



# State of New Jersey

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April 6, 2018

## **BY ELECTRONIC AND CERTIFIED MAIL**

Mr. Jose M. Brito, Administrator  
WeCare Home Care, Inc.  
811 Church Rd., Suite. 221  
Cherry Hill, NJ 08002

### **RE: Final Audit Report: WeCare Home Care, Inc.**

Dear Mr. Brito:

As part of its oversight of the Medicaid and New Jersey FamilyCare program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims billed under Healthcare Common Procedure Coding System (HCPCS) code S9122 and paid to your facility. The period of review was January 1, 2013 through December 31, 2014. OSC hereby provides you with this Final Audit Report (FAR).

### **Executive Summary**

OSC, in conjunction with Amerigroup New Jersey, Inc. (Amerigroup), conducted a joint audit of WeCare Home Care, Inc. (WCHC) to determine whether WCHC appropriately billed for personal care assistant (PCA) services in accordance with applicable state and federal laws and regulations. More narrowly, the audit sought to determine whether WCHC correctly billed HCPCS code S9122, which is used to seek reimbursement for one hour of in-home PCA services. Based on the audit, OSC determined that 26 of the 111 statistically selected claims for HCPCS code S9122 totaling \$3,580.75 in reimbursements to WCHC failed to comply with state and federal requirements. Specifically, OSC found that WCHC failed to: a) complete timely in-home evaluations of the plan of care and/or completed invalid in-home evaluations for 16 claims; b) substantiate services billed for five claims; c) maintain a valid physician's order for four claims; and, d) document services billed for one claim.

For purposes of ascertaining a final recovery amount, the error rate for claims that failed to comply with state and federal regulations was extrapolated to the total population of claims from which the sample claims were drawn, which in this case was 877 claims with a total amount of payment of \$50,305. By extrapolating to this universe of

claims/reimbursed amount, OSC has determined that the total dollar amount of improper claims is \$10,084.

### **Background**

The United States Department of Health and Human Services, Office of Inspector General (OIG) issued audit reports in December 2011, July 2015, and August 2015 focusing on New Jersey Medicaid's PCA program. In these reports, OIG found that New Jersey paid for certain Medicaid claims that did not comply with state and federal regulations. As part of these audits, OIG recommended that the New Jersey Department of Human Services (DHS) improve its monitoring efforts of the PCA program to ensure compliance with state and federal requirements.

The Division of Medical Assistance and Health Services (DMAHS), within the DHS, administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low income may receive medical assistance. DMAHS contracts with five Managed Care Organizations (MCOs), including Amerigroup, to provide healthcare services to New Jersey's Medicaid population.

OSC and Amerigroup conducted a joint audit of WCHC, a PCA/Homemaker service provider located in Cherry Hill, New Jersey. WCHC enrolled in the Medicaid program on July 1, 2009. WCHC provides services such as personal care, household duties, and health-related tasks in a recipient's place of residence.

### **Objective**

The objective of this audit was to evaluate WCHC's PCA claims for HCPCS code S9122 billed to and paid by Amerigroup to determine whether WCHC complied with Medicaid requirements under state and federal laws and regulations.

### **Scope**

The scope of this audit included a review of paid and adjusted claims billed to Amerigroup under HCPCS code S9122 for the period January 1, 2013 through December 31, 2014. The audit was conducted under the authority of *N.J.S.A. 52:15C-23* and the Medicaid Program Integrity and Protection Act, *N.J.S.A. 30:4D-53 et seq.*

### **Audit Methodology**

OSC's audit methodology consisted of the following:

- Review of a statistically valid sample of 111 claims totaling \$12,702 selected from a population of 877 claims totaling \$50,305 that WCHC billed under HCPCS code S9122 and submitted for payment to Amerigroup; and

- Review of WCHC's clinical records to determine whether: PCA services were rendered; PCA services were authorized by the attending physician; PCA services were prior authorized by Amerigroup; a Registered Nurse conducted an in-home evaluation of the plan of care at a minimum of once every 60 days; and PCA services were rendered by licensed providers, and by providers not excluded/debarred from the Medicaid program.

## **Audit Findings**

### **In-Home Evaluation of Plan of Care Not Timely Performed or Invalid**

OSC reviewed the clinical records for the 111 sample claims to determine whether WCHC completed the in-home evaluation of the plan of care at least once every 60 days. OSC found that 16 of the 111 sample claims failed because WCHC's records did not show that WCHC had satisfied this in-home plan of care evaluation requirement. Four of these claims failed because the in-home evaluation of the plan of care was not completed within 60 days of the date of service. The remaining 12 claims failed because they were associated with in-home evaluations of the plan of care that were not completed on valid dates. For example, one record pertaining to the in-home evaluation of the plan of care was dated February 31, which is not a valid date. Timely completion of the in-home evaluation of the plan of care is required to ensure the plan of care is appropriate and to see if any changes are necessary. Since a recipient's needs may change, the plan of care may need to change as well.

Pursuant to *N.J.A.C. 13:45B-14.9(2)(g)*, "the health care practitioner supervisor shall make an on-site, in-home evaluation of the plan of care not less than once during each 60 day period during which the agency has placed or referred a health care practitioner in the home care setting." In accordance with *N.J.A.C. 10:49-5.5(a)(17)*, services that are not covered by the Medicaid program include, "services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

### **Unsubstantiated Services Billed**

OSC reviewed the clinical records for the 111 sample claims to determine whether the services that WCHC billed to Amerigroup were rendered. To make this determination, OSC compared the number of hours billed according to the assignment sheet (timesheet) to WCHC's paid claims data. OSC found that for 5 of the 111 sample claims, WCHC billed for more hours of service than were rendered on the dates of service based on WCHC's timesheets. Providers are required to bill and submit claims based on true, accurate and complete information.

Pursuant to *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

### **Valid Physician Order Not Maintained**

OSC reviewed the clinical records for the 111 sample claims to determine whether services were authorized for the recipient by a physician's order that was signed and dated by the physician. OSC found that in 4 out of the 111 claims sampled, the physician did not date the physician's order. A properly dated physician's order is necessary so that caregivers understand the nature and extent of services that are to be provided at a specific time. If a physician's order is not dated, it is difficult to ensure that proper services are being provided as a recipient's needs are subject to change.

Pursuant to 42 *CFR* 440.167(a), PCA services are "services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease." The services are "authorized for the individual by a physician and in accordance with a plan of treatment." In accordance with *N.J.A.C.* 10:49-5.5(a)(17), services that are not covered by the Medicaid program include, "claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

### **Undocumented Services**

OSC reviewed the clinical records for the 111 sample claims to determine whether services that WCHC provided were adequately documented in the medical record. OSC found that 1 of the 111 sample claims did not meet the appropriate documentation requirements. Specifically, for one of the sample claims there was no assignment sheet (timesheet) in the medical record. Assignment sheets not only ensure that services were rendered to the recipient but also validate that services were in fact received by the recipient.

Pursuant to *N.J.A.C.* 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

### **Summary of Overpayments**

Based on its review, OSC determined that 26 of the 111 sample WCHC claims for Medicaid reimbursement failed to comply with state and federal regulations. WCHC received a total of \$3,580.75 in reimbursement for these 26 claims. For purposes of ascertaining a final amount of overpayment in this audit, the error rate for claims that failed to comply with state and federal regulations was extrapolated to the total population from which the sample claims were drawn, which in this case was 877 claims with a total amount of payment of \$50,305. On this basis, OSC has determined that WCHC received an overpayment totaling \$10,084.

**Recommendations**

OSC recommends that WCHC reimburse Medicaid the overpayment amount, which is \$10,084. Also, OSC recommends that WCHC prepare a Corrective Action Plan (CAP) informing OSC of the procedures it will undertake to correct the deficiencies identified in this report. As part of its CAP, WCHC must provide training to its staff to foster compliance with applicable Medicaid regulations, specifically those regarding Medicaid program documentation.

**Auditee Response**

In a written response, WCHC agreed with the audit findings and provided a CAP to address the audit's recommendations. WCHC also described the specific steps they have taken or will take to implement the recommendations made in this audit report. The full text of the response letter submitted by WCHC is included as an Appendix to this report.

**OSC Comments**

OSC notes that WCHC is in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that WCHC reimburse the Medicaid program \$10,084 and that it implement the corrective actions needed to comply with the recommendations in this audit. Given WCHC's agreement with the findings in this audit and its stated intention to implement corrective actions, OSC believes that no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN  
STATE COMPTROLLER

By:

  
Josh DeBlau, Director  
Medicaid Fraud Division

Cc: Veronica Scott, Manager, Special Investigations Unit (Amerigroup)  
Kay Ehrenkrantz, Deputy Director  
Don Catinello, Supervising Regulatory Officer  
Glen Geib, Recovery Supervisor



4/2/2018

To whom it may concern:

This letter is to inform you, that we are in agreement with the findings of the Audit of the Medicaid Fraud Division. After carefully reviewing all findings in the report, we have concluded that there were some flaws in our system due to human error rather than fraudulent intent; these errors did not occurred with a deliberated intent to increase any reimbursement or financial gains.

WeCare Home Care, Inc. is working aggressively to correct these findings, and will put in place a more stringent procedure to assure that we are in compliance, so these errors does not happen again going forward. Moreover, we are working closely with our Software vendor called Home Care System, Inc. to improve our computer system to avoid any erroneously dated document and incorporate additional reports to include any future missing documents.

As part of our corrective Action Plan, WeCare will address these errors by the following:

- A) For the in home evaluation Plan of Care, we will assign a fact checker from our current personnel to eliminate any invalid dates or missing information.
- B) We are upgrading our billing software to insure the proper billing that will alert us any possible error.
- C) Our computer software will be update to include a report for future physician orders prior to its yearly expiration.
- D) Finally WeCare will improve its filing system, by re-training our personnel regarding the guidelines of Medicaid Program documentation. Furthermore, to make sure that all services rendered and billed will be properly documented.

We considered this audit as teachable event that will enhance our future compliance to Medicaid, and

Sincerely,



Jose M Brito  
President/CEO

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