TASHAY 1 HOME HEALTHCARE, INC.
FRANKLIN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD FEBRUARY 20, 2013 THROUGH JUNE 30, 2014

Dave Yost · Auditor of State

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TASHAY 1 HOME HEALTHCARE, INC.

FRANKLIN COUNTY

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

Eugenia McMillion, Chief Executive Officer
Tashay 1 Home Healthcare, Inc.
2244 South Hamilton Road, Suite 203
Columbus, Ohio 43232

RE: *Medicaid Provider Number 0079012*

Dear Ms. McMillion:

We examined your (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 February 20, 2013 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 found that in a material number of instances the persons rendering home health aide services and/or personal care aide services did not meet minimum qualifications. In addition, in a material number of instances the Provider billed for services prior to obtaining signed plans of care (signed orders). 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.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to service documentation and service authorization for the period of February 20, 2013 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 February 20, 2013 and June 30, 2014 in the amount of $132,785.80. This finding plus interest in the amount of $6,869.39 totaling $139,655.19 is due and payable to the 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

February 17, 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 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

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)

The Provider is a Medicare certified home health agency (MCRHHA) that furnishes home health services. During our examination period, the Provider received reimbursement of $696,868.71 for 13,231 home health services, including $85,710.34 for home health aide services, $243,662.62 for home health nursing services, $232,662.80 for personal care aide services, $35,045.63 for waiver nursing services, $98,948.04 for private duty nursing services and $839.28 for physical therapy services rendered on 496 dates of service.

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 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.

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 and home health services, specifically waiver nursing, personal care aide, home health nursing and home health aide services that the Provider rendered to Medicaid recipients and received payment during the period of February 20, 2013 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 services paid at zero. From the remaining sub-population we extracted all reimbursements for a specific recipient on March 1, 2013 to examine in their entirety.

From the remaining sub-population we extracted all home health aide services (procedure code G0156), home health nursing services (procedure code G0154), personal care aide services (procedure code T1019), and waiver nursing services (procedure code T1003) and summarized them by date of service (DOS). A date of service is defined as all services for a given on a specific date of service.

Purpose, Scope, and Methodology (Continued)

We selected a statistical sample to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). Specifically, we adopted a two stage cluster sample: in stage one, we selected a simple random sample of 47 DOS and, in stage two, we selected a stratified random sample of five recipient dates of service (RDOS), except when there were five or fewer RDOS all were selected, in each of the 47 dates of service. An RDOS is defined as all services for a given recipient on a specific date of service. The following table summarizes the sampling approach used:

Strata	Population Size	Sample Size	Selection Method
Stage 1 – Selection of DOS	496 DOS 6,038 RDOS	47 DOS 656 RDOS	Simple Random
Stage 2 – Five RDOS selected per Stage 1 sample DOS except when five or fewer, then all selected	47 DOS 656 RDOS	47 DOS 232 RDOS	Stratified Random

We then obtained detailed services for the sample DOS and RDOS. This sampling approach resulted in a statistical sample of 180 home health aide services (procedure code G0156); 170 home health nursing services (procedure code G0154); 163 personal care aide services (procedure code T1019); and 3 waiver nursing services (procedure code T1003) for a total of 516 services.

An engagement letter was sent to the Provider on June 10, 2015 setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's office on June 29, 2015. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program.

Results

We reviewed 516 services in our statistical sample and identified 162 errors. The overpayments identified for 43 of 47 statistically sampled dates of service (83 of 232 RDOS) were projected to the Provider's population of paid claims using a two-stage cluster sampling approach. Dates of service were the primary units and RDOS were the secondary units in the projection which resulted in a projected overpayment amount of $166,432 with a 95 percent certainty that the true population overpayment fell within the range of $126,091 to $206,773, a precision of plus or minus $40,341 (24.24 percent.) Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were restated as a single tailed lower limit estimate (equivalent to method used in Medicare audits.) This allows us to say that we are 95 percent certain that the population overpayment is at least $132,577. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We reviewed seven services in our exception test and identified four errors resulting in an overpayment of $208.80.

While certain services had more than one error, only one finding was made per service. The basis for our findings is discussed below in more detail.

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code §§ 5101:3-12-01(A), 5101:3-46-04(A), 5101:3-47-04(A), 5101:3-50-04(A)[2] home health and waiver 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.

We searched the names of the 15 nurses who rendered services in our sample and exception test on the Ohio e-License Center website to ensure that their nursing 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 complete home health aide training and 12 hours of in-service continuing education annually. In addition, the home health aide must successfully complete a competency evaluation program which includes an annual performance review that addresses the same required subject areas as the home health aide training, except for communication skills.

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. *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 tested 18 aides that rendered home health aide services and/or personal care aide services in our sample. 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 sample to apply qualification requirements for our test. We identified the following errors:

- 3 aides rendered personal care aide services with no first aid certification;
- 1 aide had no documentation that an RN observed and evaluated the required subjects for the competency evaluation; and
- 4 aides had a competency evaluation that was completed after rendering services, ranging from 3 days to 15 months after the first date of service in our sample.

We concluded that 8 of the 18 aides (44.4 percent) tested were ineligible to render services during a portion of our examination period. Three of these eight were ineligible for personal care aide services only. In addition, the four aides who had a competency evaluation after rending services were ineligible for all dates of service prior to the date of competency evaluation. We identified 59 services rendered by an aide that did not meet provider qualifications on the date of service. The overpayments associated with these errors were used in the overall finding projection of $132,577.

In addition, we found three aides had incomplete competency evaluations. These three evaluations did not address all four of the subject areas that are to be observed by a registered nurse during the aide's care of a recipient. *See* 42 CFR 484.36 (b) While the competency evaluations were incomplete, we determined that the missing items were not material, and we did not identify an overpayment related to these instances of non-compliance. In total, 10 of the 18 aides (55.5 percent) had errors related to provider qualifications.

[2] 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. Provider Qualifications (Continued)

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 records 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(B)(8) According to Ohio Admin Code § 5101:3-45-10(A), for each unit of personal care aide service provided, the Provider is required to obtain the signature of the recipient on the dated document. This requirement was amended on October 25, 2010 to require the dated signature of the recipient or authorized representative verifying the service delivery upon completion of service delivery.

Statistical Sample

We reviewed 516 services and identified five services in which there was no supporting documentation. We also found one service in which the units billed did not match documentation as the supporting documentation did not reflect the duration of the visit. The overpayments associated with these errors were used in the overall finding projection of $132,577.

Exception Test

We reviewed seven nursing services and identified four services in which there was no supporting documentation. It appeared from the claims history that the Provider billed both home health nursing (G0154) and waiver nursing (T1003) for the same visits and billed for one waiver nursing visit twice. These four errors resulted in an overpayment of $208.80.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5160:12-03(B)(9). 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

Plan of Care

In order for home health services to be covered, MCRHHAs must provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. *See* Ohio Admin. Code § 5101:3:12-01(E)(3)(a) In addition, Ohio Admin. Code § 5101:3:12-03(B) requires that MCRHHAs 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 which states the plan of care must be reviewed and signed by the physician who established the plan of care, at least every 60 days.

C. Authorization to Provide Services (Continued)

Each review of a recipient's plan of care must contain the signature of the physician and the date of review. In addition, all documentation, including signed orders, must be complete prior to billing for services. See Ohio Admin. Code 5101:3-12-03(C)(4)

We reviewed the plans of care in effect for the 180 home health aide services and 170 home health nursing services in our statistical sample and identified 97 services in which the plans of care were signed after the service was rendered, and after the provider billed and was reimbursed by Ohio Medicaid.

The Provider described that its standard practice was to send the physician a "Physician Order for Recertification" form prior to certification period ending. This form asked the physician to recertify the patient for home health services for the next 60 day period. The form included check marks beside the service(s) to be provided: skilled nursing, home health aide, physical therapy, occupational therapy or speech therapy. The form did not include any reference to continuing the specific orders in the prior plan of care. The Provider indicated that the new plan of care was later developed and sent to the physician for signature. We noted instances in which the signed plan of care was not obtained in timely manner with lapses of one to six months after the recertification form was signed. And, in some of these instances, the physician noted changes in medication orders on the plan of care which increases the risk that a medication error could have occurred.

The Provider also used a form titled "Physician Order" which was sent to the physician for signature for approval to perform opening assessment and begin nursing and aide services pending a 60 day plan of care. In one case the plan of care was not signed by physician until nine months after the initial physician order was signed.

The Provider indicated it believed obtaining the recertification form was sufficient to bill for services. The Provider's practices raise concerns regarding the quality of care and appropriateness of the services being provided. The overpayments associated with these 97 errors were used in the overall finding projection of $132,577.

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.

We haphazardly selected one all services plan for each of the seven waiver recipients in our sample that covered a span of time during our examination period and verified that the Provider was listed as an authorized practitioner to render personal care aide services and/or waiver nursing services.

We found that the Provider was listed as authorized practitioner on all of the plans selected.

Recommendation:

The Provider should develop and implement procedures to ensure all plans of care are signed and dated by the recipient's treating physician prior to rendering services. The Provider should also ensure that all documentation, including signed orders, is complete prior to billing for services. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

APPENDIX I

Summary of Statistical Sample Analysis

POPULATION
The population is all paid Medicaid home health nursing (G0154), home health aide (G0156), waiver nursing (T1003) and personal care aide (T1019) services, less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM.

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 primary sampling unit was date of service and the secondary sampling unit was a recipient date of service (RDOS). A date of service is defined as all services furnished by and paid to the Provider on a specific date of service and RDOS is defined as all services for a given recipient on a specific date.

SAMPLE DESIGN
We used a two stage cluster random sample.

Description	Results
Number of Population Dates of Service (Primary Units)	496
Number of Population Dates of Service Sampled	47
Number of Population Recipient Dates of Service Provided (Secondary Units)	6,038
Number of Recipient Dates of Service in Sampled Dates of Service	656
Number of Recipient Dates of Service Sampled from Dates of Service	232
Number of Population Services	12,812
Number of Population Services Sampled	516
Total Medicaid Amount Paid for Population	$597,081.39
Amount Paid for Population Services Sampled	$21,267.54
Sample Recipient Dates of Service with Errors	83
Sample Services with Errors	156
Projected Population Overpayment Amount (Point Estimate)	$166,432
Precision of Overpayment Estimate at 95% Confidence Level	$40,341
Precision of Overpayment Estimate at 90% Confidence Level	$33,855
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90% overpayment precision from the point estimate)(equivalent to method used for Medicare audits)	$132,577

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

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TASHAY 1 HOME HEALTHCARE, INC.

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
MARCH 1, 2016

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