EMBER COMPLETE CARE, INC.
TUSCARAWAS COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2009 THROUGH JUNE 30, 2011

Dave Yost • Auditor of State

THIS PAGE INTENTIONALLY LEFT BLANK

EMBER COMPLETE CARE, INC.
TUSCARAWAS COUNTY

TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO HOME HEALTH AGENCY SERVICES

Lois Grandison, President
Ember Complete Care, Inc.
730 N. Water Street
Uhrichsville, Ohio 44683

RE: *Medicaid Provider Number 2016080*

Dear Ms. Grandison:

We examined Ember Complete Care, Inc. (the Provider's) compliance with specified Medicaid requirements for service documentation, service authorization, and provider qualifications related to the provision of home health nursing, home health aide, waiver nursing, and personal care aide services during the period of January 1, 2009 through June 30, 2011. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized in plans of care and all services plans. We also reviewed personnel records and licensure data to verify that the Provider's staff met certification requirements. The accompanying Compliance Examination Report identifies the specific requirements examined for compliance.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances.

Basis for Disclaimer of Opinion

As detailed in the Compliance Examination Report, subsequent events came to our attention and we were unable to satisfy ourselves as to the Provider's compliance with the specified Medicaid requirements.

Disclaimer of Opinion

Because of the matters described in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the compliance with the specified Medicaid requirements for the period of January 1, 2009 through June 30, 2011.

Our examination of nursing and aide services disclosed 16 services in which the Provider did not maintain documentation of service delivery, one service in which the hours documented on the service record did not support the units billed, and one service not authorized by the plan of care. As a result, we found the Provider was overpaid by Ohio Medicaid between January 1, 2009 and June 30, 2011 in the amount of $838.03. This finding plus interest in the amount of $72.01 totaling $910.04, is due and payable to ODM upon ODM's adoption and adjudication of this examination report. After adjudication by ODM, additional interest may be assessed until the finding and interest is paid in full.

When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B). Therefore, a copy of this report will be forwarded to ODM as it 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 ODM's Office of Legal Services at (614) 752-3631.

This report is intended solely for the information and use of the Ohio Department of Medicaid, 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 other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Sincerely,

Dave Yost
Auditor of State

March 18, 2014

[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 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 § 5160-1-29(A).

COMPLIANCE EXAMINATION REPORT FOR EMBER COMPLETE CARE, INC.

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. 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 patients. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The 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 § 5160-1-01(A)

The Auditor of State performs examinations to assess provider compliance with reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, and medical necessity. According to Ohio Admin. Code § 5160-1-17.2(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. Providers must furnish such records for audit and review purposes. Ohio Admin. Code § 5160-1-17.2(E)

The Provider, whose Ohio Medicaid Provider number is 2016080, is a Medicare certified home health agency (MCHHA) located in Tuscarawas County, Ohio, that furnishes private duty nursing, home health nursing, waiver nursing, personal care aide services, home health aide services and physical therapy services to Ohio Medicaid recipients. The Provider received total reimbursement of $19,774,631.72, which included $7,639,258.13 for 140,692 home health nursing services; $521,948.47 for 8182 waiver nursing services; $3,687,158.79 for 97,862 home health aide services; $7,132,563.69 for 115,545 personal care services; $469,633.78 for 6,625 physical therapy services; and $324,068.86 for 1,350 private duty nursing services rendered on 15,238 recipient dates of service (RDOS) during the examination period. A recipient date of service is defined as all services for a given recipient on a specific date of service.

The all services plan is the service coordination and payment authorization document and authorizes the type, frequency and duration of waiver services to be provided. The all services plan also specifies which providers can render services and subsequently bill Ohio Medicaid for them. *See* Ohio Admin. Code § 5160-45-01(E) The Plan of care is the medical treatment plan that is established and approved by the treating physician. Ohio Admin. Code § 5160-45-01(QQ) The plan of care specifies the type, frequency, scope and duration of nursing services being performed. Ohio Admin. Code §§ 5160-46-04(A) and 5160-50-04(A)

Ohio Medicaid recipients may be eligible to receive in-home private duty nursing services and waiver nursing services provided by a registered nurse, or a licensed practical nurse under the supervision of a registered nurse. Ohio Admin. Code § 5160-12-02(A) Qualifying private duty nursing services must be medically necessary and greater than four but not more than 12 hours in length, unless an authorized exception applies. Ohio Admin. Code § 5160-12-02(A) Waiver nursing services are activities performed within the scope of the nurse's practice per Chapter 4723 of the Ohio Revised Code. Waiver nursing services must be identified on the all services plan and the nurse must perform services pursuant to written orders from the treating physician. *See* Ohio Admin. Code §§ 5160-46-04(A) and 5160-50-04(A)

Ohio Medicaid recipients may also be eligible to receive personal care or home health aide services in the recipient's home. Personal care aides assist the recipient with activities of daily living such as bathing, dressing, household chores and accompanying the recipient to medical appointments. *See* Ohio Admin. Code §§ 5160-46-04(B)(1-3) and 5160-50-04(B)(1-3). While home health aide services include assisting the recipient with activities of daily living however they also help the recipient maintain a certain level of health in order to remain in the home setting. *See* Ohio Admin. Code § 5160-12-01(F)(2)

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the audit period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of home health nursing, waiver nursing, home health aide and personal care aide services for which the Provider rendered services to Medicaid recipients and received payment during the period of January 1, 2009 through June 30, 2011.

We received the Provider's claims history of services billed to and paid by Ohio's Medicaid program from ODM's Medicaid Management Information System. We removed any services paid at zero. This population was used to extract a statistical random sample of services billed with an HQ modifier. The HQ modifier indicates a group setting and is used for group visits. Ohio Admin. Code § 5160-12-05(C) There were 911 dates of service billed with the HQ modifier. We randomly selected 30 of the 911 dates of service and then selected all of the services, on these 30 dates of service for review. The resulting sample of 1,156 services included home health nursing (G0154), waiver nursing (T1003), home health aide (G0156), and personal care aide (T1019) services.

The remaining subpopulation was further limited to only home health nursing (G0154); home health aide services (G0156); and personal care aide services (T1019) during the examination period. From this remaining subpopulation, we used a multi-stage cluster sampling approach because of the large number of services (319,837) and the comparably fewer number of recipients (552). Each recipient received, on average, 579 services. First we randomly selected 30 of the 552 unique recipients and then extracted all the subpopulation services associated with the selected 30 recipients. We then summarized these selected services by RDOS which totaled 7,927 unique RDOS. We selected a stratified random sample of the RDOS for the sample recipients. If a recipient had more than 20 RDOS, we randomly selected 20 RDOS for that recipient. If the recipient had 20 or fewer RDOS, we selected all RDOS for that recipient for review. A total of 532 RDOS were selected for examination. The selected RDOS were then matched against paid services for the sampled recipients to extract all the services associated with the sample RDOS. A total of 680 home health nursing, home health aide and personal care aide services were selected for review.

A total of 1,836 services were extracted in the two samples to facilitate a timely and efficient examination of the Provider's paid services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We also interviewed key personnel and reviewed service documentation, plans of care and all services plans. In addition, we haphazardly selected 41 employees that rendered personal care or nursing services during the review period and reviewed personnel files and verified professional licensure where appropriate.

An engagement letter was sent to the Provider on May 7, 2013, setting forth the purpose and scope of the examination. Our fieldwork was performed between May 29, 2013 and June 13, 2013.

Subsequent Events

During our examination we became aware of multiple ongoing investigations of the Provider by various regulatory agencies. The results of these investigations were unknown at the time our report.

Results

We reviewed 1,156 home health services in our sample of services billed with an HQ modifier and identified and 11 instances of non-compliance. We reviewed 680 services in the second statistical sample of home health services and identified 26 instances of non-compliance. All instances of non-compliance are described below.

In certain instances, the non-compliance resulted in overpayments and the basis for our findings is also described below in more detail. While certain services had more than one error, only one finding was made per service. We did not project a finding beyond those found in either of our samples because we do not project findings from a sampling when less than 10 percent of the services examined in the sample have an error and the amount of the errors found in the sample is less than $1,000.

A. Service Documentation

According to Ohio Admin. Code § 5101:3-12-03 (C)(4), all MCHHA's are required to maintain documentation on all aspects of services provided. Documentation includes but is not limited to clinical records and time keeping records that indicate the date and time span of the service provided during a visit and the type of service provided. Waiver services provided to a recipient enrolled in an ODM administered waiver must have documented the tasks performed or not performed; arrival and departure times; and contain the dated signatures of the provider and recipient or authorized representative. *See* Ohio Admin. Code §§ 5101:3-46-04(A)(6) and (B)(8), and 5101:3-50-04(A)(6) and (B)(8)

Our examination of the two samples found 16 services with no documentation to support the date of service and one service where the hours documented on the service record did not support the units billed. The 17 errors were disallowed and the reimbursement is included in the total overpayment of $838.03.

Recommendation:

The Provider should strengthen its internal controls to ensure that services for which there is no supporting documentation are not billed. We also recommend the Provider develop and implement internal controls to verify the correct number of units are billed for actual time that services were rendered.

B. Service Authorization

Plan of Care

In order for home health services to be covered, MCHHA's must provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. This rule requires that MCHHA's implement policy components as specified in the Medicare Benefit Policy Manual, Chapter Seven: Home Health Services for "Content of the Plan of Care" section 30.2. *See* Ohio Admin. Code § 5101:3-12-03 (B)(3) The Medicare Benefit Policy Manual states that the plan of care must indicate the type of services to be provided as well as the frequency of the visits to be made. In addition, orders for services to be furnished "as needed" or

"PRN" must be accompanied by a description of the recipient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

Home health services not specified in a plan of care are not reimbursable. Additionally the MCHHA's plan of care must provide the amount, scope, duration, and type of home health service as identified on the all services plan for recipients enrolled in a Medicaid waiver. *See* Ohio Admin. Code § 5101:3-12-01

We reviewed the plans of care in effect during the examination period for each recipient in our samples to ensure that each plan of care authorizing home health services listed the service, frequency of visits, and duration; was signed and dated by the treating physician; and listed the Provider as a rendering provider.

Our examination found one date of service which was not authorized by the plan of care. This one error was disallowed and the reimbursement is included in the total overpayment of $838.03. In addition we found 19 dates of service for three recipients in which the plan of care did not include the frequency of authorized services. These plans of care indicated maximum hours per week, for example "up to 14 hours per week as needed", but did not indicate the frequency of visits to be made. We also noted that plans of care indicated "skilled nursing visit as needed for assessments and labs" but did not include a description of the signs and symptoms that would occasion a visit or a limit on the number of visits to be made under the order. These plans of care were signed and dated by the recipient's treating physician.

Recommendation:

The Provider should ensure services are provided as specified in the plan of care and that all plans of care are properly completed to include all elements required by the Medicaid Benefit Policy Manual. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future potential findings.

All Services Plan

According to Ohio Admin. Code §§ 5101:3-46-04(A)(4) and (B)(5) and 5101:3-50-04(A)(4) and (B)(5), the Provider must be identified on the recipient's all services plan and the plan must specify the number of hours for which the provider is authorized to furnish waiver nursing services to the recipient.

We obtained the all services plans for the recipients enrolled in an ODM administered waiver and reviewed them to verify that the Provider was listed as an authorized provider and had units authorized for the type of service rendered. We identified no exceptions.

C. Provider Qualifications

Nursing Services

According to Ohio Admin. Code § 5101:3-12-01(A), home health nursing requires the skills of and is performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse. In addition, all nurses providing services to recipients on a waiver must possess a current and valid license in good standing with the Ohio Board of Nursing. Ohio Admin. Codes §§ 5101:3-46-04(A)(1) and 5101:3-50-04(A)(1)

We haphazardly selected 21 employees that rendered home health and waiver nursing services during the examination period and tested to ensure that their nursing license was current and valid during the audit period. We searched each name on the Ohio e-License Center website and contacted the Ohio Board of Nursing and found no exceptions.

Personal Care Aide Services

According to Ohio Admin. Code §§ 5101:3-46-04(B) and 5101:3-50-04(B), in order to submit a claim for reimbursement, the agency must have a photo identification for all aides and prior to commencing service delivery, the personal care aide must obtain a certificate of completion for the nurse aide competency evaluation program, obtain and maintain first aid certification, and maintain evidence of the completion of eight hours of in-service continuing education within a twelve month period and annually thereafter.

We haphazardly selected 20 aides who rendered services to Medicaid recipients in our samples. We reviewed each employee's personnel file to verify it contained all required information.

We noted that a competency test was not on file for one employee and the competency tests on file for two employees were not dated. As a result, we were unable to verify that these three employees completed competency evaluation programs prior to rendering services. We also noted one instance where there was no photo identification for the employee in the personnel file.

Recommendations:

The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response

A draft report along with a detailed list of services identified as noncompliant was mailed to the Provider on March 6, 2014, and the Provider was afforded an opportunity to respond to this examination report.

We did not receive a response from the Provider to the results noted above.

This page intentionally left blank.

Dave Yost • Auditor of State

EMBER COMPLETE CARE, INC

TUSCARAWAS 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
APRIL 1, 2014

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.ohioauditor.gov