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KEITH FABER

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

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

RE: Medical Service Options Inc.
(also known as S.T.E.P.S. of Recovery - Structured Treatment Empowering Promoting Sobriety)
Ohio Medicaid Number: 0103566 National Provider Identifier: 1417377797

We examined compliance with specified Medicaid requirements for select payments during the period of January 1, 2020 through December 31, 2022 for Medical Service Options Inc. (Medical Service Options). We tested the following select payments:

- All services billed during a potential inpatient hospital stay;
- All instances in which a service that is included in a per diem service was unbundled and billed separately;
- All recipient dates of service (RDOS)[1] with six or more services;
- A sample of alcohol and/or drug treatment program, per diem; and
- A sample of substance abuse disorder (SUD) individual counseling.

Medical Service Options 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, Ohio 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 Medical Service Options 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 Medical Service Options' 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 Medical Service Options complied, in all material respects, with the specified requirements referenced above. We are required to be independent of Medical Service Options 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 Medical Service Options 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.

[1] An RDOS is defined as all services for a given recipient on a specific date of service.

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 Medical Service Options' compliance with the specified requirements.

Internal Control over Compliance

Medical Service Options 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 Medical Service Options' internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed that, in a material number of instances, Medical Service Options lacked documentation to support the reimbursement and treatment plans did not describe the services performed and were not linked to the goals or objectives outlined in the treatment plan to substantiate the medical necessity of services performed.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified paragraph, Medical Service Options has complied in all material respects, with the select requirements for the selected payments 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 Medical Service Options' compliance with other requirements.

We identified improper Medicaid payments in the amount of $8,079.14. This finding plus interest in the amount of $776.93 (calculated as of January 6, 2025) totaling $8,856.07 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 in accordance with Ohio Admin. Code 5160-1-27.

This report is intended solely for the information and use of Medical Service Options, 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

January 30, 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.

Medical Service Options is an Ohio Department of Mental Health and Addiction Services certified agency (provider type 95) located in Gallia County. Medical Service Options received payment of approximately $1.8 million including managed care and fee-for-service (FFS) payments for over 16,000 substance abuse services.[2]

Table 1 contains the procedure codes selected for this compliance examination.

Table 1: Behavioral Health Services	
Procedure Code	**Description**
82075	Breathalyzer
90833	Individual Psychotherapy with evaluation and management (E/M) – 30 minutes
90836	Individual Psychotherapy with E/M – 45 minutes
90837	Individual Psychotherapy – 60 minutes
90838	Individual Psychotherapy with E/M – 60 minutes
96372	Therapeutic Injection
99204	Office visit, new patient
99213	Office visit, established patient (20 to 29 minutes)
99214	Office visit, established patient (30 to 39 minutes)
99401	Preventive medicine counseling (15 minutes)
99402	Preventive medicine counseling (30 minutes)
H0001	Alcohol and drug assessment
H0004	SUD Individual Counseling
H0006	Case Management
H0015	Intensive Outpatient Services (IOP)
H0048	Alcohol and/or Other Drug Testing
H2036	Alcohol and/or drug treatment program, per diem

Source: Optum EncoderPro – online subscription-based coding and reference tool

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether Medical Service Options' 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.

[2] Payment data from the Medicaid payment database.

Purpose, Scope, and Methodology (Continued)

The scope of the engagement was limited to select payments, as specified below, for which Medical Service Options billed with dates of service from January 1, 2020 through December 31, 2022 and received payment.

We obtained Medical Service Options FFS claims from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We also obtained paid claims data from two managed care entities (MCE) and confirmed the services were paid to Medical Service Options' tax identification number. From the combined FFS and MCE claims data, we removed services paid at zero, third-party payments, co-pays and Medicare crossover claims. From the remaining total paid services, we selected the following payments:

- All instances in which a service was billed during a potential inpatient hospital stay (procedure codes H0004 and 90837) (Services Billed During a Potential Inpatient Hospital Stay Exception Test);
- All instances in which a service that is included in a per diem service was unbundled and billed separately (procedure codes 82075, 90833, 99204, H0004, H0006, H0048, and H2036) (Unbundled Services Exception Test);
- All RDOS with six or more services (procedure codes 82075, 90833, 90836, 90837, 90838, 96372, 99204, 99213, 99214, 99401, 99402, H0001, H0004, H0006, H0015, and H0048) (RDOS with Six or More Services Exception Test);
- A sample of alcohol and/or drug treatment program, per diem services (procedure code H2036 (Alcohol and/or Drug Treatment Program, per Diem Services Sample); and
- A sample of SUD individual counseling services (procedure code H0004) (SUD Individual Counseling Services).

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

Table 2: Exception Tests and Samples

Universe	Population Size	Sample Size	Selected Payments
Exception Tests			
Services Billed During a Potential Inpatient Hospital Stay			2
Unbundled Services			11
RDOS With Six or More Services			193
Samples			
Alcohol and/or Drug Treatment Program, per Diem Services	1,184	80	80
SUD Individual Counseling Services	6,136	85	85
Total			**371**

A notification letter was sent to Medical Service Options setting forth the purpose and scope of the examination. During the entrance conference, Medical Service Options 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 Medical Service Options, and it subsequently submitted additional documentation which we reviewed for compliance prior to the completion of our fieldwork.

Results

The summary results are shown in **Table 3**. While certain payments 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	Payments Examined	Non-compliant Services	Non-compliance Errors	Improper Payment
Exception Tests				
Services Billed During a Potential Inpatient Hospital Stay	2	2	3	$202.82
Unbundled Services	11	8	12	$530.34
RDOS with Six or More Services	193	27	27	$1,143.56
Samples				
Alcohol and/or Drug Treatment Program, per Diem Services	80	18	18	$3,846.60
SUD Individual Counseling Services	85	20	20	$2,355.82
Total	**371**	**75**	**80**	**$8,079.14**

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 six rendering practitioners in the service documentation for the selected payments 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 and owners to the same database and exclusion/suspension list. We found no matches.

Licensure/Certification

For the six licensed/certified practitioners identified in the service documentation, we verified via the e-License Ohio Professional Licensure System that their licenses/certifications were current and valid on the first date found in our selected payments and were active during the remainder of the examination period. We identified no errors.

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, type, and duration of service contact. In addition, Ohio Admin. Code 5160-27-09(B)(3) lists services included a residential per diem service that will not be reimbursed separately.

B. Service Documentation (Continued)

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

Services Billed During a Potential Inpatient Hospital Stay Exception Test

The two payments examined contained two instances in which the recipient was confirmed as a hospital inpatient on the service date billed and one instance in which there was no documentation to support the payment.

These three errors resulted in the improper payment of $202.82.

In addition, Medical Service Options submitted documentation for one service when the recipient was a confirmed inpatient. The documentation implied the recipient was in the hospital even though SUD individual counseling isn't billable for a hospital inpatient.

Unbundled Services Exception Test

The 11 payments examined consisted of three per diem services and eight services unbundled and billed separately. The three per diem services contained documentation to support the payment. The remaining eight services were unbundled from a per diem service and four instances in which there was no documentation to support the payment.

These 12 errors resulted in the improper payment of $530.34.

RDOS With Six or More Services Exception Test

The 193 payments examined contained the following errors:

- 22 instances in which there was no service documentation to support the payment;
- three instances in which the documentation did not support the minimum time requirement; and
- two instances in which the documentation did not support the procedure code billed.

These 27 errors resulted in an improper payment of $1,143.56.

Alcohol and/or Drug Treatment Program, Per Diem Services Sample

The 80 payments examined contained six instances in which there was no service documentation to support the payment.

These six errors are included in the improper payment of $3,846.60.

SUD Individual Counseling Services Sample

The 85 payments examined contained five instances in which there was no service documentation to support the payment and two instances in which the units billed exceeded the documented duration.

These seven errors are included in the improper payment of $2,355.82.

B. Service Documentation (Continued)

Recommendation

Medical Service Options 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, Medical Service Options should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for payment. Medical Service Options should address the identified issues to ensure compliance with the 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, 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).

In addition, Ohio Admin. Code 5160-27-09(A) states, "For the purpose of medicaid reimbursement, substance use disorder treatment services shall be defined by and shall be provided according to the American society of addiction medicine also known as the ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care." The ASAM Criteria states "treatment planning should be a continuous process, with updates incorporated as needed when new information is learned or the patient's circumstances evolve."

We obtained treatment plans from Medical Service Options for the sampled payments. We reviewed all sampled payments to determine if they were supported by a signed treatment plan.

Alcohol and/or Drug Treatment Program, Per Diem Services Sample

The 80 payments examined contained 12 instances in which the treatment plan did not describe the services performed and were not linked to the goals or objectives outlined in the treatment plan to substantiate the medical necessity of services performed.

These 12 errors are included in the improper payment of $3,846.60.

SUD Individual Counseling Services Sample

The 85 payments examined contained nine instances in which the treatment plan did not describe the services performed and were not linked to the goals or objectives outlined in the treatment plan to substantiate the medical necessity of services performed and four instances in which there was no treatment plan.

These 13 errors are included in the improper payment of $2,355.82.

We limited testing authorization to provide services to the two samples.

Recommendation

Medical Service Options should develop and implement controls to ensure that all services billed are substantiated by a signed treatment plan and that treatment plans are updated as recipient needs change. Medical Service Options should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official Response

Medical Service Options submitted an official response to the results of this examination which is presented in the **Appendix**.

Auditor of State Conclusion

Providers shall maintain treatment records and progress notes as specified in rules 5160-01-27 and 5160-8-05 of the Ohio Administrative Code. Furthermore, by not including the types of services to be provided, including the frequency of those services, it gives the impression these are the client's desires and not what is prescribed by the appropriate medical professional. After reviewing the official response, we made no revisions to the results of the compliance examination. Therefore, we maintain that our results and recommendations are valid.

APPENDIX

Medical Service Options Inc.

dba S.T.E.P.S. of Recovery

Structured Treatment Empowering Promoting Sobriety

1336 Jackson Pike, Gallipolis, OH 45631, Tel. (740) 441-9800 Fax/9400

Response to Ohio Medicaid Compliance Audit

Completed January 30, 2025

Given that the results of this audit are public record, our documentations being submitted for clarifications of many of the items determined not to be in compliance and resulting in takebacks of funds from our Agency are detailed as follows:

1.) Numerous disallowances were due to apparent double payments resulting from Medicaid errors in payment processing of services billed by our billing company. Specifically, when multiple services were provided on the same date and one of them was psychotherapy, then the psychotherapy billing must have a modifier code 25 attached to the billing code to be paid. In a number of instances found out of compliance in the audit, our biller apparently initially submitted the billings without the modifier, which should not have been payable. Afterwards, apparently recognizing the error, the billing company rebilled said services with the modifier. Per the audit results in these cases both claims were in fact paid, when the service without the modifier should not have been paid by Medicaid, hence **those** payments had no service documentations, were deemed out of compliance and had to be paid back to Medicaid. It is agreed, of course, that those erroneous payments need to refunded to Medicaid.

2.) Numerous additional disallowances were due to simply the number of service hours being specified in the Individualized Treatment Plans (ITP), and not the language of "3.5 Level of Care" (LOC), that the service hours documentation was in a section of the ITP stating "Client Preference" instead of the "Type and Frequency of Treatment" section below it, and that therefore the treatment was specified as the "client's preference," and not ordered as part of the treatment plan. We were also advised that there was not evidence in the ITPs that the clients had "mutually agreed upon" the ITP creations. See our responses as follows:

a.) The service hours in these ITPs were in fact specified as the client "**will** attend twelve group sessions and 2 individual sessions per week for a total of 30 hour of treatment." Service hours of 30 or more per week has to be designated and understood as ASAM 3.5 LOC Residential Treatment since no other LOC has that many weekly service hours. The Senior Auditor Cerie R. Couts has specified to us in writing that ASAM criteria is utilized as the basis for this Compliance Audit. Additionally, the state authority of OMHAS which has certified and audited this agency every three years since 2014 has agreed the same that 3.5 Residential Treatment has a requirement of provision of 30 hours or more per week of said care services. Thus, these notes were in compliance yet disallowed.

b.) During our exit interview on January 30, 2025, the Senior Auditor Cherie R. Couts stated that these ITPs were disallowed also because the location in the ITP in which the data in a.) above was typed was put in the "Client's Preference" section of the document, rather than in the "Type and Frequency of Treatment" section right below it, and this would indicate the service hours are what the client wants, and not necessarily what the client has been assigned by the ITP and the Agency. We have five responses to these statements, as follows:

1.) The specific data in fact WAS in the ITP, and it is semantics as to where it is – the fact is that THE APPROPRIATE DATA IS PRESENT. This should not be criteria to disallow these payments as the work has been done and the required information is documented.

2.) Auditor Couts also specified during our exit interview on January 30, 2025 that the ITP needs to indicate that the ITP is "mutually agreed upon" by both the client and the Agency. The evidences that this criteria has been met is represented clearly by the services to be rendered being typed into "Client Preferences," (another reason for its placement there), and the language typed in was that the client "**WILL** attend twelve group sessions and 2 individual sessions per week for a total of 30 hour of

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treatment."

3.) In the ITP is also the section:
Description of client's involvement in treatment/service planning:
_____ _____ was an active participant in the development of the individualized treatment plan.

4.) In the ITP is also the section:
Client's response to treatment plan:
_____ states he/she will commit to the treatment plan.

5.) The clients have signed the ITPs.

We as an Agency are at a loss to understand why numerous ITPs audited have been deemed in non-compliance when all of these criteria in #2.) as above are applied as explained to the Auditor, unless these clear documentations are just being disregarded, which would be appear to be inappropriate. These ITPs having been deemed as non-compliant has resulted in our Agency being expensed thousands of dollars in Medicaid takebacks.

Crystal Ickler CDCA, Residential House Manager

Crystal Ickler CDCA

Nicholas Landry DO, CEO

Nicholas P. Landry DO

OHIO AUDITOR OF STATE
KEITH FABER

MEDICAL SERVICE OPTIONS INC.

GALLIA COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

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

Certified for Release 2/25/2025

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