Final Audit Report

Santa Cruz Adult Day Care
1629197033

Report Date
June 29, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Background and Criteria

The Texas Health and Human Services Commission Office of the Inspector General (HHSC-OIG) contracted Myers and Stauffer LC (Myers and Stauffer) to conduct audits of Medicaid claims billed by providers and paid by the state Medicaid program. Santa Cruz Adult Day Care (Provider) was selected by the Texas HHSC-OIG for Myers and Stauffer to perform a claims audit. The audit focused on paid adult day care claims having dates of service during the period of September 1, 2016, through April 30, 2018.

Day Activity and Health Services (DAHS) facilities provide services to individuals residing in the community to prevent premature or unnecessarily prolonged placement in institutions. Services are designed to address the physical, mental, medical, and social needs of individuals through the provision of rehabilitative/restorative nursing and social services, which improve or maintain a person's level of functioning. The individual is able to remain in a family environment, thereby allowing the family a measure of normalcy for their daily activities.

Healthcare Common Procedure Coding System (HCPCS) procedure code S5101 is the appropriate code for a provider to utilize and bill when providing day care services for an adult, per half day. Claims for adult day care services should comply with the Texas Administrative Code (TAC) and the DAHS Provider Manual.

Audit Objective

The objective of the claims audit was to determine whether adult day care claims billed to, and paid under, the state Medicaid program were in accordance with applicable state and federal Medicaid laws, regulations, rules, policies, and contractual requirements. The specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements to be tested were agreed to by the Texas HHSC-OIG in the approved audit test plan.

Sampling Overview

Adult day care services are typically “span billed”, meaning one claim line may include multiple dates of service. As a result, Myers and Stauffer performed a procedure to expand the claims universe in order to separately identify individual units of service (half dates of service) that could be audited. Doing so reduced the burden on the Provider and the Texas HHSC-OIG while creating a more efficient and effective audit — including the ability to develop a statistically valid random sample upon which the audit results can be extrapolated.

The procedure Myers and Stauffer performed focused on the number of units of service paid in relation to the number of weekdays on the claim line in question. This resulted in each claim line being labeled as one of the following three types: Half Days, Full Days, and Other.

- **Half Days:** Indicates a 1:1 ratio of units of service billed to weekdays on the claim line. (e.g., 1 unit of service billed on claim line with 1 date of service indicating a half-day [1 unit] of service was provided on the weekday.)

- **Full Days:** Indicates a 2:1 ratio of units of service billed to weekdays on the claim line. (e.g., 10 units of service billed on claim line with 5 dates of service indicating a full-day [2 units] of service was provided for each weekday.)
- **Other:** Indicates ratios other than 1:1 or 2:1, meaning auditors would not be able to determine how audited unit(s) of service may or may not be applied to a particular date of service on the claim line.

The final claims universe only included claims that were labeled within the Half Days or Full Days categories. Claims in the Other category were excluded from the audit universe.

A statistically valid random sample was selected from the Half Days and Full Days labeled claims (claims universe) provided by the Texas HHSC-OIG. The universe included 24,644 units of service during the period of September 1, 2016, through April 30, 2018. The Provider was reimbursed a total of $393,405 for services provided to 47 unique recipients. The sample included 38 unique recipients with 105 units of service during the period of review. The Provider was reimbursed a total of $1,675 for these 105 units of service.

Audit Process

Scope

The scope of this audit includes the review of individual units of service of HCPCS procedure code S5101 billed and paid for dates of service during the period of September 1, 2016, through April 30, 2018.

In gaining an understanding of internal controls, we limited our review to the Provider's overall internal control structure significant to the audit objective. We determined significant internal controls to the audit objective included:

- **Control Environment:** The foundation for an internal control system. It provides the discipline and structure to help an entity achieve its objectives.
- **Control Activities:** The actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system, which includes the entity's information system.
- **Monitoring:** Activities management establishes and operates to assess the quality of performance over time and promptly resolve the findings of audits and other reviews.

Methodology

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS) and applicable TAC rules, including 1 TAC §371.1719, as appropriate. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to

provide a reasonable basis for our findings and conclusions based on our audit objectives. Audit testing was performed to verify compliance in the following areas:

- Facility Level:
    - *Verify the facility was providing service at least 10 continuous hours each day, five days a week (Monday through Friday), except for published holidays by obtaining and reviewing documentation to support hours during the period under review.*
    - *Verify proper credentials and qualifications were met for staff providing services during the period under review by obtaining and reviewing personnel records.*
    - *Verify the Provider performed employee background checks, as well as searches of the Employee Misconduct Registry and Nurse Aide Registry, prior to the offer of employment during the period under review by obtaining and reviewing personnel records. If unable to verify these items were performed by the Provider, we will perform:*
        - *A search of the Employee Misconduct Registry on the Department of Aging and Disability Services website to verify.*
        - *A search of the Nurse Aides Registry to verify.*
    - *Verify facility was operating within licensed capacity by obtaining and reviewing the provider enrollment agreement or similar documentation to compare with attendance and staffing records for dates sampled.*
    - *Verify the facility participates in the Child and Adult Care Food Program (CACFP) per the CACFP contract and Letter of Participation during the period under review.*
    - *Verify food service was provided by obtaining and reviewing a menu for a sample month(s) within the period under review.*
    - *Verify social activities were provided of at least three activities per day per the review of the social activities calendar for a sample month(s) within the period under review.*
    - *Verify compliance with transportation requirements by obtaining and reviewing daily transportation and mileage records for a sample month(s), vehicle inspection report, and vehicle registration form during the period under review.*
- Claims Level:
    - *Verify individuals were receiving and signing individual rights in a language understood by obtaining and reviewing records for the sampled individuals.*
    - *Verify services were supported by required DAHS forms by obtaining and reviewing the following for the sampled individuals:*
        - *Health Assessment/Plan of Care/Individual Service Plan (Form 3050 or similar).*

- *Prior Approval form (Form 2101) legibly signed by a credentialed nurse.*
- *Physician Orders (Form 3055) legibly signed by a Medicaid participating physician and not stamp dated.*

- *Verify services were accurate and sufficiently detailed to document the extent of services provided by obtaining and reviewing individual files and service delivery records for the sampled individuals.*
- *Verify services were billed appropriately by obtaining and reviewing that the individual health assessment plans of care, facility attendance records, and claims data during the period under review met the following:*
  - *Three to six hours = one unit of service; greater than six hours = two units of service.*
  - *No more than 10 units of service per week.*
  - *No less than three units of service per week.*
  - *Maximum in calendar month is 46 (within 23 calendar days).*
- *Verify facility was operating with the required ratio of staff to individuals by obtaining and reviewing attendance and staffing records to compare with claims data for dates sampled.*
- *Verify services were not billed after an individual's death, and services were appropriately suspended.*

Inquiries, observations, inspection of documents and records, review of other audit reports, and/or direct tests were performed to assess the design, implementation, and operating effectiveness of controls determined significant to the audit objectives stated in the scope.

Based on the work performed, deficiencies in internal control were identified. It does not appear that the Provider has controls in place to adequately review, document, and retain records to support that the billed services were provided in accordance with required regulations. A lack of policies and/or oversight of established policies creates an environment in which management or personnel are unable to achieve the applicable control objectives and address related risks.

Audit Results

We believe the evidence obtained during the course of the claims audit provides a reasonable basis for the findings and conclusions based on the audit objective. The audit was not intended to discover all possible errors and any errors not identified within this report should not lead to a conclusion the practice is acceptable. Due to the limited nature of the review, no inferences should be drawn from this report with respect to the Provider's overall level of performance.

Findings

Myers and Stauffer identified findings on 68 of 105 Medicaid paid units of service. One unit may have multiple Findings Types. The list of findings and supporting policy follows in the table below.

List of Findings and Supporting Policy

Finding No.	Findings Type	Finding Definition	Number of Units of Service with Finding	Supporting Policy
1	Late Rights	Documentation does not demonstrate that the recipient was informed of his/her rights prior to the date of service.	8	40 TAC §98.202 (6)
2	Late Forms	Documentation does not demonstrate that the required DAHS forms were approved prior to the date of service.	2	40 TAC §98.204 (a), (b), (c), and (d) DAHS Provider Manual §5213
3	Annual Physician (Phys.) Orders	Documentation does not demonstrate that Physician Orders were approved annually.	35	https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-3055-physicians-orders-dahs
4	Ratio	The facility the recipient attends failed ratio testing on the date of service under review.	40	40 TAC §98.211(b) DAHS Provider Manual §4300
5	Missing Service (Svc.) Notes	Documentation of service delivery was not submitted or failed to meet State requirements.	4	DAHS Provider Manual §6260 40 TAC §98.206

A lack of internal controls has also been identified as a contributing cause of all findings included in the table above.

- For findings one, two, three, and five, the Provider has not placed sufficient emphasis on designing, implementing, and/or effectively operating internal controls. Appropriate internal controls include either having policies in place to ensure DAHS forms and other documentation are reviewed for compliance prior to providing/billing for services, and/or ensuring applicable policies are being implemented and operating effectively. During the Provider's entrance

conference, the Provider's point of contact indicated facility directors and registered nurses are responsible for reviewing documentation for compliance to include monthly nursing notes and overall accuracy of billing. However, based on the findings, this undocumented process described during the entrance conference does not appear to be effective.

- For finding four, the Provider has not placed sufficient emphasis on designing, implementing, and/or effectively operating internal controls to ensure that all the Provider's locations were adequately staffed (at least one staff for every eight recipients, pursuant to State policy) when providing services. Based on information provided verbally by the Provider's point of contact during the audit, it appeared that the Provider either does not have a policy to ensure compliance for adequate staffing, or any applicable policies are not being implemented and/or monitored for effectiveness.

Recommendations

The facility-level testing performed during this audit did not result in findings with corresponding overpayment determinations; however, testing did identify the following:

- The Provider did not submit documentation to demonstrate that all employee qualification requirements have been met.
- The Provider no longer maintains the registration information for vehicles utilized in the performance of services included within the period of review.

Although these items did not result in findings with corresponding overpayment determinations, Myers and Stauffer recommends the Provider conduct a review of their internal control processes in order to prevent the occurrence of these items moving forward. Applicable policies pertaining to the above recommendations can be found in Appendix B of this report.

Management's Response

A draft copy of this report was sent to the Provider on April 16, 2021. The Provider responded on April 28, 2021. In its response, the Provider objected to the questioned claim lines and submitted additional documentation for the claims by submitting additional physician orders, signed bill of rights documents, signed plans of care, service notes, and employee time sheets. An exit conference was held on April 30, 2021, to discuss the preliminary findings.

Revised Findings Based on Management's Response

After reviewing the Provider's response and the additional documentation submitted, we revised the findings, resulting in the number of questioned Medicaid paid units decreasing from the 96 identified in the Preliminary Draft Audit Report to 68 Medicaid paid units of service. Findings were revised as follows:

- The Provider submitted recipient-signed bill of rights records that removed 1 finding for missing rights documentation and 17 findings for the rights documentation being dated later than the date of service under review.
- The Provider submitted copies of recipient physician orders and plans of care that removed 24 findings for late forms, 1 finding for a missing form, and 18 findings for annual physician orders not being documented.
- The Provider submitted employee time sheets that removed 26 findings for failed ratio testing.
- The Provider submitted a monthly nursing note that removed 1 finding for a missing service note.

Final Determination of Overpayment

The Medicaid paid units of service with identified findings are listed in detail in Appendix A of this report. The corresponding overpayment amount in Appendix A is only applicable to the sampled units of service Myers and Stauffer reviewed during the audit. The overpayment calculated from our sample is $1,085.

The total overpayment has been determined using extrapolation. Extrapolation was used as appropriate according to the 1 TAC §371.35. The estimated extrapolated overpayment is $230,973. The calculation of the estimated extrapolated overpayment is documented in Appendix C.

Appendix A-1 – Detailed Findings

Santa Cruz Adult Day Care
Project Number 006
NPI 1629197033

Population Line Number	Participant ID	Participant Name	Claim Number	Claim From Date	Claim To Date	Procedure Code	Procedure Modifier	Date of Service Under Review	Paid Amount for Unit on Date of Service Under Review	Overpayment Amount	Finding Type	Required DAHS Forms that were late (if applicable)	Supporting Policy Reference
[redacted]		[redacted]				S5101	U1	[redacted]	$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, MISSING SVC NOTES	N/A	G, H, K
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	LATE FORMS, ANNUAL PHYS ORDERS	FORM 3055	B, K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	LATE RIGHTS, ANNUAL PHYS ORDERS, RATIO	N/A	A, I, J, K
						S5101	U1		$16.00	$16.00	LATE RIGHTS, ANNUAL PHYS ORDERS	N/A	A, K
						S5101	U1		$16.00	$16.00	LATE RIGHTS, ANNUAL PHYS ORDERS	N/A	A, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	LATE RIGHTS, ANNUAL PHYS ORDERS	N/A	A, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, MISSING SVC NOTES	N/A	G, H, K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	LATE RIGHTS, MISSING SVC NOTES, RATIO	N/A	A, G, H, I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS	N/A	K

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	[redacted]					S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	LATE RIGHTS, RATIO	N/A	A, I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$15.76	$15.76	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	ANNUAL PHYS ORDERS, RATIO	N/A	I, J, K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
						S5101	U1		$16.00	$16.00	LATE RIGHTS	N/A	A
						S5101	U1		$16.00	$16.00	LATE RIGHTS, LATE FORMS, ANNUAL PHYS ORDERS, MISSING SVC NOTES	FORM 3055	A, B, G, H, K
						S5101	U1		$16.00	$16.00	RATIO	N/A	I, J
Total									**$1,085.12**	**$1,085.12**			

Appendix A-2 – Detailed Findings Legends

Finding Type	Definition
LATE RIGHTS	Documentation does not demonstrate that the recipient was informed of his/her rights prior to the date of service.
LATE FORMS	Documentation does not demonstrate that the required DAHS forms were approved prior to the date of service.
ANNUAL PHYS ORDERS	Documentation does not demonstrate that Physician Orders were approved annually.
RATIO	The facility the recipient attends failed ratio testing on the date of service under review.
MISSING SVC NOTES	Documentation of service delivery was not submitted or failed to meet State requirements.

Finding Type	Supporting Policy Reference(s)
LATE RIGHTS	A
LATE FORMS	B, C, D, E, F
ANNUAL PHYS ORDERS	K
RATIO	I, J
MISSING SVC NOTES	G, H

Supporting Policy	Policy	Reference
TAC Sub H 98.202 (6)	A DAHS facility must: ... (6) advise the individual of the individual's rights in a language the individual understands, provide the individual with a signed copy, and maintain the original in the record.	A
TAC Sub H 98.204 (a), (b), (c), and (d)	(a) The applicant may be admitted to a day activity and health services DAHS facility as soon as verbal physician's orders are obtained if he appears to: (1) be Medicaid eligible; and (2) meet the medical/functional need criteria based on the information collected on DADS' Client Health Assessment/Plan of Care form. (b) When a DAHS facility initiates a referral: (1) the DAHS facility interviews the applicant to determine whether he appears to be Medicaid eligible. The DAHS facility determines Medicaid eligibility by reviewing the information on the applicant's Medical Care Identification Card; (2) the nurse: (A) conducts a health assessment/plan of care to determine whether the applicant appears to have a medical need for the service. The nurse determines medical need by completing DADS' Client Health Assessment/Plan of Care form; and (B) obtains verbal or written physician orders, if the applicant appears to meet the medical/functional need criteria; (3) the DAHS facility verbally notifies the DADS caseworker or intake unit of the placement the day the applicant contacts the DAHS facility. The DAHS facility follows up the notification in writing within seven days using DADS' Case Information form. This verbal notification is a request for community services and supports. (c) The DAHS facility must request written prior approval for the applicant from the regional nurse within 30 days after the date of the physician orders. (d) If the DAHS facility fails to submit prior approval forms or additional documentation within required time frames, if the additional documentation is not adequate, or if the applicant is determined ineligible by the DADS caseworker, the regional nurse cancels the DAHS facility-initiated prior approval and the DAHS facility is not reimbursed for services.	B

Appendix A-2 – Detailed Findings Legends

Finding Type	Definition
LATE RIGHTS	Documentation does not demonstrate that the recipient was informed of his/her rights prior to the date of service.
LATE FORMS	Documentation does not demonstrate that the required DAHS forms were approved prior to the date of service.
ANNUAL PHYS ORDERS	Documentation does not demonstrate that Physician Orders were approved annually.
RATIO	The facility the recipient attends failed ratio testing on the date of service under review.
MISSING SVC NOTES	Documentation of service delivery was not submitted or failed to meet State requirements.

Finding Type	Supporting Policy Reference(s)
LATE RIGHTS	A
LATE FORMS	B, C, D, E, F
ANNUAL PHYS ORDERS	K
RATIO	I, J
MISSING SVC NOTES	G, H

Supporting Policy	Policy	Reference
DAHS Provider Manual §5211	A DAHS facility licensed nurse must complete the health assessment for each referral. The assessment may be conducted by an RN or LVN, dependent on the individual's presenting health conditions. The DAHS facility nurse completes the health assessment using Form 3050, DAHS Health Assessment/Individual Service Plan, Sections II and Section III.	C
DAHS Provider Manual §5212	Form 3050, DAHS Health Assessment/Individual Service Plan, Section IV, is completed at the same time Form 3050, Section II and Section III are completed by the facility nurse. A New ISP is completed for individuals who need initial prior approval; or who transfer by the receiving facility... A Provider must ensure the individual service plan (ISP) documentation of treatments, monitoring and intervention ordered by the physician, including the indicated frequency, and all medications, whether taken at the DAHS facility or at the individual's home, must be documented to include dosage, route and frequency. A provider must ensure that all treatments, skilled care and medications indicated on the ISP match the physician's orders or supplemental orders.	D
DAHS Provider Manual §5213	A new Form 3055, Physician's Orders (DAHS), is needed upon initial request for DAHS... Physician's orders are required for individuals receiving DAHS under Title XIX and Title XX	E
DAHS Provider Manual §5220	When the DADS regional nurse receives the required forms from the DAHS facility, he reviews Form 2059, Summary of Client's Need for Service, Form 3050, DAHS Health Assessment/Individual Service Plan, and Form 3055, Physician's Orders (DAHS), to determine if the individual meets the DAHS medical eligibility criteria found in Section 3200, Medical Criteria. For case manager initial cases, the DADS regional nurse establishes the beginning date of coverage on Item 4 of Form 2101, Authorization for Community Care Services, as the date Form 2101 is expected to be mailed to the provider. If this date is not feasible, the regional nurse negotiates the beginning date of coverage on Item 4 of Form 2101 with the provider and DADS case manager according to the individual's needs and the individual's unique circumstances. The DADS regional nurse determines if a condition qualifies as a chronic medical condition. The DADS regional nurse may contact the individual's physician to discuss the individual's condition and the approximate length of time needed for full recovery. Within seven days of the receipt of the prior approval request, the regional nurse uses Form 2101 to notify the provider about approval or denial of routine cases. The DADS regional nurse approves prior approval if the: individual meets the medical eligibility criteria specified; and documentation from the provider that contains no critical omissions or errors. The regional nurse sends: copies of Form 2101 to the provider and DADS case manager when granting prior approval; and copies of Form 2101 in denial of prior approval in an initial case to the provider and the case manager. If services are denied, the case manager sends the individual a written notification	F
DAHS Provider Manual §6260	DAHS providers are responsible for maintaining records pertinent to the services for which a claim or cost report is submitted. Form 3050, DAHS Health Assessment/Individual Service Plan, requires providers to document treatments, monitoring and interventions, including the frequency for each. The DAHS provider may use monthly nursing notes, daily progress notes or other forms of clinical documentation, such as medication logs, to meet documentation requirements.	G

Appendix A-2 – Detailed Findings Legends

Finding Type	Definition
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ANNUAL PHYS ORDERS	Documentation does not demonstrate that Physician Orders were approved annually.
RATIO	The facility the recipient attends failed ratio testing on the date of service under review.
MISSING SVC NOTES	Documentation of service delivery was not submitted or failed to meet State requirements.

Finding Type	Supporting Policy Reference(s)
LATE RIGHTS	A
LATE FORMS	B, C, D, E, F
ANNUAL PHYS ORDERS	K
RATIO	I, J
MISSING SVC NOTES	G, H

Supporting Policy	Policy	Reference
TAC Sub H 98.206	The DAHS facility must provide services that include the following: (1) Nursing services... (2) Physical rehabilitative services... (3) Nutrition/food service... (4) Other supportive services. Other supportive services must include: (A) community interaction, cultural enrichment, educational or recreational activities, and other social activities on site or in the community in a planned program to meet an individual's social needs and interests... (5) Transportation services.	H
TAC Sub H 98.211(b)	The DAHS facility is not entitled to payment if: (1) the DAHS facility fails to submit prior approval forms or supporting to the regional nurse within the required time frames for DAHS facility initiated referrals; (2) the DAHS facility did not maintain the staff-client ratio for one or more days; (3) the DAHS facility exceeded its license capacity; or	I
DAHS Provider Manual Section 4300	To safeguard the health and safety of individuals, a certain number of direct service staff must be present at the facility at all times. The number of staff required is determined by the number of individuals present each day, but must be at least one care giver to every eight individuals served. Direct service staff include the director, licensed nurse, activity director and attendants. A provider must maintain the required staff-individual ratio at the facility at all times. For staffing purposes, any individuals receiving DAHS, including DADS individuals and/or private-pay individuals, are included in the ratio. Although the staff-individual ratio does not apply when individuals are in transit, the provider must assure the	J
https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-3055-physicians-orders-dahs	Form 3055 is completed for: •initial and annual approval for DAHS; •new orders as determined by the DAHS nurse or member's managed care organization (MCO) due to changes in the individual's/member's condition; and •new supplemental physician's orders for nursing services	K

Appendix B – Facility Recommendations

Santa Cruz Adult Day Care Project Number 006 NPI 1629197033	
Recommendation Type	**Supporting Policy Reference**
DOC RETENTION - EMPLOYEES	L, M, N, O, P
DOC RETENTION - VEHICLES	Q

Legends

Recommendation Type	Definition
DOC RETENTION - EMPLOYEES	Provider did not submit documentation to support all employee qualifications are being met. A recommendation will be included in the audit report that the provider retain records in accordance with state policy.
DOC RETENTION - VEHICLES	Provider no longer has the registration information for vehicles used during period of review. A recommendation will be included in the audit report that the provider retain records in accordance with state policy.

Supporting Policy	Policy	Reference
TAC Sub H 98.209(a)	(a) Personnel records. The DAHS facility must keep personnel records in a central location in the DAHS facility. Personnel records include staff qualifications, performance reports, attendance, and staff development records. The DAHS facility must maintain these documents and records according to the retention requirements. The DAHS facility must document staff coverage for days when regular staff are away from the DAHS facility on sick or vacation leave.	L
TAC Sub D 98.62(a)(1), & (3)	Director. A facility must employ a director. (A) The director must: (i) have graduated from an accredited four-year college or university and have no less than one year of experience in working with people in a human service or medically related program, or have an associate degree or 60 semester hours from an accredited college or university with three years of experience working with people in a human service or medically related program; (ii) be an RN with one year of experience in a human service or medically related program; (iii) meet the training and experience requirements for a license as a nursing facility administrator under Texas Administrative Code (TAC), Title 40, Chapter 18, Nursing Facility Administrators; or (iv) have met, on July 16, 1989, the qualifications for a director required at that time and have served continuously in the capacity of director since that date. (B) The director must show evidence of 12 hours of annual continuing education in at least two of the following areas: (i) individual and provider rights and responsibilities, abuse, neglect, exploitation and confidentiality; (ii) basic principles of supervision; (iii) skills for working with individuals, families, and other professional service providers; (iv) individual characteristics and needs; (v) community resources; (vi) basic emergency first aid, such as cardiopulmonary resuscitation (CPR) or choking; or (vii) federal laws, such as Americans with Disabilities Act, Civil Rights Act of 1991, the Rehabilitation Act of 1993, and the Family and Medical Leave Act of 1993. (3) Activities director. A facility must employ an activities director. (A) Except as provided in subparagraph (B) of this paragraph, an activities director must have graduated from a high school or have a certificate recognized by a state of the United States as the equivalent of a high-school diploma and have: (i) a bachelor's degree from an accredited college or university, and one year of full-time experience working with elderly people or people with disabilities in a human service or medically related program; (ii) 60 semester hours from an accredited college or university, and two years of full-time experience working with elderly people or people with disabilities in a human service or medically related program; or (iii) completed an activities director's course, and two years of full-time experience working with elderly people or people with disabilities in a human service or medically related program. (B) An activities director hired before May 1, 1999,with four years of full-time experience working with elderly people or people with disabilities in a human service or medically related program is not subject to the requirements of subparagraph (A) of this paragraph.	M
DAHS Provider Manual Section 4110, 4120, 4130	A provider must have a director who is responsible for the overall management of the day activity and health services program. A licensed vocational nurse (LVN) may qualify to serve as a director only if he meets the qualifications for director. An LVN without a degree does not qualify. To qualify for director, the director must have worked for the required time with people in a human service or medically related program. The definitions in the adult day care and adult day health care licensing standards provide guidelines for determining a person's qualifications to be a facility director. Each applicant must be considered individually. 4120 Activities Director Revision 14-2; Effective November 7, 2014 A provider must have an activities director who is responsible for planning and directing the daily program of activities. The activities director must meet qualifications listed in §98.62 (a)(3), Program Requirements, concerning staff qualifications. 4130 Nurse Revision 14-2; Effective November 7, 2014 A provider must have a nurse who is responsible for assessing the individual's initial and continued medical needs, developing an individual's plan of care, etc. The nurse may also fulfill the functions of the director if he meets the qualifications for director.	N

Appendix B – Facility Recommendations

Santa Cruz Adult Day Care Project Number 006 NPI 1629197033	
Recommendation Type	**Supporting Policy Reference**
DOC RETENTION - EMPLOYEES	L, M, N, O, P
DOC RETENTION - VEHICLES	Q

Legends

Recommendation Type	Definition
DOC RETENTION - EMPLOYEES	Provider did not submit documentation to support all employee qualifications are being met. A recommendation will be included in the audit report that the provider retain records in accordance with state policy.
DOC RETENTION - VEHICLES	Provider no longer has the registration information for vehicles used during period of review. A recommendation will be included in the audit report that the provider retain records in accordance with state policy.

Supporting Policy	Policy	Reference
40 TAC Sub D 98.61 (b)(3)	(3) before offering employment, search the employee misconduct registry (EMR) established under §253.007, Health and Safety Code, and the DADS nurse aide registry (NAR) to determine if an individual is designated in either registry as unemployable. Both registries can be accessed on the DADS Internet website. (A) A facility must not employ a person who is listed as unemployable in either registry. (B) A facility must provide information about the EMR to an employee in accordance with §93.3 of this title (relating to Employment and Registry Information). (C) In addition to the initial search of the EMR and NAR, a facility must: (i) conduct a search of the NAR and EMR to determine if the employee is designated in either registry as unemployable as follows: (I) for an employee most recently hired before September 1, 2009, by August 31, 2011 and at least every twelve months thereafter; and (II) for an employee most recently hired on or after September 1, 2009, at least every twelve months; and (ii) keep a copy of the results of the initial and annual searches of the NAR and EMR in the employee's personnel file;	O
DAHS Provider Manual Section 4400	House Bill 1510 requires that persons convicted of certain crimes may not be employed in most facilities and agencies providing care to the aged and disabled. Therefore, criminal history checks on certain employees must be performed prior to an offer of employment except in emergency situations. The law requiring criminal history checks provides protection of confidentiality, which prevents a provider or DADS from sharing the results of a criminal history check with anyone. Information obtained as a result of a criminal history check may not be shared with anyone except the employee affected and DADS. If a provider receives inquiries from an individual, individual's family, potential employer or other interested parties, explain the following: that the provider is required by law to conduct criminal history checks on all attendants; that the provider is complying with the law; and that the provider is being monitored for compliance with the law. A provider must not share the reason for termination of the attendant with an individual or an individual's family if the termination is the result of a criminal history check. If the attendant shares the information with an individual, the provider may not confirm the reason for termination. Procedures for conducting criminal history checks may be found in Appendix VII, Criminal History Check of Employees in Certain Agencies/Facilities Serving the Elderly or Persons with Disabilities.	P
TAC Sub H 98.206 (5)(D)	(5) Transportation services. (D) Vehicles used for transportation services must: (i) be properly operated and maintained in accordance with state law; (ii) have current inspection and registration; (iii) have proper heating and cooling systems to maintain reasonable temperature levels inside the vehicle; (iv) have working seatbelts for each individual unless the vehicle was manufactured without seatbelts; (v) have a method to secure a wheelchair to ensure an individual's safety during transit; and (vi) if equipped with a wheelchair lift, have a properly operated and maintained lift.	Q

Appendix C – Extrapolated Overpayment Summary

Santa Cruz Adult Day Care Project Number 006 NPI 1629197033										
A	B	C	D	E	F	G	H	I	J	K
Strata	Universe Size (in Units)	Universe Reimbursements	Universe Weight	Sample Size	Sample Units in Error	Sample Error Rate (F/E)	Total Sample Overpayment	Average Sample Overpayment per Unit (H/E)	Extrapolated Overpayment - Point Estimate	Extrapolated Overpayment - Lower Bound[1]
S5101	24,644	$393,404.72	100.00%	105	68	64.76%	$1,085.12	$10.33	$254,683.00	$230,973.00
Totals	**24,644**	**$393,404.72**	**100.00%**	**105**	**68**	**64.76%**	**$1,085.12**			**$230,973.00**

Sample Design Summary	
Criteria	
Universe	24,644 Units
Confidence Level	One-Sided 90%
Sample Size	105

[1] Per Chapter 8.4.5.1 of the Medicare Program Integrity Manual, the lower limit of a one-sided 90 percent confidence interval was utilized to arrive at the extrapolated overpayment amount.