SUMMIT ACADEMY - YOUNGSTOWN
MAHONING COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2013

Dave Yost · Auditor of State

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SUMMIT ACADEMY - YOUNGSTOWN
MAHONING COUNTY

TABLE OF CONTENTS

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

Michael Majzun, Principal
Summit Academy - Youngstown
144 N Schenley Avenue
Youngstown, Ohio 44509

RE: Medicaid Provider Number 2889852

Dear Mr. Majzun:

We examined your (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service authorization and service documentation related to the provision of Medicaid School Program (MSP) services during the period of July 1, 2011 through June 30, 2013. We tested service documentation to verify that there was support for the service 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.

Basis for Qualified Opinion

Our examination disclosed that in a material number of instances there was no documentation of direct supervision for a speech pathologist with a conditional license and there were services rendered by practitioners who did not have criminal background checks. The Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

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, 2011 through June 30, 2013.

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 ODM for services rendered between July 1, 2011 and June 30, 2013 in the amount of $14,663.59. This finding plus interest in the amount of $1,011.89 totaling $15,675.48 is due and payable to ODM upon its 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

February 1, 2016

[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)

The Provider is a community school that furnished occupational therapy services, speech-language pathology services and mental health services through the MSP during our examination period. The Provider received a total reimbursement of $77,516.38 for 3234 services to 142 unique recipients on 322 dates of service.

Eligible recipients of MSP services are children between the ages of three to twenty-one 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 contracted with Summit Academy Management (the management company) to facilitate its day to day operations. All therapy and mental health 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 billing company 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 all procedure codes the Provider billed to Ohio Medicaid and received payment for during the period of July 1, 2011 through June 30, 2013. These procedure codes included:

- 90804 – Individual Psychology therapy 20-30 min
- 90806 – Individual Psychology therapy 45-50 min
- 90810 – Individual Psychology therapy interactive 20-30 min
- 90812 – Individual Psychology therapy interactive 45-50 min
- 90832 – Psychotherapy Patient & Family 30 minutes
- 90834 – Psychotherapy Patient & Family 45 minutes
- 90853 – Group Psychotherapy
- 92506 – Evaluation Speech therapy
- 92507 – Treatment of Speech Individual
- 92508 – Treatment of Speech Group
- 92551 – Screening Test Pure Tone Air Only
- 96110 – Developmental Screening with Interpretation and Report

Purpose, Scope, and Methodology (Continued)

- 96153 – Health & Behavior Intervention group
- 97003 – Occupational Therapy Evaluation
- 97004 – Occupational Therapy Re-Evaluation
- 97110 – Therapeutic Treatment 15 minutes each
- 97116 – Therapeutic Treatment - Gait Training with Stairs
- 97150 – Therapeutic Procedures Group
- 97530 – Therapeutic Activity Direct patient Contact 15 minutes each
- 97532 – Development of Cognitive Skills 15 minutes each
- 97533 – Sensory Integrative Techniques each 15 minutes each
- 97535 – Self-Care/Home Management Training 15 minutes each
- H0031 – Mental Health Assessment by Non-Physician

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 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) From the population of paid services, we randomly selected 30 recipients and then extracted all paid services for those 30 recipients that were billed to and paid by Ohio Medicaid during our examination period. This resulted in a sample size of 560 services.

An engagement letter was sent to the Provider on August 28, 2015 setting forth the purpose and scope of the examination. An entrance conference was held on September 10, 2015. During the entrance conference, the Provider described its documentation practices, personnel related procedures and billing process. Our fieldwork was performed following the entrance conference. The Provider was given four opportunities to provide additional documentation and we reviewed all documents received for compliance.

Results

We examined a random sample of 560 services provided to 30 unique recipients and identified 158 errors. The overpayments identified for 23 of 30 recipients (134 of 560 services) from our statistical cluster sample, where recipients were the primary units and services were the secondary units, were projected to the Provider's population of paid services. This resulted in a projected overpayment amount of $19,093.82 with a 95 percent certainty that the true population overpayment fell within the range of $13,831.24 to $24,356.41, a precision of plus or minus $5,262.58 (27.56 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 lower limit estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment is at least $14,663.59. 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 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, 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.

A. Provider Qualifications (Continued)

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 15 practitioners who rendered services in our sample. We verified through the Ohio e-License center and the Ohio Department of Education that all 15 practitioners were licensed.

We obtained background checks through the Ohio Department of Education's website and from the management company. One practitioner did not have a background check completed and three practitioners rendered services prior to completing their background checks. As a result, we concluded 38 services were non-compliant and these errors are included in the finding amount of $14,663.59.

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. Supervision Requirements

Ohio Admin. Code § 5101:3-35-05(B)(1)(b)(ii) states licensed occupational therapy assistants shall practice under the general supervision of a licensed occupational therapist who is employed or contracted by the Provider. Ohio Admin. Code § 5101:3-35-01(A)(6) defines general supervision as the licensed practitioner being available, but not necessarily present, and requires an interactive process which shall include initial and periodic face-to-face evaluation of the recipient and routine consult with the assistant. Finally, services that are not provided under the appropriate supervision and/or at the appropriate direction of a licensed practitioner are not allowable per Ohio Admin. Code § 5101:3-35-05(C)(14).

Ohio Admin. Code § 5101:3-35-05(B)(3)(b)(i) states a practitioner who can deliver speech-language pathology services is a licensed speech-language pathologist who holds a current, valid license issued under Ohio Rev. Code § 4753. Ohio Rev. Code § 4753.071 states that a person holding a conditional speech-language pathologist license may practice under the supervision of a person fully licensed.

The Provider did not submit proof that the speech-language pathologist with a conditional license practiced under the supervision of a fully licensed speech-language pathologist. We concluded the 43 services rendered by the speech-language pathologist with a conditional license were non-compliant and these errors are included in the finding amount of $14,663.59.

Recommendation:

The Provider should ensure that all licensed assistants and/or conditional practitioners are supervised as required and that evidence of the supervision is maintained. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

C. 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 560 services in our statistical sample and identified the following service documentation errors:

- 9 services in which there was no service documentation;
- 14 services in which school attendance records show that the recipients were absent or not enrolled on the date of service; however, in 13 of these instances the Provider had service documentation which included a start and end time and a detailed note; and
- 3 services in which the Provider billed the wrong procedure code resulting in an overpayment.

The 26 errors described above are included in the finding amount of $14,663.59.

In addition, we noted eight services in our sample in which the date of service on the clinical documentation did not match the date of service billed. These services were for hearing test, occupational therapy evaluation and re-evaluation, and mental health assessments. We reviewed the claims data and found no additional reimbursements for these services around the same time frame which would have indicated a duplicate billing. As such, we concluded these services were non-compliant but did not identify an overpayment for these errors.

Recommendation:

The Provider should develop and implement internal controls to ensure that only services actually rendered are billed and that services are billed with the correct date of service. 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.

D. 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 560 services in our statistical sample and identified the following errors:

- 22 services in which the Provider billed for more units than were authorized on the IEP;
- 2 services in which the service was not authorized in the IEP; and
- 3 services in which no IEP was present to cover the date of service billed.

D. Individualized Education Programs (Continued)

The 27 errors described above are included in the finding amount of $14,663.59.

In addition, we noted 16 services in which the IEP was missing frequency of service. We concluded these services were non-compliance, but did not identify an overpayment for these errors.

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
For the period July 1, 2011 through June 30, 2013

POPULATION
The population is all paid Medicaid School Program services 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 primary sampling unit was a Medicaid recipient and paid services were the secondary units.

SAMPLE DESIGN
We used a simple cluster random sample.

Description	Results
Number of Population Recipients (Primary Unit)	142
Number of Population Recipients Sampled	30
Number of Population Recipients with Errors	23
Number of Population Services	3,234
Number of Population Services Sampled (Secondary Unit)	560
Number of Services Sampled with Errors	134
Total Medicaid Amount Paid for Population	$77,516.38
Amount Paid for Population Services Sampled	$13,057.02
Estimated Population Overpayment Amount (Point Estimate)	$19,093.82
Precision of Estimate at 95 Percent Confidence Level	$5,262.58 (+/-27.56%)
Precision of Estimate at 90 Percent Confidence Level	$4,430.24 (+/- 23.20%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate.) (Equivalent to method used by HHS/OIG in Medicare audits.)	**$14,663.59**

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

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SUMMIT ACADEMY - YOUNGSTOWN

MAHONING 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 24, 2016

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