FINAL AUDIT REPORT

CTW Home Health, Inc. dba Circle of Care
San Antonio, TX

TPI NUMBER: 186012401

AUDIT/CASE TRACKING NUMBER
2017-TXIG014-ST-09-07

DATE ISSUED
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I. AUDIT SUMMARY

On November 8, 2017, an on-site audit was initiated by Health Management Systems, Inc. (HMS), contracted by the Texas Health and Human Services Commission – Office of Inspector General (OIG). The audit was for services provided to medical assistance recipients by:

Name:	CTW Home Health, Inc. dba Circle of Care
TPI Number:	186012401
Address:	4553 N. Loop, 1604 W, Suite #1119 San Antonio, TX 78249

Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited speech therapy (ST) records to verify services provided to recipients, paid by the Medicaid program. Detailed audit findings for individual claim lines are contained in the Appendices.

This report reflects only the findings of this audit and is not intended to discover all possible errors in billing or recordkeeping. Any omission of other errors from this report does not mean such practice is acceptable. Because of the limited nature of this audit, no inferences as to the overall level of provider performance should be drawn solely from this report.

II. AUDIT AUTHORITY & REFERENCES

The OIG is responsible for maintaining an ongoing program to audit providers participating in the State medical assistance programs.

This audit was carried out consistent with the *Texas Administrative Code* (TAC), *Title 1, Part 15, Chapter 371, et seq.*; and *Generally Accepted Governmental Auditing Standards*, as issued by the United States Government Accountability Office.[1]

Refer to Appendix B for the State Regulations and Policy Provider Manual provisions which were used to support the audit. The regulations and guidelines used were in effect at the time the service was provided. These include:

- *Government Auditing Standards* (GAS)
- *Code of Federal Regulations* (CFR)
- *Texas Administrative Code* (TAC)
- *Texas Medicaid Provider Procedures Manual* (TMPPM)
- Applicable coding references (CPT, HCPCS, ICD-9-CM, ICD-10-CM)

[1] 1 Tex. Admin. Code § 371.1719(b)(1)(A) (effective May 1, 2016).

III. AUDIT PROCESS

This provider audit was conducted in the following manner:

Case Selection

For the audit of speech therapy claims, a universe of paid claims with service dates ranging from January 1, 2015 through March 31, 2017 was developed. Only claims with a paid amount greater than zero were included in this universe. The universe included 623 recipients with a total Medicaid payment of $6,194,327.65. From this universe, a total of 30 randomly selected recipients totaling $374,427.72 were selected for review.

Claims previously identified as overpayments in prior audits or through post payment reviews performed by the Payment Review Program are removed from the audit universe. This prevents the same claim from being recovered twice.

Documentation Reviewed

Documentation to support services reimbursed by Medicaid was obtained on-site at the Provider's facility on November 30, 2017. No original records were removed from the Provider's premises.

An Exit Conference was held with the Provider on March 23, 2018 to review the Draft Audit Report. In response to the Draft Audit Report, the Provider submitted additional documentation to support the claims under review on April 4, 2018.

The documents were analyzed to identify any billing irregularities or deviations from program rules, regulations, and the Medicaid Provider Agreement. The results are contained in Sections IV and V of this report.

Statistical Sampling

A sample was drawn from the universe of claims paid by Medicaid program. The sample was produced using the RAT-STATS 2010-v4 random number generator. Overpayments, if any, are determined for the claims within the probability sample. These overpayments are then extrapolated to the audit universe to determine an overpayment amount. The extrapolation detail file contains the (a) population of claims, (b) sample frame, including sample size determination, (c) seed value for random number generation, (d) extrapolation validation, and (e) results printout from the RAT-STATS software.

The audit population consisted of 623 recipients. The probability sample consisted of 30 randomly selected recipients totaling $374,427.72. All claims were itemized on Medicaid remittance advices to the Provider. Overpayments identified in the probability sample will be extrapolated to the audit universe in accordance with

TAC, Title 1, Part 15, Chapter 371, Subchapter B, Rule 371.35 Use of Statistical Sampling and Extrapolation (effective 05/01/2016). See Appendix C Sampling Plan for more information.

In some instances, more than one audit finding relates to an individual service provided. This is referred to as "overlap" of findings. When more than one finding requires repayment on an individual service, the amount asserted for recoupment is limited to the amount paid by the Medicaid.

IV. FINDINGS

Of the 2,782 claim lines reviewed, there were twenty-two claim lines with recoupable monetary findings. See Appendix A for the Audit Finding Index.

Finding 1: Duplicate Payment (DP)

There were two instances of the Provider billing twice for the same service.

Example: Sample SN-404-C-052-A – The Provider was paid twice for the same date of service (DOS) for CPT code 92507. Per TMPPM, Children's Services Handbook 2.14, home health agencies that perform therapy services under CCP are allowed one visit per day, per therapy type, and may be reimbursed at the statewide visit rate.

> *Rebuttal Medical Record Review:* The rebuttal comment from the Provider confirmed that this claim was billed in error. Additional documentation submitted indicated that the transaction was voided on 03/29/2018, after the Provider was notified of the audit results. However, there was no verification that the payment had been credited by THMP. The sample remains discrepant. See Appendix A and Appendix E.

Basis for Findings:

TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015) provides, "(a) Eligible providers are required to provide separate claim information for each eligible recipient. Claims must be complete, accurate, and as specified by the Texas Health and Human Services Commission (HHSC) or its designee.
(b) Required information included the following:
(1) name, address, and appropriate Texas provider identification number of the provider of services or supplies or both;
(2) the date of the claim;
(3) the name, address, identification number, and date of birth of the individual who received services or supplies or both;
(4) the type of such services or supplies or both provided;

(5) the date(s) each service or supplies or both were provided;
(6) the amounts of each charge for various types of services or supplies or both;
(7) the total charge for service or supplies or both;
(8) credits for any payments made at the time of submission of the claim, including payments made by private health insurance and under Medicare;
(9) indication that the eligible recipient has health, accident, or other insurance policies, or is covered by private or governmental benefit systems, or other third party liability, when reported, known or suspected;
(10) the date of the eligible recipient's death, if applicable; and
(11) the name and associated national provider identifier of:
(A) the eligible billing provider;
(B) the ordering or referring provider or other professional, if services or supplies, or both, are ordered or referred; and …"

TAC, Title 1, Part 15, Chapter 371, Subchapter G, Division 2, Rule 371.1653 Claims and Billing (effective 05/01/2016) provides, "A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, claim for payment by the Medicaid or other HHS program:
(1) for an item or service for which the person knew or should have known the claim or cost report was false or fraudulent;
(2) for an item or service that was not provided as claimed; …
(6) for an item or service that was not coded, bundled, or billed in accordance with standards required by statute, regulation, contract, Medicaid or other HHS program policy or provider manual, and that, if used, has the potential of increasing any individual or state provider payment rate or fee; …"

TMPPM Children's Services Handbook, 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014) provides, "… All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy …"

TMPPM Children's Services Handbook, 2.12.3.3.1 Initial Prior Authorization Requests (August 2014) provides, "Therapy services may be initiated upon receipt of the physician's order. Therapy services initiated before the date of the physician's order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.
The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
- If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.
  Note: A verbal order is considered current when the date received is on or not more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.
- A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.
  Note: A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Requested dates of service …"

TMPPM Children's Services Handbook, 2.14.3.3 Prior Authorization and Documentation Requirements (March 2016 and July 2015) provides, "… All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of therapy

- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy …"

TMPPM Children's Services Handbook, 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015) provides, "Therapy services may be initiated upon receipt of the physician's order. Therapy services initiated before the date of the physician's order will not be approved.
The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day will be denied for dates of service that occurred before the date that the request was received.
The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
- If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.
  Note: A verbal order is considered current when the date received is on or not more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.
- A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.
  Note: A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.
- A client-specific comprehensive treatment plan is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services

Requested dates of service …"

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 2: Insufficient Documentation (ID)

There was one instance of the medical record containing insufficient documentation to support the services that were billed and paid.

Example: Sample SN-195-C-037-A – There was a discharge note dated 10/15/2015; however, there was no documentation to support that speech therapy treatment was provided. There was no time in/out and no minutes of therapy, and no specific goals addressed for a ST service. Per TMPPM, Children's Services Handbook 2.14.3.3, Prior Authorization and Documentation Requirements, documentation must include start/stop times, total minutes of therapy, specific goals addressed in the session and the clients response to therapy. CPT code 92507 is defined as treatment of speech, language, voice, communication and/or auditory processing disorder; individual.

> *Rebuttal Medical Record Review:* The rebuttal comment from the Provider confirmed that this claim was billed in error. Additional documentation submitted indicated that the transaction was voided on 03/29/2018, after the Provider was notified of the audit results. However, there was no verification that the payment had been credited by THMP. The sample remains discrepant. See Appendix A and Appendix E.

Basis for Finding:

TMPPM Children's Services Handbook, 2.12 Therapy Services (CCP) (August 2014) provides, "… Providers must maintain a comprehensive treatment plan that includes documentation that supports medical necessity for therapy services and confirms that the client meets the criteria for acute services. The treatment plan must include all of the following:

- The specific procedures and disciplines to be used
- The amount, duration, and frequency of therapy
- The therapist who participated in developing the comprehensive treatment plan
- Rehabilitation potential of the client
- Functional limitations of the client
- Date client was last seen by the physician …"

Refer to *TMPPM Children's Services Handbook, 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014);* under Finding 1.

Refer to *TMPPM Children's Services Handbook, 2.12.3.3.1 Initial Prior Authorization Requests (August 2014);* under Finding 1.

Refer to *TMPPM Children's Services Handbook, 2.14.3.3 Prior Authorization and Documentation Requirements (March 2016 and July 2015);* under Finding 1

Refer to *TMPPM Children's Services Handbook, 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015)*; under Finding 1.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 3: <u>Non-Covered Service (NCS)</u>

There were two instances of the Provider billing and receiving payment for services not covered by Medicaid.

Example: Sample SN-574-C-045-B – There was no documentation to support that the ST service was delivered at the home setting. The ST clinic note of 07/31/2015 indicated the recipient was seen at a shopping mall. Per TMPPM Children's Services Handbook 2.14, OT, PT, and ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.

> *<u>Rebuttal Medical Record Review:</u>* The rebuttal comment from the Provider confirmed that there was no authorization for services outside of an approved setting. Additional documentation submitted indicated that the transaction was voided on 03/29/2018, after the Provider was notified of the audit results. However, there was no verification that the payment had been credited by THMP. The sample remains discrepant. See Appendix A and Appendix E.

Basis for Findings:

Refer to *TAC, Title 1, Part 15, Chapter 371, Subchapter G, Division 2, Rule 371.1653 Claims and Billing (effective 05/01/2016)*; under Finding 1.

TMPPM, Children's Services Handbook, 2.12 Therapy Services (CCP) (effective August 2014) provides, "… Therapy is provided in one of the following places of service:

- CORF and ORF
- Inpatient rehabilitation facility (freestanding)
- Home

- Licensed hospital
- Medicaid-enrolled private therapist office
- Physician office

… ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.
Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS in POS 9. …"

TMPPM, Children's Services Handbook, 2.14 Therapy Services (CCP) (effective July 2015 and March 2016) provides, "… Therapy is provided in one of the following places of service:

- CORF and ORF
- Inpatient rehabilitation facility (freestanding)
- Home
- Licensed hospital
- Medicaid-enrolled private therapist office
- Physician office

… ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.
Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS in POS 9. …"

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 4: <u>Non-Eligible Provider (NEP)</u>

There are seventeen instances of services being rendered by a non-eligible provider.

Example: Sample SN-435-C-083-A – The daily note of 04/14/2016 did not include the name and signature of the therapist. Per Texas Medicaid Provider Procedures Manual, Children's Services Handbook 2.14.3.3, all documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name.

Rebuttal Medical Record Review: The additional documentation submitted had a signature only from the SLP assistant. There was no documentation of supervision of the SLP assistant as required. Per Texas Medicaid Provider Procedures Manual, Children's Services Handbook 2.14, therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern. The sample remains discrepant; however the finding was changed from Insufficient Documentation to Non-Eligible Provider. See Appendix A and Appendix E.

Basis for Findings:

TMPPM, Children's Services Handbook, 2.12 Therapy Services (CCP) (effective August 2014) provides, "…Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.
Services performed by an … SLP aide, SLP orderly, SLP student, or SLP student, or SLP technician are not a benefit of Texas Medicaid. …"

TMPPM, Children's Services Handbook, 2.14 Therapy Services (CCP) (effective July 2015 and March 2016) provides, "…Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.
Services performed by an … SLP aide, SLP orderly, SLP student, or SLP student, or SLP technician are not a benefit of Texas Medicaid. …"

V. SUMMARY OF OVERPAYMENTS

The identified overpayments for the discrepant sampled claims totaled $2,973.08. See Appendix A for detailed information. See Appendix D for the extrapolation summary.

The total amount due to the Texas Health and Human Services Commission is $2,973.08.

NOTE: Actions resulting from this report and its directives do not take into consideration any subsequent program recoveries, Provider repayments, or Medicaid and Medical Assistance reimbursements, which relate to the period covered by this report.