LOGAN-HOCKING LOCAL SCHOOL DISTRICT
HOCKING COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2014

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LOGAN-HOCKING LOCAL SCHOOL DISTRICT
HOCKING COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO MEDICAID SCHOOL PROGRAM

Stephen Stirn, Superintendent
Logan-Hocking Local School District
2019 East Front Street
Logan, Ohio 43138

RE: *Medicaid Provider Number 2906252*

Dear Mr. Stirn:

We examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation, and service authorization related to the provision of Medicaid School Program (MSP) services. Specifically, we examined speech therapy services – individual and group, psychological testing services, occupational or physical therapy services, including therapeutic activity and cognitive skills development services, during the period of July 1, 2011 through June 30, 2014. We tested service documentation to verify that there was support for the services rendered. We also examined the Individualized Education Programs (IEPs) to determine if there was authorization for the service and reviewed practitioner qualifications. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid 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.

Opinion on Compliance

In our opinion, the Provider complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation and service authorization for the period of July 1, 2011 through June 30, 2014.

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 the Provider was overpaid by Ohio Medicaid for services rendered between July 1, 2011 and June 30, 2014 in the amount of $25,345.45. This finding plus interest in the amount of $480.70 totaling $25,826.15 is due and payable to ODM upon ODM's adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the Ohio Department of Medicaid, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General, and other regulatory and oversight bodies and is not intended to be and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

April 4, 2015

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "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 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)

Eligible recipients of MSP services are children between the ages of three to 21 who have an IEP which includes services that are allowable under Medicaid. *See* Ohio Admin. Code § 5160-35-01(A)(5) The only provider of MSP services are city, local or exempted village school districts, state schools for the blind and deaf and community schools. Ohio Admin. Code § 5160-35-02 (B)(1)

The Provider is a local school district that furnished services through the MSP during our examination period. The Provider received a total reimbursement of $389,487.71 for 13,602 services, consisting of the following procedure codes:

- 92506 – Speech evaluation
- 92507 and 92508 – Speech therapy (individual and group)
- 92522 and 92523 – Evaluation of speech sound production (articulate and language comprehension)
- 92551 – Screening test pure air tone
- 92609 – Therapeutic services for the use of speech generating device
- 92610 – Evaluation of swallowing function
- 96101 – Psychological testing
- 96150 – Health and behavior assessment
- 97001 and 97002 – Physical therapy evaluation and re-evaluation
- 97003 and 97004 – Occupational therapy evaluation and re-evaluation
- 97110, 97112, 97116, 97150 and 97530 – Occupational or physical therapy procedure, activities and techniques (individual and group)
- 97532 – Cognitive skills development
- 97533 – Sensory integrative techniques
- 97535 – Self-care/home management
- T1002 – Registered Nurse (RN) services
- T1003 – Licensed Practical Nursing (LPN) services

Services were recorded and signed electronically by the rendering practitioner in an electronic health record (EHR) and were billed to Ohio Medicaid by a contracted third party vendor directly from this EHR system.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid 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 included individual speech therapy services (procedure code 92507), group speech therapy services (procedure code 92508), psychological testing services (procedure code 96101), occupational or physical therapy services (procedure code 97110), occupational or physical therapeutic activity services (procedure code 97530) and occupational or physical therapy cognitive skills development services (procedure code 97532) that the Provider billed to Ohio Medicaid and received payment for during the period of July 1, 2011 through June 30, 2014.

We obtained the Provider's claims history from the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any voids and services paid at zero. We then extracted all services for procedure codes 92507, 92508, 96101, 97110, 97530 and 97532 and stratified this sub-population by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service.

We used a statistical 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). Specifically, we stratified the services into three strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). We used estimated error standard deviations and means to calculate a stratified sample size by stratum and overall. The final calculated sample size is shown in the table below.

Strata	Population Size	Sample Size
Stratum 1 - RDOS with amount paid less than $30	9,374 RDOS	232 RDOS
Stratum 2 - RDOS with amount paid between $30 and $49.99	2,189 RDOS	96 RDOS
Stratum 3 - RDOS with amount paid of $50 and over	388 RDOS	69 RDOS
Total	**11,951 RDOS**	**397 RDOS**

We then obtained detailed services for the sample RDOS. This sampling approach resulted in a statistical sample of 101 individual speech therapy services (procedure code 92507), 94 group speech therapy services (procedure code 92508), 45 psychological testing services (procedure code 96101), 15 occupational or physical therapy services (procedure code 97110), 23 therapeutic activity services (procedure code 97530) and 155 cognitive skills development services (procedure code 97532) for a total of 433 services.

An engagement 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, personnel related procedures and billing process. Our fieldwork was initiated following the entrance conference. The Provider was given two opportunities to provide additional documentation and we reviewed all documents received for compliance.

Results

The overpayments identified for 42 of 397 RDOS (42 of 433 services) from our stratified statistical random sample were projected across the Provider's total population of paid RDOS (which excluded services not selected for examination). As a conservative measure, the one RDOS (one service) in stratum two with an overpayment was set to zero for purposes of the projection. The actual amount of the overpayment was added to the projected amounts for strata one and three to give the overall estimated overpayment. This resulted in a projected overpayment amount of $37,268.71 with a 95 percent certainty that the true population overpayment fell within the range of $26,832.71 to $47,703.71, a precision of plus or minus $10,436 (28.03 percent). Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). However, because of skewness issues in stratum one, a further adjustment was made using t values for means of non-normal populations[2]. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $25,345.45. A detailed summary of our statistical sample and projection results is presented in **Appendix I**. The non-compliance found and the basis for our findings is described below in more detail.

A. Provider Qualifications

According to Ohio Admin. Code § 5101:3-35-02[3], a MSP provider shall employ or contract with licensed practitioners and shall require all employees and contractors who have in-person contact with recipients to undergo and successfully complete criminal records checks pursuant to Ohio Rev. Code § 5111.032.

In addition, Ohio Admin. Code § 5101:3-35-05(B) states qualified practitioners who can deliver services through the MSP must be a licensed occupational therapist, occupational therapy assistant, physical therapist, physical therapy assistant, speech-language pathologist, speech-language pathology aide, audiologist, audiology aide, registered nurse, practical nurse, clinical counselor, counselor, independent social worker, social worker, psychologist or school psychologist.

We tested the 21 practitioners who rendered services in our sample. We verified through the Ohio Department of Education and the Ohio e-License website that all 21 practitioners were licensed.

We identified two practitioners who rendered services in our sample prior to the required criminal records check. As a result, we considered 15 services rendered by these practitioners prior to a criminal records check as non-compliant and are included in the finding amount of $25,345.45.

As the Provider did not maintain background checks for all practitioners rendering Medicaid services, we were unable to gain assurance that the Provider routinely ensured the background checks were successfully completed prior to the practitioner rendering services.

[2] We applied a method described by Herbert Arkin in "Sampling Methods for the Auditor, An Advances Treatment," McGraw-Hill, 1982.

[3] 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. This renumbering effects all rules noted in the Results section of this report.

A. Provider Qualifications (Continued)

Recommendation:

The Provider should verify that all practitioners complete the required criminal records checks and should review and maintain the results to ensure that individuals are eligible to provide services. The Provider should address the identified issue to ensure the safety of students in addition to compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Ohio Admin. Code § 5101:3-35-05(G) states that documentation for the provision of each service must be maintained and include the date the activity was provided, a description of the service, procedure and method provided, group size, duration in minutes or time in/time out and signature or initials of the person delivering the service. In addition, Ohio Admin. Code § 5101:3-35-05(C)(13) states that services provided on days or at times when the recipient is not in attendance are not allowable for reimbursement.

We limited our examination to ensuring documentation was present for services rendered, that the definition of the procedural code billed was consistent with the service documented (including limitations), the units billed matched the minutes documented, the date of the service on the documentation matched the service date billed and the recipient was in attendance on the date of service.

We reviewed 433 services in our sample and identified the following service documentation errors:

- 18 services in which the units billed did not match supporting documentation;
- 4 services in which the Provider had service documentation which included a start and end time and a detailed treatment note; however, school attendance records indicate the recipient was absent on the date of service; and
- 3 services in which there was no service documentation.

These 25 service documentation errors are included in the finding amount of $25,345.45.

Recommendation:

The Provider should develop and implement internal controls to ensure that only services actually rendered are billed. The Provider should also maintain documentation for all services rendered. These issues should be addressed to ensure compliance with Medicaid rules and avoid future findings.

C. Individualized Education Programs

Services not indicated on the recipient's IEP prior to the provision of the service, with the exception of the initial assessment/evaluation, are not allowable for reimbursement. In addition, the IEP shall include specific services, including the amount, duration and frequency. Ohio Admin. Code §§ 5101:3-35-05(C)(11) and 5101:3-35-05(F)(3)

We reviewed 433 services in our sample and identified three services which were not authorized on the IEP. These three errors are included in the finding amount of $25,345.45.

C. Individualized Education Programs (Continued)

We also identified four group services in which the service was authorized on the IEP but the modality of the service was not specified. Although these services are non-compliant, they did not result in an overpayment because the reimbursement for the group service was less than the reimbursement would have been for an individual service.

Recommendation:

The Provider should develop and implement internal controls to ensure only services specified in the IEP are billed to Ohio Medicaid. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

APPENDIX I

Summary of Sample Record Analysis

POPULATION
The population from which this subpopulation and sample is being taken, is all paid Medicaid procedure code services 92507, 92508, 96101, 97110, 97530 and 97532; net of any adjustments where the service was performed and payment was made by ODM during the examination period.

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 a recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date.

SAMPLE DESIGN
We used a stratified random variable sample.

Description	Results
Number of Population RDOS Provided	11,951
Number of Population RDOS Sampled	397
Number of RDOS Sampled with Errors	42
Number of Population Services	12,377
Number of Population Services Sampled	433
Number of Services Sampled with Errors	42
Total Medicaid Amount Paid for Population	$325,064.29
Amount Paid for Population Services Sampled	$16,937.76
Estimated Overpayment Amount	$37,268.71
Precision of Estimate at 95 Percent Confidence Level (two-tailed) [4]	$10,436
Precision of Estimate at 90 Percent Confidence Level (two tailed) [4]	$8,758
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate and adjusted for skewness for stratum 1 and includes the actual error in stratum 2.) (Equivalent to method used by HHS/OIG in Medicare audits.)	**$25,345.45**

Source: Analysis of MITS information and the Provider's records

[4] Precision is based on projection of strata 1 and 3; stratum 2 used only actual value and did not add to sampling error.

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LOGAN HOCKING LOCAL SCHOOL DISTRICT

HOCKING 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
MAY 24, 2016

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