OHIO AUDITOR OF STATE
KEITH FABER

SORC, LLC
LUCAS COUNTY

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OHIO AUDITOR OF STATE
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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO SELECT SUBSTANCE USE DISORDER SERVICES

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

RE: SORC, LLC
Ohio Medicaid Number: 0101281 NPI Number: 1033536255

We were engaged to examine SORC, LLC's (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation and service authorization related to the provision of case management and ambulatory detoxification services and the requirements of service documentation related to the provision of alcohol/drug screen-lab analysis of specimens (lab) services during the period of July 1, 2017 through December 31, 2017.

We also tested instances in which other Ohio Medicaid providers were paid for the same recipient, service date and procedure code.

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 payments made by Ohio Medicaid. Management of SORC, LLC, is responsible for its compliance with the specified requirements. The accompanying Compliance 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 conducting the examination 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. An 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

Attestation standards established by the American Institute of Certified Public Accountants require that we request a written statement from SORC, LLC confirming, to the best of its knowledge and belief, its representations made to us during the course of our examination. We requested that SORC, LLC provide such a statement but SORC, LLC declined to do so.

Disclaimer of Opinion

Because of the limitation on the scope of our examination discussed in the preceding paragraphs, 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 December 31, 2017.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

As described in the attached Compliance Report, the Provider had no documentation to support any of the 99 services in our ambulatory detoxification services sample, no documentation to support 55 percent of lab services and no documentation to support 64 percent of case management services. In addition, the Provider had no treatment plans to authorize 48 percent of case management services and 90 percent of ambulatory detoxification services tested. We identified improper Medicaid payments in the amount of $624,381.46. This finding plus interest in the amount of $53,594.17 (calculated as of May 11, 2021) totaling $677,975.63 is due and payable to the ODM upon its adoption and adjudication of this 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 fraud, 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 of the Administrative Code.

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

May 11, 2021

[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 constitutes an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program." Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE 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)

Addiction Services

Under the provider number 0101281, the Provider is identified as an Ohio Department of Mental Health and Addiction Services licensed treatment program provider and received $972,156 in payments for 7,343 services during the examination period for 75 unique recipients.

Mental Health Services

Under the provider number 0256885, the Provider is identified as an Ohio Department of Mental Health provider and received $502 in payments for four services during our examination period. We did not examine any services associated with this Medicaid provider number.

The Provider has a registered trade name with the Secretary of State's Office, Sarah Outreach Resource Center, but doesn't appear to use this trade name.

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 lab services, case management services and ambulatory detoxification services as specified below for which the Provider billed with dates of service from July 1, 2017 through December 31, 2017 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. We removed all services paid at zero.

During planning, we noted instances in which other Ohio Medicaid providers were paid for the same recipient on the same date as the Provider. In order to test a selection of these services, we selected the provider with the most reimbursements for the same recipient on the same date and from this population selected three recipients and one date of service for each recipient to test in their entirety (Services Rendered by Multiple Providers Exception Test).

We then selected the recipient with the highest number of services billed by the Provider and other Ohio Medicaid providers on the same day. In order to test a selection of these services, we selected the provider with the highest number of reimbursements for this recipient on the same date as the Provider and selected five services to test in their entirety (Services Rendered by Multiple Providers to One Recipient Exception Test).

Purpose, Scope, and Methodology (Continued)

From the remaining population, we extracted all lab services (procedure code H0003), case management services (H0006) and ambulatory detoxification services (H0014) into separate files. 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). We selected a simple random sample from each file. The exception tests and calculated sample sizes are shown in **Table 1**.

Table 1: Exception Tests and Sample Sizes		
Universe	**Population Size**	**Selected Services**
Exception Tests		
Services Rendered by Multiple Providers (H0003, H0006, H0014, H0015, H0016)		7
Services Rendered by Multiple Providers to One Recipient (H0006)		5
Samples		
Lab Services (H0003)	478	84
Case Management Services (H0006)	2,399	99
Ambulatory Detoxification Services (H0014)	2,437	99
Total	**5,326**	**294**

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 processes. During fieldwork we reviewed service documentation. We sent preliminary results to the Provider and it submitted no additional documentation.

Results

The summary results of the compliance examination are shown in **Table 2**. 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 more detail.

Table 2: Results				
Universe	**Services Examined**	**Non-compliant Services**	**Non-compliance Errors**	**Improper Payment**
Exception Tests				
Services Rendered by Multiple Providers	7	6	6	$860.01
Services Rendered by Multiple Providers to One Recipient	5	2	3	$117.26
Samples				
Lab Services	84	84	84	$44,386.00[1]
Case Management Services	99	81	119	$106,557.00[2]
Ambulatory Detoxification Services	99	99	188	$472,461.19[3]
Total	**294**	**272**	**400**	**$624,381.46**

[1] The overpayments identified for all 84 services from a simple random sample were projected across the Provider's population of lab (H0003) services resulting in a projected overpayment of $44,386 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $41,556 to $47,215 (+/- 6.37 percent). A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

Results (Continued)

[2] The overpayments identified for 81 of the 99 services from a simple random sample were projected across the Provider's population of case management (H0006) services resulting in a projected overpayment of $120,952 with a precision of plus or minus $17,203 at the 95 percent confidence level. 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 methods used in Medicare audits), and a finding was made for $106,557. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $106,557. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

[3] Due to the 100 percent error rate in the ambulatory detoxification services sample, the improper payment is equal to the total paid amount for this procedure code, less services tested in the exception tests, for dates of service in the examination period.

A. Provider Qualifications

Exclusion or Suspension List

Per Ohio Admin. Code § 5160-1-17.2(H), 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 nine individuals in the service documentation for the selected services and compared their names to the Office of Inspector General exclusion database and the ODM exclusion or suspension list. We found no matches on an exclusion or suspension list. We also compared identified administrative staff names to the exclusion or suspension list and found no matches.

For the three certified and six licensed practitioners, we verified via the Ohio e-License Center website that their certification or license was current and valid for all dates of service found in our selected services and were active during the remainder of the examination period.

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.

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 addiction services shall include, but is not limited to, recipient identification, date of service, duration of service, description of the service rendered, and the dated signature and credentials of the rendering practitioner. *See* Ohio Admin. Code § 5122-27-04(E)

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 requested supporting documentation from the Zepf Center for the services in which it received Ohio Medicaid reimbursement for the same recipients on the same dates for the same type of services as the Provider. The Zepf Center did not comply with our request so we were unable to compare times of service delivery.

B. Service Documentation (Continued)

We tested seven services paid to SORC, LLC and found that six of these had no documentation to support the payment. These six errors resulted in an improper payment of $860.01.

Services Rendered by Multiple Providers to One Recipient Exception Test

We obtained service documentation from Caregiver Grove Behavioral Health, LLC for the services in which it received Ohio Medicaid reimbursement for the same recipient on the same date for the same type of service as the Provider. There was one date in which the Provider had documentation for a service indicating a time of service from 12:00 pm until 12:45 pm with the recipient present while Care Grove Behavioral Health, LLC had documentation for the same service on the same date from 11:00 am until 1:00 pm again with the recipient present. We could not determine which documentation was accurate.

We also noted that both agencies provided case management services. Per Ohio Admin. Code § 3793:2-1-08(M), 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 overlapping time or case management services from more than one provider but referred this matter to ODM for further investigation.

In addition to the aforementioned, of the five services tested, we found two instances in which there was no documentation to support the payment. These two errors resulted in an improper payment of $117.26.

Lab Services Sample

The 84 services examined contained 46 instances (55 percent) in which there were no lab results to support that a service was rendered and 38 instances (45 percent) in which the Provider billed two units of service but only had one lab result. These 84 errors resulted in a projected improper payment amount of $44,386.

Case Management Services Sample

The 99 services examined contained the following errors:

- 63 instances (64 percent) in which there was no documentation to support the payment;
- 6 instances in which the units billed exceeded the documented duration; and
- 2 instances in which the documentation was not signed by the practitioner.

These 71 errors are included in the projected improper payment amount of $106,557.

Ambulatory Detoxification Services Sample

We attempted to examine 99 payments for ambulatory detoxification services but the Provider submitted no documentation to support any of the sampled services. Due to the 100 percent error rate, we identified the total paid amount for this procedure code during the examination period, less services tested in the exception tests, of $472,461.19 as an improper payment.

B. Service Documentation (Continued)

Recommendation

The Provider should develop a record keeping system that ensures compliance with the requirement to maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The Provider should implement a quality review process to ensure that documentation is present, complete and accurate prior to submitting claims for payment. In addition, the Provider should maintain such records for a period of six years from the date of receipt of payment or until any audit initiated within the required six year period is completed. *See* Ohio Admin. Code § 5160-1-17.2(D) The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

The Provider should also ensure compliance with Chapter 5122 of the Ohio Admin. Code, as applicable, and seek technical assistance from the Ohio Department of Mental Health and Addiction Services to ensure that it maintains a complete and adequate individual client record.

C. Authorization to Provide Services

Addiction services require that the complete individual treatment plan be completed within five sessions or one month of admission, whichever is longer. The treatment plan shall document treatment goals and objectives, the frequency, duration and type of treatment services, the signature of the staff member that developed the plan, and the original signature of the client and be included in the individual's client record. *See* Ohio Admin. Code § 5122-27-03

Case Management Services Sample

The 99 services examined contained 48 instances (48 percent) in which there was no treatment plan to authorize the service. These 48 errors are included in the projected improper payment amount of $106,557.

Ambulatory Detoxification

The 99 services examined contained 89 services (90 percent) in which there was no treatment plan to authorize the service. These 89 errors are included in the improper payment of $472,461.19.

We did not test service authorization for lab services.

Recommendation

The Provider should establish a system to ensure treatment plans are present to authorize services prior to submitting a claim for services to the ODM. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider outlined the following action steps in response to the results described above:

- Training staff on various aspects of documentation and plans for annual training.
- A plan for routine quantitative and qualitative reviews of a sampling of current and closed records.
- Monthly reviews of compliance with established policies and safeguards relative to medical record documentation and billing.
- Contracted with a new billing company beginning in November 2019 which now provides for a monthly quality assurance audit of a random sample of billing/records.

- Adopted policies aimed at proper medical record documentation and adherence to these new policies will be monitored and enforced by management.

In its response, the Provider also indicated that due to staffing shortages and limited resources and activities related to its CARF recertification it was unable to produce the requested documentation and did not appreciate the implications of failing to do so. The Provider indicated that maintaining paper records in multiple office locations and utilizing multiple electronic medical record systems compromised its ability to produce full and complete patient records in a timely fashion. The Provider asserts that it now can produce additional records.

AOS Conclusion

Per Ohio Admin Code §§ 5160-1-27 and 5160-1-17.2, records subject to audit and review must be made available for examination and that failure to supply requested records within 30 days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program.

AOS's initial request for records was sent to SORC, LLC on August 4, 2020 and a final request for any additional records was made eight months later on April 19, 2021. The Provider responded to the final request stating that there were no additional records; however, during the exit conference held approximately six weeks later, the Provider reported that it was in communication with vendors to obtain access to prior electronic health records and was looking through paper documentation that was in disarray.

We reviewed the Provider's response and added an additional recommendation to address the lack of clinical records being maintained by the Provider. In addition to non-compliance with the Medicaid requirement to maintain records, the Provider's lack of records would render it unable to appropriately address requests from clients or other health care professionals for clinical records to facilitate continuity of care.

Appendix I

Summary of Lab Services Sample

POPULATION
The population is all paid laboratory analysis services, net of any adjustments, where the service was billed with dates of service during the period of July 1, 2017 through December 31, 2017 and payment was made by ODM.

SAMPLING FRAME
The sampling frame for this sample is paid and processed claims from the Medicaid Information Technology System (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 service.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Services in Population	478
Number of Services Sampled	84
Number of Services Sampled with Errors	84
Total Medicaid Amount Paid for Population	$57,360
Amount Paid for Services Sampled	$10,080
Estimated Overpayment (Point Estimate)	$44,386
Upper Limit Overpayment Estimate at 95% Confidence Level	$47,215
Lower Limit Overpayment Estimate at 95% Confidence Level	$41,556
Precision of Population Overpayment Projection at the 95% Confidence Level	$2,829 (+/- 6.37%)

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

Appendix II

Summary of Case Management Services Sample

POPULATION
The population is all paid case management services, net of any adjustments, where the service was billed with dates of service during the period of July 1, 2017 through December 31, 2017 and payment was made by ODM.

SAMPLING FRAME
The sampling frame for this sample is paid and processed claims from the Medicaid Information Technology System (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 service.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Services in Population	2,399
Number of Services Sampled	99
Number of Services Sampled with Errors	81
Total Medicaid Amount Paid for Population	$150,477
Amount Paid for Services Sampled	$6,586
Estimated Overpayment (Point Estimate)	$120,952
Precision of Overpayment Estimate at 95% Confidence Level	$17,203 (14.22%)
Precision of Overpayment Estimate at 90% Confidence Level	$14,395 ($11.9%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90% overpayment precision from the point estimate) (equivalent to the estimate used for Medicare audits)	$106,557

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

OHIO AUDITOR OF STATE
KEITH FABER

SORC, LLC

LUCAS 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 7/1/2021

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