1 (C). The ASP lists all Medicaid home health services approved for the patient including PDN services, and specifies the type, frequency, scope and duration of services under the waiver program. The ASP also specifies which providers can render services and subsequently bill Ohio Medicaid for them. *See* Ohio Admin. Code § 5101:3-45-01(D).

Nurses providing both PDN services and waiver nursing services to the same patient, and nurses providing PDN services to Medicaid patients who also receive waiver nursing or personal aide services from another provider, must comply with the rules for the waiver program. *Ohio Admin. Code §§ 5101:3-12-02(C)(2) and 5101:3-12-03.1(C).*

Here the Provider furnished both PDN and waiver services to a Medicaid patient. As such, the Provider was required to comply with the waiver program requirement of an ASP as well as the requirements for all HC nursing providers to keep clinical records for the patient and follow the POC.

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or another person. "Waste and abuse" are 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 Medicaid reimbursement claims for HC nursing services complied with Ohio Medicaid regulations and to identify, if appropriate, any findings resulting from non-compliance.

We sent an engagement letter to the Provider on November 18, 2011, outlining the purpose and scope of the audit. The scope of the audit was limited to claims for services the Provider rendered to Medicaid patients and received payment during the period of July 1, 2007 to April 30, 2011. The Provider was reimbursed $377,657.73 on 1,219 recipient dates of service (RDOS) during the audit period. A recipient date of service (RDOS) is defined as all services for a given patient on a specific date of service.

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. This claims data included patient name, patient identification number, date of service, and service rendered.

We reviewed the POCs submitted by the Provider for PDN services billed to Ohio Medicaid during the audit period. During our review we calculated the number of hours of PDN services authorized by the treating physician in the POC. The number of *authorized* hours was then compared to the number of hours *billed* for PDN services for the date span of each POC.

Results

We identified findings of $195,153.21 resulting from insufficient or missing documentation. Our analyses identified services billed by the Provider to the Ohio Medicaid program that were not verified by the patient or patient's legal guardian; services that were not authorized by the attending physician in a POC; and services with missing or incomplete clinical notes. Each issue and the bases for our findings are discussed below in more detail.

A. Inadequate Clinical Documentation

Ohio Medicaid rules require waiver nursing providers to maintain clinical records for each patient served and each date of service. The clinical records must include clinical notes with the details of tasks performed during each visit, and timesheets showing services rendered. The clinical notes and timesheets must be signed and dated by the provider and approved by the consumer or consumer's authorized representative. Ohio Admin. Code §§ 5101:3-46-04(A)(6)(j)[3] and 5101:3-45-03(E)(11)[4]. Our review revealed that the Provider was not preparing clinical records and timesheets for services according to Medicaid rules. Instead she made photocopies of prior clinical notes for each service without making any substantive changes, and many of her timesheets did not contain original signatures. As discussed below, ODJFS identified this practice as a problem in a structural review with the Provider in 2007, and led us to disallow $121,238.39 in reimbursement.

[3] This section was amended Oct. 25, 2010 and (A)(6)(i) became (A)(6)(j). The prior version did not require clinical notes to be signed by the consumer, but timesheets were required to be signed by Ohio Admin. Code § 5101:3-45-03(E)(11). The Provider used a form that was a combination timesheet and clinical note throughout the audit period; so a signature was always required.

[4] This section was amended July 1, 2010 and (E)(10) became (E)(11).

Photocopied Clinical Notes

During the audit period, the Provider participated in a structural review of her clinical records with the case manager assigned by ODJFS to oversee waiver home health providers. *See* Ohio Admin. Code § 5101:3-45-06[5]. On January 10, 2008, the Provider met with the case manager following the structural review for period 7/1/07 - 9/30/07 and received a formal report identifying errors found during the review. The structural review report stated:

> Provider has daily visit notes that are all the same, every day. The form looks to be copied and then the Provider will add in pen that she spoke with her supervisor or that she gave report to "caregiver". Every note was a copy and when asked where the original one was she stated that she did not have it with her. Provider needs to have a separate daily note that is not copied from any other. She needs to hand write every daily progress note and continue to have it signed by herself and the Consumers representative. If this is not corrected for the next review it will be an overpayment. (Emphasis added.)

Following a structural review, the Provider was required to submit a Corrective Action Plan (CAP) to the case manager outlining how the errors would be rectified. Ohio Admin. Code § 5101:3-45-06(B)(6).

We found the Provider continued this practice of photocopying clinical notes after the structural review. We limited our review on this issue to January 10, 2008 to April 30, 2011, and found 61 instances where clinical notes were photocopied duplicates. We disallowed the reimbursement for the associated services totaling $18,708.58. We found another 40 instances of copied clinical notes but did not take findings because the reimbursement was disallowed for another audit issue. An additional 334 instances of copied clinical documentation other than the clinical notes were found for which no findings were taken. Clinical notes must be original and reflect each unique visit.

Daily Time Sheet not Signed by Consumer's Guardian

According to Ohio Admin. Code § 5101:3-45-03 (E)(11), the consumer or legal guardian must sign the provider's daily timesheet to verify the services were performed. However, we found the Provider was using a photocopied time sheet template, which included the guardian's signature. We found no original consumer or guardian signature on the timesheets for 329 services; so we disallowed the reimbursement for these services totaling $102,529.81. We found another 40 services where the guardian's signature was copied, but we had already taken findings for another audit issue. The consumer/guardian signature should never be signed on blank time sheets nor provided in advance of services being rendered. And the Provider should never submit timesheets with photocopied signatures from the consumer or legal guardian.

B. Services Unauthorized by the Attending Physician

Ohio Medicaid rules mandate that nurses perform HC nursing services according to an approved plan of care. *See* Ohio Admin. Code §§ 5101:3-12-02(C)(2) and 5101:3-46-04(A)(4)(e)[6]. A "Plan of care" is the medical treatment plan that is established, approved and signed by the treating physician. Ohio Admin. Code § 5101:3-45-01(QQ) The physician must sign the POC prior to provider seeking

[5] Ohio Admin. Code § 5101:3-45-06 replaced Ohio Admin. Code § 5101:3-12-30 on September 19, 2009. Both sections call for a structural review of non agency home health providers on at least a biennial basis.

[6] Ohio Admin. Code § 5101:3-46-04(A)(4) was updated on October 25, 2010 and subsection (e) became subsection (g) with no significant change in meaning.

reimbursement for a service. Services not specified on a POC are not reimbursable. Ohio Admin. Code §§ 5101:3-12(C)(2) and 5101:3-46-04(A)(4)(e)[6]. We identified one plan of care that was not signed by a physician and therefore it was invalid. We disallowed the reimbursement for the 61 services covered by this POC and made a finding for $18,623.01.

Services not specified by the treating physician in the plan of care are not reimbursable. A plan of care must be recertified and signed every 60 days by the treating physician. Ohio Admin. Code § 5101:3-12-3(B)(3)(b).

We identified 18 services not covered by the effective 60-day span of any POC. These services were associated with 14 POCs but were beyond the 60-day effective period of the plans for services billed to Ohio Medicaid. We disallowed the reimbursement for these services less findings previously taken by ODJFS/SURS for the same issue. A final finding of $5,268.21 was taken for this issue.

C. Overbilled Units

The Ohio Medicaid rules specify that nurses furnishing HC nursing services not specified in a POC or in excess of those specified in an ASP are not reimbursable. *See* Ohio Admin. Code §§ 5101:3-12-02(C)(2) and 5101:3-46-04(A)(3)(f)[7]. We examined all of the Provider's POCs and ASPs for the audit period. We compared the authorized PDN and waivered nursing units of services to the number of services actually billed and determined there were 1,488 hours, or 5,952 units, over billed to Ohio Medicaid. We calculated the amount reimbursed to the Provider for these unauthorized HC services and a finding was made for $50,023.60.

Conclusion

We found the Provider was overpaid by Ohio Medicaid for HC nursing services between July 1, 2007 and April 30, 2011 in the amount of $195,153.21 due to incomplete or missing documentation of services. This finding plus interest in the amount of $19,675.72 through August 20, 2012 totaling $214,828.93, is immediately due and payable to ODJFS as of the date of release of this audit report. Additional interest will accrue at the rate of $42.77 per day until the finding and interest is paid in full.

Provider's Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on August 20, 2012, and the Provider was afforded an opportunity to respond to the draft report. We did not receive a response from the Provider to the exceptions noted above.

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.

[7] Ohio Admin. Code § 5101:3-46-04(3) was updated on October 25, 2010 and subsection (d) became subsection (f) with no significant change in meaning.

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

Sincerely,

Dave Yost
Auditor of State

August 20, 2012

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

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CAROL S. SITO, LPN

ASHTABULA 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 20, 2012

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