JENNIFER A. JONES, RN
DBA JENNIFER A. JONES, INC.
MONTGOMERY COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2009 THROUGH DECEMBER 31, 2011

Dave Yost · Auditor of State

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JENNIFER A. JONES, RN DBA JENNIFER A. JONES, INC.
MONTGOMERY COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO WAIVER NURSING SERVICES

Jennifer A. Jones, RN DBA Jennifer A. Jones, Inc.
6981 Breckenwood Drive
Huber Heights, Ohio 45424

RE: *Medicaid Provider Number 2644133*

Dear Ms. Jones:

We have examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of waiver nursing services during the period of January 1, 2009 to December 31, 2011. We confirmed the Provider's licensure status during the examination period. We tested service documentation to verify that there was support for the date of service, the procedure code, and the duration of service paid by Ohio Medicaid. In addition, we tested the Provider's service documentation to determine if it contained the required elements. We also examined plans of care and all services plans to determine if the Provider, the service, and the units paid by Ohio Medicaid were appropriately authorized. 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 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 express an opinion and 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 attestation standards established by the American Institute of Certified Public Accountants 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. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the specified Medicaid requirements referred to above. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Adverse Opinion on Medicaid Services

Our examination disclosed that in a material number of instances the Provider's service documentation did not indicate what tasks were performed or not performed and did not include the Provider's signature and/or the signature of the Medicaid recipient at the completion of each service delivery. In addition, we noted instances where the documented arrival and/or departure times overlapped with documented arrival and/or departure times for other Medicaid recipients on the same day. These overlaps included instances where the arrival time for one recipient was the same as the departure time for a different recipient at a different address, an overlap of minutes between two recipients, and the same arrival and departure times reported for two different recipients at different addresses. We also noted instances where the arrival and departure times were omitted.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to service documentation for the period of January 1, 2009 through December 31, 2011.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

Our examination disclosed that the Provider did not maintain documentation of service delivery and service authorization as required. As a result, we found the Provider was overpaid by Ohio Medicaid for waiver nursing services between January 1, 2009 and December 31, 2011 in the amount of $34,162.77. This finding, plus interest in the amount of $2,144.53 totaling $36,307.30, is due and payable to the Ohio Department of Medicaid (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 because 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.

[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)

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.

This report replaces the report for the period of January 1, 2009 to December 31, 2011 previously dated March 10, 2014. You should rely on this report rather than on our report dated March 10, 2014. The addressee was revised to the name as listed in the Medicaid Provider Agreement.

Sincerely,

Dave Yost
Auditor of State

March 10, 2014, except for the updated addressee which is as of April 22, 2014

COMPLIANCE EXAMINATION REPORT FOR JENNIFER A. JONES, RN

DBA JENNIFER A. JONES, 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 (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 Medicaid 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's Ohio Medicaid provider number is 2644133 and the Provider is a registered nurse (RN) located in Montgomery County, Ohio, who furnishes waiver nursing services to Ohio Medicaid recipients. When Ohio Medicaid was the primary payer, the Provider received reimbursement of $506,070.75 for 9,314 waiver nursing services during our examination period. During the examination period, the Provider used multiple versions of the skilled nursing note (clinical record) to document the services rendered. One of the versions of the skilled nursing note allowed the Provider to document multiple occurrences (visits) on one form.

Home care nursing services under Ohio Medicaid may include private duty nursing services, waiver nursing services, or both. *See* Ohio Admin. Code §§ 5160-46-04 and 5160-50-04 When a Medicaid recipient receiving waiver nursing care is on an ODM administered waiver program, an all services plan is required in addition to the plan of care. *See* Ohio Admin. Code §§ 5160-46-04(A)(4) and 5160-50-04(A)(4) The all services plan lists all Medicaid home health services approved for the recipient, including the type, frequency and duration of each service. The all services plan also specifies which providers can render services and subsequently bill Ohio Medicaid for them. The plan of care is a medical treatment plan that is established, approved and signed by the treating physician. The plan of care must be signed and dated by the treating physician prior to requesting reimbursement for a service. *See* Ohio Admin. Code § 5160-45-01(E) and (QQ)

Purpose, Scope, and Methodology

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

The scope of the engagement was limited to an examination of waiver nursing services for which the Provider rendered to Medicaid recipients, and received payment, during the period of January 1, 2009 through December 31, 2011.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed services paid at zero. We also removed services associated with dates of service where the total units on those dates of service equaled or exceeded 24 hours and conducted an exception test of those services. The remaining sub-population was then used to select a statistical random sample based on dates of service to facilitate a timely and efficient examination of the Provider's waiver nursing services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

We randomly selected six Medicaid recipients and obtained from ODM (CareStar Agency) the all services plans to determine if the Provider was authorized to render services. We also verified the Provider's qualification and examined clinical notes and plans of care by recipient to determine if the Provider had documentation to support the services rendered.

An engagement letter was sent to the Provider on July 10, 2013, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on August 5, 2013. During the entrance conference, the Provider described her documentation practices, her procedures for obtaining plans of care and all services plans, and her process for submitting billing to the Ohio Medicaid program. Our fieldwork was performed in August 2013. In preparation for the exit conference, which was held on March 14, 2014, the Provider submitted additional documentation which was reviewed for compliance.

Results

We reviewed 503 nursing services and identified 298 instances of non-compliance which is 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. The overpayments identified for 18 of 30 dates of service (43 of 503 services) from our statistical random cluster sample were projected across the Provider's total population of paid services. This resulted in a projected overpayment amount of $39,014.41 with a precision of plus or minus $10,854.53 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and a finding was made for $29,876.67. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $29,876.67.

In addition, we conducted a review of 716 nursing services provided on dates in which the Provider billed total units that equaled or exceeded 24 hours (exception test) and noted 78 instances of non-compliance. While certain services had more than one error, only one finding was made per service. We identified an overpayment of $4,286.10 as a result of the 78 errors. The Provider used a vendor to submit her billing to Ohio Medicaid. The Provider entered time of service and, for any period of time equal to or less than one hour; the system calculated four 15-minute units. This resulted in a higher number of units being reported than was delivered but did not result in an overpayment because the same base rate is paid for delivery of one to four units. We noted that the billing system began reporting actual units in 2010.

A. Provider Qualifications

According to Ohio Admin. Code §§ 5101:3-46-04(A)(1) and 5101:3-50-04(A)(1), waiver nursing services requires the skills of a RN or a licensed practical nurse at the direction of an RN. All nurses shall possess a current, valid and unrestricted license with the Ohio Board of Nursing.

We verified through the Ohio e-License Center that the Provider is an RN licensed by the Ohio Board of Nursing and that the license was in active status during our examination period.

B. Service Documentation

Ohio Admin. Code §§ 5101:3-46-04(A)(6) and 5101:3-50-04(A)(6) state that providers must maintain a clinical record that includes clinical notes, documentation of tasks performed or not performed, arrival and departure times, and dated signatures of the provider and recipient. The supporting documentation for the 503 services that were randomly selected and the 716 services in the exception test were compared to regulations outlined in the Ohio Administrative Code.

The review of the sample of 503 services identified 23 instances where the Provider did not document tasks performed or not performed and one instance where the documentation was not signed by the Provider. In addition, we found 13 instances where the Provider documented arrival and/or departure times that overlapped arrival and/or departure times for other Medicaid recipients on the same day indicating that the Provider was at multiple locations at the same time. These overlaps included instances where the arrival time for one recipient was the same as the departure time for a different recipient at a different address, an overlap of minutes between two recipients, and the same arrival and departure times reported for two different recipients at different addresses. Finally, we identified seven instances where the Provider did not record the arrival and departure times of the service delivery. These errors were used in the overall finding projection.

In addition, Ohio Admin. Code §§ 5101:3-46-04(A)(6) and 5101:3-50-04(A)(6) state that providers must maintain clinical documentation that includes the dated signatures of the provider and recipient upon the completion of service delivery. We identified 127 instances where both the Provider and the recipient signed clinical documentation once when multiple visits were included on a single clinical record instead of signing after completion of service delivery.

The review of the exception test of 716 services identified 46 instances where the Provider documented arrival and/or departure times that overlapped arrival and/or departure times for other Medicaid recipients on the same day indicating that the Provider was at multiple locations at the same time. In addition, we identified 32 instances where the Provider did not record the arrival and departure times of the service delivery. These errors were consistent with those identified in the sample. These 78 errors are included in the overpayment of $4,286.10.

Recommendation:

The Provider should maintain clinical records in a manner that includes all of the required elements. The clinical record should clearly identify the tasks performed or not performed, record both the actual start and actual end times, and include a dated signature by the Provider and recipient at the completion of service delivery. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future potential findings.

C. Authorization to Provide Services

Plan of Care

Ohio Admin. Code §§ 5101:3-46-04(A)(4)(g) and 5101:3-50-04(A)(4)(g) state that in order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN must be identified

as the provider on, and be performing nursing services pursuant to the recipient's plan of care, and the plan of care must be signed and dated by the recipient's treating physician.

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

We found no exceptions.

All Services Plan

According to Ohio Admin. Code §§ 5101:3-46-04(A)(4)(f) and 5101:3-50-04(A)(4)(f), 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 randomly selected six Medicaid recipients that received services from the Provider during the examination period. We obtained the all services plans for those recipients and reviewed them to verify that the Provider was listed as an authorized provider and had units authorized. The review identified one recipient where the Provider was listed as an authorized provider; however, there were no authorized units to cover the services rendered.

Recommendation:

The Provider should develop and implement a system to track units and procedure codes authorized on the all services plans to ensure that services billed are consistent with authorized services and are not rendered in excess of the authorized units. The Provider should communicate with Case Manager to resolve concerns regarding an all services plan. 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 the service for which we took findings was mailed to the Provider on February 3, 2014 and the Provider was afforded an opportunity to respond to this examination report.

The Provider responded that she did provide all of the care that she billed for during that period of time and that, even though some documentation errors appear to exist, she does not believe that there are amounts to recover in excess of what was legitimately due to her. The Provider submitted an example of one monthly calendar signed by a recipient and indicated the calendar was confirmation of the number of visits during that month. The Provider stated she has such monthly calendars for all recipients. The Provider stated that she has improved her documentation procedures over time and can likely improve them further. She now provides a service note to capture a signature for each visit from the recipient and herself. Additionally, the Provider indicated that she now ensures that the times of service are accurately reflected in her documentation. In addition, she has committed to attend continuing education classes on provider billing and Medicaid training in the near future.

AOS response: We reviewed all of the documents provided. The statement on the calendar signed by the recipient is that the services on the calendar are within the approved all services plan and the calendar provides no times or duration for service delivery. The Provider's clinical documentation is the basis for the results reported above.

APPENDIX I

Summary of Sample Record Analysis for: Jennifer A. Jones, RN DBA Jennifer A. Jones, Inc.
For the period January 1, 2009 to December 31, 2011

Description	Analysis
Type of Examination	Cluster Random Sample
Description of Population	All paid non-exception services in audit period
Number of Dates of Service (DOS) in Population	490
Number of Dates of Service Sampled	30
Number of Dates of Service Sampled with Errors	18
Number of Services in Population	8,598
Number of Services Sampled	503
Number of Services Sampled with Errors	43
Total Medicaid Amount Paid for Population	$466,726.55
Amount Paid for Services Sampled	$26,340.72
Estimated Overpayment (Point Estimate)	$39,014.41
Precision of Overpayment Estimate at 95% Confidence Level	$10,854.53
Precision of Overpayment Estimate at 90% Confidence Level	$ 9,137.74
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate) (Equivalent to the estimate used for Medicare Audits)	$29,876.67

Source: AOS analysis of ODM MMIS and MITS information and the Provider's records.

Dave Yost • Auditor of State

JENNIFER A. JONES, RN DBA JENNIFER A JONES, INC.

MONTGOMERY 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
MAY 13, 2014

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