STEPHANIE Y. MOATS, LPN
LICKING COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2012 THROUGH DECEMBER 31, 2014

Dave Yost · Auditor of State

STEPHANIE Y. MOATS, LPN
LICKING COUNTY, OHIO

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH MEDICAID REQUIREMENTS APPLICABLE TO PRIVATE DUTY NURSING AND WAIVER NURSING SERVICES

Stephanie Y. Moats, LPN
362 Meadow Lane
Newark, Ohio 43055

Dear Ms. Moats:

We were engaged to examine your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, service authorization, and use of modifiers related to the provision of private duty and waiver nursing services during the period of January 1, 2012 through December 31, 2014. We confirmed your licensure status and the licensure status of your supervising registered nurse (RN) during the examination period. We tested service documentation to verify that there was support for the date of service, the procedure code and modifiers, and the units billed to and paid by Ohio Medicaid. In addition, we tested your service documentation to determine if it contained the required elements. We also tested the plans of care and all services plans to determine if you were appropriately authorized.

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. The examination does not provide a legal determination on the Provider's compliance with the specified requirements.

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.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the specified Medicaid requirements referred to above. 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

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.

Disclaimer of Opinion

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 subject matter is in accordance with the criteria, in all material respects.

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 January 1, 2012 and December 31, 2014 in the amount of $1,957.26. This finding plus interest in the amount of $148.00 totaling $2,105.26 is due and payable to the ODM upon its adoption and adjudication of this 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 the 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, and is not intended to be, and should not be used by anyone other than this specified party.

Dave Yost
Auditor of State

January 12, 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 for Stephanie Moats, LPN

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(A) and (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(D) and (E)

Home care nursing services under Ohio Medicaid may include private duty and waiver nursing services. A nurse rendering private duty and waiver nursing services requires written authorization. *See* Ohio Admin. Code § 5160-12-02.3(B) and 5160-47-04 (A) Private duty and waiver nursing services must be provided and documented in accordance with the recipient's plan of care, which is a medical treatment plan that is established, approved and signed by the treating physician. The plan of care must be signed and dated by the treating physician prior to requesting reimbursement for a service. *See* Ohio Admin. Code § 5160-12-02(B) and 5160-47-04 (A)

The Provider is a licensed practical nurse (LPN) who rendered private duty nursing and waiver nursing services to five Ohio Medicaid recipients during the examination period. The Provider's Medicaid number is 2089654 and during our examination period received reimbursement of $392,019.66 for 1,820 private duty nursing services (procedure code T1000) and 1,449 LPN services (procedure code T1003) provided on 822 unique dates of services (DOS). The Provider billed 3,250 of these services with an HQ modifier, indicating that these were services provided in a group setting.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's claims for reimbursement complied with Ohio Medicaid regulations. The scope of the engagement was limited to an examination of private duty nursing (procedure code T1000) and LPN services (procedure code T1003) the Provider rendered during the period of January 1, 2012 through December 31, 2014 and received payment from Ohio's Medicaid program. 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.

We received the Provider's claims history from the Medicaid Information Technology System (MITS). We removed all services with a paid amount of zero. From this population, we extracted eight services on four dates: January 7, 2013, September 11, 2013, September 12, 2013 and December 14, 2014 in which only one service was billed with a HQ modifier. These services were reviewed in their entirety (Exception Test 1). We also noted two specific dates in which the provider billed a total of 169 units and 160 of these units were billed for two recipients. We extracted all services provided these dates to examine in their entirety (Exception Test 2).

Purpose, Scope, and Methodology (continued)

After removing the services in the two exception tests, we 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). From the remaining population of private duty nursing and waiver nursing services, we selected a stratified random sample. Specifically, we stratified the services by DOS into three strata using the actual stratum standard deviation of the amount paid and a 50 percent error rate. The final calculated sample size is shown in Table 1.

Table 1 – Statistical Sample

Universe/Strata	Population	Sample
Strata 1: DOS with Less Than 96 Units of Service	473	139
Strata 2: DOS with 96 Units of Service	251	74
Strata 3: DOS with Greater Than 96 Units of Service	95	50
Total DOS:	819	263

We then obtained the detailed services for the 263 sampled DOS. This resulted in a sample size of 1,076 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. An entrance conference was held with the Provider during which the Provider described her documentation practices, procedures for obtaining plans of care, all services plans, individual service plans and process for submitting billing to the Ohio Medicaid program. Our field work was performed following the entrance conference. We sent a missing records list and a final request for information to the Provider and we reviewed all documents received for compliance.

Results

Exception Test 1 – Dates Containing Services Without an HQ Modifier

We examined eight services on dates on which at least one service was billed without an HQ modifier and found four errors. As a result, we identified $245.18 as an overpayment.

Exception Test 2 – Two Service Dates with 169 Units

We examined 16 services on two dates of service in which 169 units were billed per day and found 10 errors. As a result, we identified $1,172.34 as an overpayment.

Statistical Sample

We examined 1,076 services and identified 31 errors. As a result, we identified $539.74 as an overpayment.

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

A. Provider Qualifications & Supervision

According to Ohio Admin. Code § 5160-12-02(A)[2], private duty nursing requires the skills of and is performed by either an RN or an LPN at the direction of an RN. According to Ohio Admin. Code §§ 5160-46-04(A)(1) and 5123:2-9-59(C)(2)(a)[3], all nurses providing waiver nursing services must possess a current, valid and unrestricted license with the Ohio Board of Nursing.

In addition, a non-agency LPN, providing waiver nursing services must conduct a face-to-face visit with the directing RN every 60 days and with the recipient and the directing RN every 120 days. The LPN must have clinical notes, signed and dated by the LPN documenting these face-to-face visits. *See* Ohio Admin. Code § 5160-46-04(A)(5) and 5123:2-9-59(D)(4)

We verified through the Ohio e-License Center that the Provider and her supervisors were licensed through the Ohio Board of Nursing as an LPN and RN, respectively, and that all licenses were in active status during our examination period.

The Provider submitted "Supervisory Visit Note" forms as evidence that she worked under the direction of an RN. We received forms for each recipient; however we found 14 instances where the Provider's supervisory visits exceeded 60 days. These 14 instances included lapses of two or three days and involved supervisory visits for five different recipients. We identified no overpayment for these 14 errors.

Recommendation:

The Provider should ensure that supervisory visits occur in a timely manner as required to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Per Ohio Admin. Code § 5160-12-02, private duty nurses are required to comply with Ohio Admin. Code § 5160-12-03 which requires documentation on all aspects of services provided including time keeping records that indicate the date and time span of the services provided during a visit and the type of service provided. Ohio Admin. Code §§ 5160-46-04(A)(6) and 5123:2-9-59(E)(2)(j) state all providers must maintain a clinical record that includes tasks performed or not performed, arrival and departure times and the dated signature of the provider and recipient or authorized representative verifying service delivery upon completion of service delivery. In addition, Per Ohio Admin. Code §§ 5160-12-06(C)(2), 5160-46-04(A)(7) and the Appendix to 5123:2-9-59, a unit rate is the amount paid for each 15 minute unit after the base rate paid for the first four units of service provided.

Exception Test 1 – Dates Containing Services Without an HQ Modifier

We found no errors.

[2] Except as noted, the rules noted in the results section are the numbers effective beginning October 1, 2013. Prior to that time the rules were within the Department of Job and Family Services rules but were renumbered per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly to reflect the transfer of the Office of Medical Assistance to the ODM.

[3] This Transitions Waiver was moved to the Ohio Department of Developmental Disabilities effect January 1, 2013. Prior to that time this waiver was administered by the ODM and was numbered Ohio Admin. Code § 5101:3-47.

B. Service Documentation (Continued)

Exception Test 2 – Two Service Dates with 169 Units

We found six services in which there was no service documentation. These six errors are included in the total overpayment of $ 1,172.34.

Statistical Sample

We found five services in which there was no service documentation and four services in which units billed exceeded the units documented. The overpayment for these instance of units billed exceeding units documented is based only on the unsupported units. These nine errors are included in the total overpayment of $539.74.

In addition, we identified 13 services in which the units billed exceeded the units documented however the Provider billed less than four units and was therefore reimbursed the base rate. These instances of non-compliance resulted in no overpayment by Ohio Medicaid.

Recommendation:

The Provider should ensure that units billed are supported by time keeping records and bill accurately for services rendered. 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

According to Ohio Admin. Code § 5160-12-02(B)(2), private duty nursing services must be provided and documented in accordance with the recipient's plan of care. In addition, Ohio Admin. Code §§ 5160-46-04(A)(4)(g) and 5101:3-47-04(A)(4)(g) state that in order to be a provider and submit a claim for reimbursement of waiver nursing services, the LPN at the direction of the RN, must be identified as the provider on, and be performing nursing services pursuant to the recipient's plan of care, and the plan of care must be signed and dated by the recipient's treating physician.

All Services Plan / Individual Service Plan

Ohio Admin. Code § 5160-46-04(A)(4)(f) states that 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 waiver nursing services to the recipient. In addition, Ohio Admin. Code § 5123:2-9-59(D)(2) states a provider of waiver nursing services shall be identified as the provider and have specified in the individual service plan the number of hours for which the provider is authorized to furnish waiver nursing services.

Exception Test 1 – Dates Containing Services Without an HQ Modifier

We found no errors.

Exception Test 2 – Two Service Dates with 169 Units

We found four services in which the Provider rendered services and billed Medicaid prior to obtaining a signed plan of care. These four errors are included in the total overpayment of $1,172.34.

C. Authorization to Provide Services (Continued)

Statistical Sample

We identified eight services for one recipient in which the plan of care did not contain the scope, frequency and duration of the service. We identified no overpayment for these eight errors since the service was also authorized on the recipient's all services plan.

Recommendation:

The Provider should verify that the service, frequency and duration are noted on the plan of care and should ensure that all plans of care are signed by the physician prior to a submitting a claim to ODM for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

D. Modifiers

Per Ohio Admin. Code §§ 5160-12-04(D)(3), 5160-12-06(D) and 5160-46-06(E), an HQ modifier must be used when billing for a group visit and the amount of reimbursement shall be the lesser of the provider's billed charge or 75 percent of the Medicaid maximum. Ohio Admin. Code § 5123:2-9-59(F)(2) states claims for payments must be in accordance with Ohio Admin. Code § 5160-41-22 which includes the same requirement for the use of an HQ modifier and the same payment rate.

Exception Test 1 – Dates Containing Services Without an HQ Modifier

We found four services in which the documentation showed that services were rendered to two recipients on the same date at the same time and one of the services was not billed with an HQ modifier. The overpayment for these errors is based on the difference between the reimbursed rate and the rate for a group visit. These four errors are included in the total overpayment of $245.18.

Exception Test 2 – Two Service Dates with 169 Units

We found no errors.

Statistical Sample

We found one service in which there was documentation for two recipients on the same date at the same time and one of the services was not billed with an HQ modifier. The overpayment for the one error is based on the difference between the reimbursed rate and the rate for a group visit. This one error is included in the total overpayment of $539.74.

Recommendation:

Provider should ensure services are properly billed, including required modifiers. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Provider Response

The Provider was afforded an opportunity to respond to this examination report. The Provider declined an exit conference to discuss the results of this examination and also declined to submit an official response to the results noted above.

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STEPHANIE MOATS

LICKING 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 4, 2017

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