PREBLE COUNTY TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITES

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2014 THROUGH JUNE 30, 2016

Dave Yost · Auditor of State

PREBLE COUNTY TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO DRUG AND ALCOHOL ADDICTION SERVICES

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

RE: Preble County Treatment Accountability for Safer Communities (Preble County TASC)
Ohio Medicaid # 3136476

We examined Preble County Treatment Accountability for Safer Communities (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization for assessment, case management and counseling services as it related to the provision of drug and alcohol addiction services during the period of July 1, 2014 through June 30, 2016.

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. The Provider is responsible for compliance with the specified requirements. 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

We found assessment services that lacked service duration, were billed with units that exceeded documented duration, and instances in which the start and end timed overlapped the times for another service rendered by the same practitioner. In addition, for case management services, we found activities that did not meet the definition of this service, progress notes in which the start and end time overlapped with another service rendered by the same practitioner, and that case management plans were not reassessed within the required time frame.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for the period of July 1, 2014 through June 30, 2016.

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 found improper payments in the amount of $18,722.50. This finding plus interest in the amount of $1,251.07 (calculated as of March 5, 2018) totaling $19,973.57 is due and payable to the ODM upon it's 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. In addition, if waste and abuse[1] are suspected or apparent, the ODM and/or the office of the attorney general will take action to gain compliance and recoup inappropriate or excess payments in accordance with rule 5160-1-27 or 5160-26-06 of the Administrative Code.

This report is intended solely for the information and use of the Provider, the ODM, and other regulatory and oversight entities, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

March 5, 2018

[1] "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each State's 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

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)

Ohio Medicaid recipients may be eligible to receive alcohol and drug addiction treatment related services that assist the recipient with rehabilitation. The Ohio Department of Mental Health and Addiction Services recognize services that may be used in the treatment of alcohol and other drug addiction that include, but are not limited to: laboratory urinalysis, assessment, individual and group counseling and case management. *See* Ohio Admin. Code § 3793:2-1-08

This Provider is an ODADAS certified/licensed treatment program[2]. During the examination period, the Provider rendered services to 120 Ohio Medicaid recipients and received reimbursement of $192,903.92 for the following services:

- 2,846 case management services (H0006);
- 1,075 urine screen-lab analysis of specimens services (H0003);
- 355 behavior health counseling services (H0004);
- 95 group counseling services (H0005); and
- 85 drug assessment services (H0001).

These services were rendered on 506 dates of service. The Provider billed all 4,456 services using the (HF) modifier indicating substance abuse program.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's claims for reimbursement complied with Ohio Medicaid regulations. 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. The scope of the engagement was limited to an examination of assessment, individual and group counseling, and case management services from July 1, 2014 through June 30, 2016.

We received the Provider's claims history from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We removed services with a paid amount of zero.

[2] In 2013, the State of Ohio consolidated the Department of Alcohol and Drug Addiction Services (ODADAS) with the Department of Mental Health (ODMH) into one single agency, the Department of Mental Health and Addiction Services.

Purpose, Scope, and Methodology (Continued)

From this population, we extracted the following services: assessment (procedure code H0001), case management (procedure code H0006), group counseling (procedure code H0005), and individual counseling (procedure code H0004). We selected all 85 assessments (census) for examination. We selected two separate statistical samples to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

For the first sample, we selected a random sample from the population of case management services. For the second sample, we stratified the population of individual and group counseling services by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. We then selected a random sample from each stratum.

Table 1 shows the approaches used in the examination.

Population		**Selection/Sample**
Assessments (H001)		
85 Services		**85 Services**
Case Management (H006)		
2,846 Services		**609 Services**
Individual and Group Counseling (H0004 and H0005)		
Universe/Strata	**Population**	**Sample**
Stratum 1 – Less than or equal to 4 Units of Service	403 RDOS	184 RDOS
Stratum 2 – Greater than or equal to 5 Units of Service	46 RDOS	34RDOS
Total RDOS:	**449 RDOS**	**218 RDOS**

For individual and group counseling, we then obtained the detailed services for the sampled 218 RDOS which resulted in a sample of 219 services. Combined, we selected 913 services for this examination.

A notification letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described their documentation practices, personnel related procedures and billing process. The Provider was given opportunities to submit additional documentation and we reviewed all documents received for compliance.

Results

In total, we examined 913 services and found 263 errors. Specifically, we identified 12 errors in the individual and group counseling sample, resulting in an improper payment of $325.00. We identified 55 errors in the assessment services, resulting in an improper payment of $4,042.08.

Results (Continued)

We identified 196 errors in our case management sample and took exception with 100 out of 609 RDOS examined. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $105,176, with a 95 percent certainty that the actual correct payment amount fell within the range of $98,723 to $111,630 (6.14 percent). We subtracted the correct population amount ($105,176) from the amount paid to the Provider for this population ($119,531.42), which resulted in a projected overpayment of $14,355.42. A detailed summary of our statistical sample and projection results is presented in **Appendix I.**

While certain services had more than one error, only one finding was made per service. The basis for the findings is discussed below in more detail.

A. Provider Qualifications

According to Ohio Admin. Code § 3793:2-1-08, case management, assessment and counseling services may be provided by a chemical dependency counselor assistant (CDCA), a licensed independent chemical dependency counselor (LICDC), a licensed professional clinical counselor (LPCC), and a licensed independent social worker (LISW). In addition, students enrolled in an accredited Ohio institution performing an internship or field placement and care management specialists can perform specified alcohol and drug addiction services while under the supervision of a qualified individual. Specifically, an intern may provide case management, assessment, individual and group counseling services and care management specialists may render case management services.

We identified the practitioners who rendered services in the examined services and found seven CDCAs and one practitioner with three credentials - LICDC, LISW and LPCC. We obtained licenses from the Provider and also searched names using eLicense Ohio for all eight practitioners. We verified that the licenses were valid and active for the examined dates of service.

We found three errors in our assessment sample due to two practitioners who did not have a valid license at the time of service delivery. These three errors are included in the improper payment of $4,042.08.

Recommendation:

The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Service level progress notes shall include length of time of service contact or service delivery, type of service, summary of what occurred during the service contact or service delivery and the date, original signature and credentials of the staff member providing the service. Ohio Admin. Code § 3793:2-1-06 (P)

The Provider conducted an internal review in 2017 of a selection of Medicaid billable files and found inappropriate billing and incomplete documentation. After the review, the Provider developed a corrective plan to address these problems. The Provider self-reported its non-compliance to the ODM.

B. Service Documentation (Continued)

The Provider reported that the practitioners performing assessments billed a minimum of two hours for each assessment. The corrective action plan for case management indicated that staff rounded up the time in and out for clients, phone calls were billed for eight, 10 or 15 minute intervals, and staff billed internal phone calls and meetings.

Assessment

We found that the Provider billed 81 out of the 85 assessments (95 percent) with two units indicating duration of two hours which is consistent with Provider's statement that assessments were billed with a minimum of two hours. In examining the 85 assessments, we found five instances where the ending time on the service documentation was completed in a different colored ink subsequent to the original creation of the progress note and in each case the ending time supported duration of exactly two hours. We did not identify an overpayment for these five instances; however, we question the reliability of the documented duration. Based on these five instances, we believe the improper payment identified for this sample to be a conservative figure.

We reviewed 85 assessment services and found the following errors:

- 42 services where the units billed exceeded the duration documented;
- 5 services with no service duration documented;
- 4 services where the reported day and time of service delivery overlapped another service rendered by the same practitioner, and
- 1 service with no supporting documentation and the Provider indicated the assessment was billed under the wrong recipient identification number.

These 52 errors are included in the improper payment of $4,042.08.

Individual and Group Counseling

We examined 162 individual and 57 group counseling services and identified the following errors:

- 7 services where units billed exceeded documented duration;
- 3 services in which there is no supporting documentation; and
- 2 services where practitioner did not sign the service documentation.

In five of the seven errors where the units billed exceed duration, the documented start and end times differed from the documented duration; both of which were noted on the progress note. In these five instances, we identified an overpayment based on the shortest duration documented on the progress note. These 12 errors resulted in an improper payment of $325.00.

Case Management

We reviewed 609 case management services and identified the following errors:

- 38 services in which the note described an activity that was not a case management service;
- 34 services had overlapping times;
- 15 services where the units billed exceeded the documented duration;
- 11 services where documentation for services were a copy of documentation supporting a service for another recipient (cloned service note);
- 7 services where there was no documentation to support the service;
- 5 services where documentation was not signed by the rendering practitioner; and
- 3 services where the duration of service was not documented.

B. Service Documentation (Continued)

Out of 34 services with overlapping times, 33 were services rendered to two or more recipients, on the same date by the same practitioner. One recipient had two different services rendered on the same date by the same practitioner and the documented beginning and ending service times overlapped.

The 11 errors related to cloned service documentation were isolated to one practitioner. We compared all 244 services in the case management sample rendered by this practitioner to identify identical service documentation and found the 11 errors. We reviewed all service documentation for two additional practitioners in our case management sample and found no further errors.

These 113 errors were used in the overall finding of $14,355.42. Based on the Provider's reported practice of rounding up start and ending times for services and the errors identified in this examination, we believe the improper payment identified for this sample to be a conservative figure.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with the requirements contained in Ohio Medicaid rules. In addition, the Provider should implement a quality review process to ensure that documentation is present, complete and accurate prior to submitting claims for reimbursement. The Provider should document the actual duration of service delivery and bill the corresponding units. In addition, the Provider should ensure that staff does not use cloned service documentation. The identified issues should be addressed to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

A case management plan of care (CMP) must be written for each client that receives case management services and be completed prior to a client receiving these services. A reassessment of the CMP must be conducted at least 90 days after the initial CMP and at least once every 90 days following each reassessment. Ohio Admin. Code § 3793:2-1-06 (M)

An individual treatment plan must be written for each client within seven days of completion of the assessment or at the time of the first face-to-face contact following an assessment and identify the types of treatment services. Ohio Admin. Code § 3793:2-1-06 (L)

Individual and Group Counseling

We reviewed individual treatment plans for the 219 services in our sample and found no errors.

Case Management

We reviewed CMPs for the 609 services in our sample to determine if there was a plan completed prior to the client receiving case management services.

We found 16 errors where there was no CMP prior to the date of service. These 16 errors were used in the overall projection of $14,355.42.

We also identified 67 services where the CMP reassessment was not conducted within the 90 day time frame contained in the rule. We identified no improper payment for these 67 errors.

C. Authorization to Provide Services (Continued)

Recommendation:

The Provider should develop and implement internal controls to ensure that all case management services fully comply with requirements contained in Ohio Medicaid rules. The Provider should ensure case management plans are completed prior to services being rendered and reassessed within the required time frame. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider submitted an official response to the results of this examination which is presented in **Appendix II.** We did not examine the Provider's response and, accordingly, we express no opinion on it. The Provider declined an exit conference to discuss the results of this examination.

Appendix I

Summary of Case Management Services Sample

POPULATION
The population is all paid Medicaid case management services (procedure code H0006), less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. This system contains all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The sampling unit was Medicaid claims by service line.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population Services Provided	2,846
Number of Population Services Sampled	609
Number of Services Sampled with Errors	100
Total Medicaid Amount Paid for Population	$119,531.42
Actual Amount Paid for Population Services Sampled	$25,691.55
Projected Correct Population Payment Amount	$105,176
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$111,630
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$98,723
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$14,355.42
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90% overpayment precision from the point estimate)(equivalent to method used for Medicare audits)	$6,454 (+/- 6.14%)

Source: AOS analysis of MITS information and the Provider's medical records

Preble County TASC

225 N. Barron St., Eaton, Ohio 45320
937-456-3443 937-456-3062 Fax

Treatment Accountability for Safer Communities and Adolescent Drug & Alcohol Treatment Services

March 5, 2018

Dave Yost, Auditor of State of Ohio
Medicaid/Contract Audit Section
88 E. Broad Street, 9th Floor
Columbus, Ohio 43215

To Whom It May Concern:

In 2016, Preble County Treatment Accountability for Safer Communities (Preble County TASC) experienced a turnover in administration. During this transition, under the new administration, some discrepancies within our Medicaid billing process were discovered. Preble County TASC self-reported these discrepancies by calling the Ohio Department of Medicaid to alert them of our findings.

Once the issues were discovered our agency became proactive and immediately implemented the necessary changes to begin and maintain compliance.

An audit of our files was conducted by the Auditor of State's Office. Preble County TASC is in agreeance with the findings from their report.

Thank you for your time,

Jody Betscher

Jody Betscher, Program Director
Preble County TASC

Dave Yost • Auditor of State

PREBLE COUNTY TASC

PREBLE 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
MARCH 20, 2018

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