GAYLE A. WINDHORST, LPN
LAWRENCEBURG, INDIANA

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2009 THROUGH DECEMBER 31, 2011

Dave Yost · Auditor of State

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GAYLE A. WINDHORST, LPN
LAWRENCEBURG, INDIANA

TABLE OF CONTENTS

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO PRIVATE DUTY NURSING

Gayle A. Windhorst, LPN
22636 Brightland Drive
Lawrenceburg, Indiana 47025

RE: *Medicaid Provider Number 2251423*

Dear Ms. Windhorst:

We examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of private duty nursing services during the period of January 1, 2009 through December 31, 2011. 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 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 examined the plans of care and private duty nursing authorization to determine if you were appropriately authorized. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Disclaimer of Opinion

As described in the attached Compliance Examination Report, we were unable to gain assurance regarding the validity of documentation supporting the Provider's compliance with the specified Medicaid requirements. Our examination disclosed that the Provider submitted detailed documentation of supervisory visits that appear to be photocopied templates; some plans of care that appear to be altered and appear to contain a photocopy signature of the treating physician; and altered documentation after receipt of the draft report. 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 matters described 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 the compliance with the specified Medicaid requirements for the period of January 1, 2009 through December 31, 2011. 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, 2009 and December 31, 2011 in the amount of $344,466.54. This finding plus interest in the amount of $33,953.55 totaling $378,420.09 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 through its Fiscal Operations, 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 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 other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

January 22, 2015

[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 Gayle Windhorst, 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 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 § 5160-1-01(A) 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 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)

During the examination period, the Provider furnished private duty nursing to one Ohio Medicaid recipient and received reimbursement of $344,466.54 for 1,360 private duty nursing services provided on 849 unique dates of services. The Provider billed 96 or more units of service (24 hours or more) on 88 dates of service.

Home care nursing services under Ohio Medicaid may include private duty nursing services. *See* Ohio Admin. Code § 5160-12 The private duty nurse shall begin furnishing private duty nursing services to the recipient upon receipt of a written private duty nursing authorization. *See* Ohio Admin. Code § 5160-12-02.3(B) In addition, for private duty nursing services to be covered, the service must be provided and documented in accordance with the recipient's plan of care. The plan of care 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)

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 private duty nursing services the Provider rendered to one Medicaid recipient during the period of January 1, 2009 through December 31, 2011 and received payment.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed all services with a claim status of void and all services with a paid amount of zero. From this subpopulation we extracted two dates of service to review as an exception test. On both of these dates, the Provider was reimbursed for 128 or more units of service (32 hours or more) for one recipient. From the remaining sub-population we summarized the services into two files: dates of service in which the Provider was reimbursed for less than 96 units (24 hours per day) and dates of service in which the Provider was reimbursed for more than 96 units (24 hours) per day but less than 128 units (32 hours) per day. We selected a one stage simple cluster sample from each of these two files by date of service 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 all of the selected dates of service.

An engagement letter was sent to the Provider on July 3, 2014, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on August 7, 2014. During the entrance conference, the Provider described her documentation practices, procedures for obtaining plans of care and all services plans, and process for submitting billing to the Ohio Medicaid program. Our field work was performed following the entrance conference.

On August 7, 2014, the Provider signed a statement that the records provided to us were original, true, accurate and complete. She acknowledged she was missing records for six dates of service. After the draft report was sent to the Provider on December 18, 2014, the Provider submitted additional documents which we reviewed for compliance. Our review of these records found the following:

- one document was a duplicate of a document previously submitted for review;
- two documents were for services which were not in the original records submitted to us;
- one document was for a date not in our sample and not requested by us;
- two documents were for the same date and time as documents previously submitted for review but did not include the parental signature which was present on the first set of documents;
- two documents were for the same date and time as documents previously submitted for review but the tasks and narratives were different;
- two documents were for the same date and time as documents previously submitted for review but had a date manually added on the second page; and
- four documents had dates and/or times altered.

Results of the compliance examination were revised to reflect the examination of these additional documents.

Results

We reviewed the Provider's documentation to support that she rendered services under the direction of a registered nurse (RN) and noted the forms appeared to be photocopied templates, including the signature of the RN. In addition, the Provider submitted a plan of care with a different date of the physician's signature from the version we received from the physician and the Provider submitted altered service documentation after receipt of the draft report. Due to this, we were unable to gain assurance regarding the validity of the Provider's documentation and this non-compliance is included in the overpayment of $344,466.54.

We reviewed a statistical sample of 205 services on days in which the Provider was reimbursed for less than 96 units, or 24 hours per day and noted 15 instances of non-compliance. These 15 errors are included in the overpayment of $344,466.54.

We reviewed a second statistical sample of 62 services on days in which the Provider was reimbursed for more than 96 units, or 24 hours, per day but less than 128 units, 32 hours, per day and noted eight instances of non-compliance. These eight errors are included in the overpayment of $344,466.54.

In addition, we conducted a review of six nursing services provided on dates in which the Provider was reimbursed for 128 or 144 units of service in one day (exception test) and noted five instances of non-compliance. These five errors are included in the overpayment of $344,466.54.

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

A. Provider Qualifications

According to Ohio Admin. Code § 5101:3-12-02(A), private duty nursing requires the skills of and is performed by either an registered nurse (RN) or a licensed practical nurse (LPN) at the direction of an RN. In addition, according to Ohio Admin. Code § 5101:3-12-03.1(A)(1), a non-agency nurse is required to be an RN or LPN at the direction of an RN practicing within the scope of his or her nursing license.

We verified through the Ohio e-License Center that the Provider and her supervisor were licensed through the Ohio Board of Nursing as an LPN and RN, respectively, and that both licenses were in active status during our examination period. The Provider is an LPN who is authorized by the Nursing Board to administer medication.

The Provider submitted "Supervisory Visit" forms as evidence that she worked under the direction of an RN. We noted forms dated approximately every 60 days during our examination period; however, the forms appeared to be photocopied templates, including a photocopied signature of the supervising RN and the recipient's parent. We contacted the supervising RN who stated that she completed the forms and signed them upon each of her supervision visits. This contradicts the forms submitted by the Provider. As a result, we could not verify that the supervision occurred and that the Provider performed services at the direction of an RN as required. We identified all services as non-compliant due to the photocopied supervisory notes and identified an overpayment of $344,466.54.

After the draft report was sent to the Provider on December 18, 2014, the Provider submitted a statement from the supervising RN stating she was the supervisor during our examination period. This subsequent statement is not a substitution for the "Supervisory Visit" forms dated during our examination period and is not sufficient to overcome the contradictions we noted. In addition, the supervising RN reported to us that for some period of time she was unable to go to the recipients home so the Provider transported the recipient, who required 24 hour per day private duty nursing, to the RN's home for the supervision.

Due to the aforementioned, we cannot verify that the required supervision occurred during the examination period.

Recommendation:

The Provider should ensure that supervisory visits occur as required and obtain and maintain authentic documentation of the supervisory visits by her supervising RN. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Per Ohio Admin. Code § 5101:3-12-03.1, non-agency nurses are required to comply with Ohio Admin. Code § 5101:3-12-03(C)(4) 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.

Statistical Samples

We noted that the Provider recorded the date of service as the date the service began when rendering overnight care. In some instances this resulted in the appearance of the Provider rendering more services in one day than were actually rendered in that single day.

Sample of Less Than 96 Units Reimbursed per Day

We reviewed a statistical sample of services in which the Provider was reimbursed for less than 96 units, or 24 hours, per day. The review of 205 services in this sample identified three services where the Provider had no service documentation and two services where the units reimbursed did not agree to the units documented. These five errors are included in the overpayment of $344,466.54.

Sample of Greater than 96 Units but Less than 128 Units reimbursed per Day

We reviewed a statistical sample of services in which the Provider was reimbursed for more than 96 units, or 24 hours, per day but less than 128 units, 32 hours, per day. The review of 62 services in this statistical sample identified four services where the Provider had no service documentation. These four errors are included in the overpayment of $344,466.54.

Exception Test

We reviewed six services on two dates (three services on each date) in which the Provider was reimbursed for 128 and 144 units of service, respectively. We identified two services (one service on each date) for which the provider had no service documentation. These two errors are included in the overpayment of $344,466.54.

Recommendation:

The Provider should ensure that units billed are supported by clinical records and should only bill 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

Private Duty Nursing (PDN) Services Request

According to Ohio Admin. Code § 5101:3-12-02.3, a private duty nurse shall begin furnishing private duty nursing services upon receipt of written private duty nursing authorization.

We reviewed the authorization dates in effect during the examination period in MITS. We found no dates of service during our examination period not authorized.

Plan of Care

Ohio Admin. Code § 5101:3-12-03.1 states that "non-agency" nurses who meet the qualifications and requirements of this rule can provide private duty nursing in accordance with Ohio Admin. Code § 5101:3-12-02. According to Ohio Admin. Code § 5101:3-12-02(B)(2), private duty nursing services must be provided and documented in accordance with the recipient's plan of care in accordance with Ohio Admin. Code § 5101:3-12-03.

Providers of private duty nursing are required to implement policy components for private duty nursing as specified in the "Medicare Benefit Policy Manual, Chapter Seven, section 30.2 to 30.3 *See* Ohio Admin. Code § 5101:3-12-03(B)(3)(b) CMS Medicare Benefits Policy Manual Chapter 7, 30.2.2 states services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of a plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

We reviewed the plans of care in effect during the examination period. Each plan of care authorized nursing services, listed the scope, frequency and duration, was signed and dated by the treating physician, and identified the Provider as a rendering provider. We noted that some of the plans of care appeared to be altered and some of the physician signatures appeared to be photocopied. We contacted the supervising RN who stated that she obtained the plans of care from the treating physician and put the plans of care in a notebook at the recipient's home. As a result, we were unable to verify that all of the Provider's plans of care were valid, accurate or complete.

We requested all original plans of care from the treating physician and the records department, at the facility where the treating physician is located, supplied us with only one plan of care from our examination period. We compared this plan of care, which was for the certification period August 29, 2011 to October 29, 2011, to the version submitted by the Provider. The date of the physician signature on the plan of care we received from the records department was October 31, 2011. There was also a fax date of October 26, 2011 at the top of the form and a returned fax date of November 1, 2011 at the bottom of the form. The date of the physician signature on the plan of care we received from the Provider was August 31, 2011 even though it had the exact same fax dates of October 26th and November 1st of 2011. The documentation did not include an oral order. We relied on the date of the physician signature on the version we received from the records department and, as such, this plan of care was not valid for the certification period of August 29th to October 29th of 2011 because it was not signed until after the certification period ended.

As a result of this invalid plan of care, we found 14 services in the two samples and three services in the exception test without a valid plan of care. These 17 errors are included in the overpayment of $344,466.54.

Because the only plan of care we obtained from the treating physician was invalid for the certification period and our observation that other plans of care appear to be photocopied or altered, we have no assurance that any service was authorized by a valid plan of care. We identified all services as non-compliant and identified an overpayment of $344,466.54.

We did receive a response from the treating physician indicating that he authorized skilled nursing services and signed plans of care for the examination period. The Provider did not offer an explanation for why she maintained and submitted documents that appear to be altered and contain photocopied signatures.

Recommendation:

The Provider should take due care when obtaining and reviewing plans of care authorizing her services. If the plans of care appear to be altered, the Provider should obtain an original copy from the treating physician to ensure her services are authorized. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response

The Provider submitted an official response to the results of this examination which is presented in **Appendix I**. We did not examine the Provider's response and, accordingly, we express no opinion on it. Our response is presented in **Appendix I**.

Appendix I

Provider Response:

Consistent with our conversations, I have attached certain documents which I believe are relevant to the state's claim to be reimbursed by Ms. Windorst for services she undeniably provided to [Medicaid recipient] for the period in question. Specifically, the attached documents are:

1. Affidavit of Dorcas Wokoma, dated December 22, 2014;
2. Letter of [Medicaid recipient's designated contact], dated January 13, 2015;
3. Three separate sets of Home Health Care Skilled Nurse Notes, and related documents, consisting of 28, 16, and 6 pages respectively, for the time periods in question;
4. Health Record Reviews (Butler County MRDD) dated 9.22.06, 8.23.07, 10.03.08, 10.28.10, 10.19.11, 10.1.12, and 10.1.13;
5. Auditor Report dated September 29, 2011, re: Michael Linville, LPN;
6. Gayle Windhorst response to Specific Billing Errors.

Please see p. 7, section C of the *Linville* report, which indicates "…ODJFS advised us that the 60 day and 120 day rule for supervisory RN reviews is a quality issue rather than a monetary issue." In light of that statement, and in view of the various other documents provided, please re-consider your report and amend it accordingly.

Auditor of State Response:

We reviewed the documents attached to the Provider's response. Results of the compliance examination were revised to reflect the examination of these additional documents.

Dave Yost • Auditor of State

GAYLE A. WINDHORST, LPN

OUT OF STATE

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 19, 2015

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