FINAL AUDIT REPORT

Jordan Health Services
Addison, TX

NPI NUMBER: 1598758302
TPI NUMBERS: 158219902 and 157246301

AUDIT/CASE TRACKING NUMBER
2017-TXIG003-HH-1598758302-09-07

DATE ISSUED
June 13, 2018

TABLE OF CONTENTS

I. AUDIT SUMMARY

On October 24, 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:	Jordan Health Services
NPI Number:	1598758302
TPI Numbers:	158219902 and 157246301
Address:	1510 E. Grande Blvd, Suite C Tyler, TX 75703-3978
Correspondence:	14295 Midway Road, Suite 400 Addison, TX 75001

Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited personal care assistance records to verify services provided to recipients, paid by Texas Medical Assistance (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:

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

- *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)

III. AUDIT PROCESS

This provider audit was conducted in the following manner:

Case Selection

For the audit of Medicaid 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 228 recipients with a total Medicaid payment of $3,462,103.11. From this universe, a total of 30 randomly selected recipients totaling $650,010.09 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 6, 2017. No original records were removed from the Provider's premises.

Additional documents necessary to complete the audit, which were not received with the original record submission, were requested on November 7, 2017 during the on-site Pre-Exit Conference.

An Exit Conference was held with the Provider on February 22, 2018 to review the Revised Draft Audit Report. In response to the Revised Draft Audit Report, the Provider submitted additional documentation to support the claims under review on February 8 and 14, 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. See Appendix D Extrapolation Summary for more information.

The audit population consisted of 228 recipients. The probability sample consisted of 30 randomly selected recipients totaling $650,010.09. All claims were itemized on Medicaid remittance advices to the Provider. Overpayments identified in the probability sample are extrapolated to the audit universe in accordance with *TAC, Title 1, Chapter 371, Subchapter B, Rule 371.35 Use of Statistical Sampling and Extrapolation (effective 05/01/2016)*. See Appendix C Sampling Plan and Appendix D Extrapolation Summary 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

Out of 10,112 claim lines reviewed, there were 1,262 claim lines with recoupable monetary findings. See Appendix A for the Audit Finding Index.

Finding 1: **Missing Documentation (MD)**

There were 1,262 instances of the medical record missing documentation required by Medicaid to support the claims billed and paid.

Example: Sample SN-190-C-333-D – The prior authorization covering 06/04/2016-12/12/2016 was not located in the medical record. Per TMPPM, Children's Services Handbook 2.11.3, prior authorization is required before services are provided.

Rebuttal medical record review: The TMHP prior authorization letter covering 06/04/2016-12/12/2016 was not located in the medical record. No additional rebuttal documentation for this claim was submitted. Per TMPPM, Children's Services Handbook 2.11.3, prior authorization is required before services are provided. The sample remains discrepant.

Example: Sample SN-221-C-001-A – The Practitioner Statement of Need (PSON) covering 01/01/2015-08/14/2015 was not located in the medical record as required. Per TMPPM, Children's Services Handbook 2.11.2.2.2, in the absence of primary practitioner medical record documentation and a PSON to support the client has a physical, cognitive or behavioral health condition impacting the client's ability to perform an ADL or IADL PCS, payment may be recouped. The PCS ongoing service plan covering 01/01/2015-08/14/2015 was not located in the medical record. Per TAC 47.45, the supervisor must develop a service delivery plan that is agreed upon and signed by the individual and the provider, must record the tasks which the individual is authorized to received, the total weekly hours authorized, service schedule, and frequency of supervisory visits.

Rebuttal medical record review: The PCS ongoing service plan covering 01/01/2015-08/14/2015 was not located in original or rebuttal record submitted. Per TAC 47.45, the supervisor must develop a service delivery plan that is agreed upon and signed by the individual and the provider, must record the tasks which the individual is authorized to received, the total weekly hours authorized, service schedule, and frequency of supervisory visits. The sample remains discrepant.

Example: Sample SN-218-C-169-M – Documentation of a supervisory visit was not located in the record as required. The PCA ongoing service plan indicated supervisory visits were to occur every six months and as needed. However, the last documented supervisory visit was on 06/22/2015; no documentation of a supervisory visit for December 2015 was located and there was no other documentation of a supervisory visit until 06/25/2016. Per 2.11.3.1, the PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements.

Rebuttal medical record review: No rebuttal documentation was submitted. The original determination stands. The sample remains discrepant.

Example: SN-225-C-455-C – The case information form dated 08/16/2016 (p. 31) indicated the recipient was hospitalized on 08/14/2016 and that services were placed on hold. There was no follow up documentation indicating the hospital discharge date and when services were to be resumed. Per TAC 47.71, the provider agency must notify the case manager of the date services resume within seven days after that date. The assignment of services/assignment of benefits form did not include signatures from the recipient's caregiver (p.6).

Rebuttal medical record review: No additional documentation was submitted to indicate when the recipient was discharged from the hospital and when care resumed. The sample remains discrepant.

Example: SN-25-C-009-I - The Practitioner Statement of Need (PSON) covering the date of service (DOS) was not located in the medical record as required. Per TMPPM, Children's Services Handbook 2.10.2.2.2, in the absence of primary practitioner medical record documentation and a PSON to support the client has a physical, cognitive or behavioral health condition impacting the client's ability to perform an ADL or IADL PCS, payment may be recouped. The PCS ongoing service plan covering the DOS was not located in the medical record. Per TAC 47.45, the supervisor must develop a service delivery plan that is agreed upon and signed by the individual and the provider, must record the tasks which the individual is authorized to received, the total weekly hours authorized, service schedule, and frequency of supervisory visits. Documentation of a supervisory visit was not located in the record as required. Per 2.10.3.1, the PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements.

Rebuttal medical record review: The Provider indicated during the Exit Conference that the record could not be located. The sample remains discrepant.

Example: SN-185-C-256-A – Timesheets from 01/01/15-12/31/15 were not located in the medical record. Per TMPPM, Children's Services Handbook 2.11.3.2, all attendants' arrival and departure times are documented with signature and time, and documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.

Rebuttal medical record review: No timesheets for 09/01/2015 through 09/27/2015 were submitted with the rebuttal documentation. The sample remains discrepant.

Basis for Findings:

TAC, Title 40, Part 1, Chapter 47, Subchapter D, Rule 47.45 Pre-Initiation Activities (effective 06/01/2009) provides, "… (2) The supervisor must develop a service delivery plan on a single document that:
(A) is agreed upon and signed by the individual and the provider;
(B) indicates the location of service delivery;
(C) records the following:
(i) the tasks which the individual is authorized to receive;
(ii) the total weekly hours of service DADS authorizes the individual to receive;
(iii) the service schedule, which must include as necessary, based on an individual's needs, certain time periods for delivery of specified tasks;
(iv) frequency of supervisory visits; …"

TAC, Title 40, Part 1, Chapter 47, Subchapter E, Rule 47.63 Service Delivery (effective 10/01/2013) provides, "… (g) Documentation of service delivery. The provider agency must:

(1) maintain documentation of service delivery in the individual's record; and …"

TAC, Title 40, Part 1, Chapter 47, Subchapter E, Rule 47.71 Suspensions (effective 10/01/2013) provides, "… (e) Resuming services after suspension. …
(2) The provider agency must notify the case manager of the date services resume within seven days after that date."

TMPPM, Children's Services Handbook, 2.10.2 Services, Benefits, and Limitations (effective August 2014) provides, "… PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client.
A responsible adult is an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage. …"

TMPPM, Children's Services Handbook, 2.10.2.2.2 The Primary Practitioner's Role in the PCS Benefit (effective August 2014) provides, "… In the absence of primary practitioner medical record documentation and a Practitioner Statement of Need to support the client has a physical, cognitive or behavioral health condition impacting the client's ability to perform an ADL or IADL PCS, payment may be recouped."

TMPPM, Children's Services Handbook, 2.10.3 Prior Authorization and Documentation Requirements (effective August 2014) provides, "Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients. …"

TMPPM, Children's Services Handbook, 2.10.3.1 PCS Provider Responsibilities (effective August 2014) provides, "… The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements."

TMPPM, Children's Services Handbook, 2.10.3.2 Documentation of Services Provided and Retrospective Review (effective August 2014) provides, "Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.

- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client."

TMPPM, Children's Services Handbook, 2.11.2 Services, Benefits, and Limitations (effective July 2015, March 2016, and February 2017) provides, "… PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client.
A responsible adult is an individual, 18 years of age or older, who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, step parents, foster parents, legal guardians, court-appointed managing conservators, and the primary adult who is acting in the role of parent. …"

TMPPM, Children's Services Handbook, 2.11.2.2.2 The Primary Practitioner's Role in the PCS Benefit (effective July 2015, March 2016, and February 2017) provides, "… If the client's medical record does not include the primary practitioner's documentation and a PSON that certifies that the client has a physical, cognitive or behavioral health condition that impacts the client's ability to perform an ADL or IADL, then PCS payments may be recouped.
… HHSC requires reassessment of the client's need for PCS every 12 months or when requested due to a change in the client's health or living condition. A new PSON will be required at each annual reassessment and where there is a change in the client's medical condition that may increase the need for services."

TMPPM, Children's Services Handbook, 2.11.3 Prior Authorization and Documentation Requirements (effective July 2015, March 2016, and February 2017) provides, "Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients. …"

TMPPM, Children's Services Handbook, 2.11.3.1 PCS Provider Responsibilities (effective July 2015, March 2016, and February 2017) provides, "… The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider's licensure requirements."

TMPPM, Children's Services Handbook, 2.11.3.2 Documentation of Services Provided and Retrospective Review (effective July 2015, March 2016, and February 2017) provides, "Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.

- Each page of the record documents the client's name and Medicaid identification number.
- All attendants' arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client."

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

V. SUMMARY OF OVERPAYMENTS

The identified overpayments for the discrepant sampled claims totaled $89,283.75. See Appendix A for detailed information. When extrapolated to the universe of claims from which the sample was selected, the calculated overpayment at the lower limit of 80% confidence interval is $255,563.00. See Appendix D for the extrapolation summary.

The total amount due to the Texas Health and Human Services Commission is $255,563.00.

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.