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EMILY E. ARNOLD, RN
CLARK COUNTY

TABLE OF CONTENTS

Title	Page
Independent Auditor's Report	1
Compliance Examination Report	3
Recommendation: Service Documentation	7
Recommendation: Authorization to Provide Services	8
Additional Matter that Came to Our Attention	8
Appendix I: Summary of Sample Record Analysis: Statistical Sample 2	9
Appendix II: Summary of Sample Record Analysis: Statistical Sample 3	10
Appendix III: Provider Response	11

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

Emily E. Arnold, RN
2815 North Hampton Road
Springfield, Ohio 45502

Dear Ms. Arnold:

We examined your (the Provider's) compliance with specified Medicaid requirements for service documentation and service authorization related to the provision of nursing and personal care aide services and your licensure related the provision of nursing services during the period of January 1, 2012 through December 31, 2014. We confirmed your licensure status during the portion of the examination period in which you rendered nursing services and we 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 your plans of care, all services plans and individual service plans 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 Qualified Opinion

Our examination disclosed that in a material number of instances the Provider submitted claims for reimbursement prior to obtaining a signed plan of care.

Opinion on Compliance

In our opinion, except for the effect of the matter described in the Basis for the 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 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 found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2012 and December 31, 2014 in the amount of $36,676.46. This finding plus interest in the amount of $2,261.38 totaling $38,937.84 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 and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

March 15, 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 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 Emily Arnold, RN

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)

Ohio Medicaid recipients may be eligible to receive waiver aide and nursing services and private duty nursing services. Personal care aide services assist the recipient with activities of daily living such as bathing and dressing, general homemaking activities, household chores, personal correspondence, accompanying the consumer to medical appointments or running errands. *See* Ohio Admin. Code § 5160-47-04(B)(1) Private duty nursing is a continuous nursing service generally between four and 12 hours in duration and 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

This Provider rendered personal care aide and nursing services to one recipient on an Ohio transitions developmental disabilities waiver. The Provider's Medicaid number as a personal care aide was 2391040 and between January 1, 2012 and April 21, 2013 received reimbursement of $71,466.17 for 1,397 personal care aide services (procedure code T1019), rendered on 473 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. The provider agreement for this number expired on July 9, 2016.

The Provider's Medicaid number as a private duty nurse is 0073437 and between April 22, 2013 and December 31, 2014 received reimbursement of $159,533.10 for 936 services, rendered on 607 RDOS including $149,243.52 for 755 private duty nursing services (procedure code T1000), $2,090.76 for 19 waiver nursing services (procedure code T1002) and $8,198.82 for 162 personal care services (procedure code T1019). The provider agreement for this number became effective October 2, 2012 and is still active.

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 personal care aide, waiver nursing and private duty nursing services the Provider rendered to one Medicaid recipient during the period of January 1, 2012 through December 31, 2014.

We received the Provider's claims history for each provider number from the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. From these populations, 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).

Purpose, Scope, and Methodology (Continued)

Personal Care Aide - Provider Number 2391040

We calculated an estimate of the population overpayment standard deviation using the standard deviation of the actual amount paid per claim and a 51 percent error rate. We constructed strata using the two natural groupings in the data. The sample size and error estimate were calculated using the Health and Human Recourses/Office of Inspector General (HHS/OIG) RATSTATS statistical program. We selected a sample of 219 RDOS from the population of 454 RDOS. The final calculated sample size is shown in **Table 1**. We then obtained the detailed services for the stratified random sample of 219 RDOS which resulted in a sample of 635 services (Statistical Sample 1).

Private Duty Nurse - Provider Number 0073437

From this population, we first extracted private duty nursing services (procedure code T1000) in which 16 units or less was billed. We calculated an estimate of the population overpayment standard deviation using the standard deviation of the actual amount paid per claim and a 50 percent error rate. The sample size and error estimate were calculated using the HHS/OIG RATSTATS statistical program. We selected sample of 134 RDOS from the population of 205 RDOS (see **Table 1**).We then obtained the detailed services for the simple random sample of 134 RDOS which resulted in a sample of 134 services (Statistical Sample 2).

From the remaining population we calculated an estimate of the population overpayment standard deviation using the standard deviation of the actual amount paid per claim and a 39 percent error rate. We constructed strata using the three natural groupings in the data. The sample size and error estimate were calculated using the HHS/OIG RATSTATS statistical program. The final calculated sample size is shown in **Table 1**. We then obtained the detailed services for the stratified random sample of 303 RDOS which resulted in a sample of 369 services (Statistical Sample 3).

Table 1 summarizes the three samples selected for examination.

Table 1: Summary of Three Samples

Statistical Sample 1 – Personal Care Aide Services (Provider # 2391040)			
Universe/Strata	**Population Size**	**Sample Size**	**Selection Method**
RDOS Billed Less Than $151.83	19 RDOS	19 RDOS	Stratified Random
RDOS Billed $151.83 or Greater	454 RDOS	200 RDOS	Stratified Random
Total:	473 RDOS	219 RDOS	
Statistical Sample 2 – Private Duty Nursing Services Billed with 16 or Fewer Units (Provider # 0073437)			
Private Duty Nursing Services Billed with 16 or Fewer Units	205 RDOS	134 RDOS	Simple Random

Table 1: Summary of Three Samples

Statistical Sample 3 – Private Duty Nursing – Remaining Population (Provider # 0073437)			
Universe/Strata	**Population Size**	**Sample Size**	**Selection Method**
RDOS Billed Less Than $200	268 RDOS	100 RDOS	Stratified Random
RDOS Billed $200 or Greater and Less Than $270	318 RDOS	185 RDOS	Stratified Random
RDOS Billed $270 or Greater	18 RDOS	18 RDOS	Stratified Random
Total:	604 RDOS	303 RDOS	

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described her documentation practices, procedures for obtaining plans of care, all service plans, individual service plans, and process for submitting billing to the Ohio Medicaid program. Our field work was performed following the entrance conference. The Provider was given an opportunity to submit missing documentation and we reviewed all documentation received for compliance.

Results

Statistical Sample 1 – Personal Care Aide Services

We examined 635 services and found one error. As a result, we identified an overpayment of $12.

Statistical Sample 2 – Private Duty Nursing Services Billed with 16 or Fewer Units

We examined 134 services and identified 28 errors. The overpayments identified for 28 of 134 RDOS (28 of 134 services) from our random sample were projected across the Provider's total population of paid RDOS. This resulted in a projected overpayment amount of $4,714 with a precision of plus or minus $926 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 $3,938. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $3,938. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

Statistical Sample 3 – Private Duty Nursing - Remaining Population

We reviewed 369 services and identified 77 errors. We took exception with 77 of 369 statistically sampled services (74 of 303 RDOS) from a stratified random sample of the Provider's population of paid services, excluding private duty nursing services (procedure code T1000) billed with 16 or fewer units which were extracted for a separate review. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $104,366, with a 95 percent certainty that the actual correct payment amount fell within the range of $99,923 to $108,809 (+/- 4.26 percent.) We then calculated findings by subtracting the correct population amount ($104,366) from the amount paid to the Provider for this population ($137,092.46), which resulted in a finding of $32,726.46. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

Results (Continued)

The non-compliance found 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 a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of an RN. According to Ohio Admin. Code § 5123:2-9-59(C)(2), waiver nursing services shall be provided by an RN or an LPN working at the direction of an RN who possesses a current, valid, and unrestricted license issued by the Ohio board of nursing.

Since the Provider became an RN approximately nine months into our examination period, we limited our testing to compliance with the aforementioned nursing licensure requirements.

We verified through the Ohio e-License Center that the Provider was licensed through the Ohio Board of Nursing as an RN and was in active status from September 10, 2012 through the end of the examination period.

B. Service Documentation

Personal Care Aide Services

Ohio Admin. Code § 5160-47-04(B)(8)(g) states all personal care aide providers must maintain a clinical record that includes documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and recipient or authorized representative, verifying service delivery upon completion of service delivery.[3]

Statistical Sample 1 – Personal Care Aide Services

We reviewed 635 services and found one service in which the units billed exceeded the units documented. This one error is included in the overpayment of $12 and is based only on the unsupported units.

Nursing Services

Providers of waiver nursing services shall include clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and recipient or authorized representative. *See* Ohio Admin. Code § 5123:2-9-59(E)(2) Per Ohio Admin. Code § 5160-12-02, in order for private duty nursing services to be covered, providers bill after all documentation is completed in accordance 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.

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[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 affects rules noted in the Results section of this report.

[3] The Ohio Department of Developmental Disabilities began administering this waiver on January 1, 2013 and the rule was renumbered to Ohio Admin. Code § 5123:2-9-56(E)(2).

B. Service Documentation (Continued)

Statistical Sample 2 – Private Duty Nursing Services Billed with 16 or Fewer Units

We reviewed 134 services and found no errors.

Statistical Sample 3 – Private Duty Nursing - Remaining Population

We reviewed 369 services and found four services in which the beginning and ending times were the same for a previous service on the same date. These four errors were used in the overall projection of $32,726.46.

Recommendation:

The Provider should ensure that units billed are supported by clinical records and bill only for services actually rendered. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

All Services Plans and Individual Service Plans

According to Ohio Admin. Code § 5160-47-04, for waiver nursing services and personal care aide services to be reimbursed, the provider must 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 services.[4]

We reviewed the all services plans in effect from January 1, 2012 through December 31, 2012 and the individual service plans in effect from January 1, 2013 through December 31, 2014 and found that the Provider and the services were authorized.

Plan of Care

Ohio Admin. Code § 5160-12-02 requires that private duty nursing services be provided and documented in accordance with the recipient's plan of care. In addition, Ohio Admin. Code § 5123:2-9-59 states that documentation to validate payment for services must include the plan of care that specifies the type, frequency, scope and duration of the waiver nursing services, and the plan of care must be signed and dated by the treating physician prior to requesting payment for a service.

Statistical Sample 2 – Private Duty Nursing Services Billed with 16 or Fewer Units

We reviewed 134 services and found 28 services in which the claim was submitted for reimbursement prior to obtaining a signed plan of care. These 28 errors were used in the overall projection of $3,938.

Statistical Sample 3 – Private Duty Nursing - Remaining Population

We reviewed 369 services and found 73 services in which the claim was submitted for reimbursement prior to obtaining a signed plan of care. These 73 errors were used in the overall projection of $32,726.46.

[4] The Ohio Department of Developmental Disabilities began administering this waiver on January 1, 2013 and the rule was renumbered to Ohio Admin. Code § 5123:2-9-56 (personal care aide) and Ohio Admin. Code § 5123:2-9-59 (waiver nursing) and include the same requirements.

C. Authorization to Provide Services (Continued)

We also noted that none of the plans of care tested specifically authorized nursing services but instead authorized activities such as range of motion, bath, massage, g-tube care and feeding, and personal hygiene. We found that the activities documented on the service documentation were consistent with the activities authorized on the plans of care. (See Additional Matter below.)

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 specify nursing services and are obtained prior to submitting claim for services to ODM. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Additional Matter that Came to Our Attention

A comparison of tasks documented when the Provider rendered personal care aide services found same tasks performed and billed as nursing services. The following is a list of documented tasks that were provided but billed as two different types of service:

- Wash face, clear mucous from mouth, brush teeth;
- G-tube care;
- Range of motion/stretch/weight bearing, rocking;
- Housekeeping, laundry, dishes;
- Massage;
- Position changes all throughout day;
- Bath, dry hair, diaper changes, clothes change; and
- Outing assist/transport.

We noted the only variation in tasks performed between the services billed as aide services and those billed as nursing services were g-tube feeding and medication administration as needed. In addition, the documentation for nursing services did not include an assessment of the patient, vital signs or time and dosage of medication administered as is typically included in nursing notes. Also, as noted above under Authorization to Provide Services - Plan of Care, the plans of care authorized certain activities but did not specify a named service.

Ohio Admin. Code § 5123:2-9-59(B)(13) states waiver nursing services may include personal care aide services when provided incidental to waiver nursing services performed during the nursing visit. In addition, Ohio Admin. Code § 5160-12-02(A) states a service is not considered a private duty nursing service merely because it was performed by a licensed nurse.

Although all waiver and private duty nursing services were authorized on an Individual Services Plan, we could not determine from the Provider's documentation if personal care aide services that are incidental to waiver nursing services were rendered. We communicated this issue separately to the ODM so that it may determine if personal care aide services and/or nursing services are warranted.

Provider Response:

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

APPENDIX I

Statistical Sample 2 – Private Duty Nursing Services Billed with 16 or Fewer Units

POPULATION
The population is all paid Medicaid private duty nursing services (procedure code T1000) in which 16 or less units were billed, 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 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 an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	205
Number of Population RDOS Sampled	134
Number of RDOS Sampled with Errors	28
Number of Population Services Provided	206
Number of Population Services Sampled	134
Number of Services Sampled with Errors	28
Total Medicaid Amount Paid for Population	$22,440.64
Actual Amount Paid for Population Services Sampled	$14,631.56
Estimated Overpayment (Point Estimate)	$4,714
Precision of Overpayment Estimate at 95 Percent Confidence Level	$926
Precision of Overpayment Estimate at 90 Percent Confidence Level	$775
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)	$3,938

APPENDIX II

Statistical Sample 3 – Private Duty Nurse - Remaining Population

POPULATION
The population is all paid Medicaid private duty nursing services (procedure code T1000), waiver nursing services (procedure codes T1002) and personal care aide services (procedure code T1019), less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM. (Services excluded from this sample population included services in the population for Statistical Sample 2.)

SAMPLING FRAME
The sampling frame was paid and processed claims from 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 an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	604
Number of Population RDOS Sampled	303
Number of RDOS Sampled with Errors	74
Number of Population Services Provided	730
Number of Population Services Sampled	369
Number of Services Sampled with Errors	77
Total Medicaid Amount Paid for Population	$137,092.46
Actual Amount Paid for Population Services Sampled	$72,218.32
Projected Correct Population Payment Amount	$104,366
Upper Limit Correct Population Payment Estimate at 95 Percent Confidence Level	$108,809
Lower Limit Correct Population Payment Estimate at 95 Percent Confidence Level	$99,923
Projected Overpayment Amount (Actual Amount Paid for Population Services minus Projected Correct Population Payment Amount)	$32,726.46
Precision of Estimated Correct Population Payment Amount as the 95 Percent Confidence Level	$4,443 (+/-4.26%)

APPENDIX III

Provider Response:

At the outset, please note that Ms. Arnold is providing this information be way of explanation and it is not challenging the accuracy of the audit findings. Specifically, Ms. Arnold wanted to address three issues that we discussed: 1) the failure of the Individual Service Plan ("ISP") to include hours for both personal care services and nursing services; 2) billing for services rendered before the patient's plan of care ("POC") was signed by the physician or documented oral orders were received; 3) Ms. Arnold's emergency medical certification when she was rendering services as a Personal Care Aide. Ms. Arnold hopes that this information will help the appropriate departments and agencies provide better support to both patients and their caregivers and she would welcome the opportunity to help with moving that process forward.

I. <u>ISP Issues</u>

As explained in the audit report, Ms. Arnold was providing personal care to the patient when she obtained her license as an RN on September 10, 2012. At that point, both Ms. Arnold and the patient's mother met with the case worker responsible for the patient's ISP to request that the ISP be revised to incorporate nursing hours so Ms. Arnold could provide and bill for nursing services that the attending physician believed would enhance the patient's care. However, they were informed that the ISP could not be changed until the it was up for renewal nine months later in June 2013. While Ms. Arnold and the patient's mother believed that made little sense at the time, they did not whether they could appeal that decision or how to go about doing so.

Thanks in part to the exit interview, Ms. Arnold now realizes that they should have contacted the case worker's supervisor or, perhaps, someone at either the Ohio Department of Developmental Disabilities or the Ohio Department of Medicaid if the supervisor failed to address their concerns. However, even now, she is uncertain who they should have contacted at either department to address the issue. Indeed, under the best of circumstances, it is a formidable challenge to navigate the various departments and agencies responsible for a patient's care and it is even more difficult for a nurse and a patient's elderly mother to do so.

At the risk of revealing that she is unaware of existing efforts to assist caregivers under these circumstances, Ms. Arnold (and the patient's mother) would welcome any information that is available about who they should contact if the responsible individuals at the local level do not appear to be following proper procedures and they believe it would be helpful if the state departments that provide oversight for the local agencies made every effort educate caregivers about resources that are available and ensure that information is readily available. In September 2012, however, Ms. Arnold assumed that the case worker was providing accurate information and continued to bill only for services rendered as a personal care aide for the next nine months. Unfortunately, Ms. Arnold ran into a similar issue when the ISP plan was finally renewed in June 2013.

In June, Ms. Arnold and the patient's mother reiterated their request that the ISP be revised to include both nursing and personal care aide hours since it was obvious to them (as well as the patient's physician) that the patient required both. In response, they were informed that the ISP could <u>not</u> include hours for both services and that it could only provide one or the other. Once again, while they now appreciate that this information was not accurate, they do not believe that it is realistic to expect caregivers to be in a position to correct the county employees who are responsible for ISPs, especially given the frequent changes to the applicable regulations and the available waivers to those regulations. In any event, caregivers are not in a position to overrule the case workers and administrators responsible for implementing the programs and approving ISPs. Thus, Ms. Arnold believes that it would be helpful to have an established procedure whereby caregivers could easily

note any objections to an ISP that would trigger an automatic review by the responsible supervisors and/or administrators.

In June 2013, however, Ms. Arnold and the patient's mother did not realize that they had any alternative to accepting an ISP with only nursing hours in order to ensure that the patient received the nursing care ordered by her physician even though that precluded her (or any other aide) from submitting bills for personal care services. Thus, while Ms. Arnold agrees with the report's conclusion that the ISP should have included personal care hours, she also agrees that it would not have been appropriate to include a finding that she improperly charged personal care services as a nurse under the nursing-only ISP when her request that the ISP include hours for personal care was rejected and she had no control over that decision.

II. Billing Before POC Approved

With respect to Ms. Arnold's billing for services before the POC was approved by the patient's physician, she also relied on erroneous information from the patient's case worker that she could go ahead and bill as long as the POC was signed within sixty (60) days. However, unlike the ISP issues, Ms. Arnold realizes the she is responsible for her billing and has exercises complete control over that process. While she is also aware of the availability of verbal orders, in Ms. Arnold's experience it is generally no easier, and sometimes more challenging, to obtain verbal orders as it is to coax the physician into signing the POC.

While she and the patient's mother have taken steps to ensure that future plans receive timely approval, she remains concerned that someday the responsible physician may fail to do so and be unavailable to provide a verbal order, forcing her to choose between refusing to provide required care or providing such care free of charge until the physician responds. Given the potential risk to patient care, Ms. Arnold believes that the patient's physician should have, or at least share, the responsibility for providing timely approval for a POC in order to protect patients rather than placing the burden solely on the caregivers. Nonetheless, Ms. Arnold accepts responsibility for the errors identified in the report.

III. Emergency Medical Certification

This issue presents a final example of Ms. Arnold relying on individuals charged with enforcing applicable regulations rather than personally taking the necessary steps to ensure compliance. As noted in the report, she did not obtain the emergency medicine certification required for personal care aides after that requirement was put in place. Around that time, Ms. Arnold was undergoing her annual review through a state contractor. During that process, she recalls that this issue came up and the reviewer informed her that she was exempt from the requirement based on how long she had worked as a personal care aide (i.e., that she was "grandfathered in"). Since received passed that review without a corrective action plan related to the certification, Ms. Arnold concluded that this information must be correct.

Thanks in part to the audit process, Ms. Arnold now fully recognizes that the review process for purposes of maintaining her qualification as a personal care aide does not automatically address requirements related to billing Medicaid for such services. Although she does not presently bill for personal care services, Ms. Arnold accepts full responsibility for ensuring that she satisfies all applicable requirements for billing Medicaid in addition to maintaining her license to provide nursing services to the general public when those services are being not being billed to Medicaid and has taken steps to ensure that she will not make a similar mistake in the future.

IV. Conclusion

Ms. Arnold would like to express her appreciation for the professionalism and courtesy she has encountered throughout this process and especially during the exit interview. While no one welcomes an audit, Ms. Arnold believes that the experience has proven to be educational and appreciated the auditors efforts to help her improve her performance as both a provider and caregiver. In particular, Ms. Arnold now has a far better understanding of the relationships between the responsible state and county offices as well as the State Auditor's role in trying to improve the function of Ohio's state and local governments.

As a result, Ms. Arnold is confident that this experience will enable her to better fulfill her responsibilities as a Medicaid provider and also be a better advocate for her patients, especially in ensuring that their ISPs are appropriate for both the patient and their providers. Finally, she hopes that her experience will lead to providers receiving more information regarding their ability to action if a proposed ISP is not appropriate from either the perspective of patient care or the efficient use of state funds as well as their responsibility to do so. Please contact me if you have any questions or if Ms. Arnold can be of any further assistance.

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Dave Yost • Auditor of State

EMILY ARNOLD

CLARK 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 6, 2017

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