SABRINA M. GILBERT, RN
PREBLE COUNTY

MEDICAID COMPLIANCE REPORT

FOR THE PERIOD JANUARY 1, 2009 THROUGH JUNE 30, 2011

Dave Yost • Auditor of State

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SABRINA M. GILBERT, RN
PREBLE COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO WAIVER NURSING AND PERSONAL CARE AIDE SERVICES

Sabrina M. Gilbert, RN
2704 Sawmill Park Drive
Dublin, Ohio 43017

RE: *Medicaid Provider Number 2201049*

Dear Ms. Gilbert:

We have examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of waiver nursing and personal care aide services during the period of January 1, 2009 to June 30, 2011. We confirmed the Provider's licensure status during the examination period. We tested service documentation to verify that there was support for the date of service, the procedure code, and the duration of service paid by Ohio Medicaid. In addition, we tested the Provider's service documentation to determine if it contained the required elements. We also examined all services plans and plans of care to determine if the Provider, the service, and the units paid by Ohio Medicaid were appropriately authorized. The accompanying Compliance Examination Report identifies the specific requirements examined for compliance.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Medicaid Agency 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 report on the Provider's compliance 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 attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about the Provider's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on the Provider's compliance with specified 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 on Compliance

In all 202 instances where the Provider rendered personal care aide services on more than one occurrence to the same recipient in a single day, the service documentation did not indicate, by occurrence, what tasks were performed or not performed. In addition, the service documentation for the 202 services did not include the Provider's dated signature.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for the period of January 1, 2009 through June 30, 2011.

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.

While no overpayment was identified for the material non-compliance described in the Basis for Qualified Opinion paragraph, we did identify other errors which resulted in an overpayment. We found the Provider was overpaid by Ohio Medicaid for waiver nursing services and personal care aide services between January 1, 2009 and June 30, 2011 in the amount of $2,148.76. This finding plus interest in the amount of $178.89 totaling $2,327.65 is due and payable to the Ohio Department of Medicaid (ODM) upon ODM's adoption and adjudication of this examination report. After adjudication by ODM, additional interest may be assessed until the finding and interest is paid in full.

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 Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B). Therefore, a copy of this report will be forwarded to ODM because it 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 ODM's Office of Legal Services at (614) 752-3631.

[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)

This report is intended solely for the information and use of the Ohio Department of Medicaid, 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 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.

Sincerely,

Dave Yost
Auditor of State

January 27, 2014

Compliance Examination Report for Sabrina M. Gilbert, RN

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. 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 patients. 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 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 § 5160-1-01(A)

The Auditor of State performs examinations to assess provider compliance with Medicaid reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care and medical necessity. 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 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)

The Provider's Ohio Medicaid Provider number is 2201049 and the Provider is a registered nurse (RN) and was located in Preble County, Ohio during the examination period. The Provider furnished waiver nursing and personal care aide services to Ohio Medicaid recipients. The Provider received reimbursement of $48,967.45 for 879 waiver nursing services and $176,315.28 for 3,444 personal care aide services for services rendered to three Medicaid recipients during the examination period.

The Ohio Home Care Program offers services through the Ohio Home Care Waiver and Transitions Carve-Out Waiver. These waivers are designed to meet the home care needs of people who have certain medical conditions and/or functional abilities that would qualify them for Medicaid coverage in a nursing home or hospital. Waiver services consist of nursing services, personal care assistance services and/or skilled therapy services. See Ohio Admin. Code §§ 5160-46-04 and 5160-50-04 During the examination period the Provider rendered services to two recipients enrolled in the Ohio Home Care Waiver and one recipient in the Transitions Carve-Out Waiver.

When a Medicaid recipient is on an ODM administered waiver program, an all services plan is required in addition to the plan of care. *See* Ohio Admin. Code § 5160-12-03.1(C) The all services plan is the service coordination and payment authorization document that identifies all home health services approved for the recipient, including the type, frequency and duration of each service. The all services plan also specifies which providers can render services and the services that are covered by Medicaid. The plan of care is the medical treatment plan that is established, approved and signed by the treating physician. *See* Ohio Admin. Code § 5160-45-01

Purpose, Scope, and Methodology

The purpose of this examination was to examine Medicaid reimbursements made to the Provider and determine whether those 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 nursing and personal care aide services that the Provider rendered to Medicaid recipients during the period of January 1, 2009 through June 30, 2011.

We received the Provider's paid claims history from the Medicaid Management Information System database of services billed to and paid by Ohio's Medicaid program. We removed services paid at zero. With the remaining population, we selected a statistical random sample based on dates of service to facilitate a timely and efficient examination of the Provider's waiver nursing and personal care aide services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

We obtained all of the all services plans for the recipients receiving waiver services during the examination period from ODM (CareStar Agency) to determine if the Provider was authorized to render services. We also reviewed the all services plans to determine if there were any gaps in the authorization spans. In addition, we compared units billed to units authorized on the all services plan to ensure the Provider did not exceed authorized units. We also verified the Provider's nursing licensure and examined clinical notes and plans of care to determine if the Provider had documentation to support the services rendered.

An engagement letter was sent to the Provider on March 27, 2013, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on May 16, 2013 and our fieldwork was performed following the entrance conference. After receipt of the draft report, the Provider submitted additional service documentation which we reviewed for compliance and updated the report accordingly.

Results

We reviewed 107 waiver nursing services and 404 personal care aide services. We found 208 errors related to non-compliance in these services. In addition we reviewed the all services plans that covered the examination period for the recipients served and identified non-compliance related to authorization to provide services. We found errors which resulted in overpayments totaling $2,148.76. The basis for our findings is discussed below in more detail.

A. Provider Qualifications

Ohio Admin. Code §§ 5101:3-46-04(A)(1) and 5101:3-50-04(A)(1) require the skills of a registered nurse (RN) or licensed practical nurse at the direction of an RN to provide waiver nursing services. In addition, all nurses providing waiver nursing services are required to possess a current, valid and unrestricted license with the Ohio Board of Nursing.

We verified through the Ohio e-License Center that the Provider is an RN certified through the Ohio Board of Nursing and was in active status during our examination period. We did not test the provider qualifications outlined for a non-agency personal care aide as the qualifications to render nursing services require the provider to meet a higher standard.

B. Service Documentation

Ohio Admin. Code §§ 5101:3-46-04(A)(6)(j), 5101:3-46-04(B)(8)(g), 5101:3-50-04(A)(6)(j) and 5101:3-50-04(B)(8)(g) state that providers must maintain a clinical record that includes clinical notes, documentation of tasks performed or not performed, arrival and departure times, and dated signatures of the provider and recipient. The supporting documentation for the 511 services that were randomly selected was compared to regulations outlined in the Ohio Admin. Code.

Personal Care Aide Services

We noted one instance where the recipient did not sign the daily clinical record. Therefore, the reimbursement for the one service is disallowed and the reimbursement is included in the total overpayment of $2,148.76.

In addition, we found that in all of the 202 instances where the Provider rendered personal care aide services on more than one occurrence to the same recipient in a single day, only one "Home Health/Home Care Aide Visit Record" was used. These 202 records did not indicate tasks performed or not performed by occurrence and did not include the Provider's signature for the second occurrence. In a structural review conducted in April 2010, the Provider was educated on the rule to have the signature of the consumer or consumer representative and Provider with each shift of service delivery.

We also noted that the Provider's name was typed once at the top of each service record. The Provider considered this to be her electronic signature although it appears this is identification of service provider rather than an electronic signature at the end of service provision.

Nursing Services

We noted five instances where the Provider could not provide documentation to support services rendered. Therefore, the reimbursement for these five services is disallowed and the reimbursement is included in the total overpayment of $2,148.76.

For one recipient, we found that the "Skilled Nursing Note" record used by the Provider included identical clinical findings and time of service delivery for every day services were rendered. We also noted that during the examination period the Provider moved from only including her name on the record (as noted under Personal Care Aide Services above) to including a statement indicating the record is true and accurate with an electronic signature.

Recommendation:

The Provider should maintain clinical records in a manner that includes all required elements. The records should clearly identify tasks performed or not performed by occurrence and include a signature for every occurrence. The Provider should also develop a similar practice for electronically signing "Home Health/Home Care Aide Visit Records" as she did for the "Skilled Nursing Note" records. Furthermore, the Provider should ensure "Skilled Nursing Note" records accurately reflect the recipient's clinical findings each day. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future potential findings.

C. Authorization to Provide Services

Plan of Care

Ohio Admin. Code §§ 5101:3-46-04(A)(4)(g) and 5101:3-50-04(A)(4)(g) requires that in order to be a provider and submit a claim for reimbursement of waiver nursing services, the provider 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.

We reviewed the plan of care in effect for each service tested in our examination. We found no errors.

All Services Plan

Ohio Admin. Code §§ 5101:3-46-04(A)(4)(f) and 5101:3-50-04(A)(4)(f) state the provider must be identified on the recipient's all services plan and the plan must have specified the number of units for which the provider is authorized to furnish waiver nursing services to the recipient. Ohio Admin. Code §§ 5101:3-46-(A)(3)(f), 5101:3-50-04(A)(3)(f), 5101:3-46-04(B)(2) and 5101:3-50-04(B)(2) state waiver services do not include services performed in excess of the number of hours approved pursuant to the recipient's all services plan.

We compared paid services to the services authorized in the all service plans. The Provider was authorized to render waiver nursing and personal care aide services for two recipients during the examination period. In addition, documentation was present in the CareStar system authorizing the Provider to provide the two reimbursed services to the third recipient.

Our review of the all services plans identified 31 waiver nursing and four personal care aide services where the Provider billed more units than was authorized. CareStar conducted a structural review of this Provider in April 2009 and educated the Provider on how to read the units page of the all services plan in order to understand base and subsequent units, as well as importance of communication with the Case Manager to authorize hours. We identified noncompliance on those services that exceeded the all services plan after the date of the structural review. The reimbursement for the 35 services that exceeded the authorized units is included in the total overpayment of $2,148.76.

Recommendation:

The Provider should develop and implement a system to track units and procedure codes authorized on the all services plan to ensure that services billed are consistent with authorized services and are not rendered in excess of the authorized units. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on January 30, 2014, and the Provider was afforded an opportunity to respond to this examination report.

In responding to the examination report, the Provider acknowledged the reported non-compliance and indicated that she constructed a new service document to rectify the service documentation deficiency. Additionally, the Provider indicated that she did not do her due diligence as to the units authorized and the units billed for services provided.

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Dave Yost • Auditor of State

SABRINA GILBERT, RN

PREBLE 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
MARCH 6, 2014

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