THE BLICK CLINIC, INC. DBA THE BLICK CENTER
SUMMIT COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2013 THROUGH DECEMBER 31, 2015

Dave Yost · Auditor of State

BLICK CLINIC, INC.
SUMMIT COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH MEDICAID REQUIREMENTS APPLICABLE TO SELECT COMMUNITY MENTAL HEALTH SERVICES

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: The Blick Clinic, Inc. dba The Blick Center
Ohio Medicaid # 2098242

We have examined the Blick Clinic, Inc.'s (the Provider) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of individual and group counseling, community psychiatric supportive treatment and partial hospitalization services during the period of January 1, 2013 through December 31, 2015.

The Provider entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Management of the Blick Center is responsible for its compliance with the specified requirements. The accompanying Compliance Examination Report identifies the specific requirements examined. Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Provider complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Provider complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. Our examination does not provide a legal determination on the Provider's compliance with the specified requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed material non-compliance with the requirements for individual counseling and community psychiatric supportive treatment, particularly with the requirements for individual service plans.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for the period of January 1, 2013 through December 31, 2015.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We identified improper Medicaid payment for services in the amount of $1,540.17. This finding plus interest in the amount of $127.98 (calculated as of December 29), totaling $1,668.15 is due and payable to the ODM upon its adoption and adjudication of this examination report. Services billed to and reimbursed by the ODM, which are not validated in the records, are subject to recoupment through the audit process. *See* Ohio Admin. Code § 5160-1-27.

This report is intended solely for the information and use of the Provider and the ODM, and is not intended to be, and should not be used by anyone other than this specified party.

Dave Yost
Auditor of State

January 24, 2018

Compliance Examination Report

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(A) and (B)

Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(D) and (E)

The Provider is a mental health agency and, during the examination period, received reimbursement from the Ohio Medicaid program of $3,509,384 for 40,904 mental health services rendered on 37,236 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. These mental health services included the following:

- $1,181,152 for community psychiatric support services (procedure code H0036);
- $1,161,559 for partial hospitalization services (procedure code S0201);
- $1,032,413 for behavioral health counseling services (procedure code H0004);
- $131,731 for psychiatric diagnostic evaluation services (procedure code 90792);
- $2,024 for pharmacologic management with psychotherapy (procedure code 90863);
- $390 for mental health assessment services (procedure code H0031); and
- $115 for office outpatient visit - 25 minutes (procedure code 99214).

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's claims for reimbursement complied with Ohio Medicaid regulations. The scope of the engagement was limited to an examination of partial hospitalization, behavioral counseling (individual and group) and community psychiatric support services (procedure codes S0201, H0004 and H0036) that the Provider rendered during the period of January 1, 2013 through December 31, 2015 and received payment from Ohio's Medicaid program. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect[1].

We received the Provider's claims history from the Medicaid Information Technology System (MITS). We removed all services with a paid amount of zero. We extracted procedure code S0201, H0004 (individual and group which has an HQ modifier) and H0036 and used a sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1)

We stratified the services by RDOS (recipient dates of service) into four samples. The sample sizes are shown in **Table 1**. We then obtained the detail services for the each of the 400 sampled RDOS.

[1] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

Purpose, Scope, and Methodology (continued)

Table 1: Samples			
Universe/Strata	**Population RDOS**	**Sample RDOS**	**Sample Services**
S0201 – Partial Hospitalization Sample	9,994	100	100
H0004 – Individual Counseling Sample	14,210	100	100
H0004 – Group Counseling Sample	1,987	100	100
H0036 – Community Psychiatric Support Sample	13,738	100	105
Total RDOS:	**39,929**	**400**	**405**

A notification letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed service documentation. The Provider was given multiple opportunities to submit additional documentation and we reviewed all documents received for compliance.

Results

We examined 405 services in our four samples that included partial hospitalization, individual and group counseling and community psychiatric support services and found total of 30 errors. We identified a total improper Medicaid payment of $1,535.67.

We found no instances of non-compliance in our sample of 100 partial hospitalization services.

We found three errors in the sample of 100 group counseling services and identified an improper payment of $118.44.

We found 10 errors in the sample of 100 individual counseling services and identified an improper payment of $630.00.

We identified 17 errors in the sample of 105 community psychiatric support services and identified an improper payment of $791.73. In this sample, one service had two errors; however, only one finding was made for the service.

The noncompliance found during our examination and the basis for our finding is described below in more detail.

A. Provider Qualifications

Ohio Admin. Code § 5122-29-30, Appendices A and B, identifies those individuals who are eligible to provide and supervise partial hospitalization, community psychiatric support and behavioral counseling services.

A. Provider Qualifications (Continued)

We compiled the names and professional credentials for 41 licensed personnel that rendered and supervised services in the samples. Using the Ohio e-License Center website, we searched for their professional license and compared the licensure information to the first date of service in our samples and the end date of the examination period. We then compared each individual's license to Admin. Code § 5122-29-30, Appendix B. We found no instances of unlicensed individuals rending services and no instances of an unqualified individual rendering service.

We compiled the names of the seven qualified mental health specialist (QMHS) that rendered services in the samples. The Provider submitted a written statement outlining how each individual met the QMHS requirements. The Provider also provided copies of applications, resume's, training records and education verification forms. We compared the information to the requirements in Ohio Admin. Code § 5122-29-30, Appendix A. We found no instances of non-compliance.

B. Service Documentation

A Mental Health agency or facility must maintain a progress note that includes, but is not limited to, date of service contact, time of day and duration, location, and a description of the service rendered as well as the dated signature and credentials, or initials, of the rendering practitioner. If using initials, the individual client records must contain a signature sheet. See Ohio Admin. Code § 5122-27-06(C)

We reviewed all documentation submitted by the Provider to verify that there was documentation which supported the services and units billed and contained the required elements noted above.

We found no instances of non-compliance in our samples for partial hospitalization and group counseling.

In the individual counseling sample, we found one instance of non-compliance in which the units billed exceeded the documented duration. This error is included in the improper payment of $630.00.

In the community psychiatric support sample, we identified two services in which there was no supporting documentation and four instances in which the units billed were greater than the documented duration. These six errors are included in the improper payment of $791.73.

Recommendation

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5122-27-06. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Individual Service Plan

All Ohio Department of Mental Health providers are required by Ohio Admin. Code § 5122:27-05(A) to create an individual service plan (ISP) for recipients that identifies specific mental health needs, and the name and/or description of all services being provided. The plan must contain the signature of the staff member that developed the plan, the date of development and evidence of supervision, as applicable.

C. Authorization to Provide Services (Continued)

We reviewed ISPs to ensure that the planned services were identified, that it contained the required signature, date of development and supervisory approval, if applicable. We also ensured that the ISP covered the dates of services in the samples.

We found no instances of non-compliance in the sample of partial hospitalization services.

In the individual counseling sample, we identified six services with no ISP for the recipients, two instances in which the ISP did not include individual counseling services and one ISP that was not signed or dated. These nine errors are included in the improper payment of $630.00.

In the group counseling sample, we identified three instances in which there was no ISP for the recipients. These three errors resulted in an improper payment of $118.44.

In the community psychiatric support services sample, we identified four instances in which there was no ISP for the recipient and seven instances in which the ISP did not include community psychiatric support services. These 11 instances are included in the overpayment of $791.73.

Recommendation

The Provider should establish a system to ensure that ISPs are completed as required. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider was afforded an opportunity to respond to this examination report. The Provider declined an exit conference to discuss the results of this examination and also declined to submit an official response to the results noted above. The Provider did initiate steps to remit payment to the ODM for the $1,668.15 finding identified.

Dave Yost • Auditor of State

BLICK CLINIC, INC.

SUMMIT COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
FEBRUARY 15, 2018

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