P.E. MILLER & ASSOCIATE, INC.
FRANKLIN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2014

Dave Yost · Auditor of State

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P.E. MILLER & ASSOCIATE, INC.
FRANKLIN COUNTY

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

Ettie Miller, President
P.E. Miller & Associate, Inc.
1341 South Hamilton Road
Columbus, Ohio 43227

RE: *Medicaid Provider Number 0112685*

Dear Ms. Miller:

We examined your (the Provider) 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 July 1, 2011 through June 30, 2014. 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 the plan of care and all services plans and reviewed personnel records to verify that nursing and aide qualifications were met. 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. 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 Medicaid requirements. 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 Qualified Opinion

Our examination disclosed that in a material number of instances the Provider submitted claims for reimbursement prior to obtaining signed plans of care (signed orders). We also found that personal care aides did not consistently meet the qualification requirements to provide waiver services. In addition, we noted waiver services that were not signed by the recipient or authorized representative and nursing notes lacking duration of service. Also, in one exception test for potentially duplicate billings, we found material non-compliance with services lacking supporting documentation.

Qualified Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining with home health nursing services for the period of July 1, 2011 through June 30, 2014.

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.

We found the Provider was overpaid by Ohio Medicaid for services rendered between July 1, 2011 and June 30, 2014 in the amount of $573,184.18. This finding plus interest in the amount of $38,839.12 totaling $612,023.30 is due and payable to ODM upon its adoption and 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, the state auditor, or the office of the attorney general. Ohio Admin Code § 5160-1-29(B)

This report is intended solely for the information and use of the ODM, 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

August 8, 2016

[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 constitutes 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

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 prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) 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 from receipt of payment 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)

Ohio Medicaid recipients may be eligible to receive home health aide services, personal care aide services or both. The only provider of home health aide services is a Medicare certified home health agency (MCRHHA) that meets the requirements in accordance with Ohio Admin. Code § 5160-12-03. Personal care aide services can be provided by a MCRHHA, an otherwise-accredited home health agency or a non-agency personal care aide.

The Provider is a MCRHHA and during the examination period received reimbursement of $4,838,499.69 for 92,436 home health services including the following:

- 60,452 skilled nursing services (procedure code G0154);
- 23,870 personal care services (procedure code T1019);
- 7,898 home health aide services (procedure code G0156); and
- 216 waiver nursing services (procedure codes T1002 and T1003).

The Provider has a second Medicaid provider number (0066740) under the name P E Miller and Associates, Inc. which lists the Provider as a waiver service organization. The Medicaid agreement for the second provider number was effective as of June 1, 2010 and has the same the same service location. No payments were made to this number during our examination period.

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 home health services, specifically home health (skilled) nursing, waiver nursing, home health aide and personal care aide services that the Provider rendered to Medicaid recipients and received payment during the period of July 1, 2011 through June 30, 2014.

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, services paid at zero and services with third party payments.

Purpose, Scope, and Methodology (Continued)

We then extracted two exception tests to test these services in their entirety. First, we extracted 40 services identified as potential duplicate billings (Exception Test 1). Second, we extracted 820 services in which the Provider was reimbursed for more than 14 hours (56 units) of home health services for a single recipient in a single week (Exception Test 2).

After removing the services in the two exception tests, we used statistical sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We extracted all waiver nursing services (procedure codes T1002 and T1003) from the remaining population and then pulled all services rendered on the same RDOS as a waiver nursing service. We summarized this file by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. We randomly selected a sample of 75 RDOS with a total of 167 services (Statistical Sample 1).[2]

From the remaining population of home health nursing, home health aide and personal care aide services (procedure codes G0154, G0156 and T1019), we selected a statistical sample (Statistical Sample 2). We obtained the detailed services for the randomly selected 478 RDOS resulting in a sample size of 806 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described its documentation practices and process for billing to the Ohio Medicaid program. We sent a missing records list and a subsequent final request for information to the Provider and we reviewed all documents received for compliance. In addition, the Provider submitted additional documentation at the exit conference held on August 8, 2016 which we reviewed for compliance.

Results

We examined 40 services in Exception Test 1 (potential duplicate services) and identified 21 errors. As a result, we identified $932.46, as an overpayment.

We examined 820 services in Exception Test 2 (more than 14 hours of home health services for a single recipient in one week) and identified 136 errors. As a result, we identified $6,418.30, as an overpayment.

We examined 167 services in Statistical Sample 1 (waiver nursing and associated services) and identified 43 errors. We identified overpayments for 30 of 167 statistically sampled recipient services (23 of 75 RDOS). Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $16,979, with a 95 percent certainty that the actual correct payment amount fell within the range of $15,733 to $18,225 (+/- 7.34 percent.) We then calculated findings by subtracting the correct population amount ($16,979) from the amount paid to the Provider for this population ($20,637.21), which resulted in a finding of $3,658.21. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

[2] Due the small size of the population, a sample was calculated using a Beta control test where five percent was the acceptable error rate, a one percent minimum error rate was assumed, and a 95 percent confidence was required.

Results (Continued)

We examined 806 services in Statistical Sample 2 (Remaining Home Health Nursing, Home Health Aide, and Personal Care Aide Services*)* and identified 108 errors. We identified overpayments for 102 of 806 statistically sampled recipient services (70 of 478 RDOS). Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $4,208,025, with a 95 percent certainty that the actual correct payment amount fell within the range of $4,022,281 to $4,393,769 (+/- 4.41 percent.) We then calculated findings by subtracting the correct population amount ($4,208,025) from the amount paid to the Provider for this population ($4,770,200.21), which resulted in a finding of $562,175.21. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

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

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code § 5101:3-12-01(F)[3], home health nursing services require the skills of and must be performed by a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of a registered nurse. The nurse performing the service must be employed or contracted by the MCRHHA providing the service.

We searched the names of the nine RNs and 27 LPNs that rendered services in our exception tests and statistical samples on the Ohio e-License Center website to ensure that their professional license was current and valid on the first date of service in our tests and was active during remainder of examination period. We found no instances of non-compliance.

Aide Services

Prior to rendering services, home health aides are required to obtain state licensure or complete training and/or a competency evaluation program that meets the requirements of 42 CFR 484.36 (a) or (b). The competency evaluation program includes an annual performance review and 12 hours of in-service continuing education annually. *See* Ohio Admin. Code § 5101:3-1-01(G)(2)

In order to submit a claim for reimbursement, all individuals providing personal care aide services must complete a competency evaluation program and obtain and maintain a current first aid certification. In addition, personal care aides must complete 12 hours of in-service continuing education. *See* Ohio Admin. Code §§ 5101:3-12-03(B), 5101:3-46-04(B), 5101:3-47-04(B) and 5101:3-50-04(B)

We haphazardly selected 15 aides that rendered home health aide services and/or personal care aide services in our exception tests and/or statistical samples. The Provider could not submit a list of staff that differentiated between home health aides and personal care aides so we used the type of services provided in the exception tests and statistical samples to apply qualification requirements for our testing.

[3] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

A. Aide Services (Continued)

First Aid Certification

All 15 aides tested rendered personal care aide services during our examination period. We found one aide with no first aid certification and nine aides with lapses in time without a current certification. We determined that the aide with no first aid certification was ineligible to render personal care aide services during our examination period and aides with lapses in certification were ineligible to render personal care aide services during the lapse.

Initial Competency Evaluation

We tested the six aides that were hired during our examination period to determine compliance with the initial competency evaluation requirement. We found no errors.

In-Service Hours

For compliance of in-service continuing education hours, we limited our testing to aides who were employed for the full calendar year. We tested 11 aides for continuing education hours for calendar year 2012 and seven aides for calendar year 2013. We found no errors.

Exception Test 1- Potential Duplicate Services

We reviewed 40 services and identified 10 services rendered by an aide who was ineligible to render services. These 10 services are included in the overpayment of $932.46.

Exception Test 2- More than 14 Hours of Home Health Services for a Recipient in One Week

We reviewed 820 services and identified 40 services rendered by an aide who was ineligible to render services. These 40 services are included in the overpayment of $6,418.30.

Statistical Sample 1 – Waiver Nursing and Associated Services

We reviewed 167 services and identified 12 services rendered by an aide who was ineligible to render services. These 12 services were used in the overall projection of $3,658.21.

Statistical Sample 2 – Remaining Home Health Nursing and Aide Services and Personal Care Aide Services

We reviewed 806 services and identified 42 services rendered by an aide who was ineligible to render services. These 42 services were used in the overall projection of $562,175.21.

Recommendation:

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.

B. Service Documentation

The MCRHHA must maintain documentation of home health services provided that includes, but is not limited to, clinical records and time keeping that indicate time span of the service and the type of service provided. See Ohio Admin. Code § 5101:3-12-03(C)(4) Documentation to support personal care aide services must include the tasks performed or not performed and the arrival and departure times. See Ohio Admin. Code §§ 5101:3-46-04(B)(8), 5101:3-47-04(B)(8) and 5101:3-50-04(B)(8) According to Ohio Admin. Code § 5101:3-45-10(A), providers of waiver services must maintain and retain all required documentation including, but not limited to, the dated signatures of the provider and the recipient or authorized representative verifying the service delivery upon completion of service delivery.

Exception Test 1- Potential Duplicate Services

We reviewed 40 services and identified 11 services in which there was no service documentation to support the service. These 11 services are included in the overpayment of $932.46.

Exception Test 2- More than 14 Hours of Home Health Services for a Recipient in One Week

We reviewed 820 services and identified one service in which there was no service documentation to support the service. We also found three services with no duration documented and the Provider billed for more than the base rate (equivalent to the first four units). These four errors are included in the overpayment of $6,418.30.

Statistical Sample 1 – Waiver Nursing and Associated Services

We reviewed 167 services and identified found the following errors:

- 14 services in which the service documentation was not signed by the recipient or authorized representative;
- 4 services with no documented duration and the Provider billed for more than the base rate;
- 1 service in which there was no service documentation to support the service;
- 1 service in which the documented activity (supervision) was not a covered service; and
- 1 service in which the units reimbursed exceeded the documented units.

These 21 errors were used in the overall projection of $3,658.21.

Statistical Sample 2 – Remaining Home Health Nursing and Aide Services and Personal Care Aide Services

We reviewed 806 services and identified four services in which there was no service documentation. These four errors were used in the overall projection of $562,175.21.

We also identified nursing services in which there was no documentation of duration or of time of departure. Since the first hour (four units) of nursing is paid at the base rate, we did not associate overpayments in those instances where there was supporting documentation and the Provider billed four units or less. We noted one such instance of non-compliance in Exception Test 2, nine instances in Statistical Sample 1 and six instances in Statistical Sample 2.

B. Service Documentation (Continued)

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Medicaid rules. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Plans of Care

All home health providers are required by Ohio Admin. Code § 5101:3-12-03(B)(3)(b) to create a plan of care for recipients including recipients' medical condition and treatment plans anticipated by provider. The plan of care is also required to be signed by the treating physician of recipient. Home health providers must obtain the completed, signed and dated plan of care prior to billing ODM for the service.

Exception Test 1- Potential Duplicate Services

We found no errors.

Exception Test 2- More than 14 Hours of Home Health Services for a Recipient in One Week

We reviewed 820 services and found the following errors:

- 52 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 35 services in which units billed exceeded units authorized in the plan of care; and
- 4 services in which the plan of care did not authorize the service.

These 91 errors are included in the overpayment of $6,418.30.

Statistical Sample 1 – Waiver Nursing and Associated Services

We reviewed 167 services and identified one service that was submitted for reimbursement prior to the date physician signed the plan of care. This service was used in the overall projection of $3,658.21.

Statistical Sample 2 – Remaining Home Health Nursing and Aide Services and Personal Care Aide Services

We reviewed 806 services and found 54 services that were submitted for reimbursement prior to the date the physician signed the plan of care and two services in which the plan of care did not authorize the billed service.

These 56 services were used in the overall projection of $562,175.21.

All Services Plan

According to Ohio Admin. Code § 5101:3:12-01, the Medicare certified home health agency must be identified on the all services plan when a recipient is enrolled in home and community based waiver.

C. Authorization to Provide Services (Continued)

We haphazardly selected one all services plan from our examination period for each of the 26 waiver recipients in Exception Test 1 and the two statistical samples and found no errors.

Recommendation:

The Provider should establish a system to obtain the required plans of care completed by an authorized treating physician and to ensure the signed plans of care are obtained prior to submitting claim for services to ODM. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix III**. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Response:

The RDOS used in the two statistical samples were randomly selected from the provider's entire population excluding those services selected for the two exception tests. Each sampled RDOS could have had multiple errors causing some or all of the services for that RDOS to be identified as an overpayment. The overpayments in the two samples were projected back to their respective subpopulations using standard statistical methodology and with good precision and confidence levels obtained.

In addition, as noted in the background section of the Compliance Examination Report, providers are required to maintain records for a period of six years from receipt of payment. We examined all records submitted, including any documented verbal orders.

The Provider's response was evaluated and no changes were made to this report.

APPENDIX I

Summary of Sample Record Analysis
Statistical Sample 1 - Waiver Nursing and Associated Services

POPULATION
The population is all paid Medicaid waiver nursing services (procedure codes T1002 and T1103) and all services rendered on the same RDOS as a waiver nursing service, 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 services examined in the two exception tests.

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 an RDOS

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	177
Number of Population RDOS Sampled	75
Number of RDOS Sampled with Errors	23
Number of Population Services	389
Number of Population Services Sampled	167
Number of Services Sampled with Errors	30
Total Medicaid Amount Paid for Population	$20,637.21
Amount Paid for Population Services Sampled	$8,840.66
Projected Correct Population Payment Amount	$16,979
Upper Limit Correct Population Payment Estimate at 95 % Confidence Level	18,225
Lower Limit Correct Population Payment Estimate at 95 % Confidence Level	15,733
Projected Overpayment Amount (Actual Amount Paid for Population Services – Projected Correct Population Payment Amount)	**$3,658.21**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	$1,246 (+/- 7.34%)

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

APPENDIX II

Summary of Sample Record Analysis
Statistical Sample 2 - *Remaining Home Health Nursing, Home Health Aide and Personal Care Aide Services*

POPULATION
The population is all paid Medicaid home health nursing, home health aide and personal care aide services (procedure codes G0154, G0156 and T1019), 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 services examined in the two exception tests and waiver nursing and associated services tested in Statistical Sample 1.

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 an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	54,132
Number of Population RDOS Sampled	478
Number of RDOS Sampled with Errors	70
Number of Population Services	91,187
Number of Population Services Sampled	806
Number of Services Sampled with Errors	102
Total Medicaid Amount Paid for Population	$4,770,200.21
Amount Paid for Population Services Sampled	$42,371.62
Projected Correct Population Payment Amount	$4,208,025
Upper Limit Correct Population Payment Estimate at 95 % Confidence Level	$4,393,769
Lower Limit Correct Population Payment Estimate at 95 % Confidence Level	$4,022,281
Projected Overpayment Amount (Actual Amount Paid for Population Services – Projected Correct Population Payment Amount)	**$562,175.21**
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	$185,744 (+/- 4.41%)

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

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August 30, 2016

Dave Yost, Auditor of State
88 East Broad Street, 9th Floor
Columbus, Ohio 43215

Dear Mr Yost:

The purpose of this letter is to serve as the official response of P.E. Miller & Associate, Inc. ("P.E. Miller") to the Medicaid Compliance Examination Report for the period July 1, 2011 through June 30, 2014 (the "Report"). The Report alleged a number of concerns, and primarily (1) ineligibility based on lack of first-aid certification; (2) documentation supporting billed services that was either missing or not signed by the recipient; and (3) requests for reimbursement that post-dated doctor's signatures on the pertinent plans of care. It is P.E. Miller's position that the Report overstated the prevalence of those concerns, based upon the factors outlined below, and that P.E. Miller has taken remedial steps sufficient to address the concerns outlined in the Report.

An important fact underlying this response is that during the audit, P.E. Miller's director responsible for maintaining P.E. Miller's records, and identifying, compiling and providing to the auditor the information requested, was suffering from significant mental health concerns that were not diagnosed until after the preliminary audit had been completed, and caused the director's ability to process information and make logical decisions to severely deteriorate. As a result, records were misplaced, and forwarded late (or not at all in some cases) to the auditors. This factor combined with the passage of time prohibited P.E. Miller from locating all of the information requested by the auditors.

Ineligibility Based on Lack of First-Aid Certification

The Report reviewed 15 aides and alleged that 13 aides were ineligible over various periods during the audit period. However, for 3 of those aides, no reported services were provided. Of the remaining 10 aides, it is P.E. Miller's position that 6 aides were certified during the periods in question, but as their certifications could not be located, they were deemed ineligible in the Report. The combined periods of ineligibility of the 9 aides amounted to approximately 108 months. In contrast, the combined periods of ineligibility of the remaining 4 aides amounted to approximately 18 months (approximately 3% of the 540 months reviewed [15 aides x 36 months]).

As stated above, P.E. Miller's former director was suffering from mental health concerns and misplaced the certifications of the 6 aides. Additionally, the company that initially provided the certifications to the 6 aides was unable to provide proof of those certifications based upon the passage of time. As a result, the auditors concluded that all 6 aides were ineligible and therefore Medicaid's reimbursement for the services provided by those aides was improper. The impact was compounded as the auditors extrapolated out the ineligibility periods over the entire audit period. It is P.E. Miller's position that the periods of ineligibility should have been limited to the small periods of time allocated to the 4 aides whose certification did lapse.

Insufficient Service Documentation

The Report stated that the auditors reviewed 1,833 services and identified 40 services where the service documentation was insufficient (approximately 2% of the 1,833 services reviewed). The insufficient documentation was extrapolated out over the 3-year audit period.

P.E. Miller's position is that a number of those instances were situations where the recipient was unable to sign the document because the recipient was transferred to the hospital during the aide's visit. Additionally, the lack of supporting documentation can be attributed to the former director's mental deterioration as it applied to both the filing of such documentation, and the retrieval and facilitation of that information during the audit.

Services Provided Prior to Authorization

The Report stated that the auditors reviewed 1,833 services and identified 149 services which were improper (approximately 8% of the 1,833 services reviewed), primarily because the services were submitted for reimbursement prior to the date on which the physician signed the plan of care (107 services). This was extrapolated out over the 3-year audit period.

It is P.E. Miller's position that the services were in fact authorized, but that due to delays in receiving signed plans of care, the services were determined in the Report to be improperly provided. Medicaid requires that an authorizing physician must sign a new plan of care every 60 days in order for a health care provider, such as P.E. Miller to continue to provide services to the recipient. This requirement is cumbersome and reliant upon the receipt, signature and timely return of the plan of care back to agencies such as P.E. Miller. The practical procedure in cases where the plan of care is delayed is that the physician provides verbal authorization to continue the services that were previously authorized, in order for the recipient to continue the critical care provided by P.E. Miller. The plan of care is subsequently signed and returned to P.E. Miller by the physician, but the date of the signature in these situations is later than the date on which the actual services were performed. However, based upon the physician's verbal authorization, P.E. Miller asserts that the services were authorized and respectfully disagrees with the Report. There is no dispute that P.E. Miller provided the care to patients in these instances.

Remedial Actions

P.E. Miller has taken actions to ensure that the concerns identified in the Report are not repeated. The President of the Company has resigned along with the prior director. New management and new redundant procedures have been set in place with respect to reporting, filing, and quality control that are designed to dramatically improve P.E. Miller's compliance with documentation regulations and good business practices.

Conclusion

P.E. Miller respectfully disputes the conclusions in the Report. As set forth above, the ineligibility periods were improperly allocated to 6 of the aides, and 3 of the other aides did not provide any services during their periods of ineligibility. What was clearly an anomaly was allocated across the entire audit report when the lapses were limited to a small window during the audit period. Further, the majority of the missing supporting documentation can be explained by the recipients' admissions to health care facilities and the lost documentation as a result of the former director's health problems. Finally, the verbal physicians' authorization undercuts the auditors' conclusions that the services provided were unauthorized. The concerns set forth in the Report paint an unjustly broad picture of non-compliance. However, any non-compliance was isolated and atypical, and accordingly the overpayment set forth in the Report was overstated, and should be significantly reduced.

Very truly yours,

Joshua D. DiYanni, Esquire

JDD/asr

Dave Yost • Auditor of State

PE MILLER AND ASSOCIATED

FRANKLIN 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 13, 2016

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