



May 4, 2015

Mr. Edward Brown
Service Coordinator Supervisor
HCBS Service Coordination, Inc.
347 West Main Street
Trappe, Pennsylvania 19426

Dear Mr. Brown:

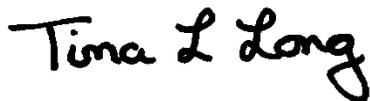
I am enclosing for your review the final audit report of HCBS Service Coordination, Inc. as prepared by the Division of Audit and Review (DAR). Your response has been incorporated into the final report and labeled as an Appendix. The report covers the period from January 1, 2013 to June 30, 2014.

I would like to express my appreciation for all of the courtesy extended to my staff during the course of the fieldwork. I understand that your staff was especially helpful to Joseph Piccolo in completing the audit process.

The final report will be forwarded to the Department's Office of Long Term Living (OLTL) to begin the Department's resolution process concerning the report's contents. The staff from OLTL will be in contact with you to follow-up on the actions taken to comply with the report's recommendations.

If you have any questions concerning this matter, please contact David Bryan, Audit Resolution Section at [REDACTED].

Sincerely,



Tina L. Long, CPA
Director

Enclosure

c: Mr. Jay Bausch
Mr. Grant Witmer
Ms. Kim Nagle
Mr. Michael Luckovich
Ms. Angela Episale
Ms. Jennifer Whalen

bc: Mr. Alexander Matolyak
Mr. Daniel Higgins
Mr. David Bryan
Mr. Grayling Williams
Ms. Shelley Lawrence
SEFO Audit File (S1401UL)

Some information has been redacted from this audit report. The redaction is indicated by magic marker highlight. If you want to request an unredacted copy of this audit report, you should submit a written Right to Know Law (RTKL) request to DHS's RTKL Office. The request should identify the audit report and ask for an unredacted copy. The RTKL Office will consider your request and respond in accordance with the RTKL (65P.S. §§ 67.101 et seq.) The DHS RTKL Office can be contacted by email at: rapwrkl@pa.gov.

May 4, 2015

Mr. Brendan Harris, Executive Deputy Secretary
Department of Human Services
Health & Welfare Building, Room 334
Harrisburg, Pennsylvania 17120

Dear Deputy Secretary Harris:

In response to a request from the Office of Long Term Living (OLTL), the Bureau of Financial Operations (BFO) initiated an audit of HCBS Service Coordination, Inc. (HCBS). The audit was designed to investigate, analyze and make recommendations regarding the reimbursements from the Provider Reimbursement and Operations Management Information System (PROMISe) for client care. Our audit covered the period from January 1, 2013 to June 30, 2014 (Audit Period).

This report is currently final form and therefore does contain HCBS views on the reported findings, conclusions and recommendations.

Executive Summary

HCBS provides supports coordination and transportation services through waiver programs, such as the OBRA, Independence and Attendant Care waivers which are funded by OLTL. HCBS employed only one Supports Coordinator (SC) during the audit period.

The report findings and recommendations for corrective action are summarized below:

FINDINGS	SUMMARY
<p>Finding No. 1 – Paid Claims Did Not Have Adequate Documentation to Support the Services That Were Billed</p>	<p>A statistically valid random sample (SVRS) of PROMISe paid claims was tested for adequacy of supporting documentation. The errors that were identified included overbilled and under billed claims. The total questioned costs related to these errors are \$42,167.</p>
HIGHLIGHTS OF RECOMMENDATIONS	
<p>OLTL should:</p> <ul style="list-style-type: none"> • Recover \$42,167 from HCBS for claims that were inadequately documented and/or overbilled. <p>HCBS should:</p> <ul style="list-style-type: none"> • Ensure that claims are accurate and are adequately supported by the required documentation before billing. 	

**HCBS Service Coordination, Inc.
January 1, 2013 to June 30, 2014**

FINDINGS	SUMMARY
Finding No. 2 – Claims Submitted as Adjustments Could Not be Supported Through Adequate Documentation	HCBS filed PROMISe claim adjustments on several dates. The documentation presented was not adequate to support the additional submission of claims for payment. The total questioned costs related to these errors are \$23,528.
HIGHLIGHTS OF RECOMMENDATIONS	
OLTL should: <ul style="list-style-type: none"> • Recover \$23,528 from HCBS for claims that were inadequately documented and overbilled. HCBS should: <ul style="list-style-type: none"> • Ensure that claims are accurate and are adequately supported by the required documentation before billing. 	

FINDINGS	SUMMARY
Finding No. 3 – Internal Control Deficiencies	Internal control deficiencies were identified, including a lack of staff supervision and claim verification.
HIGHLIGHTS OF RECOMMENDATIONS	
HCBS should: <ul style="list-style-type: none"> • Ensure that staff is properly supervised. • Establish an additional review of claims to ensure accuracy in calculating and recording units for billing purposes. • Ensure that their SCs are fully documenting the services they are delivering and that the Home and Community Services Information System (HCSIS) notes reflect the services that were delivered. 	

See Appendix A for the Background, Objective, Scope and Methodology and Conclusion on the Objective.

Results of Fieldwork

Finding No. 1 – Paid Claims Did Not Have Adequate Documentation to Support the Services That Were Billed

A SVRS of claims were selected from the claims reimbursed through PROMISe during the Audit Period. The SVRS consisted of Supports Coordination claims.

The underlying documentation was analyzed to determine the validity of each sampled claim. In order for a supports coordination claim to be considered valid, it must be supported by a HCSIS note. The note must include the date and time of service delivery, and must fully document the service delivered.¹ Analyzed documentation included SC notes entered into HCSIS as well as other notes which had not been entered into HCSIS. Based on the criteria stated below, we noted the following errors:

¹ 55 Pa. Code Chapter 1101 §1101.11 General Provisions and §1101.51 Ongoing Responsibilities of Providers. Also, 55 Pa. Code Chapter 52 §52.14 Ongoing Responsibilities of Providers, §52.15 Provider Records and §52.26 Service Coordination Services.

**HCBS Service Coordination, Inc.
January 1, 2013 to June 30, 2014**

No original documentation was available: There were 12 claims that had no original documentation to verify the claim. The SC explained that there were no notes entered into HCSIS prior to March 2014. The claims documentation that was presented was based on the SC's memory recollection and emails. For these claims the documentation was not adequate. Total questioned costs related to these errors are \$44,348.

The PROMISe date of service did not agree with the HCBS service date: There were eight claims where the PROMISe service dates did not agree with the HCBS service dates. The questioned costs related to these errors are \$5,816.

No documentation: There were five claims where there was no documentation to verify the services that were billed. The questioned costs related to these errors are \$11,632.

Under Billing: Based on the documentation presented HCBS under billed nine claims to PROMISe. These errors resulted in a under billing of \$(19,629).

Total questioned costs related to claims that were inadequately documented and/or incorrectly billed are \$42,167.

Recommendations

The BFO recommends that OLTL recover \$42,167 from HCBS for claims that were inadequately documented and/or incorrectly billed.

The BFO also recommends that HCBS ensure that claims are accurate and adequately supported by the required documentation before billing.

Finding No. 2 – Claims Submitted as Adjustments Could Not be Supported Through Adequate Documentation

HCBS filed adjustments to claims that were previously reimbursed through PROMISe. The documentation supplied by HCBS did not support all of the claim adjustments. The total questioned costs related to these errors are \$23,528.

Recommendations

The BFO recommends that OLTL recover \$23,528 from HCBS for claims that were inadequately documented and overbilled.

The BFO also recommends that HCBS ensure that claims are accurate and adequately supported by the required documentation before billing.

**HCBS Service Coordination, Inc.
January 1, 2013 to June 30, 2014**

Finding No. 3 – Internal Control Deficiencies

The BFO's analysis of HCBS PROMISe claims identified the following internal control weaknesses:

Units billed were sometimes overstated: Certain units of service were not calculated correctly and were overbilled. The SC supervisor also performed executive director duties. It appears there was a lack of supervision, as there was no evidence that the SC's billable units were verified on a regular basis to ensure that the correct number of units were calculated prior to submitting the claim to PROMISe.

Time was not documented on the service delivery notes: The HCBS SC was not documenting the actual time spent on service delivery; only the number of units was indicated on the notes. Service notes must indicate the start and end times related to a specific consumer. Prior to March 2014, service notes were not entered into HCSIS and the available HCBS notes were generally lacking in detail.

The content of service notes did not always support the units that were billed: The notes entered into HCSIS must contain sufficient detail to support the number of units that were billed. Many notes were only one sentence and lacked the service detail to support the units that were billed. Service notes need to comply with 55 PA Code Chapter 52.

Recommendations

The BFO recommends that HCBS ensure that staff is properly supervised.

The BFO also recommends that HCBS establish an additional review of claims to ensure accuracy in calculating and recording units for billing purposes.

The BFO additionally recommends that HCBS ensure that their support coordinators are fully documenting the services they are delivering and that the HCSIS notes reflect the services that were delivered.

Exit Conference/Auditor's Commentary

An Exit Conference was held on March 3, 2015 at the request of HCBS. At the Exit Conference, HCBS management presented additional SC notes. The BFO analyzed the documentation and subsequently reduced the amount of the questioned costs presented within this report. The BFO also read HCBS's response to the draft report and found their arguments to be without merit; accordingly, no additional changes were made to the report.

**HCBS Service Coordination, Inc.
January 1, 2013 to June 30, 2014**

In accordance with our established procedures, an audit response matrix will be provided to OLTL. Once received, OLTL should complete the matrix within 60 days and email the Excel file to the DHS Audit Resolution Section at:



The response to each recommendation should indicate OLTL's concurrence or nonconcurrence, the corrective action to be taken, the staff responsible for the corrective action, the expected date that the corrective action will be completed and any related comments.

Sincerely,

A handwritten signature in black ink that reads "Tina L Long".

Tina L. Long, CPA
Director

- c: Mr. Jay Bausch
- Mr. Grant Witmer
- Ms. Kim Nagle
- Mr. Michael Luckovich
- Ms. Angela Episale
- Ms. Jennifer Whalen
- Mr. Edward Brown

bc: Mr. Alexander Matolyak
Mr. Daniel Higgins
Mr. David Bryan
Mr. Grayling Williams
Ms. Shelley Lawrence
SEFO Audit File (S1401UL)

HCBS SERVICE COORDINATION, INC.

APPENDIX A

APPENDIX A

Background

HCBS began providing Supports Coordination and Transportation Services in October 2012. HCBS serves consumers who are approved by OLTL. OLTL funds the waiver eligible services which are paid through the PROMISe reimbursement process. HCBS is a related organization to [REDACTED], which provides Personal Assistance Services.

Objectives/Scope/Methodology

The audit objective, developed in concurrence with OLTL, was:

- To determine if HCBS has adequate documentation to substantiate its paid claims through PROMISe for services delivered.

The criteria used to ascertain the adequacy of supporting documentation was 55 Pa. Code Chapter 52, 55 Pa. Code Chapter 1101 and pertinent Federal Waiver Requirements.

In pursuing this objective, the BFO interviewed OLTL personal and HCBS employees and management. We also analyzed books and records, billing data, PROMISe reimbursement data, criminal background checks, electronic records available in HCSIS and from HCBS, and other pertinent data necessary to pursue the audit objective.

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 evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Government auditing standards require that we obtain an understanding of management controls that are relevant to the audit objective described above. The applicable controls were examined to the extent necessary to provide reasonable assurance of the effectiveness of those controls. Based on our understanding of the controls, there were material deficiencies in the billing procedures. Areas where we noted an opportunity for improvement in management controls are addressed in the findings of this report.

The BFO's fieldwork was conducted intermittently from September 3, 2014 through October 29, 2014 and was performed in accordance with GAGAS. This report is available for public inspection.

Conclusion on the Objective

In conclusion, HCBS did not meet the documentation requirements for reimbursement of certain PROMISE claims for supports coordination. The deficiencies included the lack of proper documentation to support the services that were billed, and inadequate service notes. As a result, total questioned costs are \$65,695.

HCBS SERVICE COORDINATION, INC.

RESPONSE TO THE DRAFT REPORT

APPENDIX B

HCBS

Service Coordination Inc.

347. W. Main Street, 2nd Floor

Trappe, Pennsylvania 19426

February 20, 2015

Mr. Daniel Higgins, Audit manager
Division of Audit and Review
Bureau of Financial Operations
Department of Human Services

Dear Mr. Higgins:

I am enclosing our response to your audit and audit findings for the period July 1, 2012 through June 30, 2014.

We look forward to discussing the information presented at the exit conference on March 3, 2015 at 2:00 P.

Very truly yours,



Edward E. Brown

RESPONSE TO DAR Findings:

HCBS SERVICE COORDINATION Inc.

Audit Period (1/1/2013 thru 6/30/2014).

As stated: BFO initiated an audit designed to investigate, analyze and make recommendations regarding the reimbursements from PROMISE for client care.

In the Executive Summary section of the DAR its states that HCBS employs only one Service Coordinator. THAT IS NOT TRUE, HCBS EMPLOYS (2) TWO SERVICE COORDINATORS; (1) ONE SC- [REDACTED] and (1) ONE SC SUPERVISOR- [REDACTED] ALSO HCBS has never provided waivers services under [REDACTED]

FINDING # 1: Paid claims DID NOT have adequate documentation to support the services that were billed. The audit team in their summary stated that a statistically valid random sample of PROMISE paid claims was tested for adequacy of supporting documentation. The total questioned costs related to these claims related to these OVER PAID claims is \$ 142,031.

RESULT OF FIELD WORK SECTION for Finding #1: The audit team states that: In order for a Supports Coordination claim to be considered valid, it must be supported by a HICSIS note. The note must include the date and time of service delivery and must fully document the service delivered(1)

Specifically citing:

1. That NO ORIGINAL DOCUMENTATION WAS AVAILABLE in HICSIS prior to march 2014. totaling \$ 47,608
2. The PROMISE date of service did not agree DID NOT AGREE with the HCBS date of service date. Totaling \$22,217
3. That there was either NO documentation or INCOMPLETE documentation. Totaling \$ 72,206

Referencing 55 Pa. Code Chapter 1101.11 General Provisions and 1101.51 Ongoing Responsibilities of Providers: Also 55 Pa Code Chapter 52.14 Ongoing Responsibilities of Providers, 52.15 Provider Records and 52.26 Service Coordination Services.

HCBS RESPONSE: HCBS DOES NOT AGREE WITH BFO FINDINGS FOR REASONS STATED BELOW:

To address point 1:

1. That NO ORIGINAL DOCUMENTATION WAS AVAILABLE in HCSIS prior to march 2014. totaling \$ 47,608

THIS IS A FACT RELATED TO THE ENTIRE "SPIN-OFF" PROCESS: In 2011 [REDACTED] was granted Service Coordination service provision credentials by OLTL-Office of Long Term Living. All services direct care and SC were billed under [REDACTED] until April 2013.

How Unlimited got SC credentials was the direct result of the consolidation of all AAA's into (1) single FMS which was later announced as PPL. Many AAA's and county agencies stopped providing SC functions. Therefore, OLTL opened up the SC service provision code to direct care agencies because there were insufficient numbers of Service Coordination entities. [REDACTED] completed the application to ADD the SC service code, it was granted and SC services were rendered. Albeit that [REDACTED] could only provide SC services to those consumers who elected to stay with [REDACTED] as their SC.

The entire HCBS service provider environmental conditions from about 2010-2013 was very dysfunctional disjointed and chaotic. The clarity of instruction or lack there of which was given then by OLTL was : that as a direct care agency [REDACTED] could not provide SC services directly but could SC through an umbrella company, hence HCBS was created albeit under [REDACTED] (This was the beginning of the "SPIN-OFF" process).

All SC services were billed under [REDACTED] using the SC service Code. [REDACTED] [REDACTED] for SC services billed and paid to [REDACTED]. This is further supported by the fact that HCBS Service Coordination Inc. although incorporated in 2012, to better meet the requirements of 52.28 generated NO revenue in 2012 and filed no tax return. It did however file a tax return for 2013.

Apparently at some point during 2012 and early 2013, unknown to both [REDACTED] and HCBS Service Coordination, HCBS was given its own provider number. Nevertheless, SC services were not billed under HCBS Service Coordination Inc until 4-2013. **This is admittedly a void that HCBS has little to no communication from DPW or OLTL. other than that which relates to the SPIN-OFF process.**

Attached please find many emails and correspondence regarding 52.28 compliance (SPIN-OFF). Specifically, my email response dated 12-14-2012 and letter from [REDACTED] dated [REDACTED] email communication history through emails. HCBS had been undergoing this "SPIN-OFF" process in June of 2012. HCBS did not hear anything from anyone until HCBS made its inquiry.

The email dated [REDACTED] from [REDACTED] is very telling with respect to the absolute confusion HCBS had to endure during this SPIN-OFF process. In this document, albeit the fact that inquiries were made from HCBS, responses were in reference to [REDACTED]

From these emails one can gather that it was not until March/April of 2013 that ALL ISP conversion issues were resolved (transferred from [REDACTED] to HCBS or to other SCE's). Even though All Transfers were facilitated, HCBS did not have Full ACCESS to HCSIS. I was not until May 2013 that full registration protocols and access authorities were granted to HCSIS and implemented by HCBS. HCBS was not put on OLTL's APPROVED SC PROVIDER LIST until 1 May 2013.

The only thing that the SC could do in the meantime within HCSIS was ACCEPT NEW consumers (but could not transfer any out... that had to be done by OLTL directly) and facilitate the ISP's. Every other tab when clicked stated that the operator did not have the authorities to access. This was brought up during the QMET audit and the recent BFO audit. The help desk was called numerous times to try to understand why and resolve.

HENCE THE REASON WHY "SERVICE NOTES' WERE KEPT IN [REDACTED] prior to March 2014. WHICH QMET WAS AWARE OF.

In conjunction to entering SC Service notes into [REDACTED] other documents as per HCBS protocols were used to document that services were being delivered as stated in the ISP's. However the BFO auditors did not want to see these documents because they were not in HCSIS. These documents included: Consumer Satisfaction Survey's (completed every two weeks). They did not want to review any ISP's... even though as we tried to explain, we entered important notes on the ISP as well.

Admittedly, HCBS did not enter many SC notes into HCSIS from May 2013 to March 2014. Simply stated we tried but data was lost after 30 days. HCBS's SC [REDACTED] took BFO's audit team member, I believe her name is [REDACTED] to her computer and they experienced the same issues. [REDACTED] instructions to [REDACTED] was to call the help desk, we did it took a few days until the situation was resolved. Nevertheless, this was after the fact, some notes were still not retrievable. Since the BFO audit internal redundancies were created within HCBS protocols to at least ensure SC notes are producible.

2. The PROMISE date of service DID NOT AGREE with the SC date of service.
Totaling \$22,217

[REDACTED] was Audited by QMET regarding SC services on 3/4/2014 for the Audit period of 2/1/13 – 1/31/2014. THE SAME OVER LAPPING AUDIT PERIOD OF BFO.

I have taken the liberty of attaching the Audit tool instructions for QMET specifically as it related to billing Documentation and audit review.

"FINANCIAL PROBE SAMPLE" For each waiver ACW, IW, OW, and CC... The task- is to Verify that provider of service only bills for services provided. The Method- Review supportive documentation for

PROMISE billing claims. Utilize protocol on Probe sample (QMET 1409) and Expanded Financial Review (QMET) 1609 to determine compliance with standard. This standard it used by both QMET and BFO to conduct their financial audits.

I JUST NOTICED THIS MYSELF: ON THE QMET CAP FOR HCBS SERVICE COORDINATION INC. IT STATES THE PROVIDER NUMBER is [REDACTED] THAT IS HCBS'S PROVIDER NUMBER. BUT! SC SERVICES WERE BEING BILLED UNDER [REDACTED] PROVIDER NUMBER UNTIL MARCH-APRIL 2013. This is an established fact. THIS IS STRANGE.

Q. HOW COULD SC services BE BILLED BY AND PAID TO [REDACTED] THROUGH PROMISE under [REDACTED] PROVIDER NUMBER.? AND NOT HCBS's Provider number.

Q. WHY WOULD HCBS BILL UNDER [REDACTED] PROVIDER NUMBER IF IT KNOWINGLY HAD ITS OWN PROVIDER NUMBER?

Q. WHAT SUPPORTIVE DOCUMENTATION WAS REVIEWED BY QMET TO VARYIFY PROMISE BILLING for SC service CLAIMS? GIVEN THAT THE ONLY SC DOCUMENTATION THAT WAS REVIEWABLE WAS THAT WHICH WAS CONTAINED IN PROMISE. QMET WAS MADE AWARE OF THE FACT THAT [REDACTED] DID NOT HAVE FULL ACCESS TO HCSIS AT THE TIME OF THEIR AUDIT. THEY KNEW IT . All they did was review consumers files.

YET! The CAP indicated that HCBS was over paid. Albeit at that time only (1) unit (.15 minutes) had been billed per week as per the ISP. Albeit that [REDACTED] was the PAYEE until April 2013.

In order to compensate for system limitations, [REDACTED] UPGRADED Its INTERNAL DATA STORAGE SYSTEM SO THAT BOTH [REDACTED] and HCBS COULD MAKE LOG ENTRIES SEPARATELY.

Billing practices had to match ISP's and at this time ISP's SC-services were calculated at 1 unit X 52 weeks.

I AM not to sure how this billing practice originated BUT ALL OF INITIAL SC TRAINING SUPPORTS 1 UNIT = 1HR. And this billing practice was consistently maintained from the beginning until it was identified during the QMET SC Audit.

During the QMET SC audit we were told that we were billing wrong (in fact under billing NOT OVER BILLING). But there was no simple fix because the calculation used in the ISP needed to be changed first by the SC. Most ISP's had been approved for (1) unit @ 52 weeks for SC during this time.

This problem had to be addressed by the SC first through ISP revisions. This took time to resolve.

THE QMET TEAM DID NOT ASK TO SEE ANY NOTES NOR DID THEY ASK ANY QUESTIONS BILLING DOCUMENTATION NOR DID THEY CITE ANY DEFICIENCIES OTHER THAN WHAT WAS STATED IN THE CAP (ATTACHED).

THERE WAS A DISCUSSION REGARDING RE-DRAFT OF THE CURRENT SC TIME SHEET being USED at the time. The re-drafted version only ADDED extra LINES SO THAT THE SC COULD WRITE WHO, WHAT,

WHERE, WHY, AND WHEN OF ANY TASKS , EVENTS OR SITUATIONS RELATED TO EACH INDIVIDUAL CONSUMER. QMET WAS MADE AWARE OF THE INTERNAL DATA STORAGE PROTOCOLS OF UNLIMITED AND WHY. The only recommendation offered by QMET was contact the help desk. THE RE-DRAFTED SC NOTE/TIME SHEET WAS APPROVED BY THE QMET TEAM DURING THEIR VISIT.

OLTL's Service Coordination Training: June 2013 offered through Itltl-long term living training institute; TRAINING MANUALS FOR SC. PAGE 67 SERVICE PLAN MONITORING AND PAGE 92-94 Service Coordination Entity requirements; PA CODE 55 CHAPTER 52.26 (ATTACHED). Clearly Monitoring participant satisfaction with services "IS" billable and documented by HCBS through its internal Consumer Satisfaction Survey Form, which is completed no less than 2 times per month.

The BFO Audit team said that because this task was not documented in HCSIS they did not want to consider it. AGAIN WE DID NOT HAVE FULL ACCESS TO HCSIS PRIOR TO APRIL/MAY 2013. Unfortunately QMET's audit did not take place until March 2014.

Q: WHY DID THE CAP CITE "OVER PAYMENT" OF BILLING! HCBS BILLED ONE (1) UNIT (.15 min) PER WEEK.

Upon discovery of this error HCBS initiated "ADJUSTMENTS", through promise obviously after the fact. Several phone calls were made to the help desk to seek direction. In the end, because Promise would only allow certain adjustments (160 day edit period) the decision was complete adjustment protocols through PROMISE. Even still not all adjustments were made and completing paper 1500's for 100's of claims was just not possible.

The BFO auditors, believing that they had a "gotcha moment" confronted me. The Auditor [REDACTED] I believe, pulled out some sheets of paper and said [REDACTED] [REDACTED] I looked at the print out and clearly said: [REDACTED] [REDACTED] I explained to Joe what we did... I thought at the time he understood but apparently he did not.

For the record, what HCBS did in order to avoid incredible amounts of hard copy 1500 form generation and literally having to hand walk paper claim adjustments through the system, we opted to bill what we could through Promise given the pathway described to us by the help desk.

Given the month for which services were actually delivered, a date was picked in that month, and submitted as an adjustment. Promise accepted the adjustments and payment was processed. I told [REDACTED] that if he wanted we could show all paper work to satisfy him. He said that he already had his sample.

In hindsight, it would have avoided a lot of confusion had we just processed paper claims. The ISP's were already corrected and the authorization to adjust billing could have been asked for.

To address the issue regarding the disagreement in service date with that of the SC note date. Nowhere in the regulations does it state that SC notes MUST agree with the service date.

Referencing 55 Pa. Code Chapter 1101.11 General Provisions and 1101.51 Ongoing Responsibilities of Providers: Also 55 Pa Code Chapter 52.14 Ongoing Responsibilities of Providers, 52.15 Provider Records and 52.26 Service Coordination Services.

Service continuity issues makes that almost impossible. Every aspect of SC function is continually fluid. I say this not as a justification but as a reality that must be entered into this obviously subjective evaluation of what constitutes a SC service note. ALL SC services were provided.... As the BFO auditors said themselves repeatedly [REDACTED] Proudly I say ... [REDACTED]

Still, there was some discussion as to what is billable and what is not. I refer you to Guidelines to Service Coordination Entities (attached)

The auditors also stated that what our notes said did not justify service delivery because NOTES did not include Type, Scope, Frequency, Amount, and Duration. Bulletin # 05-13-05 Clarification of Type Scope Amount Duration and Frequency of Service is specific to how the ISP is developed and calculated.

My intent is not to argue but rather give OLTL what it wants on a constant basis. There is no requirement to write a note that is formatted in any particular format. I will agree that a service note should reflect what actions, events were taken and why and implement other protocols to ensure the quality services are being rendered.

**3. That there was either NO documentation or INCOMPLETE documentation.
Totaling \$ 72,206**

Documents were provided for ALL Sample participants: if the issue was SC Notes. HCBS has already addressed those issues above. Furthermore, ISP's were completed, Critical Revisions were completed Incident Reports were completed LOCA/CMI recerts were performed as well as Consumer Satisfaction Survey completed at bi-weekly. All of which the BFO Audit Team refused to consider. As I stated earlier, [REDACTED] upgraded its internal Data storage system, HCBS did not have access to it to retrieve all notes. HCBS was undergoing the SC "SPIN-OFF" process. HCBS was a separate entity from UNL at the time of this audit.

Finding #2:

Claims submitted as adjustments COULD NOT be supported through adequate documentation.

Response: This matter is falsely stated, upon being accused of fraud by BFO and wanting to explain what HCBS did. BFO Auditors not only refused our desire to produce the documents they stated that they already had their participant sample. The adjustments made were for different dates not being sampled. THERE WAS NO OVER STATEMENT OF BILLING. FOR 85-90% of the participant sample what

was billed was (1) unit (.15 minutes). Admittedly a stated time Start/End were missing, but not the date. This has been corrected.

BFO states that the content of service notes did not always support the units that were billed. Again what was billed was .15 min (1) unit. We have already established contrary to BFO Auditors that a service note does not have to match the actual service date. With regards to "sufficient detail", I am unaware of any regulation that specifies what "sufficient detail" is other than ODP regulation 51.16 titled "Progress Note".

I do not want to argue or seem confrontational, but this statement is subjective. Especially when evaluated from a financial perspective.

Finding #3 Internal Control Deficiencies.

Promise will not allow you to bill let alone pay if it exceeds approved units. The calculations used have to match that which is stated in the ISP which are approved by OLTL. These are ALL issues solely contained solely created and are the sole result of OLTL's lack of oversight.

As for the SC supervisor performing the functions of Executive Director. The Title of the SC Supervisor and the functions performed by that person is that of the SC Supervisor job Description. This statement is unfounded and presumptive without merit.

In conclusion

HCBS is providing SC services at the instruction of OLTL and DHS. The issue and matter of supervision rests more heavily on that of OLTL and DHS and giving clear direct and training and guidance to its providers.

HCBS was formally accredited and licensed as an SC provider in JUNE of 2013. Prior to that date as with all other providers who have similarly undergone "the SPIN-OFF" process, ALL services were provided under a single license, in this case [REDACTED] There were no guidelines of separation other than what which was stated above.

Lastly HCBS SERVICE COORDINATION INC. IS NOT A RELATED ORGANIZATION to or of [REDACTED] [REDACTED] As of 1 May 2013, ALL requirements stated in 52.28 have been met. HCBS credentials and provider number are in full compliance. THERE IS NO SERVICE COORDINATION CONFLICTS and by definition of meeting 52.28 to suggest any thing other is incorrect, and unfounded.

Respectfully

Edward E Brown, MA, SCS
HCBS SERVICE COORDINATION INC.

§ 51.16. Progress notes.

- (a) A provider shall complete a monthly progress note that substantiates the claim for the provision of an HCBS it provides at least monthly. A provider shall maintain the progress notes in a participant's record.
- (b) A provider shall complete a progress note each time the HCBS is provided if the HCBS is occurring on a less than monthly frequency.
- (c) A provider may complete progress notes for multiple HCBS rendered to the same participant on the same form when the HCBS are rendered by the same provider from the same waiver HCBS location. Progress notes that are completed for multiple HCBS must include progress for each HCBS included on the form.
- (d) Progress notes must include the following:
- (1) The name of the participant receiving the HCBS.
 - (2) The name of the provider.
 - (3) The name, title, signature and date of the person completing the progress note.
 - (4) The name of the HCBS.
 - (5) The amount, frequency and duration of the authorized and delivered HCBS.
 - (6) The outcome of the HCBS.
 - (7) A description of what occurred during the delivery of the HCBS.
- (e) A provider shall complete a progress note if there is a recommended change to the HCBS rendered that requires discussion with the ISP team due to lack of progress in achieving an outcome as documented on the ISP.
- (f) A provider may use technology that allows staff to submit progress notes as required throughout a work shift.
- (g) Subsection (f) does not apply to an SSW provider.
- (h) This section does not apply to an SCO provider. For SCO service note requirements, see § 51.28(l) (relating to SCO requirements for Consolidated and P/FDS Waiver).
- (i) This section does not apply to an SCA provider under the Adult Autism Waiver.

Cross References

Guidance to Service Coordination Entities (SCE) When Converting Service Coordination Service from an Hourly, Weekly, or Monthly Unit to a Quarter Hour Unit

Converting Service Coordination Service (effective July 1, 2012)

The purpose of Attachment B is to provide guidance to Service Coordination Entities (SCE) when converting Service Coordination Service from an hourly, weekly, or monthly unit to a quarter hour unit. In addition, Attachment B provides guidance to SCE when requesting additional units.

Service Coordination

Services that will assist individuals who receive Office of Long-Term Living (OLTL) services in gaining access to needed waiver services and other State Medicaid Plan services, as well as medical, social and other services regardless of the funding source. Service Coordination is working with the participant whenever possible to identify, coordinate, and facilitate all necessary services.

HCBS Waivers are the payor of last resort. Funding from other sources, if applicable, are to be used for services such as information and referral.

- Service Coordination also includes: completion of needs assessment, advocacy, arranging for services from local resources, and coordination of services so a participant can realize his/her identified goals for living independently in the community.
- **Activities of a Service Coordinator (SC) include:**
 - performing level of care re-determinations annually, or more frequently if needed (Please note that this does NOT apply to service coordination in the Aging Waiver where Level of Care Assessments and re-determinations are a Title XIX administrative function);
 - maintaining current documentation of the participant's eligibility for waiver services, copies of the participant's individual service plan (ISP) and service plan addendum, financial data and related information;
 - providing information and assistance to participants regarding self-direction;
 - informing participants of rights, responsibilities and liabilities when choosing a service model;

- monitoring the health and welfare of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year, telephone calls at least quarterly or as defined in the service plan – monitoring can be more frequent, but not less frequent than specified in this definition
- providing notice of amount and frequency of waiver services;
- working with the participant to develop a comprehensive service plan – including risk identification – that meets their needs, preferences and goals;
- reviewing the service plan at least once a year or more frequently, if the needs of the participant change;
- ensuring that services are provided as planned and delivered appropriately to meet the participant's needs;
- facilitating the comprehensive ISP development process;
- gaining access to needed State Plan and HCBS services, as well as needed medical, social, educational and other services, regardless of the funding source;
- tracking and conducting ongoing review of service delivery; and
- documenting and recordkeeping including contacts with individuals, families and providers.

Examples of what Service Coordination does not include:

- Nurse (RN) review of each service plan (nurse consultation is to be provided only if an assessed need is documented by the SC)
- RN home visits as a component of the service coordination service
- Serving as a representative payee
- Health promotion and prevention services
- Services that are directed to primarily support the needs of participant family members

Frequency of Service Coordination Contact

§ 52.26. Service coordination services.

- (a) To be paid for rendering service coordination services, an SCE shall meet all of the following:

4) Review the participant need, the participant goal and participant outcome with the participant, and other persons that the participant requests to be part of the review as required by conducting all of the following: (i) At least one telephone call or face-to-face visit per calendar quarter. At least two face-to-face visits are required per calendar year.

Documentation of Services Delivered

In order to fulfill that responsibility and to be compliant with § 52.26. **Service coordination services**, the service coordinator shall document in the designated areas of Home and Community Services Information System (HCSIS) or Social Assistance Management System (SAMS) at a minimum the following information captured during participant contacts:

- Whether a contact was a home visit, telephone call or email contact;
- Whether the participant reported receiving the amount of goods and services specified in the ISP;
- Whether the participant reported receiving the frequency of services that are in ISP;
- Whether the participant reported receiving the authorized services specified in the ISP;
- Whether the participant confirmed that and/or SC concluded that the services indicated in the ISP are appropriate in supporting the participant with reaching his/her goals;
- Whether the participant confirmed that and/or SC concluded that the duration of services in the ISP needs to be continued, extended or concluded;
- Whether the participant reported any change in health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes that might impact his/her ability to perform activities of daily living that prompt a need for temporary or permanent changes to service delivery or other follow-up to identify what discharge services are and are not being provided through the participant's health insurance;
- Whether the SC had contacts with participants, families or providers;
- Any communication regarding service plan changes to the participant and the appropriate service provider(s);
- Any reminders or prompts given to the participant of "next steps" and/or his/her responsibilities; and
- The amount of times a participant has utilized his/her individualized back-up plan and if it is effective.

What constitutes a unit?

15 minutes equals one unit. Agencies are able to round up from 7½ minutes of a billable activity with proper documentation to constitute a unit.

Number of units

The number of units after the conversion will fluctuate based on participant utilization and individual needs. Additional units may be requested through your regional Bureau of Individual Support (BIS) representative.

Process to Request Additional Units

Service Coordinators have the flexibility of scheduling the hours that meet the individual needs of each participant. For example, a participant that is new to waiver services may require more hours of service coordination at the beginning of services, and fewer hours several months later.

If a participant is unable to have their needs for service coordination met with 144 units per year, OLTL will consider requests for additional units. Requests for additional service coordination units cannot be submitted until 75% of the original authorized units have been used. The service coordinator should submit a request for additional units through the regional BIS representative.

Requests for additional units must be submitted through HCSIS and SAMS. Requests must include justification of why the initial amount was not enough and how the additional units will meet the needs of the participant. Specifically, this includes:

- Identify the changes in the participant's condition, circumstances, informal supports, or any other changes that warrant the request; and
- Provide justification related to the identified changes and how additional service coordination units will meet the identified needs.

This information must be entered on the Service Notes screen or Journal Notes. The Service Coordinator will assess the need for service coordination and adjust the service plan as necessary throughout the year and annually.

Billable vs. non billable activity

	Billable	Non-Billable
Facilitate and participate in needs assessment	X	
Development of service plan	X	
Coordination of service plan services	X	
Coordination of service plan services with providers	X	
Coordination of service plan services with others as necessary to meet participant's needs	X	
Participant assistance	X	
Inform participants about services	X	
Assist participants in accessing services	X	
Inform participants about hearing and appeal rights	X	
Assist participants in exercising hearing and appeal rights	X	
Ongoing management of service plan	X	
Documentation supporting management of service plan	X	
Face-to-face visits (at least the minimum number required by the program and based on changes in participant's needs)	X	
Review of the service plan (at least annually and based on changes in participant's needs)	X	
Facilitate the resolution of barriers	X	
Disseminate relevant information necessary for service delivery	X	
Exchange information with the participant's family when relevant to the service plans and service delivery	X	
Respond to emergency situations and assist in meeting the needs of the participant	X	
Respond to and assess incidents and assure appropriate actions are being taken	X	
Evaluate participant progress	X	
Monitor participant and/ or representative satisfaction with services	X	
Arrange for modifications in service and service delivery	X	
HCSIS and SAMS documentation	X	
Obtain service authorizations	X	
Communicating relevant authorization information to service providers	X	
Assisting and obtaining participant required information	X	
Provide participant and/ or representative with information on participant directed options	X	

Assist with transition to participant direction if chosen	x	
Assistance to participant in directing their services	x	
Conducting program eligibility determination or redeterminations	x	
Assisting participant employers in managing personal assistants	x	
Service plan development prior to service plan approval	x	
Other services available under the waiver or state plan		x
General educational activities – (such as training, meetings, have been factored into the Service Coordination rate)		x
Transportation for participants not directly related to service coordination		x
General information not related to specific participant services		x
Coordination or outreach prior to participant enrollment in the waiver		x
Payee or other financial management services		x
Conducting Medicaid financial eligibility determinations or redeterminations		x
General program outreach – (such as community education programs)		x
Coordinating any burial or funeral arrangements		x
Travel – (travel time and expenses, such as mileage and tolls, have been factored into the Service Coordination rate)		x
Billing OLTL		x