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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: Highlife Recovery, LLC
Ohio Medicaid Number: 0289778 National Provider Identifier: 1114472289

We examined compliance with specified Medicaid requirements for provider qualifications, service documentation, service authorization and Medicaid coverage related to the provision of select behavioral health services as listed below during the period of January 1, 2020 through December 31, 2022 for Highlife Recovery, LLC (Highlife Recovery). We tested the following services:

- All instances in which more than one intensive outpatient level of care group counseling service (hereafter referred to as IOP) was reimbursed for the same recipient on the same day;
- All instances in which more than one psychiatric diagnostic evaluation service was reimbursed for the same recipient in a calendar year;
- All instances in which more than one urinalysis was reimbursed for the same recipient on the same day;
- All instances in which an evaluation and management (E&M) visit was reimbursed more than once for the same recipient on the same day; and
- A sample of remaining IOP services.

Highlife Recovery entered into an agreement with the Ohio Department of Medicaid (the Department) to provide services to Medicaid recipients and to adhere to the terms of the provider agreement, Ohio Revised Code, Administrative Code, and federal statutes and rules, including the duty to maintain all records necessary and in such form to fully disclose the extent of services provided and significant business transactions. Management of Highlife Recovery is responsible for its compliance with the specified requirements. The Compliance Section of this report identifies the specific requirements examined. Our responsibility is to express an opinion on Highlife Recovery'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 (AICPA). Those standards require that we plan and perform the examination to obtain reasonable assurance about whether Highlife Recovery complied, in all material respects, with the specified requirements referenced above. We are required to be independent of the Highlife Recovery and to meet our ethical responsibilities, in accordance with the ethical requirements established by the AICPA related to our compliance examination.

An examination involves performing procedures to obtain evidence about whether Highlife Recovery 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 modified opinion. Our examination does not provide a legal determination on Highlife Recovery's compliance with the specified requirements.

Internal Control over Compliance

Highlife Recovery 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 Highlife Recovery's internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed that, in a material number of instances, Highlife Recovery was reimbursed for more than one IOP service, urinalysis or E&M visit for the same recipient on the same day or more than one diagnostic psychiatric evaluation for the same recipient in the same calendar year and there was either no documentation to support the payment or the service exceeded the Medicaid coverage limitations.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, Highlife Recovery has complied, in all material respects, with the select requirements for the selected services for the period of January 1, 2020 through December 31, 2022. Our testing was limited to the specified Medicaid requirements detailed in the Compliance Section. We did not test other requirements and, accordingly, we do not express an opinion on Highlife Recovery's compliance with other requirements.

We identified improper Medicaid payments in the amount of $3,558.59. This finding plus interest in the amount of $379.84 (calculated as of January 6, 2024) totaling $3,938.43 is due and payable to the Department upon its adoption and adjudication of this examination report. Services billed to and reimbursed by the Department, which are not validated in the records, are subject to recoupment through the audit process per Ohio Admin. Code 5160-1-27.

This report is intended solely for the information and use of Highlife Recovery, the Department 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

February 5, 2025

COMPLIANCE SECTION

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 for the program are specified in the Ohio Administrative Code and the Ohio Revised Code. 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. Per Ohio Admin. Code 5160-1-17.2(D) and (E), providers must furnish such records for audit and review purposes.

Highlife Recovery is an Ohio Department of Mental Health and Addiction Services certified agency (provider type 95) with four locations in Circleville, Columbus, Grove City and Tiffin, Ohio. Highlife Recovery received payment of approximately $3.3 million including managed care and fee-for-service (FFS) for over 55,000 mental health and substance use disorder services.[1] Highlife Recovery has an additional active provider number (type 84 – 0288845) which received no reimbursements during the examination period; therefore, was not included in the scope of this examination.

Table 1 contains the behavioral health procedure codes selected for this examination.

Table 1: Behavioral Health Services	
Procedure Code	**Description**
90791	Psychiatric Diagnostic Evaluation
99211	E&M – Established Patient
99213	E&M – Established Patient
99214	E&M – Established Patient
H0015	IOP Level of Care Group Counseling, Per Diem
H0048	Alcohol and/or Other Drug Testing: Collection and Handling (Urinalysis)

Source: Appendix to Ohio Admin. Code 5160-27-03

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether Highlife Recovery's 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 of the engagement was limited to select services, as specified below, for which Highlife Recovery billed with dates of service from January 1, 2020 through December 31, 2022 and received payment.

We obtained Highlife Recovery's FFS claims from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We also obtained paid claims data from three managed care entities (MCEs) and confirmed the services were paid to Highlife Recovery's tax identification number. From the combined FFS and MCE claims data, we removed services paid at zero, third-party payments, co-payments, and Medicare crossover claims. The scope of our examination including testing procedures related to select services as identified in the Independent Auditor's Report.

The exception tests and calculated sample sizes are shown in **Table 2.**

[1] Payment data from the Medicaid claims database.

Table 2: Exception Tests and Sample		
Universe	**Population Size**	**Selected Services**
Exception Tests		
More than One IOP Service (H0015)		32
More than One Diagnostic Evaluation (90791)		22
More than One Urinalysis (H0048)		69
More than One E&M Visit (99211, 99213 & 99214)		14
Sample		
IOP Services (H0015)	3,397	80
Total		**217**

A notification letter was sent to Highlife Recovery setting forth the purpose and scope of the examination. During the entrance conference, Highlife Recovery described its documentation practices and billing process. During fieldwork, we obtained an understanding of the electronic health record system used, reviewed service documentation, and verified professional licensure. We sent preliminary results to Highlife Recovery, and it subsequently submitted additional documentation which we reviewed for compliance prior to the completion of fieldwork.

Results

The summary results are shown in **Table 3**. While certain services had more than one error, only one finding was made per service. The non-compliance and basis for findings is discussed below in further detail.

Table 3: Results				
Universe	**Services Examined**	**Non-compliant Services**	**Non-compliance Errors**	**Improper Payment**
Exception Tests				
More than One IOP Service	32	16	16	$2,210.72
More than One Diagnostic Evaluation	22	6	7	$686.27
More than One Urinalysis	69	17	17	$246.16
More than One E&M Visit	14	6	6	$415.44
Sample				
IOP Services	80	0	0	$0.00
Total	**217**	**45**	**46**	**$3,558.59**

A. Provider Qualifications

Exclusion or Suspension List

Per Ohio Admin. Code 5160-1-17.2(H), in signing the Medicaid provider agreement, a 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 17 rendering practitioners in the service documentation for the selected services and compared their names to the Office of Inspector General exclusion database and the Department's exclusion/suspension list. We also compared identified administrative staff names to the same database and exclusion/suspension list. We found no matches.

A. Provider Qualifications (Continued)

Licensure and Medicaid Enrollment

For the 17 licensed/certified practitioners identified in the service documentation for the selected services, we verified via the e-License Ohio Professional Licensure System that their licenses or certifications were current and valid on the date of service found in our selected services. There was one instance in which the rendering practitioner did not have a current and valid licensure on the selected date of service.

In accordance with Ohio Admin. Code 5160-1-17, the Department requires that providers and practitioners who want to furnish Medicaid covered services to Medicaid recipients enroll as Medicaid providers. This includes both providers and practitioners who will submit claims seeking reimbursement for services furnished to Medicaid recipients and rendering practitioners who are employed by provider groups or organizations who will submit claims to the department for payment.

We searched the Medicaid Information Technology System and verified that each rendering practitioner had an active Medicaid provider number on the first date found in our selected services and was active during the remainder of the examination period.

More than One Diagnostic Evaluation Exception Test

The 22 services examined contained one service rendered by a practitioner who did not have a current and valid certification on the selected service date; however, the service was co-rendered with a licensed practitioner. We did not associate an improper payment with this service.

B. Service Documentation

In accordance with Ohio Admin. Code 5160-27-02(H), providers shall maintain treatment records and progress notes as specified in rules 5160-1-27 and 5160-8-05 of the Ohio Administrative Code. Per Ohio Admin. Code 5160-8-05(F), documentation requirements include the date, time of day, and duration of service contact. In addition, each record is expected to bear the signature and indicate the discipline of the professional who recorded it.

We obtained service documentation from Highlife Recovery and compared it to the required elements. We also compared units billed to documented duration and ensured the services met the duration requirements, where applicable. For errors where the units billed exceeded the documented duration, the improper payment was based on the unsupported units.

More than One Diagnostic Evaluation Exception Test

The 22 services examined contained five instances in which there was no documentation to support the payment. These five errors are included in the improper payment of $686.27.

More than One Urinalysis Exception Test

The 69 services examined contained 17 instances in which there was no documentation to support the payment. These 17 errors resulted in the improper payment amount of $246.16.

More than One E&M Visit Exception Test

The 14 services examined consisted of seven dates of service in which the claims data indicated that two E&M visits were reimbursed for the same recipient on the same day. For two service dates, the MCE claims data confirmed only one E&M visit paid. For four service dates, there was documentation to support only one E&M visit. Finally, for the remaining service date, there was no documentation to support either E&M visit reimbursed. These six errors resulted in the improper payment of $415.44.

B. Service Documentation (Continued)

IOP Services Sample

All 80 services examined were supported by documentation that contained the required elements.

Recommendation

Highlife Recovery should develop and implement procedures to ensure that all service documentation and billing practices fully comply with requirements contained in Ohio Medicaid rules. In addition, Highlife Recovery should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. Highlife Recovery should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

A treatment plan must be completed within five sessions or one month of admission, whichever is longer, must specify mutually agreed treatment goals and track responses to treatment and is expected to bear the signature of the professional who recorded it in accordance with Ohio Admin. Code 5160-27-02(H) and 5160-8-05(F).

We obtained treatment plans from Highlife Recovery to confirm if the treatment plan indicated the service examined and was signed by the recording practitioner. We limited our testing of treatment plans to the sampled services.

IOP Services Sample

All 80 services were supported by a signed treatment plan.

D. Medicaid Coverage

More than One IOP Service Exception Test

Per Ohio Admin. Code 5160-1-17.2, by signing the Medicaid Provider Agreement the provider agrees to comply with the terms of the provider agreement, Ohio Revised Code, Ohio Administrative Code, and federal statutes and rules; and the provider certifies and agrees to submit claims only for services performed.

The 32 services examined contained 16 instances in which a duplicate per diem IOP service was reimbursed for the same recipient on the same day. These 16 errors resulted in the improper payment amount of $2,210.72.

More than One Diagnostic Evaluation Exception Test

Ohio Admin. Code 5160-27-02(B)(4) limits psychiatric diagnostic evaluations to one per recipient, per calendar year, per billing provider. We confirmed with two of the MCEs that it imposed the same limitation, and the remaining MCE did not impose the limitation.

The 22 services examined consisted of 11 instances in which more than one psychiatric diagnostic evaluation was reimbursed for the same recipient in a calendar year. Eight of these instances were paid by the MCE that did not impose the limitation. In two instances, there was no documentation to support one of the evaluations as described in the Service Documentation section. In the remaining instance, Medicaid's coverage limitation was exceeded, and no prior authorization was obtained. This error is included in the improper payment of $686.27.

D. Medicaid Coverage (Continued)

More than One Urinalysis Exception Test

Ohio Admin. Code 5160-27-02(C)(2) limits substance use disorder urine drug screening to one per day, per recipient. We confirmed with two of the MCEs that it imposed the same limitation, and the remaining MCE did not impose the limitation.

The 69 services examined consisted of 37 instances in which more than one urinalysis was reimbursed for the same recipient on the same day. In 20 instances, payment was made by the MCE that did not impose the limitation. For the remaining 17 instances, there was no documentation to support more than one urinalysis as described in the Service Documentation section.

Recommendation

Highlife Recovery should ensure that services billed to Medicaid are consistent with coverage and limitations contained in the Ohio Admin. Code. Highlife Recovery should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Official Response

Highlife Recovery submitted an official response to the results of this examination which is presented in the **Appendix**. We did not examine Highlife Recovery's response, and accordingly, we express no opinion on it.

APPENDIX

Highlife Recovery

Re: Report from Ohio Auditor of State
Report Date: 01/06/2025

Highlife Recovery's Attachment to Report from Ohio Auditor of State dated January 6, 2025

This document is being provided to accompany the report from the Auditor of State dated January 6, 2025. We would like to indicate that communication, professionalism, and feedback from the Auditor's office has made this process smooth and productive. Additionally, we appreciate this opportunity to provide this additional information in support of the findings.

We evaluated every line item provided by the Auditor's office in which inconsistencies were identified. We are in agreement with the Auditor's office that overpayments were made that require reimbursements. We are not in dispute of the amount of the overpayments, however, from Highlife Recovery's perspective, some phrasing in the Auditor's report may not elucidate the reasons that these incidents occurred. This response is not intended to challenge any of the information in the auditor's report, but rather enhance the findings and to clarify the following:

It is Highlife Recovery's perspective that during the period audited, for the types of services examined, every episode that services were represented to have been provided by our healthcare staff, each was:

1. Medically indicated
2. Justified by patients' individualized treatment plans
3. All services sent to the billing department were appropriately documented (with the exception that two bodily fluid collections, other than blood, could have been better documented)
4. Services performed did not exceed allowable limitations; with the exception of eleven instances of diagnostic evaluations which were provided at the time of admission as either a substance use or a mental health evaluation. Later there was an indication for the opposite condition and was performed by another provider, within a year of the admission procedure. The second evaluations were medically indicated; however, two of the three managed care organizations required a prior authorization for the second if performed within one year of the original. Highlife Recovery's utilization review services did not request these prior authorizations; however, we do not see any reason that these would not have been approved.

In the following paragraphs we have provided a brief explanation of our billing process, specifically focused on the resubmission process. We are including this information to enhance understanding as to why the same service line may have appeared twice in the ODM MITS software and may lead the reader to conclude that the services were provided in excess of allowable amounts per diem, and/or billed without proper documentation in the patient's chart. Rather, our current understanding is that this occurred as the result of the administrative processes that are described below in detail.

Our Process

Each service line was manually created and entered in the NueMD cloud-based software in accordance with existing documentation in Kipu, a cloud-based healthcare record system, and existed only once in both software systems. In addition, each service line was linked to a certain claim ("ticket") that would be submitted through the EDI and Clearinghouse.

Each claim would be submitted initially, and then would be resubmitted when appropriate, based on the denial reason and would follow the guidelines given by the Ohio Department of Medicaid, as well as the Managed Care Organizations (MCOs) in their associated provider manuals.

Example Resources Used for Resubmission Process

Molina Healthcare has issued a "Corrected Claims Billing Guide" which includes the following section:

"Billing Requirements: Follow these billing requirements when submitting corrected claims for all lines of business:

- Always submit through the appropriate channel based on the line of business: Availity or EDI.
- Do not submit corrected claims through the claim dispute/reconsideration process.
- Always include the original claim (most recent adjudication of the original claim) in the appropriate fields with a corrected claim indicator.
- Do not submit a corrected claim with only codes that were edited by Molina on the original claim. All codes billed on the original claim should be resubmitted.
- Do not submit paper corrected claims for the Medicaid line of business. (Paper submission is nonpreferred for all other lines of business.)"

In the ODM released EDI Adjustment information as well as 5010 277CA and 835 Companion Guides found on the ODM Trading Partner website more details about the specific requirements are included, and include statements such as:

"Key Fields used in adjustment claims: The key fields used in the 5010X22x 837 for adjustments are

1. CLM05-3 Frequency code (last digit) of the Bill type
    1. The data in this field will always be 'xx7 'or 'xx8'
2. 2. 2300 REF=F8 Original Reference Number REF01=F8 REF02=internal control number (ICN) for the claim that is being voided or replaced
    1. This will be the ICN assigned by the original payer of the claim.
    2. The ICN from the Fiscal Intermediary for Fee-for-Service claims will be 13 digits.
3. If the ICN is not found in the system, the adjustment will be rejected."

Claim Correction, Replacement, and Cancelation Procedures Followed During the Review Period
Based on the above information, our process at the time the services were billed included the following steps when a claim needed to be resubmitted:

- Indicating on the CMS1500 claim form that the new submission was in fact a resubmission, and utilize box 22 on the form to indicate whether it was a correction, replacement, or cancelation using the appropriate indication number (xx6, xx7, xx8)
- Indicating on the CMS1500 claim form the original reference number in box 22
- Indicating the previous amount paid towards the claim in box 29
- When applicable, attaching in the EDI file the response and associated denial from the first submission

We believe that other instances of overpayment were represented clearly in the Auditor's report and does not require further information at the present time.

Summary

In summary, although a claim may have been transmitted to ODM more than once, it was our understanding at the time, based on the data within the NueMD software, that there was no reason this would be viewed as a separate and duplicative service line. In fact, the software continued to show the service line only once and would instead show a second transmission of the claim on the same "Ticket" (as it was called in NueMD).

Upon reviewing the service lines and claims assessed by the Auditor's Office, we identified a communication issue between our software, NueMD, and the ODM MITS system. This error resulted in what appeared to be duplicate claim submissions for a single service line. Our intention, however, was to resubmit the same claim using the correct identification methods to indicate that it was a replacement, correction, or cancellation, and should not have been processed or paid as a separate encounter. As stated above, we agree with the Auditor's office that we received overpayments, and we believe that is largely due to what we have described above.

Present and Future Administrative Quality Assurance and Quality Improvements

During the time period of the audit, we utilized two separate systems, one for clinical documentation, and another for billing and collections. In the time since the period of the audit, Highlife Recovery has changed to a singular cloud-based platform, that is a single system for EHR/documentation and billing/collections. This system allows for significantly improved reports to be generated and are presently in use, improving upon the Quality Assurance. In addition, Highlife Recovery is currently developing Quality Assurance and Quality Improvement plans that will include the findings and recommendations of the Auditor's report; our intention is to make any needed improvements in an effort to assure errors identified in the report and/or as described above, do not persist and/or are resolved within the allowed timeline.

Highlife Recovery, LLC is presently working through the process of returning the excess funds, as identified by the Auditor's report by following the process indicated by Ohio Medicaid.

We appreciate the opportunity to attach this information to the Ohio Auditor of State's report and will make ourselves available for any additional questions that may arise.

Respectfully submitted,

Jonathan Lee Haimes, MD, FASAM, FACOG
MM/CEO, Highlife Recovery, LLC

OHIO AUDITOR OF STATE
KEITH FABER

HIGHLIFE RECOVERY, LLC

FRANKLIN 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 3/4/2025

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