Dave Yost · Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Virginia K. Collins, LPN

A Compliance Audit by the:

Medicaid/Contract Audit Section

Dave Yost • Auditor of State

November 22, 2011

Virginia K. Collins, LPN
600 Sunrise View Drive
Wooster, Ohio 44691

Dear Ms. Collins:

We enclose our report on Medicaid reimbursements made to Virginia K. Collins, LPN, Medicaid provider number 2687212, for the period July 1, 2006 to June 30, 2009. Our audit was performed according to our authority in Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $126,362.67 in findings for improper charges to Ohio Medicaid plus $23,818.50 in interest totaling $150,181.17 that is due and payable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After November 22, 2011, additional interest will accrue at $27.70 per day until repayment occurs. Interest is calculated pursuant to Ohio Admin. Code § 5101:3-1-25.

We are forwarding this report to ODJFS because it is the state agency charged with administering Ohio's Medicaid program. ODJFS is responsible for making a final determination regarding recovery of our findings and any accrued interest. If you agree with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are also being sent to the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Board of Nursing. In addition, copies are available on the Auditor of State website at www.auditor.state.oh.us.

88 E. Broad St. / Ninth Floor / Columbus, OH 43215-3506
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

Questions regarding this report should be directed to Charles Brown, III, Chief, Medicaid/Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Dave Yost,
Auditor of State

cc: Ohio Attorney General, Medicaid Fraud Control Unit
Ohio Department of Job and Family Services, Surveillance and Utilization Review Section
U. S. Department of Health and Human Services/Office of Inspector General
Ohio Board of Nursing

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ACRONYMS

AOS	Auditor of State
ASP	All Service Plan
CMN	Certification of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HC	Home Care
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
LPN	Licensed Practical Nurse
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
PDN	Private Duty Nursing
POC	Plan of Care

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Virginia K. Collins, LPN, provider number 2687212, doing business at 600 Sunrise View Drive, Wooster, OH 44691 (the Provider). Within the Medicaid program, the Provider furnishes both private duty nursing (PDN) services and waiver nursing services to Medicaid recipients. This audit, however, only examined the Provider's PDN services.

We performed our audit of Medicaid reimbursements to the Provider for nursing services between July 1, 2006 and June 30, 2009, according to Ohio Rev. Code § 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $126,362.67 in findings for improper charges, based on reimbursements that did not meet the rules of the Ohio Administrative Code in effect at the time the services were provided. Additionally, we assessed accrued interest of $23,818.50 according to Ohio Admin. Code § 5101:3-1-25, for a total finding of $150,181.17, which is due and payable to ODJFS as of the release of this audit report. Additional interest of $27.70 per day will accrue after November 22, 2011, until repayment.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. Providers must follow the rules and regulations specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Handbook. A fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services. *See* Ohio Admin. Code § 5101:3-1-01 (A).

The Auditor of State performs audits to assess compliance with reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, medical necessity, and sound fiscal, business, or medical practices. According to Ohio Admin. Code § 5101:3-1-17.2 (D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated within the six year period is completed. When the AOS identifies fraud, waste, or abuse by a provider in its audits,[1]

[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 defined as 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 § 5101:3-1-29(A)(2).

"any amount in excess of that legitimately due to the provider will be recouped by ODJFS through its office of fiscal and monitoring services, the state auditor, or the office of the attorney general." *See* Ohio Admin. Code § 5101:3-1-29 (B).

Some Ohio Medicaid patients may be eligible to receive private duty nursing (PDN) services provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. *See* Ohio Admin. Code § 5101:3-12-02 (A). Qualifying PDN services must be medically necessary and greater than 4 but no more than 12 hours in length, unless an authorized exception applies. *See* Ohio Admin. Code § 5101:3-12-02 (A).

All LPNs providing PDN services, such as the Provider here, must be supervised by an RN. LPNs providing PDN services at the direction of an RN must maintain records for each patient containing all of the information listed in Ohio Admin. Code § 5101:3-12-03(B) and (C)(4)[2] including:

- Signed and dated certification by treating physician of treatment plans at least every 60 days (§ 5101:3-12-03 (B)(3)(b));
- Contents of plans of care (POC) specifying the services to be performed, the identity of the professionals performing them, and the nature, frequency and duration of each service provided (§ 5101:3-12-03 (B)(3)(b) and § 5101:3-12-02 (B)(2)); and
- Clinical records (including all signed orders) and time keeping records documenting the details of each visit including the date, type and time span of services provided (§ 5101:3-12-03 (C)(4)).

Ohio Medicaid does not pay for PDN services not specified by the POC. Ohio Admin. Code § 5101:3-12-02 (C)(2).

Home Care (HC) nursing services under Ohio Medicaid may include PDN services, waiver nursing services, or both. *See*, e.g., Ohio Admin. Code §§ 5101:3-12-02 and 5101:3-46-04. When a patient receiving PDN care is also on an ODJFS administered waiver nursing program, an all services plan (ASP) is required in addition to the POC. *See* Ohio Admin. Code § 5101:3-45-10 (A)(7). The ASP lists all Medicaid home health services approved for the patient including services under the waiver program and PDN services. The ASP also specifies which providers can render services and subsequently bill Ohio Medicaid for them. *See* Ohio Admin Code § 5101:3-45-01 (D).

The Provider only rendered PDN services to one Medicaid patient who also received waivered nursing services from other providers. As such, the Provider was required to comply with the waiver program requirement of an ASP for each patient. The Provider also rendered 13 waivered nursing services to this same patient during a brief period early in the audit period. These waivered services were excluded from our review.

[2] Section number changed from (C)(3) to (C)(4) on November 8, 2007 with no change to content.

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services complied with regulations and to identify, if appropriate, any findings resulting from non-compliance.

An entrance conference was held with the Provider on February 15, 2011, to discuss the purpose and scope of the audit. The scope of the audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of July 1, 2006 to June 30, 2009 (excluding T1003 waivered LPN services). The Provider was reimbursed $137,047.67 for 495 PDN services during the audit period.

We reviewed the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. This claims data included: patient name, patient identification number, date of service, and service rendered.

We reviewed all plans of care (POC) for the patients for whom the Provider rendered services during the audit period to determine if the POCs properly specified the type and nature of the services to be provided, the professional who was to provide them; the frequency, scope and duration of services to be provided; and covered the time period billed. *See* Ohio Admin. Code § 5101:3-12-03(B)(3)(b).

We also determined if the Provider furnished and billed more PDN services than specified via the POCs. *See* Ohio Admin. Code § 5101:3-12-02 (B)(2). According to Ohio Admin. Code § 5101:3-12-02 (C)(2), services which are not specified in the POC are not reimbursable to the provider.

Our fieldwork was performed between March 2011 and May 2011.

RESULTS

We identified findings of $126,362.67 from our 100 percent review of the Provider's plans of care. The bases for our findings are discussed below.

Testing of Private Duty Nursing Services

We reviewed the POCs submitted by the Provider for the patients for whom Ohio Medicaid was billed for PDN services during the audit period. During our review, we calculated the number of hours of PDN services authorized by the treating physician via the POC. The number of *authorized* hours was then compared, by patient, to the number of hours *billed* for PDN services for the date span of each POC. Findings were taken when billed hours exceeded authorized hours.

Our review revealed instances where the Provider improperly billed the Ohio Medicaid program for:

- POCs not specifying frequency, scope, or duration of services to be provided;
- Services beyond the 60 day certification period where the corresponding POCs had certification periods greater than the allowed 60 days;
- More PDN services than were authorized by the attending physician via the POC;
- Services for which no authorizing POC was found; and
- POCs where the certification span appeared to have been altered without authorizing signatures or dates.

Each issue is discussed below in more detail.

1. Plans of Care not Specifying Frequency, Scope, or Duration

Ohio Medicaid rules require that nurses perform PDN services and waivered nursing services in accordance with an approved plan of care. This plan of care consists of "signed and dated written orders from the treating physician." Ohio Admin. Code § 5101:3-12-03(B)(3)(b). A plan of care must contain a description of the type, frequency, scope, and duration of the nursing services that are to be performed. Ohio Admin. Code §§ 5101:3-12-03 (B)(3)(b) and 5101:3-12-02 (B)(2). Services not included in the plan of care are not reimbursable. Ohio Admin. Code § 5101:3-12-02 (C)(2).

Our review identified seven plans of care, which did not contain the required frequency, scope, and duration of treatment. None of the seven plans of care contained any of the required elements: number of days (frequency), the particular types of services referred to as "skilled nursing services" (scope), or length of the services to be provided (duration). We denied the reimbursement for all services which were covered by plans of care not containing the required elements of frequency, scope, and duration of treatment and made a finding for $82,163.86,

2. Services beyond 60 day Certification Period on Plan of Care Spans Exceeding 60 Days

A plan of care is required to be recertified and signed by the treating physician every 60 days. *See* Ohio Admin. Code § 5101:3-12-03 (B)(3)(b). We requested that the Provider furnish us with all the plans of care that covered services administered by the Provider during the audit period. We then reviewed each plan of care to determine if it was properly signed and authorized by a treating physician and if it was for a period of 60 days or less.

We found eight plans of care that had spans exceeding 60 days. When certification spans overlapped, we shortened the previous span so as to not duplicate findings. After eliminating overlapping dates, these remaining eight plans of care ranged from one day to 31 days over the maximum 60-day plan of care span. For the days in each span exceeding 60, we verified whether the Provider billed services for those particular dates. There were a total of 189 days where services were billed for plans of care past the 60-day certification span. We denied the

reimbursement for services billed for dates beyond the required certification span resulting in a finding for $31,283.01.

3. Unauthorized Private Duty Nursing Services

Our review identified five instances where the units of service billed exceeded those authorized on the plan of care. Services not included in the plan of care are not reimbursable by Ohio Medicaid. *See* Ohio Admin. Code § 5101:3-12-02 (C)(2)(a).

For the Provider's POCs that specified the amount of services authorized, we converted the prescribed number of visits and hours of service into the maximum number of service units that could be billed during the period covered by each plan of care. We then compared the maximum allowed units of service under each plan of care to the actual units of service billed during the time period covered by the plan of care and disallowed the reimbursement for all units in excess of that allowed by the plan of care.

We determined that 2,096 units were billed in excess of the amount authorized on the POCs. A finding is made for the $9,028.80 paid for these services.

4. Missing Plans of Care

We also identified that one patient had two spans of time where no applicable plan of care covered the services billed to Ohio Medicaid. Home health services not specified in a plan of care are not reimbursable. *See* Ohio Admin. Code § 5101:3-12-02(B)(2). We therefore disallowed the reimbursement for the 408 service units billed during the time spans with no identifiable plan of care resulting in a finding of $2,873.00.

5. Altered Plans of Care

During our review, we noticed one plan of care where the certification date span was altered. The change was not initialed or dated by the attending physician. Therefore, we are unable to determine whether this POC contained the correct date span of coverage. For PDN services to be covered, it must be provided and documented in accordance with the consumer's POC. *See* Ohio Admin Code § 5101:3-12-02 (B)(2).

The dates contained in the certification span are those for which the treating physician authorized PDN services on that specific POC. We disallowed the reimbursement received by the Provider for the dates of service billed covered by the altered POC and made a finding for $1,014.00.

CONCLUSION

We found the Provider was overpaid by Ohio Medicaid for PDN services between July 1, 2006 and June 30, 2009 in the amount of $126,362.67. This finding is the sum of $82,163.86 from findings for POCs not specifying frequency, scope, and duration, $31,283.01 from services on days beyond the sixtieth day on POC spans exceeding 60 days, $9,028.80 for unauthorized PDN services, $2,873.00 for missing plans of care, and $1,014.00 for services billed on a POC with uncertain coverage dates. This finding plus interest

in the amount of $23,818.50 through November 22, 2011 totaling $150,181.17, is immediately due and payable to ODJFS as of the date of release of this audit report. After November 22, 2011, additional interest will accrue at the rate of $27.70 per day until the finding and interest is paid in full.

PROVIDER'S RESPONSE

A draft report along with a detailed list of services for which we took findings was mailed to the provider on October 24, 2011. The Provider was afforded an opportunity to respond to this audit report. We did not receive a response from the Provider to the exceptions noted above.

Dave Yost • Auditor of State

VIRGINIA K COLLINS, LPN

WAYNE 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
NOVEMBER 22, 2011

88 East Broad Street, Fifth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.auditor.state.oh.us