
# Office of Inspector General

## Texas Health and Human Services Commission

**Stuart W. Bowen, Jr., Inspector General**

# Performance Audit Report

## Health Care Unlimited, Inc.

**August 31, 2015**

OIG Report No. 14-26-R-11-012905801-HH-01

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# Executive Summary

The Health and Human Services Commission (HHSC), Office of Inspector General (OIG), Audit Division, has completed its performance audit of services provided by Health Care Unlimited, Inc. under the Department of Aging and Disability Services' (DADS) Medically Dependent Children Program (MDCP).

## Background

The MDCP is a fee for service Medicaid Waiver Program administered by DADS for qualified children under age 21. The MDCP provides a variety of services to support families caring for children who are medically dependent, and encourages de-institutionalization of children who are currently receiving services in nursing facilities. Specific services include adaptive aids, flexible family support services, minor home modifications, respite, financial management services and transition assistance services.

The audit of the Provider covered the period September 1, 2012 through August 31, 2013. Payments to the Provider for the MDCP contract for the audit period totaled $754,914.79.

## Results

The audit of Health Care Unlimited, Inc. identified the following significant findings resulting in overpayments:

- Requirements for Recertification were Not Met
- Incomplete Clinical Records
- Missing Required Elements of Documentation

Our audit revealed overpayments of $37,152.06 from claims billed to the Texas Department of Aging and Disability Service's MDCP waiver program for the period September 1, 2012 through August 31, 2013.

In addition, the audit identified findings that were significant but did not result in overpayments:

- Review of payroll supporting documentation revealed inconsistent supervisory review.
- Review of personnel files found that the approved pay rate was missing for four out of twelve records sampled.

Management did not provide the audit team the detailed journal entries that resulted in the mid-year adjustments for revenue. Therefore, these adjustments could not be validated.

# DETAILED FINDINGS

## Finding 1: Requirements for Recertification Were Not Met

Forty-six claim details did not meet the requirements for recertification for continuation of services. Details of this finding are listed below:

- Eight claim details for three clients did not contain an updated six month Plan of Care (POC) for skilled tasks.
- Twenty-six claim details for twelve clients did not have a POC signed by the Registered Nurse (RN) prior to the start of care.
- The POCs for three claim details for two clients were dated by the RN at least eighteen days after the start of care.
- Three claim details for two clients did not have a POC dated by the RN.
- One claim detail for one client did not have a POC dated by the physician.
- One claim detail for one client did not have a POC signed by the physician prior to the start of care.
- Three claim details for two clients had incomplete Respite Service Authorization (RSA).
- One claim detail for one client was missing the RSA and the POC.

The POC and the RSA document the services and care to be provided to the client. The POC must be revised and updated at least every six months when skilled tasks are provided to a client. Additionally, the RSA must be complete.

The Provider billed and was paid $23,928.94 forty-six claim details in the sample.

### Criteria:

- *TAC Title 40, Part 1, Chapter 97, Subchapter D, Rule §97. 401*
- *TAC Title 40, Part 1, Chapter 51, Subchapter D, Rule §51.413*

### Recommendation:

The Provider should implement procedures to ensure that POCs and RSAs are prepared in compliance with the rules and regulations, accurately completed, and are kept in a client's clinical records. A process should be in place to make certain that the POC is signed and dated by the appropriate healthcare professionals prior to the start of care. The provider should reimburse $23,928.94 to DADS.

### Management Response:

*HCU's management has reviewed and is in agreement with the recommendations stated within the report.*

*TAC Title 40, Part 1, Chapter 97,Subchapter D,Rule 97.401requires a Plan of Care to be signed and approved by a practitioner in a timely manner. There is no defined time within this regulation that requires agencies to obtain a signed POC prior to the start of care. Health Care Unlimited has a policy in place to submit Plan of Cares to be approved and signed by a practitioner in a timely manner. A procedure has been implemented to ensure all POCs and RSAs are prepared accurately in accordance with rules and regulations. The MDCP Coordinator has been trained to review all admission and recertification paperwork for completeness prior to filing in the record.*

**Finding 2: Incomplete Clinical Records**

Eight claim details had incomplete clinical records. Details of this finding are listed below:

- Seven claim details for four clients were missing the Nursing Assessments.
- One claim detail for one client was missing the competency checklist for delegated attendant tasks.

Without a nursing assessment, it is not possible to determine if the POC addresses the medical needs or ensures the health and safety of the client, furthermore it is not possible to validate the hours submitted for reimbursement without acknowledgment of who is caring for the client. The competency checklist is vital to document that unlicensed personnel have been trained by the RN to provide delegated nursing tasks to the client as directed by the POC.

The Provider billed and was paid $4,403.82 for eight claim details in the sample population.

**Criteria:**

- *TAC Title 40, Part 1, Chapter 97, Subchapter C, Rule §97.301 Client Records,*
- *TMPPM Vol. 1, Texas Medicaid Provider Procedures Manual 2013, 1.6.3 Retention of Records and Access to Records and Premises*

**Recommendation:**

The provider should develop procedures including appropriate supervision and review to ensure documents such as nursing assessments, competency checklists, and service notes are in a client's clinical records. The provider should reimburse $4,403.82 to DADS.

**Management Response:**

*The MDCP Coordinator has been trained to review admissions, recertification and service delivery records to ensure that documentation is complete and accurate. Field staff will be alerted to incomplete records in a timely basis so that appropriate corrections can be made and the record is filed in the medical chart timely. Quarterly audits of the records will also identify missing or incomplete records.*

**Finding 3: Missing Required Elements of Documentation**

The service delivery records for three claim details for one client did not indicate the tasks assigned to the attendant.

A service delivery record documents assigned tasks and facilitates communication between the attendant, provider, and the primary caregiver regarding delivery of services. Accuracy of the service delivery record is necessary to document tasks as ordered on the POC, and ensure that care reflects the physician's orders. The Provider billed and was paid $1,084.38 for these three claim details.

**Criteria:**

- *TAC Title 40, Part 1, Chapter 51, Subchapter E, Rule §51.509*

**Recommendation:**

The provider should ensure that service delivery records are in a client's clinical record. The provider should reimburse $1084.38 to the DADS.

**Management Response:**

*See Finding 2 for management response.*

## Outliers

A random sample of items from the population was tested to determine the extent to which the Provider billed correctly for Medicaid claims. Fourteen claim details were identified as outliers (high-dollar) using standard statistical criteria and removed from the population. These claims were tested separately and the following issues were identified:

- Three claim details for one client did not contain an updated six month Plan of Care (POC) for skilled tasks. When skilled tasks are provided, the POC must be revised and updated at least every six months.
- Six claim details for two clients were missing the nursing notes. Nursing notes are required to document that care was provided as ordered by the physician and for reimbursement. The Provider indicates that four claim details were recognized as being submitted in error and that repayment was made for $4,691.02. However, the documentation submitted was not sufficient to substantiate the repayment.

The Provider billed and was paid $7,734.92 for nine claim details noted as exceptions.

**Criteria:**

- *TAC Title 40, Part 1, Chapter 97, Subchapter D, Rule §97. 401*
- *TAC Title 40, Part 1, Chapter 97, Subchapter C, Rule §97.301 Client Records*

**Recommendation:**

The Provider should implement procedures to ensure that POCs are prepared in compliance with the rules and regulations, accurately completed, and are kept in a client's clinical records. Additionally, the provider should develop procedures to ensure service notes are in a client's clinical records. The provider should reimburse $7,734.92 to DADS, or provide proof of reimbursement for the four claim details noted above and reimburse $3,043.90 for the remaining exceptions.

**Management Response:**

*None.*

# Appendices

**APPENDIX A**

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

The audit objectives were to determine whether the services billed by the Provider to the State's Medically Dependent Children Program waiver were allowable and the Provider followed pertinent rules.

Applicable criteria are contained in the Texas Medicaid Provider Procedures Manual, Texas Department of Aging & Disability Services Licensing Standards (Ch. 97), Health and Safety Code (Ch. 142 and Subchapter B), the Human Resources Code, 42 Code Federal Regulations 440.70, the Texas Administrative Code, Generally Accepted Accounting Principles, and the DADS policies and procedures.

This audit was conducted under the authority granted to OIG Audit in the Texas Government Code, Sections 531.102(h) (4) and Section 531.0241(4).

### Scope

The audit of the Provider covered the period September 1, 2012 through August 31, 2013. The scope of the audit included an examination of the services billed for Medicaid recipients, as authorized by the contract. In addition, OIG reviewed the related financial records of the Provider.

### Methodology

The methodology employed during this performance audit included reviewing and analyzing documentation, conducting test of accounting records, conducting interviews of operational and administrative personnel, observations, and other tests necessary to achieve the objectives of the audit.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and recommendations, based on our audit objectives. OIG believes that the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objective.

### Criteria Used

- Texas Medicaid Provider Procedures Manual (TMPPM)
- TMPPM Children's Services Handbook
- TAC Title 1, Part 15, Chapter 354
- TAC Title 1, Part 15, Chapter 355
- TAC Title 22, Part 11, Chapter 217

- TAC Title 40, Part 1, Chapter 51
- TAC Title 40, Part 1, Chapter 97
- DADS Licensing Standard, Chapter 97
- Texas Government Code, Section 531.102(h)(4)
- Texas Government Code, Section 531.0241(4)
- 42 CFR 440.70
- 42 CFR 484.18
- Nursing Practice Act of Texas
- Generally Accepted Accounting Principles
- DADS Policies and Procedures

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# APPENDIX B

## SAMPLING PROCEDURES AND RESULTS

### Sampling Frame

The sampling frame (population) was the Provider's claims paid by TMHP that had a "date of service" within the audit period September 1, 2012 through August 31, 2013. High-dollar outlier claims were identified using standard statistical criteria and removed from the population.

### Sample Unit

The sampling unit is a paid claim. A paid claim may include one or more claim details. Paid claims in this sample are for Medicaid services rendered to a Medicaid recipient by a contracted provider for which, a) TMHP paid the Provider, and b) have a "date of service" within the audit period September 1, 2012, through August 31, 2013.

### Sampling Procedures

OIG conducted its sampling methodology in accordance with guidance issued by the American Institute of Certified Public Accountants and Statements on Auditing Standards (SAS) Number 39. A random sample of items from the population was tested to determine the extent to which the Provider billed correctly for Medicaid claims. One hundred percent of all claims identified as outliers (high dollar) were tested separately. Questioned costs were calculated on a dollar for dollar basis.

### Testing Results

The tables below summarize the results of our claims testing:

**Population Sample**

| Sample Unit | Population | Error Rate | Sample | Exceptions |
|---|---|---|---|---|
| Dollars | $754,914.79 | 76.94% | $38,233.81 | $29,417.14 |
| Claim Details | 1,591 | 57.58% | 99 | 57 |

## Outlier Claims

| Sample Unit | Population | Error Rate | Sample | Exceptions |
|---|---|---|---|---|
| **Dollars** | N/A | 72.26% | $10,703.97 | $7,734.92 |
| **Claim Details** | N/A | 64.29% | 14 | 9 |

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## APPENDIX C

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