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ZIMAM HOLDINGS, LLC DBA ZIMAM HOME HEALTHCARE
FRANKLIN COUNTY

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

Mark Glover, Chief Executive Officer
Zimam Holdings, LLC, DBA Zimam Home Healthcare
415 East Mound Street, Second Floor
Columbus, Ohio 43215

RE: Medicaid Provider Number 2581620

Dear Mr. Glover:

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 all services plans and plans of care 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.

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Basis for Qualified Opinion

Our examination found that in a material number of instances the Provider billed for services prior to obtaining signed plans of care (signed orders), aides did not meet minimum qualifications and service documentation for personal care aide services did not include the signature of the recipient or authorized representative.

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, service authorization and provider qualifications 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 the Ohio Medicaid for services rendered between July 1, 2011 and June 30, 2014 in the amount of $671,678.59. This finding plus interest in the amount of $37,319.57 totaling $708,998.16 is due and payable to the ODM upon it'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, 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 ODM, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services 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

March 24, 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)

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 registered the fictitious name of Zimam Home Health Care in 2004; however, the fictitious name was cancelled in 2009. The owner of Zimam Holdings, LLC also has a second business, Zimam Home Healthcare Plus+, LLC. We found no Ohio Medicaid number associated with this second business.

The Provider is a MCRHHA that furnishes home health services. During our examination period, the Provider received reimbursement of $1,603,225.37 for 33,577 home health services rendered on 20,052 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. These home health services included:

- $393,784.52 for home health aide services (G0156);
- $868,532.30 for home health nursing services (G0154);
- $292,599.72 for personal care aide services (T1019);
- $35,230.05 for waiver nursing services (T1003);
- $11,330.28 for physical therapy services (G0151); and
- $1,748.50 for occupational therapy services (G0152).

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 aide services, 15 minute unit (procedure code G0156); personal care aide services, 15 minute unit (procedure code T1019); home health skilled nursing services, 15 minute unit (procedure code G0154); and waiver licensed practical nursing services, 15 minute unit (procedure code T1003) 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 voids and services paid at zero. We extracted all services billed with procedure codes T1003, T1019, G0154 and G0156 and used a 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).

Purpose, Scope, and Methodology (Continued)

Specifically, we stratified this sub-population by RDOS into three strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). Estimates of the population overpayment standard deviation were made for each stratum using the standard deviation of the actual amount paid per claim and a 50 percent error rate. The estimated error standard deviations and means were then used to calculate a stratified sample size by stratum and overall. The final calculated sample size is shown in the table below.

Universe/Strata	Population Size	Sample Size
Stratum 1 – RDOS with Amount Paid Less Than $75	10,135	116
Stratum 2 – RDOS with Amount Paid Between $75 and $124.99	8,165	199
Stratum 3 – RDOS with Amount Paid of $125 and Over	1,720	82
Total:	**20,020**	**397**

We then obtained the detailed services for the 397 sampled RDOS. This resulted in a sample size of 794 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's office during which the Provider described its documentation practices, personnel procedures and billing process. Our field work was performed following the entrance conference and a list of missing records was supplied to the Provider. We reviewed all submitted documentation for compliance.

Results

We reviewed a statistical sample of 794 services and identified 388 errors. We took exception with 343 of 794 statistically sampled recipient services (197 of 397 RDOS) from a stratified random sample of the Provider's population of paid services which included all paid T1003, T1019, G0154 and G0156 services. Based on this error rate, we calculated the Provider's correct payment amount for this population to be $918,468, with a 95 percent certainty that the actual correct payment amount fell within the range of $844,395 to $992,540 (+/- 8.06 percent.) We then calculated findings by subtracting the correct population amount ($918,468) from the amount paid to the Provider for this population ($1,590,146.59), which resulted in a finding of $671,678.59. A detailed summary of our statistical sample and projection results is presented in **Appendix I.**

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.

[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)

We haphazardly selected 10 nurses from a list submitted by the Provider who rendered services during our examination period and searched their names on the Ohio e-License Center website to ensure that their nursing license was current and valid during their employment span in our 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.

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 15 aides that rendered home health aide services and/or personal care aide services during our examination period. The Provider could not submit a list of staff that differentiated between home health aides and personal care aides. For those aides that provided services in our sample, we used the type of services provided in the sample to apply qualification requirements for our test. For those employees that did not render a service included in the sample, we applied the requirements for the home health aide services. Of the 15 aides selected, five provided personal care aide services and were tested for compliance with first aid certifications. For compliance of in-service continuing education hours, we limited our testing to aides who were employed for the full calendar year. We identified the following errors:

- 1 of the aides tested had no first aid certification and 2 had lapses in this certification;
- 6 of the 9 aides tested did not obtain the required 12 hours of in-service continuing education in 2012 (5 of these 6 had no hours completed); and
- 7 of the 10 aides tested did not obtain the required 12 hours of in-service continuing education in 2013 (3 of these 7 had no hours completed).

We concluded that the three aides who had no first aid certification or a lapse in certification and rendered personal care aide services were ineligible to render those services during the period of no certification and/or during the lapse. We also concluded that the six aides in 2012 and the seven aides in 2013 who did not complete the required 12 hours of in-service continuing education were ineligible to render services in the year of non-compliance.

We reviewed 794 services and identified 62 services rendered by an aide who was ineligible to render services. These 62 errors were used in the overall projection of $671,678.59.

We also identified three aides in 2012 and two aides in 2013 that did not obtain the required 12 hours of in-service continuing education but were not materially non-compliant. We concluded these four aides were non-compliant but did not consider them ineligible or associate an overpayment with the services they rendered while non-compliant. We identified 21 errors for these aides in our statistical sample.

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. In addition, the Provider should maintain a signature log in which to confirm signatures. 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, the arrival and departure times and the dated signatures of the provider and recipient or authorized representative to verify the service delivery. *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.

We reviewed 794 services and identified the following errors:

- 50 personal care aide or waiver nursing services in which the service documentation was not signed by the recipient or authorized representative;
- 15 services in which there was no supporting documentation; and
- 7 services in which the units reimbursed did not agree to the units on the service documentation.

The overpayments associated with these 72 errors were used in the overall finding projection of $671,678.59.

Recommendation:

The Provider should strengthen its internal controls to ensure that services for which there is no supporting documentation are not billed, that the correct number of units is billed and that documentation includes all required elements. The Provider should also ensure that documentation for personal care aide services and waiver nursing services includes the signature of the recipient or authorized representative, upon completion of service delivery. 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)

C. Authorization to Provide Services (Continued)

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. 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 578 state plan services and identified the following errors:

- 188 services in which the claim was submitted for reimbursement prior to the date the physician signed the plan of care;
- 39 services in which the plan of care was not signed and/or dated by the physician; and
- 6 services in which there was no plan of care.

The overpayments associated with these 233 errors were used in the overall finding projection of $671,678.59.

We also identified 77 services in which either the plan or care or the addendum to the plan of care was signed and dated but both pages were not signed and dated. In these instances, we accepted either the plan of care or the addendum to the plan of care as authorization for the services.

All Services Plan

According to Ohio Admin. Code § 5101:3:12-01, the MCRHHA's plan of care must provide the amount, scope, duration and type of home health service as identified on the all services plan when a recipient is enrolled in home and community based waiver.

We reviewed the all services plan in effect for each of the 216 waiver services and determined the Provider was listed as an authorized provider to render services.

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.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix II**. The Provider disputes the identified findings and repeats a portion of the opinion rendered. In addition, the Provider indicates it will be examining the methodology used in this examination. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Response:

As stated in the Independent Auditor's Report (see page 2), the examination resulted in a qualified opinion and the basis for the qualified opinion notes those areas which were found to have material non-compliance. In addition, the Provider waived the exit conference and made no inquiries to us regarding the methodology used for this examination.

APPENDIX I

Summary of Sample Record Analysis
For the period July 1, 2011 to June 30, 2014

POPULATION
The population is all paid Medicaid home health aide services (G0156), home health nursing services (G1054), personal care aide services (T1019) and waiver nursing services (T1003) 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 a recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	20,020
Number of Population RDOS Sampled	397
Number of RDOS Sampled with Errors	197
Number of Population Services Provided	33,390
Number of Population Services Sampled	794
Number of Services Sampled with Errors	343
Total Medicaid Amount Paid for Population	$1,590,146.59
Actual Amount Paid for Population Services Sampled	$40,027.79
Projected Correct Population Payment Amount	$918,468
Upper Limit Correct Population Payment Estimate at 95 Percent Confidence Level	$992,540
Lower Limit Correct Population Payment Estimate at 95 Percent Confidence Level	$844,395
Projected Overpayment Amount (Actual Amount Paid for Population Services minus Projected Correct Population Payment Amount)	$671,678.59
Precision of Estimated Correct Population Payment Amount at the 95 Percent Confidence Level	$74,073 (+/-8.06%)

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

PetersonConners

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May 9, 2016

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RE: Zimam Home Health Care's response to Ohio Auditor of State's Medicaid Compliance Examination Report for the Period July1, 2011 through June 30, 2014.

Dear Ms. Couts,

Thank you for the opportunity to offer a response to the Ohio Auditor of State's ("Auditor") Medicaid Compliance Examination Report (the "Report") for Zimam Home Health Care ("Zimam"). Initially, we note that Report itself states that "[Zimam] has complied, in all material respects, with the aforementioned requirements pertaining to service documentation, service authorization and provider qualifications for the period of July 1, 2011 through June 30, 2014." *Report*, Pg. 2. With respect to provider qualifications, we note that no instances of non-compliance were discovered regarding nurses. While irregularities have been identified regarding aides, procedures have been implemented that assure that such aides have completed and obtained the various licensure, training, and competency evaluations. No patients suffered any harm, and Zimam provides excellent care.

With respect to service documentation and authorization to provide services, Zimam disputes the amount of the Auditor's findings and intends to do a thorough examination of the underlying data and methods used to form the basis of the Report. While Zimam acknowledges that the Ohio Medicaid audit recovery program allows for statistical sampling in determining overpayments, such extrapolations based on minor clerical errors in paperwork has the potential of grossly over-exaggerating the final finding of $671,678.59 in this matter.

As such, Zimam intends to conduct a thorough examination of the Auditor's methodology and assessment of Zimam's documentation and authorization records. Zimam will conduct a complete statistical review of the Auditor's samples and calculations, and will determine if such findings are based on minor clerical issues or legitimate errors requiring repayment.

Thank you in advance for your consideration in this matter.

PETERSON, CONNERS, SWISHER & PEER LLP

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ZIMAM HOLDING LLC dba ZIMAM HH

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
MAY 24, 2016

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