JAMES T. DELVER, LPN
MIAMI COUNTY

MEDICAID PROVIDER AUDIT

FOR THE PERIOD JULY 1, 2006 TO JUNE 30, 2009

Dave Yost · Auditor of State

JAMES T. DELVER, LPN
MIAMI COUNTY

TABLE OF CONTENTS

ACRONYMS

AOS	Auditor of State
ASP	All Services Plan
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HC	Home Care
LPN	Licensed Practical Nurse
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
PDN	Private Duty Nursing
POC	Plan of Care
RDOS	Recipient Date of Service
RN	Registered Nurse

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Independent Accountant's Report on Medicaid Provider Reimbursements

James T. Delver, LPN
1208 Charleston Court
Troy, Ohio 45737

RE: *Medicaid Provider Number 2746532*

Dear Mr. Delver:

The Auditor of State performed an audit of Medicaid reimbursements made to James T. Delver, LPN, Ohio Medicaid Provider No. 2746532 (the "Provider"), during the period of July 1, 2006 to June 30, 2009. The Provider furnishes private duty nursing and waiver nursing services to Ohio Medicaid patients. This audit, however, only examined the Provider's private duty nursing services during the audit period. Our audit was performed according to our authority in Section 117.10 of the Ohio Revised Code and our Letter of Arrangement with the Ohio Department of Job and Family Services (ODJFS).

We identified $68,529.32 in findings for improper charges to Ohio Medicaid based on reimbursements that did not meet the Medicaid rules in effect at the time the services were provided. We also assessed interest in the amount of $13,893.62 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $82,422.94. The total amount of the findings and interest is repayable to ODJFS as of the release of this audit report. Additional interest of $15.02 per day will accrue after January 31, 2012, until repaid.

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (collectively referred to as "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Handbook. A fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services. *See* Ohio Admin. Code § 5101:3-1-01(A)

The Auditor of State (AOS) audits Medicaid providers to assess compliance with the Medicaid reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, medical necessity, and sound fiscal, business or medical practices. According to Ohio Admin. Code § 5101:3-1-17.2(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 or until any audit initiated within the six year period is completed. When the AOS identifies fraud, waste or abuse by a provider in an audit,[1] "any amount in excess of that legitimately due to the provider will be recouped by ODJFS

[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 defined as 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 § 5101:3-1-29(A)

through its office of fiscal and monitoring services, the state auditor, or the office of the attorney general." Ohio Admin. Code § 5101:3-1-29(B)

Some Ohio Medicaid patients may be eligible to receive private duty nursing (PDN) services provided by a registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a RN. Ohio Admin. Code § 5101:3-12-02(A) Qualifying PDN services must be medically necessary and greater than four but no more than 12 hours in length, unless an authorized exception applies. Ohio Admin. Code § 5101:3-12-02(A)

All LPNs providing PDN services, such as the Provider here, must be supervised by a RN. Ohio Admin. Code § 5101:3-12-02(A). LPNs providing PDN services at the direction of an RN must maintain records for each patient containing all of the information listed in Ohio Admin. Code § 5101:3-12-03 (B) and (C)(4)[2] including:

- Signed and dated certifications by treating physicians of treatment plans at least every 60 days (§ 5101:3-12-03(B)(3)(b));
- Contents of plans of care (POC) specifying the services to be performed, the identity of the professionals performing them, and the nature, frequency, scope, and duration of each service provided (§ 5101:3-12-03(B)(3)(b)); and
- Clinical records (including all signed orders) and time keeping records documenting the details of each visit including the date, type and time span of services provided (§ 5101:3-12-03(C)(4)(a) and (b)[2]).

Ohio Medicaid will only pay the PDN for services provided to the patient as specified by the POC, and which services are properly documented. Ohio Admin. Code § 5101:3-12-02(C)(2)

Home care (HC) nursing services under Ohio Medicaid may include PDN services, waiver nursing services, or both. *See, e.g.,* Ohio Admin. Code §§ 5101:3-12-02 and 5101:3-46-04 When a private duty nursing patient receiving PDN nursing care is also on an ODJFS administered waiver nursing program, an all services plan (ASP) is required in addition to the POC. *See* Ohio Admin. Code § 5101:3-12-03.1(C) The ASP lists all Medicaid home health services approved for the patient including PDN services, and services under the waiver program such as the type, frequency and duration. The ASP also specifies which providers can render services and subsequently bill Ohio Medicaid for them. *See* Ohio Admin. Code § 5101:3-45-01(D)

Here the Provider only provided PDN services to Medicaid patients who also received waivered nursing or aide services from another provider during the audit period. Consequently, the Provider was required to comply with the waiver program requirement that there must be an ASP for each patient covering the PDN services. *See* Ohio Admin Code § 5101:3-12-03.1(C)

Purpose, Scope, and Methodology

The purpose of this audit was to determine whether the Provider's claims for reimbursement for private duty nursing services during the audit period complied with Ohio Medicaid regulations and to identify, if appropriate, any findings resulting from non-compliance.

We held an entrance conference with the Provider on April 6, 2011, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for PDN services which the Provider rendered to Ohio Medicaid patients and received payment during the period of July 1, 2006 to June

[2] Section number changed from (C)(3) to (C)(4) on November 8, 2007 with no change to content.

30, 2009. The Provider was reimbursed $223,133.69 for 961 services rendered on 955 recipient dates of service (RDOS) during the audit period. A recipient date of service (RDOS) is defined as all services for a given patient on a specific date of service.

We reviewed the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. This claims data included: patient name, patient identification number, date of service, and service rendered.

Prior to beginning our fieldwork, we performed a series of computerized exception tests on the Provider's Medicaid payments to determine if any potentially inappropriate reimbursements occurred. Our exception tests analyzed:

- Dates where the Provider billed for multiple patients on the same date of service without using the 'HQ' group modifier; and

- Whether there were claims billed for the same patient, for the same procedure, for the same date, without using a modifier to show that a second visit occurred on that date.

The exception tests did not reveal any errors by the Provider failing to use the proper modifiers.

We selected a pilot statistical random sample of 50 recipient dates of service (RDOS) to facilitate a timely and efficient audit of the Provider's nursing services. All supporting documentation was requested from the Provider for the services on the selected RDOS.

Our review of the pilot sample determined the Provider was missing an all service plan covering a portion of the audit period which caused the Provider to bill for services which were not authorized by Ohio Medicaid. According to Ohio Admin. Code § 5101:3-1-17.2(D), the Provider must maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. Therefore, we changed our methodology from a statistical sample of the billed PDN services to a 100 percent review of all ASPs and POCs for the patients who received services from the Provider during the audit period.

Our fieldwork was performed between August, 2010 and May 2011.

Results

We identified findings of $68,529.32 from our 100 percent review of the Provider's plans of care and all services plans. The bases for our findings are discussed below in more detail.

A. Billed Services Not Authorized on the All Services Plan

We reviewed the ASPs obtained from ODJFS for all of the patients for whom the Provider billed Ohio Medicaid for PDN services during the audit period. We compared the number of hours billed for PDN services to the number of hours approved by the case manager in the ASPs for the date span of each ASP. *See* Ohio Admin. Code § 5101:3-46-04(A)(6).

Our comparison revealed 264 RDOS where the Provider billed the Ohio Medicaid program for more PDN services than were approved. These issues included:

- 197 services where there was no ASP authorizing the services billed; and
- 67 services where the Provider billed for more hours than authorized by the ASP.

The 67 services identified where the Provider billed for more hours than authorized on the ASP were subsequent to a structured review conducted by CareStar, the contract case manager retained by ODJFS. In this structured review on April 14, 2008 and reported to the Provider on May 5, 2008, the Provider was informed that "Waiver nursing services do not include services performed in excess of the number of hours approved pursuant to the all services plan." The Provider was further instructed that all services to consumers must be prior approved by CareStar; that services without prior approval could not be billed; and that billings over the authorized amount could be considered an overpayment and subject to refunding.

The total reimbursement for these 264 private duty nursing services was denied and a finding was made in the amount of $59,701.45.

B. Billed Services not Supported by Plans of Care

Ohio Medicaid rules require that nurses perform PDN services and waivered nursing services in accordance with an approved plan of care. This plan of care consists of "signed and dated written orders from the treating physician." Ohio Admin. Code § 5101:3-12-03(B)(3)(b) A plan of care must contain a description of the type, frequency, scope, and duration of the nursing services that are to be performed. Ohio Admin. Code §§ 5101:3-12-03 (B)(3)(b) and 5101:3-12-02(B)(2) Services not included in the plan of care are not reimbursable. Ohio Admin. Code § 5101:3-12-02(C)(2)

Our review identified five plans of care which did not contain the required elements of frequency, scope and duration of treatment. Instead, these five POCs stated that skilled nursing should be provided "as requested" which does not satisfy the requirement to specify the number of days (frequency) and the length of the service to be provided (duration). We also found three services for which the Provider was unable to produce a plan of care.

We denied the reimbursement for all services which were covered by the plans of care which did not contain the required elements of frequency and duration of treatment, and the services that did not have a plan of care. We made a finding for $8,827.87.

Conclusion

We found the Provider was overpaid by Ohio Medicaid for PDN services between July 1, 2006 and June 30, 2009 in the amount of $68,529.32. The finding is the sum of $59,701.45 for services not authorized on the ASPs, and $8,827.87 for services not supported by the POCs. We also found instances where the Provider failed to submit documentation for supervisory visits but we did not take a finding for this error. This finding plus interest in the amount of $13,893.62 through January 31, 2012, totaling $82,422.94 is immediately due and payable to ODJFS as of the date of release of this audit report. After January 31, 2012, additional interest will accrue at the rate of $15.02 per day until the finding and interest is paid in full.

Provider Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on December 07, 2011, and the Provider was afforded an opportunity to respond to this audit report. A written response was received from the Provider on December 29, 2011 and is attached in Appendix I.

Auditor of State's Conclusion

The Provider in his response submitted that all 264 services, either lacking an ASP or billed in excess of the ASP, were included on the POCs prescribed for the patients in his care by the various treating physicians. The Provider further submitted that his Case Manager had knowledge of the services rendered and should have updated the ASP to reflect the services furnished.

Our review of the Provider's records, however, showed an across the board lack of ASPs to authorize services for approximately the first four months of billing. Missing ASPs cropped up occasionally thereafter. One patient had no ASPs and no POCs. Another patient had no ASP for the last four months billed. We also reviewed structured reviews of the Provider conducted by CareStar in 2008, 2009 and 2010 which showed that the Provider had been instructed about problems with a lack of documentation of communication with the case manager (the 2008 review); billing for more hours than authorized on the ASP (all three reviews); having POCs that did not specify the type, frequency, scope and duration of the nursing service to be provided (the 2009 review); and providing nursing services without a signed and dated POC (the 2009 review). The Provider failed to heed the guidance of the case manager. The Provider cannot bill Ohio Medicaid for services that are not authorized in a POC and/or ASP.

We are forwarding this report to ODJFS because it is the state agency charged with administering Ohio's Medicaid program. ODJFS is responsible for making a final determination regarding recovery of our findings and any accrued interest. If you agree with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are also being sent to the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Board of Nursing. In addition, copies are available to the public on the Auditor of State website at www.auditor.state.oh.us.

Questions regarding this report should be directed to Charles H. Brown, III, Chief, Medicaid Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Dave Yost
Auditor of State

January 20, 2012

cc: Ohio Attorney General, Medicaid Fraud Control Unit
Ohio Department of Job and Family Services, Surveillance and Utilization Review Section
U. S. Department of Health and Human Services/Office of Inspector General
Ohio Board of Nursing

APPENDIX I

FAUST, HARRELSON, FULKER, McCARTHY & SCHLEMMER, LLP
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December 28, 2011

Charles H. Brown, III, Chief Auditor
Medicaid/Contract Audit Section
Auditor of State's Office
88 East Broad Street
Ninth Floor
Columbus, Ohio 43215-3506

Re: James T. Delver; Medicaid Provider Number 2746532

Dear Mr. Brown:

I am writing on behalf of James T. Delver and in response to your letter to Mr. Delver of December 7, 2011.

In this regard, please be advised that Mr. Delver disagrees with, and intends to vigorously contest, the proposed findings contained in the draft audit report which was forwarded with your letter. In short, Mr. Delver will contest the proposed findings based upon the simple fact that he provided each and every service for which he received reimbursement. As Mr. Delver provided all of the services for which he received reimbursement, he was not overpaid by Ohio Medicaid in any amount.

More specifically, the draft audit report proposes a finding against Mr. Delver in the amount of $59,534.16 based upon:

- 197 services where there was no ASP authorizing the services billed; and
- 67 services where the Provider billed for more hours than authorized by the ASP.

In response to both of those assertions, Mr. Delver would submit:

1. That all 264 of the services were included on the POCs prescribed by the patients' physicians. If a patient's ASP was not consistent with the POC prescribed by the patient's physician, that circumstance is a result of the Case Manager's negligence and/or incompetence. Mr. Delver performed nursing services pursuant to a physician's POC and should not be penalized for the Case Manager's negligence in

APPENDIX I

preparation of the ASP;

2. Mr. Delver's Case Manager had actual knowledge that the prescribed services were to be provided, and were being provided. Mr. Delver provided to his Case Manager a calendar of all services performed;

3. All of the services performed were well within the scope of what was normal and routinely provided in each patient's case.

The draft audit report also proposes a finding against Mr. Delver in the amount of $8,827.87 based upon the assertion that:

> Our review identified five plans of care which did not contain the required elements of frequency, scope and duration of treatment. Instead, these five POC's stated that skilled nursing should be provided "as requested" which does not satisfy the requirement to specify the number of days (frequency) and the length of the service to be provided (duration).

In response, it is my understanding that Mr. Delver, as an LPN, is required to be supervised by an RN. It is my further understanding that the RN actually prepares the POC, submits it to the patient's physician for approval and, once approved, the POC is returned to the RN and forwarded to the Provider. Again, it would seem to me that both the physician and the supervising RN should have some responsibility for preparing a POC which complies with applicable reimbursement requirements.

As mentioned above, Mr. Delver performed nursing services pursuant to POCs prescribed by the patients' physicians. Mr. Delver did not request or receive reimbursement for any service which he did not perform. At all times, Mr. Delver acted in each patient's best interests, providing only services actually prescribed by each patient's physician, and was simply not overpaid by Ohio Medicaid.

Based upon the foregoing, I would respectfully request that you withdraw all of the proposed findings against Mr. Delver which are contained in your draft audit report.

Very truly yours,

FAUST, HARRELSON, FULKER, McCARTHY & SCHLEMMER, LLP

William J. Fulker

WJF/csb
cc: James T. Delver

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JAMES T DELVER, LPN

MIAMI 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 2, 2012

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