AMANDACARE, INC.

FRANKLIN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2014

Dave Yost • Auditor of State

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AMANDACARE, INC.

FRANKLIN COUNTY

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

Pauline Crocco, President
Amandacare, Inc.
6430 E. Main Street, Suite 201
Reynoldsburg, Ohio 43068

RE: *Medicaid Provider Number 2011594*

Dear Ms. Crocco:

We examined your (the Provider) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of home health nursing, home health aide, private duty nursing, waiver nursing, personal care aide and physical therapy services during the period of July 1, 2011 through June 30, 2014. We reviewed the Provider's records to determine if it had 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 plan of care and all services plans and reviewed personnel records to verify that nursing, physical therapy and 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.

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. 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 Qualified Opinion

Our examination found material non-compliance with personal care aide qualifications. 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.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for the period of July 1, 2011 through June 30, 2014.

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 July 1, 2011 and June 30, 2014 in the amount of $766,969.81. This finding plus interest in the amount of $27,111.86 totaling $794,081.67 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. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

May 16, 2016

[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

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 home health aide services, personal care aide services or both. The only provider of home health aide services is a Medicare certified home health agency (MCRHHA) that meets the requirements in accordance with Ohio Admin. Code § 5160-12-03. Personal care aide services can be provided by a MCRHHA, an otherwise-accredited home health agency or a non-agency personal care aide.

The Provider is a MCRHHA and, during the examination period, received reimbursement of $2,888,545.45 for 43,635 home health services, including the following:

- 16,759 skilled nursing services (procedure code G0154);
- 12,594 personal care services (procedure code T1019);
- 3,980 home health aide services (procedure code G0156);
- 3,788 physical therapy services (procedure code G0151);
- 2,158 private duty nursing services (procedure code T1000);
- 1,881 speech pathology services (procedure code G0153);
- 1,333 waiver nursing services (procedure codes T1002 and T1003); and
- 1,142 occupational therapy services (procedure code G0152).

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 home health services, specifically skilled nursing, waiver nursing, private duty nursing, home health aide, personal care aide, and physical therapy services that the Provider rendered to Medicaid recipients and received payment during the period of July 1, 2011 through June 30, 2014.

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 services paid at zero and services with third party payments. We then selected two exception tests from this population of paid services. The exception tests include services reviewed in their entirety which were then excluded from the population used to draw the statistical sample (see below).

The first exception test consisted of services to recipients with same last name, living at same address and receiving the same services on the same date. The data pulled showed all services were for physical therapy. We selected all 203 physical therapy (G0151) services for examination.

We then removed all other physical, speech and occupational therapy services from the paid claims to focus the examination on nursing and aide services (procedure codes G0154, G0516, T1000, T1002, T1003 and T1019). We then extracted all services provided during August 2011 for two recipients with the same address and same dates of service. We selected all 114 services as our second exception test for examination.

We summarized the remaining sub-population by RDOS. A recipient date of service (RDOS) is defined as all services for a given recipient on a specific date of service. A statistical sample was pulled from this sub-population 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 population of 24,703 RDOS, we selected a random sample of 434 RDOS. We then obtain the detailed the detailed services for the 434 RDOS which resulted in a sample of 649 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program.

After receiving the initial results of our testing, the Provider submitted additional documentation which included, in part, continuing education documentation. These documents had been provided during our initial fieldwork and, upon our review at that time, we noted that there were no dates on these documents to indicate when the continuing education occurred. The more recent continuing education documents submitted by the Provider were altered to include a date (usually only a month and year). We reviewed all records received for compliance and updated our results accordingly. We did not change any results based on documents that had been altered.

Approximately one and a half months after submitting documentation in response to our final request for records, the Provider submitted 120 pages of additional documentation along with its official response. The Provider submitted documents that had been previously submitted, documents that were never requested, and documents submitted for the first time in response to our previous requests. We reviewed all of the records received for compliance and updated our results accordingly.

Results

We reviewed 649 services in our statistical sample and found 233 errors. We took exception with 146 of 434 RDOS (210 of 649 services). Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $1,638,950, with a 95 percent certainty that the actual correct payment amount fell within the range of $1,493,474 to $1,784,425 (+/- 8.88 percent.) We then calculated findings by subtracting the correct population amount ($1,638,950) from the amount paid to the Provider for this population ($2,405,919.81), which resulted in a finding of $766,969.81. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We reviewed 203 physical therapy services in our first exception test and found no errors.

We reviewed 114 nursing and aide services in our second exception test and found no errors.

While certain services had more than one error, only one finding was made per service. The basis for our findings is discussed below in more detail.

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code §§ 5101:3-12-01(A), 5101:3-46-04(A), 5101:3-47-04(A), 5101:3-50-04(A)[2], home health and waiver nursing requires the skills of and is performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse.

Physical therapy providers are licensed physical therapists and licensed physical therapy assistants under the direction of a physical therapist who are contracted or employed by a MCRHHA. Ohio Admin. Code 5101:3-12-01(G)(3)

We searched the names of the 22 nurses and one physical therapist that rendered services in our exception tests and statistical sample on the Ohio e-License Center website to ensure that their professional license was current and valid on the first date of service in our tests and was active during remainder of examination period. We found no instances of non-compliance.

Aide Services

Home health aides are required to complete 12 hours of in-service continuing education annually.

In order to submit a claim for reimbursement, all individuals providing personal care aide services must obtain and maintain a current first aid certification. In addition, personal care aides must complete 12 hours of in-service continuing education. *See* Ohio Admin. Code §§ 5101:3-12-03(B), 5101:3-46-04(B), 5101:3-47-04(B) and 5101:3-50-04(B)

We tested 37 aides that rendered home health aide services and/or personal care aide services in our sample. The Provider submitted a staff list that identified aides but did not differentiate between home health aides and personal care aides so we used the type of services provided in the exception tests and statistical sample to apply qualification requirements for our testing. Of the 37 aides selected, 32 provided personal care aide services and were tested for compliance with first aid certifications.

We found that 22 of the 32 aides that provided personal care aide services did not have a first aid certification and six of the 10 with first aid certification had lapses in time without a current certification.

For compliance of in-service continuing education hours, we limited our testing to 24 aides and only tested those were employed for the full calendar year. We did not include 2011 or 2014 as our examination period did not include either of these two full calendar years. We found three aides did not have the required twelve in-service training hours.

We reviewed 649 services in the statistical sample and identified 168 services rendered by an aide who was ineligible to render services. These 168 errors were used in the overall projection of $766,969.81.

[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 also identified one aide in 2012 and two aides in 2013 that did not obtain the required 12 hours of in-service continuing education but were not materially non-compliant. We concluded these aides were non-compliant but did not consider them ineligible or associate an overpayment with the services they rendered while non-compliant. We identified one associated error in our statistical sample.

Recommendation:

The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Service Authorization

Plan of Care

All home health providers are required by Ohio Admin. Code § 5101:3-12-03(B)(3)(b) to create a plan of care for recipients including recipients' medical condition and treatment plans anticipated by provider. The plan of care is also required to be signed by the treating physician of recipient. Home health providers must obtain the completed, signed and dated plan of care prior to billing ODM for the service.

Our review of the statistical sample of 388 paid state plan services identified the following errors:

- 8 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 2 services in which the physician's signature on the plan of care was not dated; and
- 2 services which were provided after receipt of a verbal order discontinuing the services.

The overpayments associated with these 12 errors were included in the finding amount of $766,969.81.

We also identified 12 services in which either the plan of care or the addendum to the plan of care was signed and dated by the physician, but not both. In these instances, we accepted either the plan of care or the addendum to the plan of care as authorization for the services.

All Services Plan

According to Ohio Admin. Code § 5101:3:12-01, the MCRHHA must be identified on the all services plan when a recipient is enrolled in home and community based waiver.

Our review of the statistical sample of 261 paid waiver services identified one service in which there was no all services plan for the service rendered and 16 services which were not authorized on the all services plans. The overpayments for these 17 errors are included in the overall finding of $766,969.81.

B. Service Authorization (Continued)

Recommendation:

The Provider should establish a system to obtain the required plans of care completed by an authorized treating physician and to ensure the signed plans of care are obtained prior to submitting claim for services to ODM. In addition, the Provider should ensure there is an all services plan for waiver recipients and only render services authorized on the plan. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Service Documentation

The MCRHHA must maintain documentation of home health services provided that includes, but is not limited to, clinical records and time keeping that indicate time span of the service and the type of service provided. See Ohio Admin. Code § 5101:3-12-03(C)(4). Documentation to support personal care aide services must include the tasks performed or not performed and the arrival and departure times. See Ohio Admin. Code §§ 5101:3-46-04(B)(8), 5101:3-47-04(B)(8) and 5101:3-50(B)(8). According to Ohio Admin. Code § 5101:3-45-10(A), providers of waiver services must maintain and retain all required documentation including, but not limited to, the dated signatures of the provider and the recipient or authorized representative verifying the service delivery upon completion of service delivery.

Statistical Sample of Service Documentation

Our review of the statistical sample of 649 services identified the following errors:

- 8 instances where in which there was no service documentation to support the service rendered;
- 4 services in which the service documentation did not include the tasks performed;
- 21 instances where the service documentation was not signed by the recipient or authorized representative; and
- 2 services in which the units billed exceeded the units on the service documentation.

The overpayments associated with these 35 errors are included in the overall finding of $766,969.81.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Medicaid rules. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. 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 II**. The Provider disputes the identified findings and the results of the extrapolation. We did not examine the Provider's response and, accordingly, we express no opinion on it.

APPENDIX I

Summary of Sample Record Analysis

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 the following: (1) physical therapy services examined in the first exception test; (2) all other physical therapy (G0151), occupational therapy (G0152), and speech pathology (G0153) services; and (3) services included in the second exception test. Services in items (1) and (3) 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 primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RODS	24,703
Number of Population RDOS Sampled	434
Number of Population RDOS Sampled with Errors	146
Number of Population Services Provided	36,710
Number of Population Services Sampled	649
Number of Population Services Sampled with Errors	210
Total Medicaid Amount Paid for Population	$2,405,919.81
Amount Paid for Population Services Sampled	$43,197.20
Projected Correct Population Payment Amount	$1,638,950
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	1,784,425
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$1,493,474
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$766,969.81**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$145,475 (+/-8.88%)**

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

Dinsmore

Legal Counsel.

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May 11, 2016

VIA HAND DELIVERY

Kristi S. Erlewine, Chief Auditor
Medicaid/Contract Audit Section
Ohio State Auditor's Office
88 East Broad Street, Ninth Floor
Columbus, Ohio 43215-3506

RE: Amandacare, Inc., Medicaid Provider Number 2011594

Dear Ms. Erlewine:

Given the opportunity to respond to the findings of the Ohio State Auditor's Office, Amandacare, Inc. responds as follows:

Amandacare, Inc. recognizes the importance of ensuring that its employees are fully qualified to provide services and of maintaining accurate service documentation. Amandacare has always endeavored to accomplish these duties to the best of its ability.

The Auditor believes it has discovered certain deficiencies in Amandacare's employee qualifications and service documentation. Amandacare disputes many of these findings; however, we also recognize that errors can happen. To the extent that any deficiencies do exist in Amandacare's paperwork, we submit that such deficiencies are merely isolated, inadvertent errors which had no impact on patient outcomes.

Amandacare wishes to emphasize that it has provided excellent care to its patients since 1997. During this time, Amandacare has been surveyed by the Ohio Department of Health numerous times, and has always been found compliant with the requirements and laws outlined by the Medicaid program. The Auditor's findings do not indicate in any way that any patient suffered harm because of Amandacare.

Finally, Amandacare asserts that the Auditor's extrapolation greatly exaggerates the scope of deficiencies discussed in the report. To that end, enclosed are records, including:

1. *Copies of first-aid certification for certain Amandacare employees;*
2. *Copies of All Service Plans for certain Amandacare patients;*
3. *Copies of Plans of Care for certain Amandacare patients;*
4. *Service documentation for certain Amandacare patients.*

Names of Amandacare employees and patients are not disclosed in this letter for confidentiality reasons. We trust that the Auditor's office will protect the confidentiality of the enclosed records. We submit that these records directly contradict certain of the Auditor's findings and significantly lessen or eliminate the scope of the deficiencies defined by the extrapolation of those findings.

If you have any questions, please contact me.

Regards,

TM Hess : Sarah Persinger (0083875)

Thomas W. Hess

TWH:pj

cc: Sarah Persinger

Enclosures

Dave Yost • Auditor of State

AMANDACARE, INC.

FRANKLIN 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 31, 2016

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