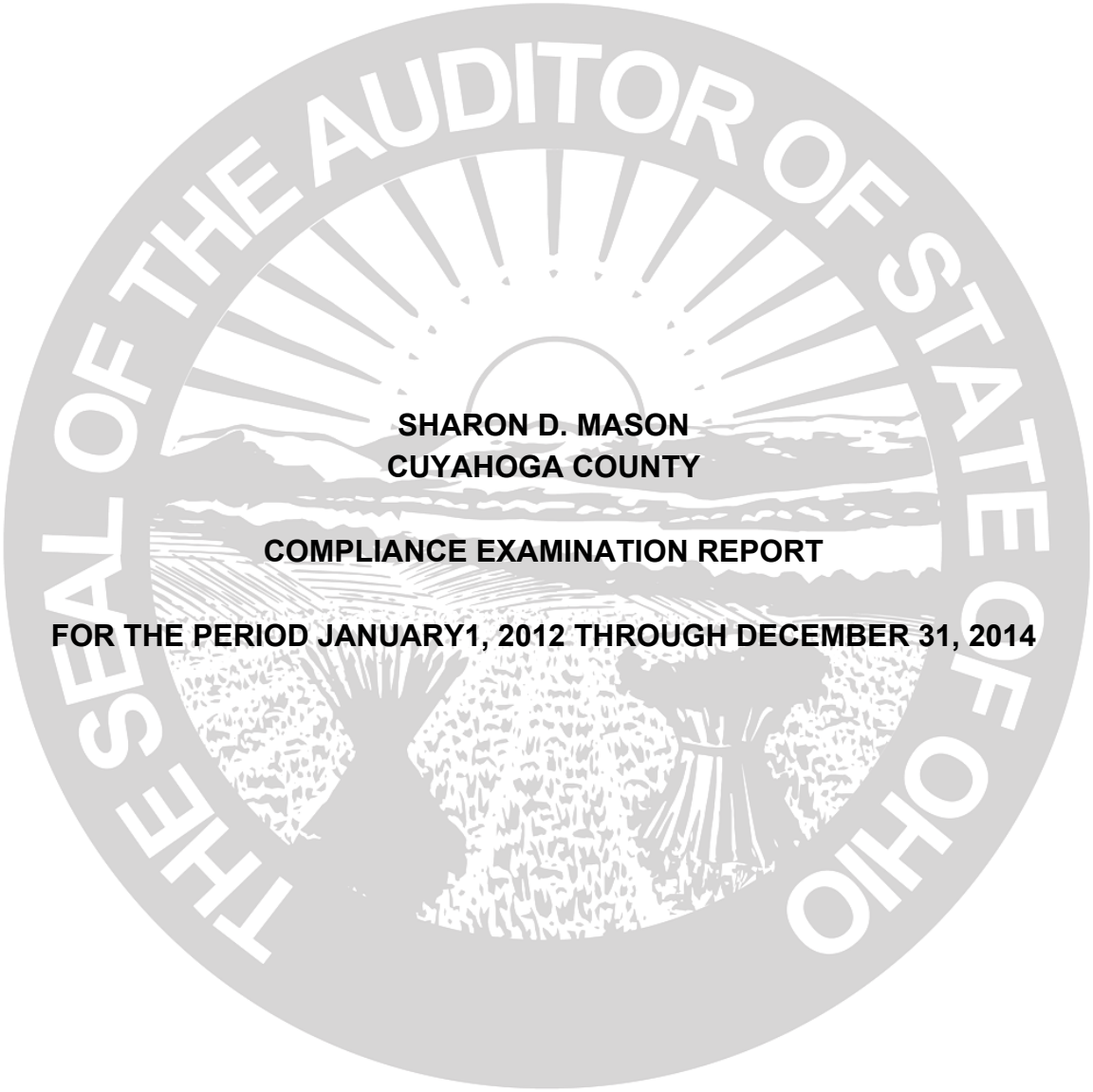

SHARON D. MASON
CUYAHOGA COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY1, 2012 THROUGH DECEMBER 31, 2014

Dave Yost · Auditor of State

SHARON D. MASON
CUYAHOGA COUNTY

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

Sharon D. Mason
6937 Elmwood Drive
Solon, Ohio 44139

Dear Ms. Mason:

We examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of personal care aide services during the period of January 1, 2012 through December 31, 2014. We reviewed your records to determine if there was 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, as well as reviewed if 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.

Basis for Disclaimer of Opinion

As described in the Compliance Examination report, we were unable to gain assurance regarding the validity of documentation supporting the Provider's compliance with the specified Medicaid requirements. We found documentation that could not have been completed and signed contemporaneously with service delivery and documentation that included false information.

Disclaimer of Opinion

Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements 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 the specified Medicaid requirements for the period of January 1, 2012 through December 31, 2014, in all material respects.

We found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2012 and December 31, 2014 in the amount of $49,530.24. This finding plus interest in the amount of $2,386.61 totaling $51,916.85 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 Ohio Department of Medicaid, 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.

Dave Yost
Auditor of State

January 25, 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) 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 personal care aide services that assist the recipient with activities of daily living such as bathing and dressing, general homemaking activities, household chores, personal correspondence, accompanying the consumer to medical appointments or running errands. *See* Ohio Admin. Code § 5160-46-04(B)(1)

This Provider is a personal care aide located in Cuyahoga County, Ohio, who rendered services to one Ohio Medicaid recipient on an Ohio Home Care waiver. The Provider's Medicaid number is 3093898 and during our examination period received reimbursement of $175,230.09 for 1,269 personal care aide services (procedure code T1019), rendered on 987 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service.

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 personal care aide services the Provider rendered to one Medicaid recipient during the period of January 1, 2012 through December 31, 2014.

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 all services with a paid amount of zero. We then removed 75 services dated March 1, 2014 through May 31, 2014 previously identified in a structural review as non-compliant for which the Provider was required to adjust the claims in MITS, but had not yet done so.

From the remaining population we extracted all services on five specific dates in 2012 to test in their entirety as an exception test. ODM's Surveillance and Utilization Review (SURS) section received these five dates of service as a referral of alleged overpayments due to lack of supporting documentation but had not yet investigated the referral.

We clustered the remaining population by RDOS and selected a statistical random sample by RDOS to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We then obtained the detailed services for the 277 sampled RDOS. This resulted in a sample size of 342 services.

Purpose, Scope, and Methodology (Continued)

An engagement letter was sent to the Provider, setting forth the purpose and scope of the examination. During the entrance conference the Provider described her documentation practices, procedures for obtaining all service plans, and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed personnel records and service documentation. The Provider was given multiple opportunities to submit additional documentation and we reviewed all documents received for compliance.

Results

Exception Test

We examined 10 personal care aide services and found two errors for units billed exceeding units documented. As a result, we identified $96 as an overpayment.

Statistical Sample

We examined 342 personal care aide services in our Statistical Sample and found 164 errors. We identified overpayments for 164 of 342 statistically sampled recipient services (151 of 277 RDOS). Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $113,000, with a 95 percent certainty that the actual correct payment amount fell within the range of $105,274 to $120,725 (+/- 6.84percent.) We then calculated findings by subtracting the correct population amount ($113,000) from the amount paid to the Provider for this population ($162,434.24), which resulted in a finding of $49,434.24. 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 described below in more detail.

A. Provider Qualifications

According to Ohio Admin. Code § 5101:3-46-04(B)(7)[2] personal care aide services requires aides to obtain and maintain first aid certification, as well as support of completion of 12 hours of in-service continuing education (CE) within a 12 month period.

First Aid Certification

The Provider maintained first aid certification for the examination period.

In-Service Continuing Education

We applied an 80 percent threshold in determining eligibility. If the Provider completed less than 80 percent (10 of the 12 required CE hours), we identified the Provider as ineligible to render services for that year. If the Provider completed at least 10 of the 12 CE hours, we identified the Provider as not materially compliant but eligible to render services.

[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. This renumbering effects all rules noted in the Results section of this report.

A. Provider Qualifications (Continued)

We obtained documentation of the Provider's CE hours from the Provider and the ODM's designees that monitored waiver providers during the examination period. We found that the Provider was compliant in 2012 and 2013 by was not materially compliant in 2014. She was eligible to render services in all three years. The Provider did not maintain documentation to support all of her CE hours in each year and did not make any effort to obtain this documentation until after we had issued a draft report. ODM's designee's records showed that the Provider did not complete the required hours for 2014 within the 12 month time frame; however, she did complete the hours in response to her annual structural review. We identified no overpayments for this non-compliance.

Recommendation:

The Provider should obtain the required annual in-service education by her anniversary date and maintain proof of such, for at least six years. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Ohio Admin. Code § 5101:3-46-04(B)(8)(g) states all personal care aide providers must maintain a clinical record that includes documentation of tasks performed or not performed, arrival and departure times, and dated signatures of the provider and recipient or authorized representative, verifying service delivery upon completion of service delivery.

The Provider's documentation largely consisted of a template which included the exact same tasks for every day of every week. At times this documentation had a typed date, at times a handwritten date was added and at times the typed date was crossed out and a different handwritten date was added. The Provider also submitted a second set of documentation labeled "PCA activity sheets". On these forms the Provider manually added the date and time of service and check marked the tasks performed. Neither set of documents covered the entire examination period. There were instances in which the Provider submitted a typed service document based on the template and a PCA activity sheet for the same service. In some of these instances, the two documents contained conflicting information.

We noted that the typed documentation from the template included a statement that the Provider called a specific physician every day. We contacted this physician and found that the recipient was referred to this physician in October, 2013, was seen for the first time on November 5, 2013 and the Provider did not call the physician daily after that date. Accordingly, the typed documentation could not have completed, signed and dated contemporaneously prior to November 5, 2013 and included false information after that date.

Due to the aforementioned, we determined that the typed template- based documentation was unreliable and reviewed only the PCA activity sheets for compliance.

Exception Test

We reviewed 10 services and identified two services in which the units billed exceeded the units documented. The overpayment is based only on the unsupported units. The two errors are included in the overpayment of $96.00.

B. Service Documentation (Continued)

These 10 services were referred to ODM by the contracted administrator of the Ohio Home Care Program after the Provider failed to submit supporting documentation as requested for a structural review. The production of these documents for this examination, after it was previously documented that they did not exist, contributed to our questioning the reliability of the Provider's service documentation.

Statistical Sample

We reviewed 342 services and found the following errors:

- 74 services in which the Provider submitted only typed documentation based on a template that was determined to be unreliable;
- 51 services in which one continuous shift was documented but two separate shifts were billed which resulted in overpayment for a second base rate;
- 18 services in which there was no documentation;
- 17 services in which the units billed exceeded the units documented; and
- 4 services in which the time in and/or time out were missing so there was no service duration.

The overpayment for instances of units billed exceeding units documented is based only on the unsupported units. The overpayment for billing one visit in two separate shifts is based on the difference in billing a second base rate instead of four units. These 164 errors were used in the overall projection of $102,234.

Recommendation:

The Provider should ensure that only services actually rendered are billed. The Provider should also contemporaneously prepare accurate and reliable documentation for all services rendered and maintain the documentation as required by Ohio Admin. Code § 5160-46-04(B). These issues should be addressed to ensure compliance with Medicaid rules and avoid future findings.

C. All Services Plan

Ohio Admin. Code § 5101:3-46-04(B)(5)(d) states that in order to submit a claim for reimbursement, the Provider must be identified on the recipient's all services plan and have specified the number of hours for which the provider is authorized to furnish personal care aide services to the recipient.

We reviewed the ASPs in effect for our examination period and verified that the Provider was authorized to render personal care aide services to the recipient.

Provider Response:

The Provider was afforded an opportunity to respond to this report but declined to do so. An exit conference was held with the Provider during which the results of the examination were discussed. The Provider submitted additional documentation after the exit conference and we reviewed all documents received for compliance.

APPENDIX I

POPULATION
The population is all paid Medicaid personal care aide services (procedure code T1019), 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 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	977
Number of Population RDOS Sampled	277
Number of RDOS Sampled with Errors	151
Number of Population Services Provided	1,184
Number of Population Services Sampled	342
Number of Services Sampled with Errors	164
Total Medicaid Amount Paid for Population	162,434.24
Actual Amount Paid for Population Services Sampled	$46,366.62
Projected Correct Population Payment Amount	$113,000
Upper Limit Correct Population Estimate at 95 Percent Confidence Level	$120,725
Lower Limit Correct Population Estimate at 95 Percent Confidence Level	$105,275
Projected Overpayment Amount (Actual Amount Paid for Population Services minus Projected Correct Population Payment Amount)	$49,434.24
Precision of Estimated Correct Population Payment Amount at the 95 Percent Confidence Level	$7,726 (+/-6.84%)

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Dave Yost • Auditor of State

SHARON MASON

CUYAHOGA 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
FEBRUARY 16, 2017

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