DONNA COURTNEY, R.N.
ASHTABULA COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2012 THROUGH DECEMBER 31, 2014

Dave Yost · Auditor of State

DONNA COURTNEY, RN
ASHTABULA COUNTY

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

Donna Courtney, RN
3339 Lake Road
Conneaut, Ohio 44030

Dear Ms. Courtney:

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 and waiver nursing services during the period of January 1, 2012 through December 31, 2014. We confirmed your licensure status and tested service documentation to verify that there was support for the date of service, the procedure code, and the units paid by Ohio Medicaid. In addition, we tested to determine if your service documentation contained the required elements. We also examined the plans of care and private duty nursing authorizations 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 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 Disclaimer of Opinion

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 controls 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, 2012 through December 31, 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 identified improper Medicaid payments for services rendered between January 1, 2012 and December 31, 2014 in the amount of $7,328.17. This finding plus interest in the amount of $486.97 totaling $7,815.14 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 the 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 ODM and is not intended to be, and should not be used by anyone other than this specified party.

Dave Yost
Auditor of State

April 4, 2017

[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

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(A) and (B) 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(D) and (E)

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

The Provider's Ohio Medicaid number is 2121260 and she is a registered nurse (RN). During the examination period, the Provider furnished private duty and skilled nursing services to 11 Ohio Medicaid recipients and received reimbursement of $331,535.30 for 1,944 private duty nursing services (procedure code T1000) and 549 RN services (procedure code T1002) provided on 736 unique dates of services (DOS). The Provider billed 2,465 of these services with an HQ modifier, indicating that these were services provided in a group setting.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's 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 (procedure code T1000) and RN services (procedure code T1002) the Provider rendered during the period of January 1, 2012 through December 31, 2014 and received payment from Ohio's Medicaid program.

We received the Provider's claims history from the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed all services with a paid amount of zero. We also removed 84 services associated with overpayments previously identified by the ODM. From the remaining population, we extracted all services on dates in which there was at least one service billed without an HQ modifier. This resulted in an exception test of 93 services rendered on 28 separate dates (Exception Test 1).

We then extracted all services on five specific dates in which we found that, in addition to the Provider, another provider billed Ohio Medicaid for nursing services to the same recipient on the same date. This resulted in an exception test of 13 services rendered on these five separate dates (Exception Test 2).

Purpose, Scope, and Methodology (Continued)

After removing the services in the two 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). We first extracted all private duty nursing services (procedure code T1000) and summarized this file by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. We selected a random sample of 572 RDOS. We then obtained the detailed services for the 572 RDOS. This resulted in a sample size of 572 services (Statistical Sample 1).

We then selected a stratified random sample from the remaining population of waiver nursing services (procedure code T1002). Specifically, we stratified the services by RDOS into six strata using the standard deviation of the actual amount paid per claim and a 32 percent error rate. The final calculated sample size is shown **Table 1**.

Table 1: Statistical Sample 2 – Waiver Nursing Services		
Universe/Strata	**Population**	**Sample**
Strata 1: RDOS with Amount Paid Less than $30.00	1	1
Strata 2: RDOS with Amount Paid Between $30.00 - $39.99	1	1
Strata 3: RDOS with Amount Paid Between $40.00 - $49.99	423	164
Strata 4: RDOS with Amount Paid Between $50.00 - $99.99	1	1
Strata 5: RDOS with Amount Paid Between $100 & $199.99	96	96
Strata 6: RDOS with Amount Paid $200 and Over	1	1
Total RDOS:	523	264

We then obtained the detailed services for the 264 sampled RDOS. This resulted in a sample size of 265 services (Statistical Sample 2). **Table 2** summarizes the two exception tests and two samples used in this examination.

Table 2: Summary of Tests			
Universe/Strata	**Population Size**	**Sample Size**	**Selection Method**
Exception Test 1 – Dates Containing Service Without An HQ Modifier			
Dates of Service with Services Billed without an HQ	28 DOS	93 Services	Census
Exception Test 2 - Two Providers Billed for the Same Recipient			
Dates of Service in which Two Providers Billed Medicaid for the Same Recipient	5 DOS	13 Services	Census

Table 2: Summary of Tests			
Universe/Strata	**Population Size**	**Sample Size**	**Selection Method**
Statistical Sample 1 – Private Duty Nursing Services			
Private Duty Nursing Services	1,857 RDOS	572 RDOS	Simple Random
Statistical Sample 2 – Waiver Nursing Services			
Waiver Nursing Services	523 RDOS	264 RDOS	Census and Stratified Random

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. An entrance conference was held with the Provider during which 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. We sent a missing records list and a final request for information to the Provider and we reviewed all documents received for compliance.

Results

Exception Test 1 – Dates Containing Service Without An HQ Modifier

We examined 93 services on dates which included at least one service that was billed without an HQ modifier and identified 16 errors. As a result, we identified $723.67 as an overpayment.

Exception Test 2 - Two Providers Billed for the Same Recipient

We examined 13 services on five DOS in which the Provider and another provider billed services for the same recipient and found three errors. As a result, we identified $301.62 as an overpayment.

Statistical Sample 1 - Private Duty Nursing Services

We examined 572 private duty nursing services and identified 116 errors. The overpayments identified for 19 of 572 RDOS (19 of 572 services) from our statistical random sample were projected across the Provider's subpopulation of paid RDOS. This resulted in a projected overpayment amount of $7,944 with a precision of plus or minus $3,050 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). Additional correction was then done for skewness and a finding was made for $5,494.80. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $5,494.80.

Statistical Sample 2 - Waiver Nursing Services

We examined 265 waiver nursing services and identified 17 errors. These 17 errors are included in the overpayment of $808.08.

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

A. Provider Qualifications

According to Ohio Admin. Code § 5160-12-02(A)[2], private duty nursing requires the skills of and is performed by either an registered nurse (RN) or a licensed practical nurse at the direction of an RN. According to Ohio Admin. Code §§ 5160-46-04(A)(1) and 5123:2-9-59(C)(2)(a)[3] all nurses providing waiver nursing services must possess a current, valid and unrestricted license with the Ohio board of nursing.

We verified through the Ohio e-License Center that the Provider was licensed through the Ohio Board of Nursing as an RN and that her license was in active status during our examination period.

B. Service Documentation

Clinical Records

Per Ohio Admin. Code § 5160-12-02, private duty nurses are required to comply with Ohio Admin. Code § 5160-12-03 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. According to Ohio Admin. Code §§ 5160-46-04(A)(6) and 5123:2-9-59(E)(2)(j), all providers must maintain a clinical record that includes tasks performed or not performed, arrival and departure times and the dated signature of the provider and recipient or authorized representative verifying service delivery upon completion of service delivery. In addition, Per Ohio Admin. Code §§ 5160-12-06(C)(2), 5160-46-06(A)(7) and the Appendix to 5123:2-9-59, a unit rate means the amount paid for each 15 minute unit after the base rate paid for the first four units of service provided.

Exception Test 1 – Dates Containing Service Without An HQ Modifier

We found two services in which there was no service documentation and two services in which the units billed exceeded the documented duration. The overpayment for the overbilled units is based on the unsupported units. These four errors are included in the total overpayment of $723.67.

Exception Test 2 - Two Providers Billed for the Same Recipient

We found one service in which the Provider documented the same exact time on the same date as another Medicaid provider who also billed for rendering nursing services to the same recipient. This one error is included in the total overpayment of $301.62.

Statistical Sample 1 - Private Duty Nursing Services

We found seven services in which the Provider billed for more units than the service documentation supported. The overpayment for these instances of units billed exceeding units documented is based only on the unsupported units. These seven errors are included in the overall projection of $5,494.80.

[2] Except as noted, the rules noted in the results section are the numbers effective beginning October 1, 2013. Prior to that time the rules were within the Department of Job and Family Services rules but were renumbered per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly to reflect the transfer of the Office of Medical Assistance to the ODM.

[3] The Transitions Waiver was moved to the Ohio Department of Developmental Disabilities effective January 1, 2013. Prior to that time, this waiver was administered by the ODM and the rules for the program were found in Ohio Admin. Code § 5101:3-47.

B. Service Documentation (Continued)

Statistical Sample 2 - Waiver Nursing Services

We found three services in which the service documentation was not signed by the Provider and three services in which the units billed exceeded the units documented. The overpayment for these instances of units billed exceeding units documented is based only on the unsupported units. These six errors are included in the total overpayment of $808.08.

Recommendation:

The Provider should ensure that documentation include all required elements, that units billed are supported by time keeping records and that it bills accurately 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

Plan of Care

According to Ohio Admin. Code § 5160-12-02(B)(2), a private duty nurse must be provided and documented in accordance with the recipients plan of care. In addition, Ohio Admin. Code §§ 5160-46-04(A)(4)(g) and 5123:2-9-59 states that in order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN 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.

All Services Plan / Individual Service Plan

Ohio Admin. Code § 5160-46-04(A)(4)(f) states that the provider must be identified on the recipient's all services plan and have specified the number of hours for which the provider is authorized to furnish waiver nursing services to the recipient. In addition, Ohio Admin. Code § 5123:2-9-59(D)(2) states a provider of waiver nursing services shall be identified as the provider and have specified in the individual service plan the number of hours for which the provider is authorized to furnish waiver nursing services.

Exception Test 1 – Dates Containing Service Without An HQ Modifier

We found eight services in which the plan of care did not specify the frequency or duration of the service; however, the services were authorized on the recipient's All Services Plan (ASP) or Individualized Service Plan (ISP). We identified no overpayment for these eight errors.

Exception Test 2 - Two Providers Billed for the Same Recipient

We found one service in which there was no plan of care to support the service. This one error is included in the overpayment of $301.62.

In addition, we identified one plan of care that did not specify the frequency or duration of the service; however, the services were authorized on the recipient's All Services Plan (ASP) or Individualized Service Plan (ISP). We identified no overpayment for this one error.

C. Authorization to Provide Services (Continued)

Statistical Sample 1 - Private Duty Nursing Services

We found 12 services in which there was no plan of care to support the service. These 12 errors are included in the total overpayment of $5,494.80.

In addition, we identified 97 services in which the plan of care did not specify the frequency or duration of the service. We noted that some of these plans of care also did not specifically identify private duty nursing services; however, the services were authorized on the recipient's ASP or ISP. We identified no overpayment for these 97 errors.

Statistical Sample 2 - Waiver Nursing Services

We found one service in which there was no plan of care to support the service. This one error is included in the total overpayment of $808.08.

In addition, we identified 10 services in which the plan of care did not specify the frequency or duration of the service. We noted that some of these plans of care also did not specifically identify skilled nursing services; however, the services were authorized on the recipient's ASP or ISP. We identified no overpayment for these 10 errors.

Recommendation:

The Provider should maintain plans of care and verify that all plans of care specify the service, frequency and duration. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

D. Modifiers

Per Ohio Admin. Code §§ 5160-12-04(D)(3), 5160-12-06(D) and 5160-46-06(E), the modifier HQ must be used when billing for a group visit and the amount of reimbursement shall be the lesser of the provider's billed charge or 75 percent of the Medicaid maximum. Ohio Admin. Code § 5123:2-9-59(F)(2) states claims for payments must be in accordance with Ohio Admin. Code § 5160-41-22, which includes the same requirement for the use of an HQ modifier and the same payment rate.

Exception Test 1 – Dates Containing Service Without An HQ Modifier

We found four services in which the documentation showed that services were rendered to two recipients on the same date at the same time and neither service was billed with an HQ modifier. The overpayment for these instances is based on the difference between the reimbursed rate and rate for a group visit. These four errors are included in the total overpayment of $723.67.

We found no additional errors in the second exception test or in either of the statistical samples.

Recommendation:

Provider should ensure services are properly billed, including required modifiers. 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**. The Provider acknowledged the errors but disputed the use of statistical methods to identify the improper payment amount. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Conclusion

We conducted a post payment examination of the Provider's records and documentation to determine compliance with Ohio Medicaid rules and to identify any improper payments. Ohio Admin. Code § 5160-1-27(B)(1) allows for the use of statistical methods to determine the amount of overpayment.

Appendix I

Summary of Sample Record Analysis
Statistical Sample 1 – Private Duty Nursing Services

POPULATION
The population is all paid Medicaid private duty nursing services (procedure code T1000), 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 population included private duty nursing services included in Exception Test 1 and Exception Test 2.

SAMPLING FRAME
The sampling frame was paid and processed claims from the MITS. This system contains 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 RDOS Provided	1,857
Number of Population RDOS Sampled	572
Number of RDOS Sampled with Errors	19
Number of Population Services Provided	1,863
Number of Population Services Sampled	572
Number of Services Sampled with Errors	19
Total Medicaid Amount Paid for Population	$281,820.63
Actual Amount Paid for Population Services Sampled	$86,553.52
Estimated Overpayment (Point Estimate)	$7,944
Precision of Overpayment Estimate at 95 Percent Confidence Level	$3,050
Precision of Overpayment Estimate at 90 Percent Confidence Level	$2,559[1]
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) Due to skewness, lower limit precision was changed to $2,449.10.[1]	$5,494.80

Source: Analysis of MITS information and the Provider's medical records
[1]Correction in lower limit confidence level using method described "Sampling Methods For The Auditor, An Advanced Treatment" by Herbert Arkin. This technique use of tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, vol 1, Cambridge University Press, New York, 1954, table 42.

APPENDIX II

Donna Courtney RN
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440-265-9170

Mr. Yost,

This is in response to the letter that accompanied the result of my recent audit. I would like to address several items. First, let it be said that I have been a RN for 37 years and an Independent Provider for at least 18 yrs. I am an excellent nurse and pride myself on knowing I deliver quality care to my patients. I do not refer to them as consumers in a businesslike manner. To clear the air, I resent the insinuation in your report of fraud, waste or abuse. I have never deliberately done any kind of fraud, waste or abuse of state money. As a matter of fact, if I kept track of the amount of time I have stayed over by a few minutes to help out and have not charged the state, I am beyond sure that the state would owe me. I cannot accept the figure that that you have arrived at using a projection. I am a human being not a piece of mechanical equipment. There is no way of knowing that the human errors I may have made would be continued to be made. Each year we are reviewed by an independent consulting group and each chart is gone over. Mistakes that had been made and were pointed out. Therefore, each year I have improved and corrected what I had erroneously done incorrect. That is the purpose of the review- to make sure I am compliant with the OAC. I concede that some mistakes may have been made as I am only human. I deal daily with patients with seizures, respiratory problems, trachs, ventilators, tube feeds. I care for the children that people don't want to know about. There are times I get called away from my paper work to suction a patient or to medicate a patient during a seizure. So perhaps there was a time I forgot to sign or date a document. My care of the patient takes precedence over documentation.
What I don't understand is why my pay needs to be paid back because of this. Services were rendered. No one has ever called my employer to see if I was there on those dates. I know of no other occupation which insists on paying the employer back their day's wages due to a human mistake. I put in my time and effort and the services were rendered within the scope of nursing.

I will address the findings of the audit.

1) 2 days of no documentation from 3 years ago. Possibly misfiled. $48.39, $292.12,-$340.51

2) Forgotten HQ modifier when billing indicating group billing- I have no way of knowing whether that was my mistake or my billing company's mistake when they submitted it.
3) There was no POC for one child that was in the home for respite care. We asked the child's foster parent for paper work when the child arrived and we never received it. The family went out of town and the child needed services.
4) 3 No signatures- complete documentation and services rendered other than signature.
5) Actual incorrect billing – More than likely my mistake for charting the incorrect time of the full shift rather than overbilling the hours. $955.95
6) One no time in/out. Human error. Services were rendered.
7)

Therefore, I concede that there were human errors as no one is perfect. I will also concede that I owe the State of Ohio $ 1209.46. I know that I am highly paid due to the unique circumstances of the home I work in. I work for a family that fosters and adopts county children. Even the people who audited us – 3 of us nurses in that home were audited – were surprised that no true fraud was found. They felt because we had multiple patients and made a good salary that we were committing fraud. We have three patients at one time as the foster children come and go. I realize that Independent Providers have come under scrutiny the past several years and that some fraud has been found, however our home is not one of those homes. We pride ourselves in the fact that we give excellent nursing care. The reason that the need for Independent Providers exists is the fact that agencies are unable to fill the needs of the patients. They don't pay the caregivers enough or have consistent hours to accommodate the nurses and aides. The need for IP's is readily evident when talking to patients and their families. Pleases do not assume ALL IP's are trying to rip off the state. We work long hours, holidays without holiday pay, no vacation, no sick time and no benefits. We are a dedicated group of professionals. Thank you for allowing me to respond to this audit. I believe I am being reasonable and fair in my assessment of the situation.

Sincerely,

Dawn Courtney RN
Medicaid Provider # 2121260
dcourtnern@gmail.com

Dave Yost • Auditor of State

DONNA COURTNEY

ASHTABULA 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 18, 2017

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