HEALING TOUCH HEALTH CARE, LTD
DBA HEALING TOUCH HOME HEALTHCARE
MONTGOMERY COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2013 THROUGH DECEMBER 31, 2015

Dave Yost • Auditor of State

HEALING TOUCH HEALTH CARE, LTD.
DBA HEALING TOUCH HOME HEALTHCARE
MONTGOMERY COUNTY

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

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Healing Touch Health Care Ltd.
Ohio Medicaid # 2547551

We were engaged to examine Healing Touch Health Care Ltd.'s (the Provider's) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of home health services during the period of January 1, 2013 through December 31, 2015.

The Provider entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Management of Healing Touch Health Care Ltd. is responsible for its compliance with the specified requirements. The accompanying Compliance Examination Report identifies the specific requirements examined.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Provider complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Provider complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. Our examination does not provide a legal determination on the Provider's compliance with the specified 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 Disclaimer of Opinion

As described in the attached Compliance Examination Report, we were we were unable to gain assurance regarding the validity of documentation supporting the Provider's compliance with the personal care aide requirements. After receipt of the draft examination report, the Provider submitted additional first aid cards to demonstrate compliance; however, after contacting the training center and instructor identified on these cards, we were unable to substantiate the reliability of the documents.

Disclaimer of Opinion

Our responsibility is to express an opinion on the subject matter based on conducting the examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. Because of the limitation on the scope of our examination discussed 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 whether the Provider complied with specified Medicaid requirements, in all material respects.

We found improper Medicaid payments for services rendered between January 1, 2013 and December 31, 2015 in the amount of $3,722,656.90. This finding plus interest in the amount of $222,339.51 (calculated as of the date of this report) totaling $3,944,996.41 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 Provider and ODM, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

August 29, 2017

[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) 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

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 Medicaid reimbursement of $8,498,912.06 for 102,151 home health services including the following:

- 36,693 skilled nursing services (procedure code G0154);
- 22,500 home health aide services (procedure code G0156);
- 21,710 personal care service (procedure code T1019)
- 16,824 licensed private duty nursing (procedure code T1000);
- 2,738 LPN services (procedure code T1003);
- 911 Physical therapy (procedure code G0151);
- 320 Occupational therapy (procedure code G0152);
- 190 Registered nursing services (procedure code T1002);
- 164 Nursing assessment/evaluation (procedure code T1001); and
- 101 Speech therapy (procedure code G0153)

The Provider had a second Medicaid identifier of 3105437 under the name Ally Home Healthcare, LC; however, the Medicaid agreement for this second number is inactive. This agency's location was listed as Cincinnati, Ohio. There were no payments made to this second number during the 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, personal care aide services and physical, occupational and speech therapy services the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2013 through December 31, 2015.

Purpose, Scope, and Methodology (Continued)

We received the Provider's claims history from 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. We extracted all services rendered during September 2015 to recipients living at one address and examined these 175 services in their entirety (exception test). We limited our testing to the requirements for service documentation for these 175 services.

After removing the services in the exception test, we used a stratified random sampling approach because of the large variability in the amount paid and the number of services provided per recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. We used stratification to ensure adequate coverage of all procedure categories furnished by this Provider. This facilitated a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code 5160-1-27(B)(1).The final calculated sample is shown in the table below.

Universe/Strata	Population Size	Sample Size
Therapy Services	1,190 RDOS	163 RDOS
Waiver Nursing Services	2,982 RDOS	63 RDOS
State Plan and Private Duty Nursing and Aide Services		
Less Than $100	37,695 RDOS	172 RDOS
Less Than $250	24,344 RDOS	310 RDOS
Less Than $950	6,046 RDOS	188 RDOS
Total:	**72,257 RDOS**	**896 RDOS**

The number of population RDOS expanded from 70,305 to 72,257 due to stratification as certain recipients had different types of services on the same date. From the expanded population of 72,257 RDOS, we selected a stratified random sample of 896 RDOS. We then obtained the detailed services for the 896 RDOS which resulted in a sample of 1,325 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. All of the Provider's records were maintained electronically.

We sent a missing records list to the Provider and we reviewed all documents received for compliance. The Provider then signed a statement certifying that the records submitted to us were original, true, accurate and complete. After receipt of the draft examination report, the Provider submitted additional documentation. We reviewed all documentation for compliance and updated our results accordingly.

Results

Exception Test

We examined 175 services and identified four errors. As a result, we identified $37.90 as an overpayment.

Statistical Sample

We examined 1,325 services and identified 779 errors. The overpayments identified for 432 of 896 statistically sampled RDOS (628 of 1,325 services) from a stratified random sample were projected to the Provider's population of paid claims resulting in a projected overpayment of $3,722,619 with a 95 percent degree of certainty that the true population overpayment amount fell within the range, after adjustment, of $3,401,760 to $4,044,815 (+/- 8.66 percent.) An adjustment was made to the original range of $3,401,069 to $4,044,168 to correct for skewness in one stratum. 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 non-compliance and the basis for the findings are described below in more detail.

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code § 5160-12-01(F)[2], 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 for the names of one RN and 19 LPNs that rendered services in our exception test and sample on the Ohio e-License Center website to ensure that their professional licenses were current and valid on the first date of service in our tests and were active during the remainder of the 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 § 5160-12-01(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 §§ 5160-12-03(B), 5160-46-04(B), 5160-47-04(B) and 5160-50-04(B)

[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 20 aides that rendered home health aide services and/or personal care aide services in our sample. We used the type of services provided in the statistical sample to apply qualification requirements of home health or personal care aide for our testing.

Initial Competency Evaluation

We tested the one aide that was 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 20 aides for continuing education hours for calendar year 2013, 17 aides for calendar year 2014 and 11 aides for calendar year 2015.

We found no errors.

First Aid Certification

From the 20 aides tested, 11 aides rendered personal care aide services during our examination period and therefore were required to obtain and maintain first aid certification. Six of the 11 aides had no first aid certification and five of the 11 aides had lapses in time without a current certification.

The Provider stated that in some cases the wrong cards were issued by the trainer of the program. The cards only reflected basic life support/cardiopulmonary resuscitation (CPR) training but the Provider indicated that the cards should have included first aid. We contacted the first aid testing centers listed on the cards and confirmed that the aides did not receive first aid training.

As result of non-compliance found with the 11 original aides, we expanded the test to include all aides that rendered personal care services in the sample. We examined 37 additional aides and found that 16 of these aides had no first aid certification and 17 had lapses in time without a current certification.

After receipt of the draft examination report, the Provider submitted additional first aid cards. We contacted the training center and instructor identified on these cards to verify the information. The training center and the instructor both indicated that its records did not match the information on these additional cards; therefore, we did not use the additional cards as evidence for this examination.

We identified the services rendered by an aide that did not meet the provider qualifications at the time of service delivery to be an improper payment.

Statistical Sample

We reviewed 154 personal care aide services and identified 106 services rendered by either one of the 22 aides that lacked first aid certification or one of the 22 aides whose certification had lapsed before the date of service tested. These 106 services were used in the overall projection of $3,722,619.

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 that indicate time span of the service and the type of service provided. See Ohio Admin. Code § 5160-12-03(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 §§ 5160-46-04(B)(8), 5160-47-04(B)(8) and 5160-50-04(B)(8) According to Ohio Admin. Code § 5160-45-10(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

We reviewed 175 services and found four errors for overlapping times, resulting in an overpayment of $37.90. We noted that, with the exception of 10 services, the remaining 165 visits were 35 minutes in duration, which is the minimum time to be reimbursed for at the base rate.

Statistical Sample

We reviewed 1,325 services and identified the following instances of non-compliance:

- 27 services with no documentation to support the service;
- 20 services where the units billed exceeded the duration documented;
- 2 waiver services that were not signed by the person receiving the service or an authorized representative;
- 2 waiver services that were not signed by the practitioner providing the service; and
- 1 service billed as two separate visits resulting in the incorrect payment of second base rate.

These 52 errors were used in the overall projection of $3,722,619.

We also found 12 nursing services in which there was no documentation of duration or of arrival and/or departure times. Before June 30, 2015, the first hour (four units) of nursing was paid at the base rate. We noted six such instance of non-compliance with dates of service on or before June 30, 2015 and we did not associate overpayments for these errors as the Provider was reimbursed at the base rate. The remaining six errors were used in the overall projection of $3,722,619.

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 § 5160-12-03(B)(3)(b) to create a plan of care for recipients. The plan of care is required to be signed by the treating physician and home health providers must obtain the completed, signed and dated plan of care prior to billing the ODM for the service.

Statistical Sample

We reviewed 1,325 services and found the following errors:

- 430 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 76 services in which the plan of care did not authorize the service with most of these errors involving therapy (occupational, physical and speech) services;
- 12 services where the plan of care was not signed and dated by a physician; and
- 1 service that was not covered by a plan of care.

These 519 errors are included in the overpayment of $3,722,619. We also noted two plans of care that were incomplete as they lacked frequency and or duration for services. We did not associate an overpayment for these two errors.

All Services Plan

According to Ohio Admin. Code § 5160-12-01, the MCRHHA 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 from our examination period for each of the 66 waiver recipients in the statistical sample and compared the procedure codes authorized on the all services plan to the billed procedure codes and scanned the plans to verify that the Provider was authorized to render waiver services.

We found two services in which the provider was not authorized on the all services plan. These two errors are included in the overpayment amount of $3,722,619.

In addition, we found six procedure codes used by the Provider in its billing that were not authorized on the all service plan. We compared the reimbursed rate between the billed code and the authorized code and determined that the rates were the same. We identified no improper payment for these six 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 use codes as authorized on the all service plan and put additional measures in place to ensure that the Provider is authorized to render a waiver service. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

D. Healthchek Services

According to Ohio Admin, Code § 5160-12-01(H), a recipient may qualify for increased services if (1) the individual is under age 21; (2) requires more than, as ordered by the treating physician, eight hours per day of any home health service or a combined total of 14 hours per week of home health aide and home health nursing services; (3) has a comparable level of care as evidenced by either enrollment in a home and community based service waiver or a level of care initially and annually evaluated by ODM or its designee; and (4) requires nursing or combination of nursing and skilled therapy visits at least once per week as ordered by treating physician. The MCRHHA must assure and document the consumer meets all requirements prior to increasing services. The U5 modifier must be used when billing for Healthchek services in accordance to Ohio Admin. Code § 5101:3-12-05 which indicates that all conditions of this rule have been met.

Statistical Sample

For services that the Provider billed with a U5 modifier, we first determined waiver status using the ODM's care management system. For those individuals found not to be on a waiver, we reviewed the clinical records to verify that an initial and/or annual level of care evaluation form (Healthcheck form) was completed and it demonstrated the comparable level of care.

We reviewed the 272 services billed with the U5 modifier and found 80 services in which there was no Healthchek certification form. We did not associate an overpayment with these errors.

Recommendations:

The provider should establish a system to obtain the Healthchek certification form when rendering additional services as required. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official 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 the application of Medicaid rules regarding plans of care. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Conclusion

We reviewed the additional first aid certificates submitted by the Provider and determined the certificates were not reliable (see page 6). We reviewed the additional service documentation and updated our results accordingly. As per Ohio Admin. Code §§ 5160-12-01 and 5160-12-03, clinical records (including all signed orders) must be complete prior to billing for services. After review of the Providers' response related to service authorization, we determined no change to our results was warranted.

APPENDIX I

Summary of Sample Record Analysis

POPULATION
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. All services paid during September 2015 for recipients living at one address were excluded from this sample population and were examined in their entirety.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. This system contains 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
A stratified random sampling approach was used because of the large variability in the amount paid and the number of services provided per RDOS.

Description	Results
Number of Population RDOS[1]	72,257
Number of Population RDOS Sampled	896
Number of RDOS Sampled with Errors	432
Number of Population Services	101,976
Number of Population Services Sampled	1,325
Number of Services Sampled with Errors	628
Total Amount Paid for Population	$8,493,034.08
Amount Paid for Population Services Sampled	$153,157.42
Projected Population Overpayment Amount	$3,722,619
Upper Limit Overpayment Estimate at 95 % Confidence Level[2]	$4,044,815
Lower Limit Overpayment Estimate at 95 % Confidence Level[2]	$3,401,760
Precision of Population Overpayment projection at the 95% Confidence Level	$322,195.77 (8.66%) Upper $320,858.85 (8.62%) Lower

Source: AOS analysis of MITS information and the Provider's medical records
[1] Number of RDOS expanded from population of 70,305 due to stratification – certain recipients having different types of services on the same date of service.
[2]Adjusted for skewness using the method described in "Sampling Methods For The Auditor, An Advanced Treatment" by Herbert Arkin. This technique made use of tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, Volume 1 3rd Ed., Cambridge University Press, New York, 1969, table 42.

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June 29, 2017

VIA FedEx

Dave Yost, Auditor of the State of Ohio
ATTN: Kristi Erlewine, Chief Auditor
Medicaid/Contract Audit Section
88 East Broad Street, Ninth Floor
Columbus, OH 43215

RE: Response to Draft Compliance Examination Report
Healing Touch Health Care, Ltd.
Chapman File No.: 61.0017.H

Dear Ms. Erlewine:

Please accept this letter as Healing Touch Health Care's ("HTH") initial response to the State Auditor's May 30, 2017, Draft Compliance Examination Report ("Report"). HTH disagrees with your findings and contends that it is not liable for the projected overpayment amount. In addition to HTH's response, we have enclosed one (1) data thumb drive which contains additional documentation for your review. These documents were recently located by HTH and are responsive to your missing documents request made subsequent to the entrance conference. HTH hereby requests that your office cease all recoupment efforts at this time and issue a revised draft compliance examination report based on this response for further supplemental review by HTH before moving to the adoption and adjudication stages.

The Report indicates that your review found improper Medicaid payments during the examination period of January 1, 2013, through December 31, 2015, in the amount of $3,822,822.90. The Report further states that the projected overpayment amount was reached using statistical sampling techniques and was based on the following non-compliance matters: (1) personal aide care services were performed by individuals that did not meet Medicaid's qualification requirements; (2) HTH failed to submit supporting documentation for all services billed for reimbursement; and (3) HTH submitted claims for reimbursement prior to obtaining a signed Plan of Care ("POC"). We will address each alleged area of non-compliance in turn below.

Introduction

HTH has provided high quality health care services in the State of Ohio since 2004. HTH is a Medicare Certified Home Health Agency (MCHHA) that provides a complete range of home health care services. HTH has established internal controls regarding compliance and as explained during the entrance conference, HTH has made every attempt to comply in good faith with all Medicaid regulations.

Provider Qualifications

In subsection A of the results section of the Report, you indicate that no instances of non-compliance were found regarding nursing services or provider qualifications for personal care aides as to initial competency evaluations and in-service hours. However, the section further states that twenty (20) personal care aides were "haphazardly" selected for further review with regards to first aid certification. In your findings, you conclude that one hundred (100) out of one hundred fifty-four (154) personal care aide services reviewed were rendered by one (1) of twenty-two (22) aides that either lacked certification or held a certification that lapsed during the date of service. Thus, the services did not meet the provider qualifications at the time of service and payment for these services was improper.

For personal care aide services to be reimbursable, all individuals providing personal care aide services must complete a competency evaluation program, obtain and maintain a current first aid certification, and complete twelve (12) hours of in-service continuing education. Ohio Administrative Code §§ 5160-12-03(B), 5160-46-04(B), and 5160-47-04(B).

The instances of non-compliance were listed in an attachment to the Report entitled "Exception Test." HTH conducted an additional search for personal aide records of individuals listed on the Exception Test report and located valid first aid certifications for the following twenty-four (24) aides:

Esmaa Al-Mosawi
Michael Blake
Bettie Bledsoe
Kimberly Blythe
Deundria Bryant
Natasha Fall
Shakora Flowers
Michael Freeman
Jerry Gates
Elizabeth Hannon
Phoenix Johnson
Crystal Jones
Lakeisha Jones
Mukhabbat Kurbanova
Ashley Nicholson
Mary Lou Ovaska
Mermill Reynolds
Erika Sy
Ronald Thompson
Nargisa Umarova
Janae Wilbur
Regina Wilcox
Karina Wilkins
Debra Woody

First aid certifications for these aides can be found on the enclosed thumb drive. Therefore, payment for the services rendered by these aides at the time of service delivery were proper. The one hundred (100) alleged services were used in the overall projection of the total overpayment amount. Given the submission of the requisite first aid certifications, the overall projection must be recalculated.

Service Documentation

In subsection B of the results section of the Report, you indicate that seventy-eight (78) instances of non-compliance were found. Of the seventy-eight (78) instances, forty-six (46) services did not have documentation to support the service; twenty-seven (27) services had the units billed exceeding the duration; three (3) services were not signed by the recipient; and two (2) services were not signed by the practitioner providing the service.

Under the applicable regulations, a MCHHA must maintain documentation of home health services provided including, but not limited to, clinical records and time keeping that indicate time span of the service and the type of service provided. Ohio Administrative 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. Ohio Administrative Code §§ 5101:3-46-04(B)(8), 5101:3-47-04(B)(8), and 5101:3-50-04(B)(8). Additionally, 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 verifying the services upon completion. Ohio Administrative Code §§ 5101:3-45-10(A).

The instances of non-compliance were listed in an attachment to the Report entitled "Full Sample." HTH conducted an additional search for missing documentation and located supporting documentation related to numerous services provided to twenty-four (24) recipients. Documentation for these services can be found on the attached thumb drive. Therefore, payment for these services was proper. These services were used in the overall projection of the total overpayment amount. Given the submission of the requisite documentation, the overall projection must be recalculated.

Authorization to Provide Services

In subsection C of the results section of the Report, you indicate that five hundred nineteen (519) instances of non-compliance were found. Of the five hundred nineteen (519) instances, four hundred thirty (430) services were deemed non-compliant because the claims were submitted for reimbursement prior to the date the physician signed the POC.

Pursuant to Ohio Administrative Code § 5101:3-12-03(B)(3)(b), all home health providers must create a POC for recipients. Moreover, home health services are reimbursable if a qualifying treating physician certifying the need for home health services documents a face-to-face encounter with the individual within

ninety (90) days prior to the start of care date or within thirty (30) days following the start of care date. Ohio Administrative Code § 5101:3-12-01(B). A MCHHA must bill after all documentation is completed for the services rendered during a visit. Ohio Administrative Code § 5101:3-12-01(E)(8).

In the case of HTH, the home health services were medically necessary and rendered pursuant to a valid physician order. As you are aware, the treating physician initially submits a verbal order via telephone which is documented immediately by a nurse. Following the start of care and in compliance with Medicaid regulations, the treating physician then signs the POC within thirty (30) days of the start of care date. Finally, HTH submitted claims for reimbursement once the documentation was complete for each service provided.

The auditor's application of the regulations in this case is misguided. Pursuant to the applicable code, home health services are reimbursable if the treating physician signs the POC within thirty (30) days following the start of care. Here, the physicians signed within the thirty (30) day timeframe. Additionally, an agency cannot bill until all documentation is completed for the services rendered during a visit. In the State of Ohio, Medicaid has a fee for service payment model which means services are unbundled and paid for separately. In this case, HTH submitted claims for reimbursement after the documentation was complete for each service. The interpretation that the documentation is not "complete" because a physician has not signed a POC is not supported by the regulations. A physician is permitted to sign a POC within an allotted timeframe after the start of care. Because a physician has only entered a verbal order, which is permitted by the regulations, does not make the documentation incomplete. Providers should not be unfairly penalized for complying with this regulation by interpreting this regulation as such. Therefore, the services met the requirements for payment, and HTH properly billed for the services.

The four hundred thirty (430) services were used in the overall projection of the total overpayment amount. Given HTH's compliance addressed above, the overall projection must be recalculated.

Conclusion

HTH has been very cooperative at every stage of the process and will continue to cooperate during the remainder of the audit. In this case, HTH has substantially complied with Medicaid's requirements for payment, and a revised draft compliance examination report should be issued for additional review by HTH before continuing to the adoption and adjudication stages. HTH reserves the right to submit additional documentation at all stages of the audit process and provide a supplemental response if a revised report is issued.

Appendix I of the Report contains a summary of the data used to calculate the projected overpayment. HTH respectfully requests the data used to formulate the overall projection and reserves the right to challenge the extrapolation calculations in the future.

As requested, please also find enclosed a Medicaid Provider Representation Letter. Thank you for your time and consideration. We look forward to working with you on this matter. If you have any additional questions or concerns, please do not hesitate to contact us.

Sincerely,

CHAPMAN LAW GROUP

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MMF/rb
Enclosures

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Dave Yost • Auditor of State

HEALING TOUCH HEALTHCARE LLC

MONTGOMERY COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
SEPTEMBER 26, 2017

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