PATRICIA L. FUGATE, RN
CLERMONT COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

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

Dave Yost · Auditor of State

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Patricia L. Fugate, RN
Clermont County

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

Patricia L. Fugate, RN
612 Brantner Lane
Cincinnati, Ohio 45244

RE: *Medicaid Provider Number 2082919*

Dear Ms. Fugate:

We 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 and personal care aide services during the period of January 1, 2009 through December 31, 2011. We tested service documentation to verify that there was support for the date of service, the procedure code, and the units billed to and paid by Ohio Medicaid. In addition, we tested your service documentation to determine if it contained the required elements. We also examined the plans of care to determine if the Provider and service were appropriately authorized and we reviewed your provider qualifications. The accompanying Compliance Examination Report identifies the specific requirements examined.

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 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 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.

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 Disclaimer of Opinion

Our examination disclosed that the Provider submitted detailed documentation of service delivery for dates of service when the recipient was hospitalized and 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 or three recipients, and the same arrival and departure times reported for two to three different recipients at different addresses. In addition, we noted instances where the arrival and departure times were omitted. We also found that the Provider submitted altered plans of care that did not match the original plans of care obtained directly from the authorizing physician. As a result of our findings, we were unable to gain assurance regarding the validity of documentation supporting the Provider's compliance with the specified Medicaid requirements. The Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

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 December 31, 2011.

We found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2009 and December 31, 2011 in the amount of $137,851.76. This finding plus interest in the amount of $8,358.92 totaling $146,210.68 is due and payable to the Ohio Department of Medicaid (ODM) upon ODM's adjudication of this examination report. 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 through its Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

[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.

Dave Yost
Auditor of State

December 5, 2014

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Compliance Examination Report for Patricia Fugate, RN

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. 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) 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)

During the examination period, the Provider furnished waiver nursing services and personal care aide services to 47 Ohio Medicaid recipients and received reimbursement of $843,071.58 for 15,530 waiver nursing services and $444.96 for 18 personal care aide services rendered on 1,010 dates of service. ODM's Surveillance and Utilization Review Section conducted a limited review of the Provider's services for the period of July 1, 2009 through June 30, 2010 and identified 12 instances in which the Provider received payment for services provided while the recipient was hospitalized. Prior to the release of this report, the Provider's Medicaid number became inactive due to suspension by ODM.

We noted a filing with the Ohio Secretary of State for Healing Hands Home Health Care Inc., a for profit corporation, effective April 29, 2013 with the Provider as the statutory agent and incorporator. In addition, the Provider supervises at least one other licensed practical nurse who also renders services to Medicaid recipients.

Home care nursing services under Ohio Medicaid may include private duty nursing services, waiver nursing services, or both. When a Medicaid recipient receiving waiver nursing care is on an ODM administered waiver program, a plan of care is required. 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.

Ohio Medicaid recipients may be eligible to receive personal care aide services that assist the recipient with activities of daily living such as bathing and dressing, general homemaking activities, household chores, personal correspondence, accompanying the recipient to medical appointments or running errands. Personal care aide services are authorized in the all services plan (or individual service plan), which lists services approved for the recipient under a waiver program, including the type of service, frequency and duration; and it specifies which provider can render services and subsequently bill Ohio Medicaid for those services.

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 examination period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of waiver nursing 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 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 any voids and services paid at zero. We then extracted 16 services to recipients who appeared to be a hospital inpatient on the same date the Provider billed for waiver nursing services. From those 16 services, we removed 12 services previously identified and recouped by ODM (for services rendered while the recipient was hospitalized). We examined the remaining four services as an exception test. We also extracted four dates of service where the Provider was reimbursed for services that included registered nursing (RN) services, one licensed practical nursing (LPN) service, two personal care aide services, and three services delivered in group setting (with a HQ modifier) and examined all of these services as an exception test. A random sample from the remaining sub-population was then selected. This sample included 923 nursing (RN) services on 58 dates of service.

An engagement letter was sent to the Provider on March 13, 2014, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on April 7, 2014. During the entrance conference, the Provider described her documentation practices, procedures for obtaining plans of care and all services plans, and process for submitting billing to the Ohio Medicaid program. Our field work was performed following the entrance conference.

On July 20, 2014, the Provider signed a statement that the records provided to us were original, true, accurate and complete. After the draft report was sent to the Provider on October 7, 2014, the Provider submitted additional documents which we reviewed for compliance. Some of the documents submitted after the draft were the same documents received during our fieldwork but the second version provided had previously missing recipient signatures. Results of the compliance examination were revised to reflect the examination of these additional documents.

Results

We reviewed 923 services that consisted of waiver nursing services in our statistical sample and identified 181 instances of non-compliance in 179 services in the sample. The overpayments identified for 48 of 58 dates of service (179 of 923 services) from our statistical random cluster sample were projected across the Provider's sub-population of paid services. This resulted in a projected overpayment amount of $160,630.74 with a precision of plus or minus $28,104.16 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 $136,971.63. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $136,971.63. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We also reviewed four waiver nursing services in our exception test of reimbursement on a date the recipient was potentially a hospital inpatient and found four instances of non-compliance and identified an overpayment of $221.50.

Finally, we reviewed 71 services in our exception test of four dates of service when the Provider was reimbursed for services which included an LPN service, two personal care aide services and services in a group setting (HQ modified) and found 13 instances of non-compliance. We identified an overpayment of $658.63 for these 13 errors.

The non-compliance found during our examination and the basis for our findings is described below in more detail. While certain services had more than one error, only one finding was made per service.

A. Provider Qualifications

According to Ohio Admin. Code §§ 5101:3-46-04(A)(1), 5101:3-47-04(A)(1) and 5101:3-50-04(A)(1) all nurses providing waiver nursing services shall provide services as set forth in Chapter 4723 of the Revised Code and rules of the Administrative Code adopted thereunder, and 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 was a registered nurse (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 § 5101:3-45-10(A)(11) notes that for each unit provided, the provider must clearly document the service provided and obtain the signature of the recipient on the dated document. In addition, Ohio Admin. Code §§ 5101:3-46-04(A)(6), 5101:3-47-04(A)(6) and 5105:3-50-04(A)(6) state all waiver nursing service providers must maintain a clinical record for each recipient served that includes clinical notes, documentation of services performed during each visit and the dated signature of the provider. Effective October 25, 2010, providers are required to document tasks performed or not performed, arrival and departure times and the dated signature of the recipient, or authorized representative, verifying the service delivery.

Statistical Sample

Our review of 923 nursing services in the statistical sample found 172 errors. These errors include:

- 104 services in which the arrival and departure time overlapped the arrival time of another service and the recipients did not live at the same address;
- 23 services with no supporting documentation;
- 28 services in which the documentation was not signed by the recipient upon service delivery;
- 13 services in which the supporting documentation did not support the duration of services provided as the notes did not contain the arrival and/or departure times;
- 3 services in which documentation was not signed by the Provider; and
- 1 service in which the documentation did not reflect tasks performed as the clinical note indicates that no service was rendered.

In identifying the 104 services with overlapping times, we used the recipient addresses from the Provider's plans of care. If the arrival time matched the departure time of the prior visit or the departure time matched the arrival time for the subsequent visit, we compared addresses and identified non-compliance when the recipients did not live at the same address or in the same building. For the overlapping times, we identified findings if the service was not billed with a HQ modifier indicating a group service. There were instances in which the Provider's documentation showed up to three different recipients living at three different addresses being seen at the same time.

There were instances in which the original documentation lacked the recipient signature but the copies submitted by the Provider in response to the draft report contained the recipient signature. These instances are identified as non-compliant as the original documentation did not contain the required recipient signature.

These 172 errors were used in the overall finding projection of $136,971.63.

Exception Test – Inpatient

Our review of the four services for four unique recipients in the inpatient exception test found that the Provider submitted detailed service documentation indicating clinical status of the recipient and tasks performed. However, hospital records showed that each of the four recipients was hospitalized on the same date as the service documentation. For the purpose of this test we did not consider the admission or discharge date as an inpatient date. These four errors resulted in an overpayment of $221.50.

Exception Test – Licensed Practical Nurse, Personal Care Aide and Group Services

We reviewed 71 services consisting of two personal care aide services and 69 nursing services (68 RN and 1 LPN). In addition, three of the nursing services included an HQ modifier (group setting). In this exception test we found the following 13 errors:

- 8 services in which the arrival and departure time overlapped the arrival time of another service and the recipients did not live at same address;
- 3 services in which the documentation was not signed by the recipient upon service delivery;
- 1 service with no supporting documentation; and
- 1 group service that was not billed with the required HQ modifier.

These 13 errors are included in the overpayment of $658.63.

Recommendation:

The Provider should develop and implement procedures to ensure all service documentation fully complies with Medicaid requirements including dated signatures of the provider and recipient and actual times of service delivery. The Provider should only seek reimbursement for those services that were actually rendered, ensure that units billed reflect actual service delivery time, and verify that accurate billing codes are used in submitting claims.

C. Authorization to Provide Services

According to Ohio Admin. Code §§ 5101:3-46-04(A)(4)(g), 5101:3-47-04(A)(4)(g) and 5101:3-50-04(A)(4)(g), 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.

Plan of Care – Statistical Sample

We reviewed the plans of care submitted and found four services had no plans of care covering the date of service and five services did not have a plan of care signed and dated by the treating physician.

These nine errors were used in the overall finding projection of $136,971.63.

We also noted manual revisions on typed plans of care. To determine if the revisions were made before or after the physician signed the plan of care, we haphazardly selected three recipients and requested plans of care directly from the authorizing physician. We then compared the 16 plans of care submitted by the Provider to the 16 plans of care received directly from the physician and noted the following:

- 9 plans of care contained different physician signature dates;
- 8 plans of care contained different certification periods;
- 6 plans of care contained differing information (diagnosis, goals, medications, etc.);
- 3 plans of care were on different forms; and
- 1 plan of care with same physician name and date but was not the same version of plan of care.

The plans of care we received directly from the physicians covered the date of service, listed the Provider by name, and authorized nursing services. We did not identify any findings for the altered plans of care since the plans of care provided by the physician were complete and covered the dates of service. However, it is unclear why the Provider maintained and submitted altered documents and did not have the plans of care as signed by the physician in the clinical records.

Recommendation:

The Provider should develop and implement procedures to ensure all plans of care are signed and dated by the recipient's treating physician before services are rendered. The Provider should perform nursing services pursuant to the recipient's plan of care. The Provider should also maintain the original plan of care signed by the physician and not alter this document.

Provider Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on October 7, 2014, and the Provider was afforded an opportunity to respond to this examination report.

The Provider explained that the differing plans of care occurred because she updates the documentation as new information develops and the physician likely retained an older version. In each of the cases where the date of service was during inpatient stay, the Provider explained that she misdated her notes. The Provider disagreed with certain instances of non-compliance and stated other service documentation errors were due to imprecise record keeping. The Provider maintained that all of the services were actually rendered.

We did not examine the Provider's response and, accordingly, we express no opinion on it.

APPENDIX I

POPULATION

The population is all paid Medicaid services, less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM during the examination period. Services excluded from this sample subpopulation included the following: (1) services on four specific dates of service where the provider billed for personal care services, LPN services, and one service billed with group (HQ) modifier; and (2) services where our computerized analyses identified services potentially billed while the recipient was a hospital inpatient. Services with identified potential exceptions were segregated from the rest of the provider's services and examined in their entirety.

SAMPLING FRAME

The sampling frame was paid and processed claims from MMIS and MITS. These systems contain all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT

The sampling unit was date of service. A date of service is defined as all services furnished by and paid to the Provider on a specific date of service.

SAMPLE DESIGN

We used a cluster random sample.

Summary of Sample Record Analysis
For the period January 1, 2009 to December 31, 2011

Description	Results
Number of Dates of Service in Population	1,006
Number of Dates of Services Sampled	58
Number of Dates of Services Samples with Errors	48
Number of Services in Population	15,461
Number of Services Sampled	923
Number of Services Sampled with Errors	179
Total Medicaid Amount Paid for Population	$838,740.25
Amount Paid for Services Sampled	$50,264.98
Estimated Overpayment (Point Estimate)	$160,630.74
Precision of Overpayment Estimate at 95% Confidence Level	$28,104.16
Precision of Overpayment Estimate at 90% Confidence Level	$23,659.11
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)	**$136,971.63**

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

Dave Yost • Auditor of State

PATRICIA L. FUGATE, RN

CLERMONT 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
DECEMBER 30, 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