MICHAEL P. MATSON, LPN
WARREN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

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

Dave Yost · Auditor of State

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WARREN COUNTY

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

Michael P. Matson, LPN
4800 US Highway 42, Apt. 2, Building A
Mason, Ohio 45040

RE: *Medicaid Provider Number 2195824*

Dear Mr. Matson:

We examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of waiver nursing services during the period of January 1, 2009 through December 31, 2011. We confirmed your nursing licensure status 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 all services plans to determine if you were appropriately authorized and we reviewed your supervision documentation and the licensure status of your supervising registered nurses. 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 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 the 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.

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 Adverse Opinion on Medicaid Services

Our examination disclosed that in a material number of instances the documented arrival and/or departure times overlapped with documented arrival and/or departure times for other Medicaid recipients on the same day. These overlaps included instances where the arrival time for one recipient was the same as the departure time for a different recipient at a different address and overlaps of minutes between two recipients. We also noted instances where the arrival and departure times were omitted. In addition, in a material number of instances the Provider did not have signed and dated plans of care. Finally, we noted lapses in the required supervision, services with no documentation and documentation not signed by the recipient.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to service authorization and service documentation 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 $97,123.83. This finding plus interest in the amount of $7,791.86 totaling $104,915.69 is due and payable to the Ohio Department of Medicaid (ODM) upon ODM's 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

October 20, 2014

[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 constitute 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 Michael Matson, 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 waiver nursing services to nine Ohio Medicaid recipients and received reimbursement of $502,544.69 for 9,245 services rendered on 1,048 dates of service. The Provider billed for delivering services on 95.7 percent of the days in the three year examination period.

Home care nursing services under Ohio Medicaid may include waiver nursing services. When a Medicaid recipient receiving waiver nursing care is on an ODM administered waiver program, a plan of care is required. 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. Waiver nursing services are authorized in the all services plan (or individual service plan), which lists services approved for the recipient under a waiver program, including the type of service, frequency and duration; and it specifies which provider can render services and subsequently bill Ohio Medicaid for those services.

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 waiver nursing services for which the Provider rendered services to Medicaid recipients and received payment during the period of January 1, 2009 through December 31, 2011.

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 any voided services and services paid at zero. We then extracted all services on one date of service in which the Provider was reimbursed for 96 units, or 24 hours of service, to examine as an exception test. A simple random sample from the remaining sub-population was then selected. This sample included 884 services on 103 dates of service.

An engagement letter was sent to the Provider on May 21, 2014, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on June 23, 2014. During the entrance conference, the Provider described his 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.

Results

We reviewed 884 waiver nursing services in our statistical sample and identified 209 instances of non-compliance in 196 services. The overpayments identified for 77 of 103 dates of service (196 of 884 services) from our statistical random cluster sample were projected across the Provider's total subpopulation of paid services. This resulted in a projected overpayment amount of $113,374.75 with a precision of plus or minus $19,506.00 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and a finding was made for $96,953.88. This allows us to say that we are 95 percent certain that the subpopulation overpayment amount is at least $96,953.88. A detailed summary of our statistical sample and projection results is presented in **Appendix I.**

We also reviewed 14 waiver nursing services in our exception test of a date of service in which the Provider was reimbursed for 96 units, or 24 hours of service and found four instances of non-compliance. One of the errors did not result in an overpayment. We identified an overpayment of $169.95 for the remaining three services.

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 §§ 5101:3-46-04(A)(1), 5101:3-47-04(A)(1) and 5101:3-50-04(A)(1) all nurses providing waiver nursing services shall provide services as set forth in Chapter 4723 of the Revised Code and rules of the Administrative Code adopted thereunder, and shall possess a current, valid and unrestricted license with the Ohio board of nursing. In addition, a licensed practical nurse (LPN), at the direction of a registered nurse (RN), must conduct a face-to-face visit with the directing RN at least every 60 days to evaluate the provision of waiver nursing services and LPN performance and to assure nursing services are being provided in accordance with the plan of care. The LPN must also conduct a face-to-face visit with the recipient and directing RN no less than every 180 days for the same purpose and to also evaluate the recipient's satisfaction with care delivery. *See* Ohio Admin. Code §§ 5101:3-46-04(A)(5), 5101:3-47-04(A)(5) and 5101:3-50-04(A)(5)

We verified through the Ohio e-License Center that the Provider was a licensed practical nurse and his four supervising nurses were registered nurses. All were licensed by the Ohio Board of Nursing and their licenses were in active status during our examination period.

We also reviewed the Provider's documentation of the required supervisory reviews. We noted lapses in the 60 day reviews with the RN for four recipients ranging from 2 to 20 days. These lapses resulted in 23 instances of non-compliance and were used in the overall finding projection of $96,953.88.

We also noted lapses in the 120 day reviews with the RN and recipient for four recipients ranging from 4 to 71 days. However, the Provider's supervisory documentation for both the 60 and 120 day reviews included skills performed and recipient comments of job performance. Due to this, we considered the 60 day reviews to meet the requirements of the 120 day reviews. The Provider's usual practice was to obtain the dated signature or initials of the recipient on the 120 day reviews. We noted two instances where the dated signature or initials of the recipient did not appear consistent with other signatures or initials by the same recipient.

Recommendation:

The Provider should develop and implement a tracking log for the required 60 and 120 supervisory reviews. In addition, the Provider should ensure dated signatures and initials are affixed by the recipient. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Ohio Admin. Code § 5101:3-45-10(A)(11) notes that for each unit provided, the provider must clearly document the service provided and obtain the signature of the recipient on the dated document. In addition, Ohio Admin. Code §§ 5101:3-46-04(A)(6), 5101:3-47-04(A)(6) and 5105:3-50-04(A)(6) state all waiver nursing service providers must maintain a clinical record for each recipient served that includes clinical notes, documentation of services performed during each visit and the dated signature of the provider. Effective October 25, 2010, providers are required to document tasks performed or not performed, arrival and departure times and the dated signature of the recipient, or authorized representative, verifying the service delivery.

Statistical Sample

Our review of 884 nursing services in the statistical sample found 137 errors. These errors include:

- 109 services in which the arrival and/or departure time was the same or overlapped the arrival or departure time of another service and the recipients did not live at the same address;
- 6 services with no supporting documentation;
- 19 services in which the documentation was not signed by the recipient upon service delivery; and
- 3 services in which the documentation did not indicate any duration of service as the record did not include the arrival and/or departure time.

These 137 errors were used in the overall finding projection of $96,953.88.

Exception Test

Our review of the 14 services on a date of service in which the Provider was reimbursed for 96 units, or 24 hours of service, found that the Provider billed one 15 minute service as 44 units; however only the base rate (less than or equal to the first four units of service) was reimbursed so no overpayment occurred. We also found three services in which the arrival time was the same as the departure time of another service and the recipients did not live at the same address. These three errors resulted in an overpayment of $169.95.

For the purpose of our examination, we obtained the recipient addresses from the plans of care submitted by the Provider. We took into account any recipient change of address during our examination period. For those services with overlapping times, we compared addresses and identified non-compliance when the recipients did not live at the same address.

We noted that the Provider's service documentation was a template that included space for fourteen services on a single sheet of paper. Although the Provider did include handwritten notations for each visit, the documentation was at times difficult to decipher due to the number of services documented on each sheet of paper.

Recommendation:

The Provider should develop and implement procedures to ensure all service documentation fully complies with Medicaid requirements including the dated signature of the recipient and actual times of service delivery. The Provider should only seek reimbursement for those services that were actually rendered and ensure that units billed reflect actual service delivery time.

C. Authorization to Provide Services

Plan of Care

According to Ohio Admin. Code §§ 5101:3-46-04(A)(4)(g), 5101:3-47-04(A)(4)(g) and 5101:3-50-04(A)(4)(g), in order to be a provider and submit a claim for reimbursement of waiver nursing services, the LPN 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.

Plan of Care – Statistical Sample

We reviewed the plans of care submitted and found six services that had no plans of care covering the date of service and 43 services that did not have a plan of care signed and/or dated by the treating physician. These 49 errors were used in the overall finding projection of $96,953.88.

We found no errors in the exception test.

All Services Plans

In order to submit a claim for reimbursement, the LPN, at the direction of the RN, must be identified as the provider on the all services plan that is prior-approved by the designated case management agency. Ohio Admin. Code §§ 5101:3-46-04(A)(4), 5101:3-47-04(A)(4) and 5101:3-50-04(A)(4).

We reviewed the all services plans in effect for our examination period for the nine recipients the Provider rendered services to and found the Provider was authorized to render waiver nursing services for the examination period.

Recommendation:

The Provider should develop and implement procedures to ensure all plans of care are signed and dated by the recipient's treating physician before services are rendered.

Provider Response:

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

APPENDIX I

POPULATION
The population is 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. Services excluded from this sample subpopulation included all services on one date in which the Provider was reimbursed for 96 units, or 24 hours of service. Services with identified potential exceptions were segregated from the rest of the provider's services and examined in their entirety.

SAMPLING FRAME
The sampling frame was paid and processed claims from MMIS and 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 date of service. A date of service is defined as all services furnished by and paid to the Provider on a specific date of service.

SAMPLE DESIGN
We used a cluster random sample.

Summary of Sample Record Analysis
For the period January 1, 2009 to December 31, 2011

Description	Results
Number of Dates of Service in Population	1,047
Number of Dates of Services Sampled	103
Number of Dates of Services Samples with Errors	77
Number of Services in Population	9,231
Number of Services Sampled	884
Number of Services Sampled with Errors	196
Total Medicaid Amount Paid for Population	$501,751.59
Amount Paid for Services Sampled	$48,070.84
Estimated Overpayment (Point Estimate)	$113,374.75
Precision of Overpayment Estimate at 95% Confidence Level	$19,506.00
Precision of Overpayment Estimate at 90% Confidence Level	$16.420.86
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate) (Equivalent to the estimate used for Medicare Audits)	**$96,953.88**

Source: Analysis of MMIS and MITS information and the Provider's records.

APPENDIX II

Official Response by Michael P. Matson, LPN
To
State of Ohio Auditor Medicaid Compliance Examination Report
For the Period January 1, 2009 through December 31, 2011

Michael P. Matson provided all of the services to his clients that he documented. He has conscientiously assisted clients using utmost care and concern. Mr. Matson is an independent waiver-service provider and keeps hand-written documentation. The Auditor's Report has identified form over substance documentation issues which Mr. Matson understands and has implemented corrections to his supervisory and documentation protocol and physician signed and dated plans of correction. Mr. Matson understands the requirements for supervisory reviews and endeavors and covenants to comply with both the 60 day and 120 day review requirements.

Approximately 80% of the errors reported in the statistical sample for service documentation relate to arrival/departure time notations. Despite the errors noted, Mr. Matson provided all of the services documented. His shortfall in documentation does not mean he failed to provide such services that were documented. While the end time for one service may have also been listed as the start time of the next service provided, there was ample time for each service entry for Mr. Matson to fully service his clients. To deny payment for this reason is too harsh of a penalty since (a) he provided such services during the listed time slot, and (b) his clients (and/or responsible parties) are willing to provide affidavits that he provided all of such services. Mr. Matson has developed and implemented procedures to ensure of his service documentation fully complies with the Medicaid requirements including proper dated signatures from each recipient and proper and actual times of service delivery.

Mr. Matson has implemented procedures to ensure that he has plans of care signed and dated by the respective physicians. While there were some gaps in signatures and dates by physicians, please note that the Auditor's Report found that Mr. Matson rendered services authorized and found in the service plans in effect for the examination period. Mr. Matson understands that requirement for signed and dated plans of care and will make sure that his records contain such fully executed plans of care in the future.

Finally, Mr. Matson has implemented the recommendations found in the Auditor's Report. He has done the following:

- Created a calendar of appointments for RN supervisory reviews to make sure that the 60 day and 120 day reviews are performed; each RN supervisory review will be logged; and he will secure the appropriate signatures and initials from recipients and RNs.
- Revised his forms to provide sufficient space for signatures from recipients for each and every service provided.
- Limited the number of entries per page so that a review of his notations is easier to read and will endeavor to use better handwriting so that the services provided are clearer to a reviewer.
- Increased the space for making time entries and is using the actual time of start of service and the actual end of service to avoid any overlaps or simultaneous time entries.
- Require all plans of care to be signed and dated by the treating physician prior to rendering waiver nursing services.

APPENDIX II (Continued)

Since the date of receipt of the draft of the Auditor's Report on December 2, 2014, Mr. Matson has been on medical leave due to a number of surgeries (knee surgeries and other) and has not rendered any waiver nursing services since that date. Mr. Matson is giving notice to his clients and other referring sources that he will not return to provide such waiver nursing services at this time.

Michael P. Matson faithfully and fully provided the services he submitted for reimbursement. He has deficiencies in documentation and record keeping that he has made provisions above to correct. Mr. Matson stands by his services rendered to his clients as do his clients. He vigorously objects to the amount of overpayment claimed in the Auditor's Report and respectfully requests for such amount to be substantially reduced given that he provided the services he documented, his clients (and/or responsible parties) will provide affidavits that he provided all of such services, and that he has implemented the recommendations in the report.

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Dave Yost • Auditor of State

MICHAEL P. MATSON, LPN

WARREN 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
JANUARY 22, 2015

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