

Audit Report

Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions

**A Texas Medicaid Durable Medical
Equipment and Supplies Provider**

July 30, 2020

OIG Report No. AUD-20-014



**Inspector
General**

**Texas Health
and Human Services**



HHS OIG

TEXAS HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

July 30, 2020

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A Texas Medicaid Durable Medical Equipment and Supplies Provider

WHY OIG CONDUCTED THIS AUDIT

The HHS OIG Audit and Inspections Division conducted an audit of Aveanna, a DME and supplies provider in Houston, Texas. The audit evaluated whether there was valid authorization and evidence of delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Aveanna as required by state laws, rules, and guidelines.

During state fiscal year 2018, Aveanna processed 28,994 Medicaid fee-for-service claims for DME and supplies delivered to 1,521 Medicaid beneficiaries, for which it received reimbursements of \$1.9 million.

WHAT OIG RECOMMENDS

Aveanna should submit Medicaid fee-for-service DME and supplies claims to TMHP only (a) when it has a current, complete, and valid prior authorization form when required, (b) when it has a current and valid Title XIX form, and (c) when it has documentation to support all deliveries associated with each claim.

Based on issues identified in this audit, Aveanna owes the State of Texas \$50,728.39.

MANAGEMENT RESPONSE

Aveanna provided management responses to the recommendations, generally indicating that it implemented improvements to its controls and processes designed to prevent future overpayments. Aveanna noted concerns regarding proof of delivery for several procedure codes. Aveanna's management responses are included in the report following each recommendation.

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WHAT OIG FOUND

Aveanna Healthcare Medical Solutions (Aveanna) generally complied with guidelines related to Title XIX forms, prior authorization forms, and documentation supporting delivery of durable medical equipment (DME) supplies to Medicaid beneficiaries. Of 1,938 claims tested, 1,694 (87 percent) were completed as required by laws, rules, and guidelines. Additionally, Aveanna Healthcare Medical Solutions stopped services after a beneficiary's death for all beneficiaries tested. However, Aveanna did not always meet authorization requirements for DME and supplies, and Aveanna did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims.

The unauthorized claims represent the following overpayments to Aveanna:

- \$2,792.16 for 46 unauthorized claims due to missing prior authorization forms when required. Prior authorization of certain DME is required to avoid unnecessary utilization of DME.
- \$41,480.28 for 173 unauthorized claims due to missing or expired Title XIX forms. DME should only be provided when currently prescribed by a physician.
- \$6,455.95 for 25 additional claims lacking sufficient delivery supporting documentation. Delivery of DME must be documented and verifiable.

Any claim with multiple exceptions was only included for recovery once.

The OIG Audit and Inspections Division presented preliminary audit results, issues, and recommendations to Aveanna in a draft report dated May 11, 2020.

BACKGROUND

The Texas Medicaid Healthcare Partnership (TMHP) requires prior authorization for certain fee-for-service DME deliverables, a cost-control measure that requires providers to obtain approval to qualify for payment.

Texas Medicaid also requires a Title XIX form for all fee-for-service DME. The Title XIX form serves as the physician order for the Medicaid beneficiary to receive the DME and supplies listed on the form. The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division examined prior authorization forms, Title XIX forms, and delivery documentation for a risk-based sample of Medicaid beneficiaries. The OIG Audit and Inspections Division also evaluated information technology (IT) general controls and confirmed the data used for audit testing was reliable.

The OIG Audit and Inspections Division audited 1,938 claims associated with 272 beneficiaries and totaling \$420,751.97.

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INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division has completed an audit of Aveanna Healthcare Medical Solutions (Aveanna), doing business as Medco Respiratory Instruments, Inc. in Texas. Aveanna provides durable medical equipment (DME)¹ and expendable supplies from its office in Houston, Texas. The audit focused on Medicaid fee-for-service claims² submitted to and paid by the Texas Medicaid and Healthcare Partnership (TMHP), the Texas Medicaid claims administrator.

Background

Medco Respiratory Instruments, Inc. was founded in 1971 and is based in Houston, Texas. It provides services to Medicaid beneficiaries across the state. As of October 2015, Medco Respiratory Instruments, Inc. became a subsidiary of Epic Health Services Inc. In March 2017, Aveanna Healthcare Holdings Inc. concurrently acquired PSA Healthcare and Epic Health Services Inc. Aveanna received Texas Medicaid reimbursements of \$1.9 million for DME and supplies delivered to 1,521 Medicaid beneficiaries during the audit scope.

Objective and Scope

The objective of the audit was to determine whether there was valid support for the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Aveanna as required by state laws, rules, and guidelines. The audit was designed to test whether:

- Services ceased upon death of eligible beneficiaries
- Authorization and prior authorization documentation was completed as required for DME and supplies
- Documentation existed to support delivery of DME and supplies

The scope of the audit included paid fee-for-service claims for deliveries made from September 1, 2017, through August 31, 2018, and a review of relevant activities, internal controls, and information technology (IT) general controls through the end of fieldwork in December 2019.

¹ “Durable medical equipment” is medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or improve a beneficiary’s disability, condition, or illness.

² In the context of this report, the term “claims” refers to individual claim items.

Methodology

The OIG Data and Technology (DAT) unit compiled Medicaid fee-for-service claims paid for DME services rendered by Aveanna from September 1, 2017, through August 31, 2018.

The OIG Audit and Inspections Division conducted an on-site planning visit in August 2019, during which appropriate personnel were interviewed, internal controls were evaluated, and samples were collected. The OIG Audit and Inspections Division issued an engagement letter to Aveanna on October 4, 2019, providing the final scope and objective as well as other information about the upcoming audit. The OIG Audit and Inspections Division selected a risk-based sample for testing and began gathering the relevant supporting documentation during the on-site fieldwork conducted at Aveanna's facility in Houston, Texas, from October 7, 2019, through October 11, 2019.

Each fee-for-service claim was reviewed for (a) Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms (Title XIX forms), (b) prior authorizations, where required, (c) delivery tickets, and (d) delivery notifications, delivery tracking information, and customer signatures, where appropriate. Claim-level details of these issues were provided to Aveanna electronically in a separate Excel workbook.

The OIG Audit and Inspections Division presented preliminary audit results, issues, and recommendations to Aveanna in a draft report dated May 11, 2020. Aveanna provided management responses to the recommendations, generally indicating that it implemented improvements to its controls and processes designed to prevent future overpayments. Aveanna noted concerns regarding proof of delivery for several procedure codes. Aveanna's management responses are included in the report following each recommendation.

Criteria

The OIG Audit and Inspections Division used the following criteria to evaluate the information provided:

- 1 Tex. Admin. Code § 371.1659(3) (2016)
- Texas Medicaid Provider Procedures Manual, Vol. 1, § 4.3 (2017 through 2018)

- Texas Medicaid Provider Procedures Manual, Vol. 2, “Durable Medical Equipment, Medical Supplies, and Nutritional Products” (2017 through 2018)
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form and Instructions (2016 and 2018)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit and Inspections Division conducted this audit in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit and Inspections Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

ISACA (formerly known as the Information Systems Audit and Control Association)

The OIG Audit and Inspections Division performs work in accordance with the IT Standards, Guidelines, and Tools and Techniques for Audit and Assurance and Control Professionals published by ISACA.

AUDIT RESULTS

For this audit, the OIG Audit and Inspections Division selected 1,938 claims associated with 272 Patient Control Numbers (PCNs). Aveanna's data was sufficiently reliable for the purposes of this audit.

Of 1,938 claims tested, 1,694 (87 percent) were completed as required by laws, rules, and guidelines. Additionally, Aveanna stopped services after a beneficiary's death for all beneficiaries tested. However, Aveanna did not always meet authorization requirements for DME and supplies by obtaining and maintaining Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms (Title XIX forms) and prior authorization where required. In addition, Aveanna did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims.

Authorization

The OIG Audit and Inspections Division tested whether Aveanna met Texas Medicaid requirements for prior authorization from TMHP for certain DME and incontinence supplies. For all 1,938 claims, the OIG Audit and Inspections Division also tested whether Aveanna had valid Title XIX forms prior to billing for DME and supplies claims.

The OIG Audit and Inspections Division identified the following errors related to authorizations for DME and supplies:

- Prior authorizations were missing
- Title XIX forms were missing
- Title XIX forms were expired
- Title XIX forms did not include date last seen by physician

After removing duplicate claims, there were 219 unauthorized claims totaling \$44,272.44 that require repayment.

Table 1 details the findings related to authorizations. The total exceptions columns include the number of claims in exception for each issue, and a claim may be included more than once. The recoupment columns include each claim for recoupment only once, regardless of the total number of times an exception was noted on that claim.

Table 1: Summary of Issues and Exceptions Related to Authorization

Issue	Total Exceptions (Dollars)	Total Exceptions (Claims)	Recoupment (Dollars) ³	Recoupment (Claims) ³
Missing Prior Authorizations	\$ 2,792.16	46	\$ 2,792.16	46*
Missing Title XIX Forms	32,084.72	134	31,680.09	132*
Expired Title XIX Forms	9,886.66	41	9,800.19	41*
Missing Information on Title XIX Forms	5,015.36	30	—	—
Total	\$49,778.90	251	\$44,272.44	219

*Prior authorization claim amounts may be pro-rated. If a pro-rated amount is less than the full claim amount, the remainder may be included in a subsequent issue.

Source: OIG Audit and Inspections Division

Confirmation of Delivery

Aveanna subcontracts most deliveries to McKesson Corporation (McKesson), and the remaining orders are shipped directly from Aveanna's warehouses. The OIG Audit and Inspections Division tested evidence of delivery associated with the selected sample of 1,938 claims. Unconfirmed deliveries had the following issues:

- Missing Brightree⁴ delivery tickets, which are Aveanna's primary support that a shipment of supplies was initiated. These are generated by Brightree at the point of sale.
- Missing independent delivery confirmation in the form of delivery notification from McKesson, delivery service tracking numbers, or customer signatures, as applicable.

After removing duplicate claims, there were 25 delivery claims totaling \$6,455.95 that require recoupment.

³ Each claim and claim amount is counted and included for recoupment only once, regardless of the number of exceptions. Claims with multiple issues were recouped with the first cited exception, in descending order.

⁴ Brightree is the software used by Aveanna for the daily management of DME clients, sales, and billing.

Table 2 details the findings related to deliveries. The total exceptions columns include the number of claims in exception for each issue, and a claim may be included more than once. The recoupment columns include each claim for recoupment only once, regardless of the total number of times an exception was noted on that claim.

Table 2: Summary of Issues and Exceptions Related to Confirmation of Delivery

Issue	Total Exceptions (Dollars)	Total Exceptions (Claims)	Recoupment (Dollars) ⁵	Recoupment (Claims) ⁴
Missing Delivery Ticket	\$ 328.48	2	\$ 328.48	2
Missing Delivery Confirmation	6,860.68	25	6,127.47	23
Total	\$7,189.16	27	\$6,455.95	25

Source: *OIG Audit and Inspections Division*

Aveanna should repay the Medicaid authorization overpayments of \$44,272.44 and the delivery overpayments of \$6,455.95, totaling \$50,728.39, to the State of Texas.

AUTHORIZATION

Texas Administrative Code (TAC) requires that services or items furnished to a Medicaid recipient be medically necessary and not substantially exceed the patient's needs.⁶

A Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX form) is required for fee-for-service DME claims. The authorization period begins when the physician signs and dates the form, and it extends until the earlier of (a) the date of the supply, in the case of a one-time supply, (b) the end of the duration of need period, or (c) six months from the date of the physician's signature.⁷ If a patient's duration of need exceeds six months, authorization must be renewed with a new Title XIX form after the previous one has expired. Either the physician or the DME and supplies provider may initiate obtaining a new Title XIX authorization. Authorization for a DME or supply order is renewed when a new Title XIX form is (a) completed, signed, and dated by the physician, and (b) certified by the DME and supplies provider.

⁵ Each claim and claim amount is counted and included for recoupment only once, regardless of the number of exceptions. Claims with multiple issues were recouped with the first cited exception.

⁶ 1 Tex. Admin. Code § 371.1659(3) (May 1, 2016).

⁷ Texas Medicaid Provider Procedures Manual, Vol. 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products" § 2.2.1 (Apr. 2017, through Aug. 2018).

A single Title XIX form provides support for a provider's claim for DME and supplies prescribed by a physician for a beneficiary for six months. If the form is missing, expired, or invalid, claims for which the form would have provided support are invalid.

Most DME and supplies exceeding certain monthly maximum quantities require prior authorization from TMHP. Title XIX forms are submitted to TMHP with the prior authorization request. The prior authorization request lists the authorized Healthcare Common Procedure Coding System (HCPCS) codes, authorized quantities, and the authorization expiration date. Approved prior authorizations should be maintained by the provider and presented to the Texas Health and Human Services Commission (HHSC) upon request.

The OIG Audit and Inspections Division reviewed 1,938 DME and supplies claims associated with 272 beneficiaries who received DME and supplies from September 1, 2017, through August 31, 2018, to determine whether the claims were (a) for items delivered before date of death, where applicable, (b) supported by a current, complete, and valid prior authorization, when required, and (c) supported by a Title XIX form.

Missing Prior Authorizations

TMPPM requires prior authorization for certain fee-for-service deliverables, thereby evaluating the medical necessity and determining whether it will reimburse the cost of those services and supplies. Thus, the prior authorization process is a prepayment cost control measure that requires providers to obtain approval to qualify for payment. Prior authorization must be obtained from TMHP within three business days of the date of service.⁸

Issue 1: Prior Authorization Documentation Was Missing

Aveanna submitted and received reimbursement for DME and supplies claims that were delivered to beneficiaries without the required prior authorization. Of the 1,938 claims included in the audit sample, 942 required prior authorizations as well as Title XIX forms. Aveanna obtained prior authorization as required for 896 of the 942 claims.

⁸ Texas Medicaid Provider Procedures Manual, Vol. 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products" § 2.2.1.3 (Apr. 2017, through Aug. 2018).

Aveanna did not obtain required prior authorizations for the remaining 46 claims tested. Specifically:

- 12 claims tested for regular DME totaling \$1,750.46 did not have an approved prior authorization from TMHP, as required by TMPPM.⁹
- 34 claims totaling \$1,041.70 for certain incontinence and other supplies in excess of monthly allowed maximums did not have required prior authorization by TMHP.¹⁰ Beneficiaries frequently receive two or three shipments per month of supplies, and in some cases, those are subject to maximum quantity limitations. For example, any combination of incontinence products, such as diapers, pull-ons, briefs, and liners, may not exceed 240 per month. The OIG Audit and Inspections Division calculated recoupment for the quantities in excess of the monthly maximum. Therefore, the unit cost of these products is calculated on a pro-rated basis. Thirty-four claims were recouped on a pro-rated basis.¹¹

As a result, Texas Medicaid reimbursed Aveanna a total of \$2,792.16 for the 46 unauthorized DME claims. These errors occurred because Aveanna's DME software, Brightree, lacked systemic controls to identify whether prior authorization was obtained. Instead, Aveanna relied on (a) internal policies and procedures and (b) manual reviews of prior authorization documents but did not always successfully identify sales lacking the proper authorization.

Obtaining prior authorization is important because it allows TMHP to assess the medical necessity of services and supplies before incurring the expenses.

Recommendation 1

Aveanna should:

- Implement controls to ensure that Medicaid fee-for-service DME and supplies are provided to beneficiaries only after prior authorization is received, when required.
- Return the overpayment amount of \$2,792.16 to the State of Texas for the 46 unauthorized claims.

⁹ Texas Medicaid Provider Procedures Manual, Vol. 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products" § 2.2.1.3 (Apr. 2017, through Aug. 2018).

¹⁰ Amounts overpaid are based on the average price paid for the relevant product(s) during the month.

¹¹ Total amount paid per month was divided by total quantity paid to obtain the average monthly product cost subject to the limitation. The average product cost for the month was multiplied by the quantity of product over the maximum allowed.

Management Response

Action Plan

Aveanna Medical Solutions (“AMS”) has ensured that all Texas Medicaid claims are now being reviewed manually for authorization before billing, instead of using automated billing technology. This will ensure that the prior authorization is on file before any claim is billed.

AMS has formalized the quality assurance program for the prior authorization team. The quality assurance team reviews a sample of the authorization team’s completed work monthly. As part of the audit criteria, the sample tests for any missing or incorrect authorizations for all payors, including Texas Medicaid. Employees are held accountable for the accuracy of their quality assurance audit scores and will receive coaching and training as necessary.

AMS is committed to building new tools and training resources for our employees. AMS has developed a new, intranet learning database, accessible to all employees. Once fully launched, the site will include payor profiles, payor guidelines, job aids, processes, etc. The learning tool will include, but is not limited to, Texas Medicaid authorization requirements. AMS has developed a review, approval, and update process to ensure the learning database remains current with applicable updates and changes.

Responsible Managers

*AMS Site Operations Director, Houston
AMS Director of Revenue Cycle
AMS Knowledge Manager*

Target Implementation Date

Manual claim authorization review was implemented in May 2020. The quality assurance program for the authorization team was implemented on June 1, 2020.

The intranet learning database has been created, the approval process for payor information has been completed and will be accessible to all AMS employees on July 1, 2020.

Missing¹² Title XIX Forms

TMPPM requires a DME and supplies provider to retain copies of completed Title XIX forms to support Medicaid claims.¹³ A completed Title XIX form must (a) include the procedure codes and numerical quantities for services requested, (b) be signed and dated by the prescribing physician¹⁴, and (c) have all fields filled out completely, including the most appropriate procedure code description using HCPCS.¹⁵

Issue 2: Title XIX Forms Did Not Exist

Aveanna submitted and received reimbursement for DME and supplies claims that were not supported by a Title XIX form, either because a Title XIX form did not exist for the service date or because the delivered supplies were not included on an existing Title XIX form.¹⁶ Of the 1,938 claims tested, 134 claims totaling \$32,084.72 did not have a corresponding Title XIX form to support the claims. Two of these claims for regular DME totaling \$230.16 were fully identified for recoupment under Issue 1. Another six claims for incontinence supplies over maximum allowed quantities were partially included for recoupment on a pro-rated basis totaling \$174.47 under Issue 1. The remainder of the six claims is included for recoupment within this issue.

These errors occurred because Aveanna did not obtain a Title XIX form for the DME and supplies delivered as required by TMPPM. As a result, Texas Medicaid reimbursed Aveanna an additional \$31,680.09 for the 132 unsupported claims.

¹² When there was not a Title XIX form in effect between September 1, 2017, and the date of service for a claim within the audit scope period, the Title XIX form needed to support the claim was considered missing.

¹³ Texas Medicaid Provider Procedures Manual, Vol. 2, “Durable Medical Equipment, Medical Supplies, and Nutritional Products” § 2.2.1 (Apr. 2017, through Aug. 2018).

¹⁴ Texas Medicaid Provider Procedures Manual, Vol 2, “Durable Medical Equipment, Medical Supplies, and Nutritional Products” § 2.2.2.2 (Apr. 2017, through Aug. 2018).

¹⁵ Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (Apr. 1, 2016 and July 1, 2018).

¹⁶ Instances of a different size being supplied than the size authorized were not included as exceptions.

Recommendation 2

Aveanna should:

- Implement controls to ensure that products are delivered and Medicaid fee-for-service DME and supplies claims are submitted to TMHP only when Aveanna has a current, complete, and valid Title XIX form.
- Return the overpayment amount of \$31,680.09 to the State of Texas for the 132 additional unauthorized claims not supported by a Title XIX form.

Management Response

Action Plan

During an internal review of documentation, Aveanna Medical Solutions (“AMS”) identified that in some instances, a Title XIX form was not completed in the following scenarios:

Several of the patients reviewed by the auditors were identified as being eligible at one point with a Texas Medicaid Managed Care Organization (“MCO”), then switching to Texas Medicaid FFS for a short time and then becoming eligible again with an MCO.

Many of the MCOs in Texas no longer require a Title XIX form on file, as they are burdensome for providers as it relates to difficulties with the completion of the (form). When a patient is eligible with an MCO that does not require a Title XIX, AMS will obtain a signed, generic prescription, instead of the Title XIX. When that patient becomes eligible with Texas Medicaid FFS, AMS requests a Title XIX to meet the requirement. In some instances, AMS is unable to obtain the Title XIX due to the short period of time that the patient was eligible with Texas Medicaid FFS. The process to obtain a valid form can extend beyond this short period of time, creating order duplication, and an unattainable burden of absolute compliance for the physician and providers.

In the original context of the requirement, the majority of Texas Medicaid patients received authorization through Texas FFS Medicaid programs with a small percentage of patients authorized services through an MCO. This afforded providers a protracted window to complete the Title XIX form and return before billing. This scenario is now reversed with the majority of patient authorizations provided through an MCO and FFS becoming a short-term pass-through payor as patients transition from one MCO to another. In effect, the current requirement has become incongruous with the interpretive latitude currently applied by the MCO’s. As such, AMS will endeavor to do everything in its power to work within the requirements to obtain a valid Title XIX, however absolute compliance with this

mandate will continue to be a dubious undertaking until further regulatory clarification is provided by issuing authorities.

Holding to the absolute letter of the guidance in this situation places a provider such as AMS in a contradictory scenario of not being paid for services as we uphold our commitment to provide medically necessary services ordered by the physician.

Additionally, to further support our commitment as a compliant organization, AMS has enabled site settings within the Brightree electronic medical record system that enforces the Title XIX requirement before billing Texas Medicaid.

AMS checks eligibility for all Medicaid patients at the beginning of each month to identify any changes in health plans. As changes to Texas Medicaid FFS are identified, the eligibility and authorization team will continue to request that the Title XIX form be completed and signed. The eligibility and authorizations teams will continue to follow up with the physician to ensure that the request is completed and signed in a timely manner to meet the Title XIX requirements.

Responsible Managers

*AMS Site Operations Director, Houston
AMS Patient Access Manager
AMS Director of Revenue Cycle*

Target Implementation Date

AMS will continue to follow and enforce previously established processes for eligibility, insurance changes, and appropriate Brightree system settings. All AMS processes, policies, and procedures will be reviewed annually, at a minimum.

Expired¹⁷ Title XIX Forms

TMPPM states that a Title XIX form may be valid for up to but no more than six months from the date of the physician's signature on the form.¹⁸ Upon expiration, a new Title XIX form must be submitted by the beneficiary's physician. Physicians frequently indicate a duration of need period on the Title XIX form that

¹⁷ Unless the physician indicated a duration period of less than six months, when there is a Title XIX form in effect on or after September 1, 2017, but the effective date on the form was more than six months prior to the date of service for a claim within the audit scope period, the Title XIX form used to support the claim was considered expired. If the physician indicated a duration of less than six months, the Title XIX form is expired beginning the day after the authorized duration period ended.

¹⁸ Texas Medicaid Provider Procedures Manual, Vol. 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products" § 2.2.1 (Apr. 2017, through Aug. 2018).

is more than six months in the future. However, this does not extend the Title XIX authorization beyond six months for Texas Medicaid.

Issue 3: Title XIX Forms Were Expired

Aveanna submitted and received reimbursement for DME and supplies claims that were not supported by a current¹⁹ Title XIX form. Of the 1,938 claims tested, 41 claims totaling \$9,886.66 did not have a current Title XIX form signed by a physician to support the claim. A single claim for incontinence supplies over maximum allowed quantities was partially recouped on a pro-rated basis totaling \$86.47 under Issue 1.²⁰ The remainder is included for recoupment within this issue.

These errors occurred because Aveanna did not consistently follow its process to ensure that it obtains a current Title XIX form at least every six months. As a result, Texas Medicaid reimbursed Aveanna for an \$9,800.19 for 41 unsupported claims.

Recommendation 3

Aveanna should:

- Implement controls to ensure that Aveanna has a current, complete, and valid Title XIX form prior to delivering products and submitting Medicaid fee-for-service DME and supplies claims to TMHP.
- Return the overpayment amount of \$9,800.19 to the State of Texas for the 41 additional unauthorized claims not supported by a current Title XIX form.

Management Response

Action Plan

During an internal review of documentation, Aveanna Medical Solutions (“AMS”) identified that in some instances, a Title XIX form was not completed because of the following scenario:

When signing the original Title XIX form, the physician indicated that the length of need (“LON”) was for longer than six months. In some instances, AMS employees

¹⁹ A Title XIX form is current within six months (or duration of need if less than six months) of the date the physician signed the form.

²⁰ Under Issue 1, \$86.47 of \$96.88 was recouped for this claim; therefore, it is excluded from Issue 3.

logged the Title XIX to reflect the LON identified by the physician, which is the standard practice for other medical documentation. However, because Texas Medicaid will only accept a Title XIX form for six months, the audit findings determined that some of the Title XIXs were expired.

AMS has re-trained all prior authorization employees regarding the six-month requirement for renewals. These requirements are included in AMS's new hire training curriculum and captured within the intranet learning database.

AMS has formalized the quality assurance program for the prior authorization team. The quality assurance team will review a sample of the authorization team's completed work monthly. As part of the audit criteria, the sample tests for complete and accurate Title XIXs. Employees are held accountable for the accuracy of their scores and will receive coaching and training as necessary.

Responsible Managers

AMS Site Operations Director, Houston

AMS Patient Access Manager

AMS Director of Revenue Cycle

Target Implementation Date

The formalized quality assurance program for the authorization team was implemented on June 1, 2020.

The intranet learning database has been created and the approval process for payor information has been completed. Payor information will be accessible to all AMS employees on July 1, 2020.

Missing Information on Title XIX Forms

For services rendered prior to July 1, 2018, TMPPM requires a physician to sign the Title XIX form within 12 months of the date the physician last saw the beneficiary, unless a physician waiver is obtained, in order for the Title XIX form to be valid. For services rendered on or after July 1, 2018, this requirement was changed to require a physician to have seen the patient within the previous six months unless a physician waiver is obtained.²¹ Otherwise, the Title XIX form is not valid. During the OIG Audit and Inspections Division's review of supporting documents, no waivers were noted. In addition, the Title XIX form specifically states that the date last seen by physician must be completed.²² When the date last

²¹ Texas Medicaid Provider Procedures Manual, Vol. 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products" § 2.2.2.2 (Apr. 2017 through June 2018, and July 2018 through Aug. 2018).

²² Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (Apr. 1, 2016, and July 1, 2018).

seen is not included, the Title XIX form does not provide evidence that the physician signed the form within the timeframe required.

DAT obtained the information directly from TMHP to supplement the date last seen by physician, where missing. The OIG Audit and Inspections Division used both the dates listed on the Title XIX forms and those obtained from TMHP to validate compliance with the requirement of a physician exam within 12 months (6 months after July 1, 2018) of signing the Title XIX form.

Issue 4: Title XIX Forms Did Not Include Date Last Seen by Physician

Aveanna submitted and received reimbursement for DME and supplies claims that were not supported by a completed Title XIX form that included the date a physician last saw the beneficiary. Of the 1,938 paid claims tested, 30 claims totaling \$5,015.36 had a corresponding Title XIX form on which the date last seen by physician was missing.

DAT requested physician exam billing dates from TMHP to supplement the missing Title XIX dates. DAT was able to obtain the date last seen by physician for each of the missing dates. The review of TMHP's records indicated that each of the beneficiaries of the 30 claims had seen a physician within the previous 6 or 12 months, as required, of the completion of the Title XIX form.

Aveanna did not ensure that the date last seen by physician was included on the Title XIX forms as required.²³ Compliance with this requirement ensures that a physician has recently examined the patient and that the procedures are medically necessary. However, since the dates were ultimately determined and there were not any instances of noncompliance regarding allowable elapsed time between the date last seen by physician and the physician's issuance of the Title XIX, Aveanna does not need to reimburse Texas Medicaid for these claims.

Recommendation 4

Aveanna should implement controls to ensure that products are delivered and Medicaid fee-for-service DME and supplies claims are submitted to TMHP only when Aveanna has a Title XIX form that includes the date the beneficiary was last seen by a physician.

²³ Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (Apr. 1, 2016 and July 1, 2018).

Management Response

Action Plan

Aveanna Medical Solutions (“AMS”) has formalized the quality assurance program for the prior authorization team. The quality assurance team will review a sample of the authorization team’s completed work monthly. As part of the audit criteria, the sample tests for the accuracy of the Title XIX. Employees are held accountable for the accuracy of their scores and will receive coaching and training as necessary.

AMS is committed to building new tools and providing new training resources for our employees. AMS has developed a new, online intranet learning database accessible to all employees. Once completely launched, the site will include payor profiles including payor guidelines and requirements and other information, job aids, process specifics, etc. This will include, but is not limited to, Texas Medicaid Title XIX requirements. AMS has developed a review, approval and update process to ensure the intranet learning database remains current with applicable updates and changes.

AMS has re-trained all prior authorization employees regarding six-month requirement for date last seen by a physician. These requirements are included in our new hire training curriculum and captured within the intranet learning database.

Responsible Manager

AMS Site Operations Director, Houston

Target Implementation Date

The quality assurance program for the authorization team was implemented on June 1, 2020.

The intranet learning database has been created and the approval process for payor information has been completed. Payor information will be accessible to all AMS employees on July 1, 2020.

The authorization team was re-trained on the six-month requirement for date last seen and will be included in the ongoing training curriculum. Training and coaching will be provided as necessary, based on quality assurance review findings.

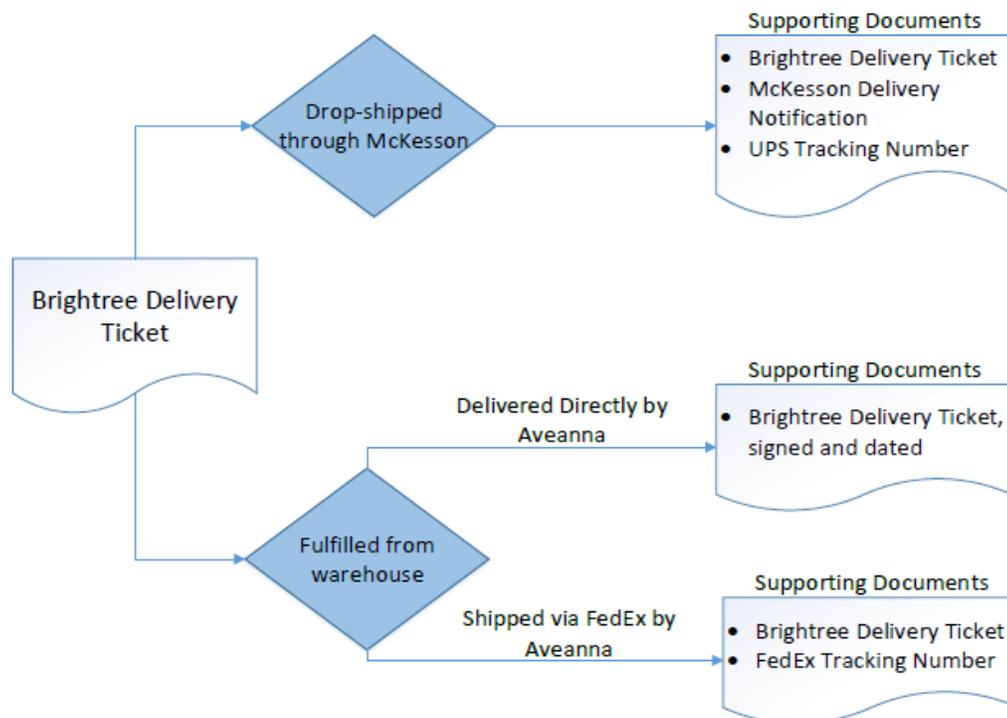
CONFIRMATION OF DELIVERY

Texas Medicaid reimburses providers for DME and supplies that are properly authorized and delivered to qualified individuals. As confirmation that DME and supplies were shipped and delivered, providers are required to retain (a) individual delivery slips or invoices signed and dated by the beneficiary or caregiver or (b) dated carrier tracking documents with shipping dates and delivery dates printed from the carrier’s website. Aveanna must supply this information to HHSC if requested.²⁴

Aveanna subcontracts with McKesson for the delivery of most of Aveanna’s orders. A small percentage of orders are delivered directly from Aveanna’s warehouses. The delivery documentation varies depending on the delivery point of origin.

Figure A depicts the delivery options and corresponding supporting documents.

Figure A: Aveanna’s Delivery Options and Corresponding Supporting Documents



Source: OIG Audit and Inspections Division

²⁴ Texas Medicaid Provider Procedures Manual, Vol. 2, “Durable Medical Equipment, Medical Supplies, and Nutritional Products” § 2.2.3 Medical Supplies (Apr. 2017, through Aug. 2018).

In all instances, Aveanna's Home Health software system, Brightree, initiates delivery by generating a delivery ticket. This delivery ticket includes key information necessary to validate that the correct item was processed, including the beneficiary's name and address as well as item descriptions, quantities, Brightree item number and universal HCPCS procedure codes.

- If the order is subcontracted to McKesson, Aveanna receives a delivery notification from McKesson once delivery is completed. The delivery notification includes (a) the beneficiary's name and address, (b) item descriptions, quantities, and McKesson's own inventory numbers, and (c) United Parcel Service (UPS) tracking information so that the delivery date, time, and address can be confirmed. The OIG Audit and Inspections Division obtained a crosswalk of McKesson's inventory numbers to the Brightree item numbers to validate that the correct items were sent.
- If the order is fulfilled directly from Aveanna's warehouses, two methods of delivery are possible:
 - An Aveanna employee may deliver DME and supplies, especially if training is required or if equipment must be installed or fitted. In this circumstance, the Brightree delivery ticket should be signed and dated by the receiver.
 - If delivery by an Aveanna employee is not required, the order may be shipped via Federal Express (FedEx). In this case, the delivery documentation should consist of the Brightree delivery ticket and the FedEx tracking information, which confirms the delivery date, time, and address.

Issue 5: Brightree Delivery Tickets Were Missing

Aveanna submitted and received reimbursement for DME and supplies claims that were not supported by Brightree delivery tickets. The Brightree delivery ticket initiates the delivery process, and it includes the HCPCS codes necessary to validate that the correct items were sent. Aveanna submitted and received reimbursement for two DME and supplies claims totaling \$328.48 that did not have Brightree generated delivery tickets to support the initiation of delivery. These claims also lacked delivery notification from McKesson, tracking numbers from either delivery service, or any indication that the order was placed.

Because Aveanna did not maintain supporting documentation for these claims, delivery of these supplies could not be verified. As a result, Texas Medicaid reimbursed Aveanna \$328.48 for two claims not supported by corresponding Brightree delivery tickets indicating the delivery was initiated.

Recommendation 5

Aveanna should:

- Implement controls to ensure Medicaid fee-for-service DME and supplies claims are submitted to TMHP only when Aveanna has corresponding Brightree delivery tickets indicating initiation of delivery to the beneficiary.
- Return the overpayment amount of \$328.48 to the State of Texas for two additional claims not supported by corresponding Brightree delivery tickets.

Management Response

Action Plan

AMS ensures that all Texas Medicaid claims are being reviewed manually for documentation that demonstrates proof of delivery prior to billing, instead of using automated billing technology. This will ensure that the proof of delivery is accurately documented with items delivered matching items billed.

AMS completes a monthly audit to test a sample of claims that have been billed. The audit tests for accuracy of the items that were sent to ensure that they match the items that were billed. This information is reported to the division's Performance Improvement Committee quarterly. Any deficiencies identified are addressed by AMS Leadership.

Responsible Manager

AMS Director of Revenue Cycle

Target Implementation Date

Manual claim review was implemented in May 2020.

AMS continues to follow and enforce the previously established claims audits. Findings will be reported and reviewed during the quarterly Performance Improvement Committee meeting.

Issue 6: Delivery Confirmation Was Missing

For shipments contracted to McKesson, after a delivery ticket initiates the delivery, delivery notifications from McKesson with UPS tracking numbers confirm the delivery is complete.²⁵ For shipments delivered directly by Aveanna, customer signatures and FedEx tracking numbers confirm delivery from Aveanna's warehouses is complete. Of the 1,866 claims tested,²⁶ 25 lacked independent delivery confirmation. Specifically:

- Of the 1,818 claims subcontracted to McKesson, 19 were not supported by McKesson delivery notifications. Those claims totaled \$5,099.34.
- Of the 1,799 claims with a McKesson delivery notification, a smaller sample of 138 UPS tracking numbers was sent to UPS for independent verification of delivery dates and addresses. Of those 138 deliveries, an additional two claims totaling \$209.26 referenced UPS tracking numbers that were not validated.
- Of the 46 claims delivered directly by Aveanna, four lacked the necessary independent verification. Those claims totaled \$1,552.08. In each instance, documentation indicated that the deliveries were made by Aveanna employees. However, there was neither a customer signature nor a FedEx delivery tracking number as required.

As a result of the missing and invalid delivery documentation, delivery of supplies could not be verified for these 25 claims, which totaled \$6,860.68. Two of the claims totaling \$733.21 were included in previous authorization issues. Therefore, Texas Medicaid reimbursed Aveanna \$6,127.47 for 23 claims not supported by independent delivery documentation.

²⁵ According to Aveanna, approximately 95 percent of deliveries are made by McKesson. Therefore, claims without any delivery confirmation information are classified as McKesson deliveries.

²⁶ Certain DME equipment, such as power wheelchairs and parenteral or enteral infusion pumps, can be rented monthly. The 72 claims for rentals delivered prior to the scope of this audit were omitted from testing, leaving 1,865 non-rental claims with a delivery ticket to be tested for delivery confirmation.

Recommendation 6

Aveanna should:

- Implement controls to ensure Medicaid fee-for-service DME and supplies claims are submitted to TMHP only when Aveanna has valid individual delivery confirmation documentation for all DME and supplies provided to a beneficiary.
- Return the overpayment amount of \$6,127.47 to the State of Texas for 23 claims not supported by independent proof of delivery.

Management Response

Action Plan

Aveanna Medical Solutions ('AMS') is seeking further communication and clarification regarding the billing requirements for the following HCPC codes: B4034, B4035 and B4036. Claims for these codes were reviewed in the audit and identified as deficient in proof of delivery documentation, which is contradictory to the guidance provided for billing these codes.

Organizations like the National Home Infusion Association provides the following guidance on how to appropriately bill for the aforementioned codes; "Enteral and parenteral nutrition support therapies consist of medical treatment necessary to maintain or restore optimal nutrition status and health. Pumps, supplies (often in the form of kits) and nutrients are billed using the following codes. Note: Kits are a daily allowance of supplies for each day nutrients are delivered.

Enteral Kit Codes

B4034: Syringe/bolus fed

B4035: Pump fed

B4036: Gravity fed"

CMS provides the following guidance in the Enteral Nutrition LCD:

"Enteral feeding supply allowances (B4034, B4035, and B4036) include all supplies, other than the feeding tube and nutrients, required for the administration of enteral nutrients to the beneficiary for one day. Only one unit of service may be billed for any one day. Codes B4034, B4035, and B4036 describe a daily supply fee rather than a specifically defined "kit". The use of individual items may differ from beneficiary to beneficiary, and from day to day. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supply allowances include, but are not limited to, a catheter/tube anchoring device, feeding bag/container, flushing solution bag/container, administration set

tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc.”

The TMHP manual directs providers to use these codes and does not recommend deviance from the standard interpretation of how they are to be used. Based on this guidance, B4034, B4035 and B4036 should be billed as a daily service charge with units being billed in number of days, and not the number of individual supplies provided. Because of this, the number of supplies provided will not always match the number of units billed. Based on the patient’s medical needs, the supply quantities will vary from patient to patient.

AMS ensures that all Texas Medicaid claims are being reviewed manually for documentation that demonstrates proof of delivery prior to billing, instead of using automated billing technology. This will ensure that the proof of delivery is accurately documented with items delivered matching items billed.

AMS completes a monthly audit to test a sample of claims that have been billed. The audit tests for accuracy of the items that were sent to ensure that they match the items that were billed. This information is reported to the division’s Performance Improvement Committee quarterly. Any deficiencies identified are addressed by AMS Leadership.

Responsible Manager

AMS Director of Revenue Cycle

Target Implementation Date

Manual claim review was implemented in May 2020.

AMS continues to follow and enforce the previously established claims audits. Findings will be reported and reviewed during the quarterly Performance Improvement Committee meeting.

Auditor Comments

The OIG Audit and Inspections Division appreciates the feedback provided by Aveanna Healthcare Medical Solutions in its management response letter and respects Aveanna’s position on reported issues. The OIG Audit and Inspections Division offers the following comments regarding Aveanna’s management response for Issue 6.

The OIG Audit and Inspections Division stands by its methodology for testing delivery of HCPCS codes B4034, B4035, and B4036. This testing was conducted consistent with Texas Administrative Code § 371.1653(2)(5). While we acknowledge that some of the miscellaneous items may vary by patient, the primary components of the kits should equal both the amount prescribed on the Title XIX form and the amount claimed. In the event of a lesser amount being delivered than prescribed, the lesser amount should be billed to Medicaid. In all instances, the quantity claimed should equal the quantity delivered.

The OIG Audit and Inspections Division has consulted with the HHS Medicaid Policy Division on this issue, and the agency agrees.

CONCLUSION

The OIG Audit and Inspections Division completed an audit of Aveanna's activity for services rendered from September 1, 2017, through August 31, 2018. The audit evaluated whether evidence to support the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Aveanna (a) existed and (b) was completed in accordance with the relevant state laws, rules, and guidelines. The OIG Audit and Inspections Division also evaluated IT general controls to determine whether data used for audit testing was reliable. Aveanna's data was sufficiently reliable for the purposes of this audit.

Of 1,938 claims tested, 1,694 (87 percent) were completed as required by laws, rules, and guidelines. Additionally, Aveanna stopped services after a beneficiary's death for all beneficiaries tested. However, 219 claims totaling \$44,272.44 did not meet all authorization requirements and 25 additional claims totaling \$6,455.95 did not include adequate proof of delivery. The specific issues were:

- Prior authorization documentation was missing
- Title XIX forms did not exist
- Title XIX forms were expired
- Title XIX forms did not include date last seen by physician
- Brightree delivery tickets were missing
- Delivery confirmation was missing

As a result, Aveanna did not meet Texas requirements for DME and supplies for a total of 244 claims, for which Texas Medicaid made payments of \$50,728.39 in error. The total amount due to the State of Texas is \$50,728.39.

The OIG Audit and Inspections Division offered recommendations to Aveanna, which, if implemented, will correct deficiencies in compliance with state laws, rules, and guidelines.

The OIG Audit and Inspections Division thanks management and staff at Aveanna for their cooperation and assistance during this audit.

Appendix A: Sampling Methodology

Aveanna processed 28,994 Texas Medicaid fee-for-service claims for DME and supplies with dates of service from September 1, 2017, through August 31, 2018. Aveanna received Texas Medicaid reimbursements of \$1.9 million for DME and supplies delivered to 1,521 Medicaid beneficiaries during the audit scope.

During the sample selection process, the OIG Audit and Inspections Division considered beneficiaries with high-dollar claims as well as claims considered to be at high risk for noncompliance. Auditors selected a risk-based sample of 1,938 claims associated with 272 beneficiaries totaling \$420,751.97 for audit. The OIG Audit and Inspections Division performed multiple tests during this audit, including (a) assessing dates of death to ensure services were no longer provided after a beneficiary was deceased, (b) validating authorization documentation, and (c) confirming proof of delivery documentation.

Any claim with multiple exceptions was only included for recovery once. The amounts identified are to be returned to the State of Texas on a dollar-for-dollar basis.

Services Rendered after Death

A total of nine Medicaid beneficiaries associated with all 28,994 DME claims from September 1, 2017, through August 31, 2018, were deceased as of the end of the audit period and had DME deliveries after death. Three of these beneficiaries were included in the audit sample. The deliveries after death were made by Aveanna after verifying beneficiary eligibility; therefore, there are no audit issues for these deliveries after death.

Authorization

The OIG Audit and Inspections Division tested whether Aveanna met Texas Medicaid authorization requirements associated with the selected sample of 1,938 claims. Prior authorizations were reviewed for those claims requiring it, and Title XIX forms were reviewed for all sample claims.

Deliveries

The OIG Audit and Inspections Division tested evidence of delivery associated with the selected sample of 1,938 claims. Testing included a review of delivery initiation and delivery confirmation.

The OIG Audit and Inspections Division kept Aveanna apprised of all aspects of the audit process. Aveanna had multiple opportunities to provide relevant documentation and information to ensure the accuracy of audit findings.

Appendix B: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- Audrey O’Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy VerColen, CPA, Assistant Deputy Inspector General of Audit and Inspections
- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Melissa Larson, CISA, CIA, CFE, HCISPP, Senior Managing Auditor
- Bruce Andrews, CPA, CISA, Senior Managing Auditor
- Priscilla Suggs, CPA, CIA, CFE, Senior Managing Auditor
- Donna Keel, CIA, CGAP, Audit Project Manager
- Babatunde Sobanjo, CGAP, Senior Auditor
- Megan Pedersen, Staff Auditor
- Leia Villaret, Staff Auditor
- Ashley Rains, CFE, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Phil Wilson, Acting Executive Commissioner
- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, State Medicaid Director, Medicaid and CHIP Services
- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services

- Caryl Chambliss, Operations Management Claims Administrator
- Kimberly Williams, Encounter and File Support and Coordination

Aveanna Healthcare

- Tony Strange, Chief Executive Officer
- Korey Hinz, President, Medical Solutions Division
- Linda Trelstad, Vice President of Revenue Management
- Jaime Walsh, Director of Compliance, Quality and Training
- Paddy Cunningham, Chief Compliance Officer
- Mario Reyna, Site Operations Director, Houston
- Jennifer Hannosh, Patient Access Manager
- Leah Clark, Director of Revenue Cycle
- Jessica Szekalski, Knowledge Manager

Appendix C: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services
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