OHIO AUDITOR OF STATE
KEITH FABER

SAFE HAVEN DARTS, LLC
ROSS COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO SELECT BEHAVIORAL HEALTH SERVICES

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

RE: Safe Haven Darts, LLC
Ohio Medicaid Number: 0151487 and NPI: 1578937116

We were engaged to examine Safe Haven Darts, LLC (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation and service authorization related to the provision of group counseling services, case management services and intensive outpatient program services during the period of July 1, 2017 through June 30, 2018.

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 reimbursements made by Ohio Medicaid. Management of Safe Haven Darts, LLC 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. 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. 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 Disclaimer of Opinion

As described in the attached Compliance Examination Report, 10 other behavioral health agencies billed for the same recipient on the same day as the Provider during the examination period. In total, there were 222 services in which the Provider was paid for the same recipient on the same date. Further, there were 19 services in which the Provider billed for the same procedure code on the same date to the same recipient. In a test of nine of these 19 services, we found services that overlapped in time between agencies (33 percent) and a service with a start time only five minutes after the stop time of the same service from another agency that was more than 50 miles in distance from the Provider.

As such, we were unable to gain sufficient reliance on the documentation to determine the Provider's compliance with the specified Medicaid requirements. Nor were we able to satisfy ourselves as to the Provider's compliance with these requirements by other examination procedures.

Disclaimer of Opinion

Because of the limitation on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the Provider's compliance with the specified Medicaid requirements for the period of July 1, 2017 through June 30, 2018.

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 payments in the amount of $448.31. This finding plus interest in the amount of $34.29 (calculated as of January 26, 2021) totaling $482.60 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 ODM and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Keith Faber
Auditor of State
Columbus, Ohio

January 26, 2021

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

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. *See* Ohio Admin. Code § 5160-1-17.2(D) and (E)

The Provider is identified as an Ohio Department of Mental Health and Addiction Services licensed treatment program and received payment of $840,896 during the examination period from the Ohio Medicaid program under the provider number examined for 6,904 services.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for payment 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 for the engagement was limited to group counseling services, case management services and intensive outpatient program services as specified below for which the Provider billed with dates of service from July 1, 2017 through June 30, 2018 and received payment.

We received the Provider's claims history from the Medicaid database of services billed to and paid by Ohio's Medicaid program. During planning, we noted instances in which other Medicaid providers were reimbursed by Ohio Medicaid for the same behavioral health service for the same recipient on the same date.

In order to test a selection of these services, we summarized the unique recipients that received services during the examination period and searched the claims history for services reimbursed to any other Medicaid provider for these recipients during our examination period. We removed all claims paid at zero. We identified 10 other behavioral health agencies billing for services to the same recipient on the same day as the Provider during the examination period. In total, there were 222 services in which the Provider was paid for the same recipient on the same date as another behavioral health agency. We then extracted all services which were reimbursed for the same recipient, date of service and procedure code as the Provider. We identified 19 services between six other providers. We selected Health Recovery Services, Inc. (provider number 2864002) as it had the most potential duplicates and extracted nine of the 19 services to test in their entirety (Services Rendered by Multiple Providers Exception Test).

From the remaining population, we extracted all group counseling services (procedure code H0005), case management services (H0006), and intensive outpatient program services (H0015) into separate files. We summarized each file by recipient date of service (RDOS). A RDOS is defined as all services for a given recipient on a specific date of service.

We used a statistical sampling approach to examine services in order to facilitate a timely and efficient examination as permitted by Ohio Admin. Code § 5160-1-27(B)(1). The calculated sample sizes are shown in **Table 1**.

Purpose, Scope, and Methodology (Continued)

Table 1: Exception Test and Sample Sizes			
Universe	**Population Size**	**Sample Size**	**Services Selected**
Exception Test:			
Services Rendered by Multiple Providers (H0005 and H0006)	9		9
Samples:			
Group Counseling Services (H0005)	1,660 RDOS	92 RDOS	92
Case Management Services (H0006)	3,284 RDOS	58 RDOS	58
Intensive Outpatient Program Services (H0015)	1,281 RDOS	89 RDOS	89
Total		**239 RDOS**	**257**

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 billing process. During fieldwork, we reviewed service documentation and personnel records. We sent preliminary results to the Provider, and it subsequently submitted additional documentation which we reviewed for compliance prior to the completion of our fieldwork.

Results

The summary results of the compliance examination are shown in **Table 2**. The noncompliance and basis for the findings is discussed below in more detail.

Table 2: Results				
Universe	**Services Examined**	**Non-compliant Services**	**Non-compliance Errors**	**Improper Payment**
Exception Test:				
Services Rendered by Multiple Providers	9	3	3	$0.00
Samples:				
Group Counseling Services	92	4	4	$276.36
Case Management Services	58	2	2	$171.95
Intensive Outpatient Program Services	89	0	0	$0.00
Total	**257**	**9**	**9**	**$448.31**

A. Provider Qualifications

Exclusion or Suspension List

Per Ohio Admin. Code § 5160-1-17.2, in signing the Medicaid provider agreement, the Provider agrees that the individual practitioner or employee of the company is not currently subject to sanction under Medicare, Medicaid, or Title XX; or, is otherwise prohibited from providing services to Medicaid beneficiaries.

We identified three certified practitioners, three case management specialists and one licensed practitioner in the service documentation for the selected services and compared their names to the Office of Inspector General exclusion database and the ODM's exclusion or suspension list. We found no matches on the exclusion or suspension list.

A. Provider Qualifications (Continued)

We also compared identified administrative staff names, which included two licensed supervisors, to the exclusion or suspension list and found no matches.

Group Counseling and Intensive Outpatient Program Services

For the three certified and one licensed practitioners, we verified via the Ohio e-License Center website that their licenses were current and valid for all dates of service found in our selected services.

We then compared each individual identified as a rendering practitioner to the qualifications contained in Ohio Admin. Code §§ 5160-30-02(C) and 3793:2-1-08(BB–YY) for the selected services with a date of service in 2017 and to Admin. Code §§ 5160-8-05(C) and 5160-27-01(A) for 2018 dates of services.

All of the licensed and certified individuals met the required qualifications for the services rendered. We did not examine qualifications for the individuals identified on the case management services documentation.

B. Service Documentation

Documentation requirements for 2017 include the date, time of day and duration of the service contact, the description of the service, and the signature and credentials of staff providing the service. *See* Ohio Admin. Code §§ 5160-30-03(B) and 5122-27-04(E)

Documentation for 2018 services require all the above elements, with the exception of the original signatures and credentials of staff providing the service. *See* Ohio Admin. Code § 5160-8-05(F)

For errors where units billed exceeded the documented duration, the improper payment was based on unsupported units.

Services Rendered by Multiple Providers Exception Test

We obtained service documentation from Health Recovery Services for the services in which it received Ohio Medicaid reimbursement for the same recipient on the same date for the same service code as the Provider. The nine services selected were for services to seven recipients. We found three recipients (43 percent) in which the Provider had documentation indicating a time of service with the recipient present while the Health Recovery Services also had documentation for the same recipient on the same date with the recipient present.

There was also one recipient (14 percent) in which the Provider had documentation for a service indicating a time of service beginning at 9:00 am with the recipient present while Health Recovery Services had documentation for the same service on the same date ending at 8:55 am. These two agencies are located more than 50 miles apart; therefore, the documentation does not appear reasonable or accurate for the actual service performed.

We also noted that both agencies were providing case management services. Per Ohio Admin. Code § 3793:2-1-08, case management services means those activities provided to assist and support individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Having two agencies rendering the same service with no indication of any awareness or any coordination of activities could lead to over utilization of services which is an additional cost to the Medicaid program and could contribute to uncoordinated care that negatively impacts the recipient.

We did not identify improper payments related to the results of this exception test and referred this matter to ODM for further investigation.

B. Service Documentation (Continued)

Group Counseling Services Sample

The 92 services examined contained three services in which the documentation did not support the number of units billed. This error is included in the improper payment of $276.36.

Case Management Services Sample

The 58 services examined contained one service in which there was no supporting documentation to support the payment and one service in which the documentation did not support the number of units billed. These two errors resulted in an improper payment amount of $171.95.

Intensive Outpatient Program Services

All 89 services examined contained the required elements.

Recommendation

The Provider should implement a quality review process to ensure that documentation is present, complete and accurate prior to submitting claims for payment. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

In 2017, services required that within seven days of completion of the assessment or at the time of the first face-to-face contact following the assessment, providers shall develop an individual treatment plan based on the assessment for clients receiving specific drug and alcohol prevention and treatment services. The treatment plan shall contain the frequency, duration and type of treatment services, the signature of the staff member that developed the plan, and the original signature of the recipient. *See* Ohio Admin. Code §§ 5160-30-02(B) and 5122-27-03(C) and (D)

Effective January 1, 2018, the requirements stated a treatment plan must be completed within five sessions or a month of admissions, whichever is longer, must specify mutually agreed treatment goals and track responses to treatment and the medical record is expected to bear the signature of the professional who recorded it. *See* Ohio Admin. Code § 5160-8-05(F)

Group Counseling Services Sample

The 92 services examined contained one service in which there was no treatment plan. This error is included in the improper payment of $276.36.

All of the services examined in the exception test, case management and intensive outpatient program samples were authorized by a signed treatment plan.

Recommendation

The Provider should ensure that all individual treatment plans are completed within the required timeframe. The Provider should address this issue to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider responded to the one instance in which the Provider had documentation for a service beginning five minutes after receiving services from another agency. The Provider attributed this to its referral process. We reviewed the response and made no change to our results.

SAFE HAVEN DARTS, LLC

ROSS COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

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

Certified for Release 2/16/2021

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This report is a matter of public record and is available online at
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