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June 15, 2018

BY ELECTRONIC MAIL AND CERTIFIED MAIL

Mr. William Miska, Managing Member
C&M Health Services LLC d/b/a
Health and Comfort Home Care Agency
1254 Highway 27
North Brunswick, NJ 08902-1765

RE: Final Audit Report: Health and Comfort Home Care Agency

Dear Mr. Miska:

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) codes S9122, S5130, and T1019 and paid to your facility. The period of review was July 1, 2014 through December 31, 2014. OSC hereby provides you with this Final Audit Report (FAR).

Executive Summary

OSC, in conjunction with WellCare Health Plans (WellCare), conducted a joint audit of Health and Comfort Home Care Agency (HCHC) to determine whether HCHC 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 HCHC correctly billed HCPCS code S9122 (PCA services provided in home, per hour), S5130 (PCA services provided in home, per 15 minutes) and T1019 (PCA services provided in home, per 15 minutes), which are used to seek reimbursement for in-home PCA services. Based on the audit, OSC determined that 60 of the 798 claims for HCPCS code S9122 and T1019 totaling $4,648.40 in reimbursements to HCHC, failed to comply with state and federal regulations. Specifically, OSC found that HCHC failed to: a) bill claims which were true and accurate as they billed claims twice for the same service for the same recipient on the same day, once using HCPCS code S5130 and once using HCPCS code S9122 for 36 claims; b) maintain a valid physician's order for 12 claims; c) substantiate services billed for six claims; d) complete timely in-home evaluations of the

plan of care for five claims; and, e) document services billed for one claim. OSC has determined that the total dollar amount of improper claims is $4,648.40.

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 incomes receive medical assistance. DMAHS contracts with five Managed Care Organizations (MCOs), including WellCare, to provide healthcare services to New Jersey's Medicaid population.

OSC and WellCare conducted a joint audit of HCHC, a PCA/Homemaker provider located in North Brunswick, New Jersey. HCHC enrolled in the Medicaid program as a PCA/Homemaker provider on February 9, 2014. HCHC provides services such as personal care, household duties, and health related tasks performed by a qualified individual in a recipient's place of residence.

Objective

The objective of this audit is to evaluate HCHC's PCA claims billed to and paid by WellCare to determine whether HCHC complied with Medicaid requirements under state and federal laws and regulations.

Scope

The scope of this audit includes a review of paid and adjusted claims billed to WellCare under HCPCS codes S9122, S5130, and T1019 for the period July 1, 2014 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 consists of the following:

- Review of 798 claims totaling $61,196.16 that HCHC submitted for payment to WellCare; and
- Review of HCHC's clinical records to determine whether: PCA services were rendered; PCA services were authorized by the attending physician; PCA services

were prior authorized by WellCare; 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

Duplicate Billing

OSC reviewed the clinical records for the 798 claims to determine whether services that HCHC billed to WellCare were rendered. OSC found that 36 of the 798 claims were duplicates as HCHC billed twice for the same service, once using HCPCS code S5130 and once using HCPCS code S9122. 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 798 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 12 of the 798 claims included a physician's order that was signed by a physician's assistant, but not a physician. A properly signed and dated physician's order authorized for the recipient by a physician is necessary to ensure that the services are medically necessary and appropriate. If a physician's order is not authorized by a physician, it is difficult to ensure the services were properly authorized and medically necessary and appropriate.

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."

Unsubstantiated Services Billed

OSC reviewed the clinical records for the 798 claims to determine whether the services that HCHC billed to WellCare were rendered. OSC compared the number of hours billed according to the assignment sheet (timesheet) to HCHC's paid claims data. OSC found that for 6 of the 798 claims, HCHC billed for more hours of service than were rendered

on the dates of service based on HCHC'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."

In-Home Evaluation of Plan of Care Not Timely Performed

OSC reviewed the clinical records for the 798 claims to determine whether HCHC completed the in-home evaluation of the plan of care at least once every 60 days. OSC found that 5 of the 798 claims failed because HCHC's records did not show that HCHC satisfied this requirement. Specifically, there was no in-home evaluation of the plan of care in the medical record for the dates of service. Timely completion of the in-home evaluation of the plan of care is required to ensure that the plan of care is appropriate and, if not, to make any necessary changes thereto. Since a recipient's needs are subject to change, the plan of care is subject 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 or NJ FamilyCare-Plan A 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."

Undocumented Services

OSC reviewed the clinical records for the 798 claims to determine whether services that HCHC provided were adequately documented in the medical record. OSC found that 1 of the 798 claims did not meet the appropriate documentation requirements. Specifically, for one of the claims reviewed 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(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Summary of Overpayments

Based on its review, OSC determined that 60 of the 798 HCHC claims for Medicaid reimbursement failed to comply with applicable requirements. On this basis, OSC determined that HCHC received an overpayment of $4,648.40 for these 60 claims.

Recommendations

OSC recommends that HCHC reimburse Medicaid the overpayment amount, which is $4,648.40. Also, OSC recommends that HCHC 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, HCHC must provide training to its staff to foster compliance with applicable Medicaid regulations, specifically those regarding Medicaid program documentation.

HCHC Response

In a written response, HCHC agreed with the audit findings and provided a CAP to address the audit's recommendations. HCHC 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 HCHC is included as an Appendix to this report.

OSC Comments

OSC notes that HCHC is in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that HCHC reimburse the Medicaid program $4,648.40 and that it implement the corrective actions needed to comply with the recommendations in this audit. Given HCHC'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 Lichtblau, Director
Medicaid Fraud Division

Cc: Lori Peters, Senior Director, Special Investigations Unit (WellCare)
Jennifer Jarke, Manager, Special Investigations Unit (WellCare)
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Philip James Degnan
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Re. Draft Audit Report: Health and Comfort Home Care Agency [redacted]

June 4, 2018

Mr. Degnan

This letter will confirm that we agree with the findings of the above Draft Audit report. At the same time, we assure you that any findings that were found were made in error and without any intent to commit fraud nor to increase payments. In fact, even prior to the Audit report our Agency started to take corrective action to avoid any further discrepancies from taking place, as listed below.

Duplicate Billing-In order to avoid potential duplicate billing, we have implemented the following corrective action. We initially had some duplicate codes when servicing Global Options and they have all been eliminated which will prevent this from reoccurring. We have also implemented electronic payments and if we receive direct deposit as a duplicate payment it will show in our system as unapplied cash and we will immediately be aware of the problem and take the necessary corrective action.

Valid Physician's Order Not Maintained-We have already implemented that our Director of Nursing and nurses check more carefully to assure that all physician's orders are properly signed and dated by a physician only to assure that services are medically necessary and appropriate.

Unsubstantiated Service Billed and Undocumented Services- We now have several checkpoints to assure CHHA time sheets and names are matched to master/patient schedule daily for accuracy. We also do Quality Assurance checks by phone and on-site visits to assure services are provided as per time sheets, and master/patient schedule. We also carefully check the filing of time sheets by proper name and hours worked and approved. In addition, with the near future implementation of electronic verification this will further alleviate mistakes such as this taking place.

In-Home Evaluation of Plan of Care Not Timely Performed- The following corrective action has been taken. Medical records are reviewed by RN Supervisor and DON. The plan of care is reviewed at initial assessment, at 6-month reassessment, when the plan of care is updated to reflect any changes in patient's status during each monitoring visit and more frequently if necessary. In addition, we have already implemented whereby the Director of Nursing audits patient records quarterly or more frequently to assure that all records are reviewed by an RN supervisor. Case coordinators document in a centralized data base all changes so that the RN will conduct a reassessment and review of the plan of care changes.

Please note all our staff are aware of the changes we made and have been in-serviced on a regular basis to avoid these issues from reoccurring. Please let us know to whose attention and to whom to make out the check for the overpayment amount of $4648.40 so that we may process it as soon as possible. We thank you for bringing these matters to our attention.

Sincerely,

William Miska
Administrator
Cc:Michael M. Morgese, Audit Supervisor Medicaid Fraud Division