PERSONAL TOUCH HOME CARE OF OHIO, INC.
HAMILTON COUNTY

COMPLIANCE EXAMINATION REPORT

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

Dave Yost · Auditor of State

PERSONAL TOUCH HOME CARE OF OHIO, INC.
HAMILTON COUNTY

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

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Personal Touch Home Care of Ohio, Inc.
Ohio Medicaid # 2251236

We have examined Personal Touch Home Care of Ohio, Inc.'s (the Provider) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of home health nursing, home health aide, private duty nursing, waiver nursing, personal care aide and therapy services during the period of January 1, 2012 through December 31, 2014.

The Provider entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Management of Personal Touch Home Care of Ohio, Inc. is responsible for its compliance with the specified requirements. The accompanying Compliance Examination Report identifies the specific requirements examined. Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Provider complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Provider complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. Our examination does not provide a legal determination on the Provider's compliance with the specified requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Adverse Opinion

Our examination disclosed that in a material number of instances the Provider submitted claims for reimbursement prior to obtaining signed plans of care, provided personal care aide services with individuals that did not meet all of the qualification requirements, and did not obtain the signature of the recipient or authorized representative on waiver services. 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 control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements for service documentation, service authorization and provider qualifications related to the provision of home health nursing, home health aide, private duty nursing, waiver nursing, personal care aide and therapy services 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 improper Medicaid payments for services rendered between January 1, 2012 and December 31, 2014 in the amount of $4,251,744.00. This finding plus interest in the amount of $253,473.83 totaling $4,505,217.83 (calculated as of October 17, 2017) 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 Provider and 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

October 17, 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

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) According to Ohio Admin. Code § 5160-1-17.2, 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 Medicaid recipients may be eligible to receive home health aide services, personal care aide services or both. The only provider of home health aide services is a Medicare certified home health agency (MCRHHA) that meets the requirements in accordance with Ohio Admin. Code § 5160-12-03. Personal care aide services can be provided by a MCRHHA, an otherwise-accredited home health agency or a non-agency personal care aide.

The Provider is a MCRHHA with the Medicaid Provider Number of 2251236, and during the examination period of January 1, 2012 through December 31, 2014, received reimbursement of $9,456,365.32 for 169,105 home health services, including the following:

- 69,612 skilled nursing services (procedure code G0154);
- 51,715 personal care services (procedure code T1019);
- 33,609 home health aide services (procedure code G0156);
- 3,943 physical therapy services (procedure code G0151);
- 3,972 private duty nursing services (procedure code T1000);
- 1,023 speech pathology services (procedure code G0153);
- 4,349 waiver nursing services (procedure codes T1002 and T1003); and
- 882 occupational therapy services (procedure code G0152).

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of home health services, specifically skilled nursing, waiver nursing, private duty nursing, home health aide, personal care aide, and physical therapy, occupational therapy, and speech therapy services that the Provider rendered to Medicaid recipients during the period of January 1, 2012 through December 31, 2014 and received payment.

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 services paid at zero and services with third party payments.

Purpose, Scope, and Methodology (Continued)

We summarized the population by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. A stratified random sample was pulled from this population to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

Prior to calculating the sample size, the population was broken down into four strata as follows:
1) Therapy services (procedure codes G0151, G0152 and G0153);
2) Waiver nursing services (procedure codes T1002 and T1003);
3) State plan and private duty nursing services (procedure codes G0154 and T1000); and
4) Aide services (procedure codes G0156 and T1019).

The error standard deviations and the overall sample size were calculated using the U.S. Department of Health and Human Services/Office of Inspector General's (HHS/OIG) RAT-STATS[2] statistical program. The final calculated sample size is shown in the table below.

Universe/Strata	Population Size	Sample Size
Therapy Services	5,164 RDOS	128 RDOS
Waiver Nursing Services	2,919 RDOS	152 RDOS
State Plan and Private Duty Nursing Services	48,409 RDOS	517 RDOS
Aide Services	64,207 RDOS	426 RDOS
Total	**120,699 RDOS**	**1,223 RDOS**

From the population of 120,699 RDOS, we selected a stratified random sample of 1,223 RDOS. We then obtained the detailed services for the 1,223 RDOS which resulted in a sample of 1,728 services. During the examination we noted a large difference in the error rates found in the Aide Services stratum between home health aide services and personal care aide services. As a result, we performed a post stratification of the Aide Services stratum. See **Appendix I**.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. The Provider was afforded multiple opportunities to submit additional documentation and we reviewed all documentation submitted for compliance. In addition, after receipt of the draft report, the Provider submitted additional documentation which we reviewed for compliance and updated our results accordingly.

Results

We reviewed 1,728 services in our statistical sample and found 773 errors. The overpayments identified for 611 of 1,728 RDOS from the stratified random sample were projected to the Provider's population of paid claims resulting in a projected overpayment of $4,251,744 with a 95 percent degree of certainty that the true population overpayment amount fell within the range after adjustment of $3,970,186 to $4,533,563 (+/-6.63 percent.) An adjustment was made to the original range of $3,970,053 to $4,533,434 to correct for skewness in one stratum.

[2] RAT-STATS is a free statistical software package that providers can download to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services.

Results (Continued)

While certain services had more than one error, only one finding was made per service. The basis for our findings is discussed below in more detail.

A. Provider Qualifications

Nursing and Therapy Services

According to Ohio Admin. Code §§ 5160-12-01(B), 5160-46-04(A), 5160-47-04(A), and 5160-50-04(A)[3], home health and waiver nursing requires the skills of and is performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse.

Skilled therapy providers are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants, under the direction of a physical therapist, or certified occupational therapy assistant under the direction of a licensed occupational therapist who are contracted or employed by a MCRHHA. Ohio Admin. Code 5160-12-01(G)(3)

We haphazardly selected 20 of the nurses and all of the physical therapists, physical therapy assistants, speech therapists, and occupational therapists that rendered services in the sample and verified via the Ohio e-License Center website that their professional licenses were current and valid on the first date of service in the sample and were active during the remainder of the examination period.

We found no instances of non-compliance with the professional licenses.

Aide Services

Prior to rendering services, aides are required to obtain state licensure or complete training and/or a competency evaluation program that meets the requirements of 42 CFR 484.36 (a) or (b), and obtain a satisfactory rating on their competency evaluations. In order to submit a claim for reimbursement, all individuals providing personal care aide services must obtain and maintain a current first aid certification. Home health aides are also required to complete 12 hours of in-service continuing education annually. *See* Ohio Admin. Code §§ 5160-46-04(B), 5160--47-04(B) and 5160-50-04(B)

We haphazardly selected 20 aides from the service documentation that rendered home health aide services and/or personal care aide services in our sample to test for provider qualifications. We reviewed personnel documentation for evidence of completed competency evaluations, in-service education and, for personal care aides only, first aid certifications.

Competency Evaluation

Of the 20 aides selected, we tested initial competency evaluations for five aides that were hired during our examination period. We found no instances of non-compliance with the initial competency evaluations tested.

[3] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

A. Provider Qualifications (Continued)

In-service continuing education

Of the 20 aides selected, we tested the continuing education hours only for those aides that were employed for the full calendar year. We found one aide in 2012 and one aide in 2013 that did not have the required twelve in-service training hours; however, each had completed 10 of the required hours. We did not identify an overpayment for these instances of non-compliance.

First Aid

Seventeen of the 20 aides selected provided personal care aide services (waiver services) and we tested these 17 aides for compliance with first aid certifications. We found that 16 of the 17 aides did not have a first aid certification and the remaining one aide had a lapse in time without a current certification.

The Provider indicated that during our examination period it was unaware of the first aid requirement for personal care aide services; however, its staff did receive first aid training through in-service modules. We determined that the in-service modules was not consistent with the requirement to obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

As a result of the testing of the 17 aides, we expanded our testing to include all aides that rendered personal care aide services. We tested an additional 63 aides and found that 60 out of the 63 lacked first aide certification and one aide had a lapse in time without a current certification.

We reviewed 1,728 services in the statistical sample and identified 273 services rendered by an aide who did not meet the qualifications to render personal care aide services. These 273 errors were used in the overall projection amount of $4,251,744.

Recommendation:

The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Authorization to Provide Services

All Services Plan

According to Ohio Admin. Code § 5160-12-01, the MCRHHA must be identified on the all services plan when a recipient is enrolled in home and community based waiver.

We haphazardly reviewed one all services plan or individual service plan from our examination period for each of the 90 waiver recipients in our statistical sample.

We found no errors.

B. Authorization to Provide Services (Continued)

Plans of Care

All home health providers are required by Ohio Admin. Code § 5160-12-03(B)(3)(b) to create a plan of care for recipients, including recipients' medical condition and treatment plans anticipated by provider. The plan of care is also required to be signed by the treating physician of recipient. Home health providers must obtain the completed, signed and dated plan of care prior to billing ODM for the service.

We tested 1,387 state plan home health and waiver nursing services to determine if plans of care were present, authorized the Provider and services rendered and were signed by the physician prior to the submission of the claim for reimbursement. We identified the following errors:

- 221 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 11 services in which there was no plan of care authorizing services;
- 16 services in which the plan of care was not signed by the physician, with 10 of the 16 having a physician's name and credentials typed on the signature line, but no indication that this was an electronic signature; and
- 6 services which the plan of care did not authorize the service.

The overpayments associated with these 254 errors were included in the overall projection amount of $4,251,744.

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 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.

C. Service Documentation

The MCRHHA must maintain documentation of home health services provided that includes, but is not limited to, clinical records and time keeping that indicate time span of the service and the type of service provided. See Ohio Admin. Code § 5160-12-03(C)(4). Documentation to support personal care aide services must include the tasks performed or not performed and the arrival and departure times. See Ohio Admin. Code §§ 5160-46-04(B)(8), 5160--47-04(B)(8) and 5160-50(B)(8). According to Ohio Admin. Code § 5160-45-10(A), providers of waiver services must maintain and retain all required documentation including, but not limited to, the dated signatures of the provider and the recipient or authorized representative verifying the service delivery upon completion of service delivery.

Our review of the statistical sample of 1,728 services identified the following errors:

- 181 instances where the service documentation was not signed by the recipient or authorized representative;
- 45 instances where in which there was no service documentation to support the service rendered;
- 13 services in which rendering provider was not listed on the documentation;
- 6 services in which the provider billed more units than the service documentation supported; and
- 1 home health aide services in which the rendering provider name was illegible.

C. Service Documentation (Continued)

The overpayments associated with these 246 errors are included in the overall projection amount of $4,251,744.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Medicaid rules. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official Response

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

Auditor of State Conclusion

We reviewed electronic service documentation generated by the Provider's Automated Time and Leave System and found the element that was missing was the dated signature of the recipient or designee. The Medicaid rules have no exception for any requirements for providers using such a system and ODM's decision to require use of an electronic visit verification system in the future does not negate the requirement to follow Medicaid rules in effect at the time of service delivery.

We found that in 16 percent of services that require a plan of care, the Provider billed prior to obtaining signed plan of care and as the rule has no "allowance period" we identified an overpayment for each instance.

We reviewed the in-service documentation while on-site at the Provider's office along with interviewing key personnel regarding the first aid requirement. The Provider had acknowledged that staff providing personal care aide services did not have the required first aid certification. In addition, the in-service training was not hands-on training by a certified instructor and did not include a return demonstration of what was learned.

In response to the request for copies of our confidential work papers during the examination, we offered to arrange a time for the Provider to review working papers that pertain specifically to the calculation of the improper payment prior to the examination being finalized. This was to allow the Provider to view the calculation and afford an opportunity to address any questions. The Provider did not respond to this offer. After the exit conference, the Provider indicated it would accept our offer; however, in a later communication indicated it was unable to schedule a time to review those records. We reviewed the sampling approach used in the examination and found that it was appropriate.

APPENDIX I

Summary of Sample Record Analysis

POPULATION
The population is all paid Medicaid services, less certain excluded services, net of any adjustments where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame for this sample is 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. Thus, for a given time period and specified services, this sampling frame and the population of paid claims should be identical.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RODS[1]	127,368
Number of Population RDOS Sampled	1,260
Number of Population RDOS Sampled with Errors	474
Number of Population Services Provided	169,105
Number of Population Services Sampled	1,728
Number of Population Services Sampled with Errors	611
Total Medicaid Amount Paid for Population	$9,456,365.32
Amount Paid for Population Services Sampled	$101,434.83
Projected Population Overpayment Amount	$4,251,744
Upper Limit Overpayment Estimate at 95% Confidence Level[2]	$4,533,583
Lower Limit Overpayment Estimate at 95% Confidence Level [2]	$3,970,186
Precision of Population Overpayment Projection at the 95% Confidence Level[1]	$281,838.79 (6.63%) Upper $281,558.18 (6.62%) Lower

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

[1] We noted a large difference in the error rate between home health aide services and personal care aide services and so performed a post stratification of the Aide Services stratum prior to performing the projection. Due to this, the Number of Population RDOS is higher than the overall population count of RDOS because some RDOS included both home health aide services and personal care aide services.

[2] Adjusted for skewness using the method described in "Sampling Methods For The Auditor, An Advanced Treatment" by Herbert Arkin. This technique made use of tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, Volume 1 3rd Ed., Cambridge University Press, New York, 1969, table 42.

Personal Touch Home Care of Ohio, Inc.'s Response to the Auditor of the State of Ohio's Draft Compliance Examination Report

Personal Touch Home Care of Ohio, Inc. ("PTHC-OH") is a Medicare Certified Home Health Agency dedicated to the provision of individualized, comprehensive quality patient and family-centered care to its patients in full compliance with Ohio Medicaid regulations. In July of 2016, the Auditor of the State of Ohio (the "AOS") commenced an audit (the "Audit") to examine PTHC-OH's compliance with certain Medicaid requirements for service documentation, service authorization, and provider qualifications related to the provision of home health nursing services, home health aide services, private duty nursing services, waiver nursing services, personal care aide services, and therapy services during the period January 1, 2012 to December 31, 2014 (the "Examination Period"). PTHC-OH fully cooperated with the AOS during a site visit to PTHC-OH's offices and promptly responded to numerous document requests issued by the AOS during the Audit.

Following the site visit and the provision of documents, the AOS issued an initial draft compliance examination report, and then a subsequent revised draft compliance examination report (the "Report"), in which the AOS alleges that PTHC-OH is not in full compliance with certain Medicaid requirements in the following areas: (1) provider qualifications; (2) service documentation; and (3) authorization to provide services. Importantly, there was no allegation in the Report that PTHC-OH did not provide quality care to its patients, or that care provided to its patients was not medically necessary.

PTHC-OH specifically contests the AOS's findings set forth in the Report as noted below:

- Provider Qualification Requirement – First Aid Certification for Personal Care Aides

The specific elements of the first aid certification requirement for personal care aides ("PCAs") are not defined in the applicable Ohio Medicaid regulations. The vast majority of the PCAs tested by the AOS attended annual first aid in-service training provided by PTHC-OH. The first aid training materials, designed by a third-party provider of quality training modules for the home health industry, cover the following core first aid requirements that a student would cover in a basic first aid course offered by an outside agency such as the American Red Cross: (1) calling for help; (2) positioning the victim; (3) breathing difficulties; (4) seizures; (5) injury emergencies; (6) bleeding: (7) wounds and abrasions; (8) burns; (9) fractures; (10) cold emergencies; (11) heat emergencies; and (12) poison emergencies. At the conclusion of the in-service training, the attendees were required to take and pass a test demonstrating their knowledge of the materials covered during the annual first aid in-service training. PTHC-OH believes that its annual first aid in-service training of its PCAs constitutes compliance with the applicable Medicaid regulations.

- Service Documentation Requirement

PTHC-OH aides verify the delivery of services to their patients through the use of an Automated Time and Leave System (the "ATL System"). The ATL System requires a PTHC-OH aide, upon arrival at the patient's residence, to dial a toll-free number using the patient's telephone. The recipient, aide, call date, and call time are then verified by the ATL System against a pre-existing schedule. The aide then provides aide services to the patient at the patient's home. At the end of the visit, the aide once again calls the toll-free number, using the patient's telephone, and the aide enters the tasks performed during the visit which tasks are number-coded. The ATL System was implemented in 2006, at the urging of Ohio's PASSPORT Medicaid program, and no one from the Ohio Medicaid program has ever questioned the legitimacy of the ATL System. Moreover, the Ohio Department of Medicaid ("ODM") is mandating that all home health care providers adopt an electronic visit verification system ("EVV System") by the end of 2017. ODM's EVV

System is substantially similar to PTHC-OH's ATL System. Because of the similarities between the ATL System and ODM's impending EVV System, PTHC-OH believes that any alleged error in the Report relating to services which can be substantiated by its ATL System should be removed from the Report.

- Authorization to Provide Services Requirement

The Report identifies a number of alleged errors relating to the physician signature requirement on a plan of care and the timing of the submission of a reimbursement claim, or relating to the authorization of services identified in a plan of care. There is no assertion in the Report that the services underlying these alleged errors were not provided, or were not medically necessary. In addition, many of the physician signatures on the plans of care are dated within a week to ten days of the submission of the reimbursement claim, and a fair number are dated within one day of the submission of the reimbursement claim. PTHC-OH has requested that any alleged error relating merely to the timing of submission of a reimbursement claim, as compared to when the physician affixed his or her signature to the plan of care, be removed from the Report. With respect to the scope of the service authorization contained within a plan of care, PTHC-OH has provided to the AOS plans of care which authorize the services for certain of its patients.

- Alleged Noncompliance with certain Medicaid requirements constitute Conditions of Participation which cannot serve as a basis for claiming an Overpayment

The Report fails to make any distinction between Ohio Medicaid requirements which constitute Conditions of Participation versus Ohio Medicaid requirements which constitute Conditions of Payment. Noncompliance with a Condition of Participation is remedied through the submission of a plan of correction, and does not give rise to a recoverable overpayment. Applicable Ohio Medicaid requirements relating to six of the eight types of home health services contained in the Report—Home Health Aide Services, Skilled Nursing Services, Physical Therapy Services, Speech Therapy Services, Occupational Therapy Services, and Private Duty Nursing Services—do not specifically state that the submission of a claim for payment is contingent upon compliance with such requirements. Consequently, these requirements are merely Conditions of Participation which are remedied by a plan of correction and which cannot serve as a basis for an alleged overpayment. Therefore, PTHC-OH has requested the deletion of any alleged error, relating to the six types of home health services identified above, based upon alleged noncompliance with a Condition of Participation.

- Challenge to the Extrapolation of the Alleged Overpayment Sum

The AOS has tested a very small portion of the home health services provided by PTHC-OH to its patients during the Examination Period. Based on this very small sample size, the AOS has used a statistical extrapolation method to calculate the alleged overpayment sum. PTHC-OH has requested certain statistical files to test the accuracy or inaccuracy of the extrapolation method employed by the AOS. The AOS was unwilling to provide to PTHC-OH copies of the requested statistical files. PTHC-OH intends to closely examine the propriety of the extrapolation method employed by the AOS as this matter proceeds through the administrative hearing process.

PTHC-OH is committed to providing quality care that is medically necessary to its patients, and there is no allegation in the Report that PTHC-OH did not provide quality care to its patients, or that care provided to its patients was not medically necessary. PTHC-OH intends to vigorously contest any effort by ODM to seek the recovery of any alleged overpayment sum set forth in any final compliance examination report issued by the AOS and certified to ODM.

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Dave Yost • Auditor of State

PERSONAL TOUCH HOME CARE OF OHIO

HAMILTON 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 14, 2017

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