SHIFO HEALTHCARE SERVICES, LLC
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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SHIFO HEALTHCARE SERVICES, LLC
FRANKLIN COUNTY

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

Abdulkadir H. Elmi, CEO
Shifo Healthcare Services, LLC
3556 Sullivant Avenue, Suite 306
Columbus, Ohio 43204

RE: Medicaid Provider Number 3085423

Dear Mr. Elmi:

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, 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 all services plans and plans of care and reviewed personnel records to verify that nursing 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 Adverse Opinion

Our examination disclosed that in a material number of instances the Provider did not have service documentation to support billed services; aides did not meet the provider qualification requirements; plans of care were not signed by the physician before the service was submitted to ODM for reimbursement; and the units billed did not match supporting documentation.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements 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 the Ohio Medicaid for services rendered between July 1, 2011 and June 30, 2014 in the amount of $2,055,555.14. This finding plus interest in the amount of $109,817.33 totaling $2,165,372.47 is due and payable to 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 ODM, 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

February 22, 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 an MCRHHA that furnishes home health services. The Provider has two additional Medicaid provider numbers, 2998163 and 2975768, which are identified with provider type 45 – waivers services organization. We found no payments made to these two provider numbers for the time frame covered by this examination.

During our examination period, the Provider received reimbursement of $3,098,475 for 95,125 home health services rendered on 45,414 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. These home health services included:

- $1,982,481 for home health aide services (G0156);
- $269,843 for home health nursing services (G0154);
- $836,319 for personal care aide services (T1019);
- $9,552 for waiver nursing services (T1002 and T1003);
- $140 for physical therapy services (G0151); and
- $140 for occupational therapy services (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 waiver home health services, specifically waiver nursing and personal care aide, and state plan home health services, specifically home health nursing, home health aide services 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.

Purpose, Scope, and Methodology (Continued)

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 voids. We then extracted three exception tests and tested these services in their entirety. First, we extracted all services associated with the four recipients with highest number of potential duplicate services (Exception Test 1). Second, we then extracted all services during the month of August 2011 for three recipients residing at the same address (Exception Test 2). Third, we then extracted all services during the month of August 2013 for two recipients residing at the same address (Exception Test 3).

After removing the services in the three exception tests, we used a statistical sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). Specifically, we stratified the remaining population by RDOS into three strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). Estimates of the population overpayment standard deviation were made for each stratum using the standard deviation of the actual amount paid per claim and a 50 percent error rate. The estimated error standard deviations and means were then used to calculate a stratified sample size by stratum and overall. The final calculated sample size is shown in the table below.

Universe/Strata	Population Size	Sample Size
Stratum 1 – RDOS with Amount Paid Less Than $100	35,483	178
Stratum 2 – RDOS with Amount Paid Between $100 and $249.99	9,678[1]	124
Stratum 3 – RDOS with Amount Paid of $250 and Over	29	29
Total:	**45,190**	**331**

[1] We removed two occupational therapy services from the population after the sample was drawn which resulted in one less RDOS in the population.

We then obtained the detailed services for the 331 sampled RDOS. This resulted in a sample size of 789 services.

An engagement letter was sent to the Provider on August 3, 2015, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on August 17, 2015. During the entrance conference, the Provider described its documentation practices, personnel procedures and process for submitting billing to the Ohio Medicaid program.

Results

We examined 475 services in our exception test of all services associated with the four recipients with highest number of potential duplicate services (Exception Test 1) and found 483 errors. As a result, we identified $18,608.96 as an overpayment.

We examined 174 services in our exception test of all services during the month of August 2011 for three recipients residing at the same address (Exception Test 2) and found 83 errors. As a result, we identified $2,566.34 as an overpayment.

We examined 124 services in our exception test of all services during the month of August 2013 for two recipients residing at the same address (Exception Test 3) and found 84 errors. As a result, we identified $1,953.84 as an overpayment.

Results (Continued)

We also examined 789 services in our statistical sample and identified 657 errors. The overpayments identified for 247 of 331 RDOS (548 of 789 services) from a stratified random sample were projected to the Provider's population of paid services resulting in a projected overpayment of $2,032,426 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $1,870,319 to $2,194,532 (+/- 7.98 percent). See Ohio Admin. Code § 5160-1-27(B)(1) A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

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. The Provider did not submit documentation for the one physical therapy service in our statistical sample therefore we did not test provider qualifications for a physical therapist.

After conducting our review of the records initially submitted by the Provider, we inquired of the Provider to ensure there were no additional documents related to the examination. The Provider submitted additional documentation which we evaluated for compliance and incorporated into our results. The Provider confirmed on February 22, 2016 that there were no additional documents to support the services selected for examination.

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.

We searched the names of the 10 nurses who rendered services in our exception tests and statistical sample on the Ohio e-License Center website to ensure that their nursing 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

Prior to rendering services, home health aides are required to complete home health aide training. The home health aide must also successfully complete a competency evaluation program which includes an annual performance review that addresses the same required subject areas as the home health aide training, except for communication skills. In addition, home health aides must 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 complete a competency evaluation program and obtain and maintain a current first aid certification. *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)

[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.

A. Provider Qualifications (Continued)

We tested 15 aides that rendered home health aide services and/or personal care aide services in our sample. The Provider could not submit a list of staff that differentiated 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 15 aides selected, six provided personal care aide services and were tested for compliance with first aid certifications. For compliance of in-service continuing education hours, we limited our testing to aides who were employed for the full calendar year. We identified the following errors:

- 6 of the aides tested (100 percent) had no first aid certification;
- 5 of the 8 aides tested did not obtain the required 12 hours of in-service continuing education in 2012; and
- 5 of the 10 aides tested did not obtain the required 12 hours of in-service continuing education in 2013.

Due to the 100 percent non-compliance of personal care aides with no first aid certification, we tested an additional 12 personal care aides, for a total 75 percent of aides who rendered personal care aide services in our sample, to determine only compliance with the first aid requirement. None of these additional 12 aides had first aid certification. We confirmed with the Provider's Human Resource Director that it did not require aides to have first aid certifications.

We concluded that the 18 aides who rendered personal care aide services were ineligible to render those services during our examination period. We also concluded that the five aides in 2012 and the five aides in 2013 who did not complete the required 12 hours of in-service continuing education were ineligible to render services in the year of non-compliance.

Exception Test 1 – Potential Duplicate Services

We reviewed 475 services and identified 312 services rendered by an aide who was ineligible to render services. These 312 errors are included in the overpayment of $18,608.96.

We identified no errors in the two other exception tests.

Statistical Sample

We reviewed 789 services and identified 212 services rendered by an aide who was ineligible to render services. These 212 errors were used in the overall projection of $2,032,426.

We also identified one aide in 2012 and one aide 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 seven errors for these two aides 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 Documentation

The MCRHHA must maintain documentation of home health services provided that includes, but is not limited to, clinical records and time keeping records 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, the arrival and departure times and the dated signatures of the provider and recipient or authorized representative to verify the service delivery. *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), for each unit of personal care aide service provided, the Provider is required to obtain the signature of the recipient on the dated document.

Exception Test 1 – Potential Duplicate Services

We reviewed 475 services and identified 140 services in which there was no supporting documentation and seven services in which the units billed did not match supporting documentation. These 147 errors are included in the overpayment of $18,608.96.

Exception Test 2 – Services for Three Recipients Residing at the Same Address, August, 2011

We reviewed 174 services and identified 32 services in which there was no supporting documentation. These 32 errors are included in the overpayment of $2,566.34.

Exception Test 3 – Services for Two Recipients Residing at the Same Address, August, 2013

We reviewed 124 services and identified no errors.

Statistical Sample

We reviewed 789 services and identified the following errors:

- 81 services in which there was no supporting documentation;
- 60 services in which the units billed did not match supporting documentation; and
- 1 service in which the activity documented was not a covered service (supervision of aide).

These 142 errors were included in the finding amount of $2,032,426.

We also noted instances in which the recipient's guardian was the waiver service provider and signed the service documentation as the provider and for the recipient. While there is no Medicaid rule prohibiting this, it does not allow for verification that the service was rendered.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in the 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. We also recommend that an authorized representative be identified in the all services plan when a guardian is a provider and that the authorized representative sign service documentation when the recipient is unable to do so. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Plan of Care

In order for home health services to be covered, MCRHHAs must provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. *See* Ohio Admin. Code § 5101:3:12-01(E)(3)(a) In addition, Ohio Admin. Code § 5101:3:12-03(B) requires that MCRHHAs implement policy components as specified in the Medicare Benefit Policy Manual, Chapter Seven: Home Health Services for "Content of the Plan of Care" section 30.2 which states the plan of care must be reviewed and signed by the physician who established the plan of care, at least every 60 days. Each review of a recipient's plan of care must contain the signature of the physician and the date of review. In addition, all documentation, including signed orders, must be complete prior to billing for services. See Ohio Admin. Code 5101:3-12-03(C)(4)

Exception Test 1 – Potential Duplicate Services

We reviewed the 38 state plan home health services and identified two services in which the physician's signature on the plan of care was not dated and 14 services in which the claim was submitted for reimbursement prior to the date the physician signed the plan of care. These 16 errors are included in the overpayment of $18,608.96.

Exception Test 2 – Services for Three Recipients Residing at the Same Address, August, 2011

We reviewed 174 state plan home health services and found no errors.

We identified 174 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.

Exception Test 3 – Services for Two Recipients Residing at the Same Address, August, 2013

We reviewed 124 state plan home health services and identified 84 services in which the physician's signature on the plan of care was not dated. These 84 services are included in the overpayment of $1,953.84.

Statistical Sample

We reviewed 505 state plan home health services in the statistical sample and identified the following errors:

- 220 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 35 services in which the physician's signature on the plan of care was not dated;
- 25 services in which there was no plan of care to cover the service; and
- 13 services in which the plan of care did not authorize the home health service.

The overpayments associated with these 293 errors were included in the finding amount of $2,032,426.

We also identified 68 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.

C. Authorization to Provide Services (Continued)

All Services Plan

According to Ohio Admin. Code § 5101:3:12-01, the MCRHHA's plan of care must provide the amount, scope, duration and type of home health service as identified on the all services plan when a recipient is enrolled in home and community based waiver.

Exception Test 1 – Potential Duplicate Services

We reviewed the 437 waiver services and identified eight services in which there was no all services plan. These eight errors are included in the overpayment of $18,608.96.

Statistical Sample

We reviewed 284 waiver services and identified no errors.

While reviewing all services plans, we noted instances where more than one home health agency was authorized to render services to a single recipient. We judgmentally selected five recipients in which more than one home health agency was authorized to render services during the same time period and searched MITS for all claims submitted by home health agencies for these five recipients during our examination period to determine if there were billings by multiple agencies on the same day for the same recipient, which could indicate potential duplicate billings. We noted one recipient with services billed by two agencies on the same day. We did not identify any duplicate billing pattern by multiple agencies and performed no further review.

Recommendation:

The Provider should develop and implement procedures to ensure all plans of care are signed and dated by the recipient's treating physician prior to rendering services. The Provider should also ensure that all documentation, including signed orders, is complete prior to billing for services. In addition, the Provider should ensure an all services plan is in place prior to rendering wavier services. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

D. Healthchek Services

According to Ohio Admin. Code § 5101:3-12-01(H), a recipient may qualify for increased services if the individual is under age 21; requires more than, as ordered by the treating physician, eight hours per day of any home health service or a combined total of 14 hours per week of home health aide and home health nursing services; and has a comparable level of care as evidenced by either enrollment in a home and community based service waiver or a level of care initially and annually evaluated by ODM or its designee. The U5 modifier must be used when billing for Healthchek services in accordance to Ohio Admin. Code § 5101:3-12-05 which indicates that all conditions of this rule have been met.

Exception Test 2 – Services for Three Recipients Residing at the Same Address, August, 2011

We reviewed the 165 services modified with U5 and identified 51 services in which the Healthchek certification form did not authorize additional services. These 51 errors are included in the overpayment of $2,566.34.

C. Healthchek Services (Continued)

Statistical Sample

We reviewed the 68 services modified with U5 and identified three services in which there was no Healthchek certification form. The overpayments associated with these three errors were included in the finding amount of $2,032,426.

Recommendation:

The Provider should develop and implement procedures to ensure Healthchek services are authorized on a Healthchek certification form prior to billing. In addition, the Provider should also ensure all Healthchek certification forms are maintained. The Provider should address the identified issue 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.** 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 home health aide (G0156), home health nursing (G0154), personal care aide (T1019), waiver nursing (T1002 and T1003) and physical therapy (G0151) services, less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM.

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 a recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date.

SAMPLE DESIGN
We used a stratified random sample.

Summary of Sample Record Analysis
For the period July 1, 2011 to June 30, 2014

Description	Results
Number of Population RDOS Provided	45,189
Number of Population RDOS Sampled	331
Number of RDOS Sampled with Errors	247
Number of Population Services	94,350
Number of Population Services Sampled	789
Number of Services Sampled with Errors	548
Total Medicaid Amount Paid for Population	$3,070,120.33
Amount Paid for Population Services Sampled	$34,888.89
Estimated Population Overpayment Amount	$2,032,426
Upper Limit Overpayment Estimate at 95 Percent Confidence Level	$2,194,532
Lower Limit Overpayment Estimate at 95 Percent Confidence Level	$1,870,319
Precision of Population Overpayment Projections at the 95 Percent Confidence Level	$162,107 (+/-7.98%)

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

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Dinsmore

Legal Counsel.

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March 31, 2016

VIA EMAIL [KSERLEWINE@OHIOAUDITOR.GOV]
Kristi S. Erlewine, Chief Auditor
Ohio State Auditor's Office
(614) 728.7245

Re: Shifo Healthcare Services, LLC

Dear Ms. Erlewine:

Given the opportunity to respond to the findings of the Ohio State Auditor's Office, Shifo Healthcare Services, LLC responds as follows:

> *Shifo Healthcare Services, LLC recognizes the importance of maintaining accurate documentation and ensuring the high quality of our employees. Shifo has always endeavored to accomplish these duties to the best of its ability.*
>
> *As for its employees, Shifo takes pride in making certain that they are paid on time, and that they are fully qualified to provide services. Any alleged deficiency with regard to employee qualifications referenced by the auditor has been addressed, now that it has been brought to our attention.*
>
> *The Auditor believes it has discovered certain deficiencies in Shifo's documentation. Shifo disputes many of these findings; however, we also recognize that errors can happen. To the extent that any deficiencies do exist in our paperwork, we submit that such deficiencies are merely isolated, inadvertent errors which had no impact on patient outcome.*
>
> *To this point, Shifo wishes to emphasize that all patients received excellent care from Shifo. The Auditor's findings do not indicate in any way that any patient suffered harm because of Shifo.*
>
> *Shifo also asserts that the Auditor's extrapolation greatly exaggerates the scope of deficiencies discussed in the report.*

If you have any questions, please contact me.

Regards,

Brendan T. O'Reilly

Brendan T. O'Reilly

BTO:cls

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Dave Yost • Auditor of State

SHIFO HEALTHCARE SERVICES, LLC

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
APRIL 12, 2016

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