OHIO AUDITOR OF STATE
KEITH FABER

URBAN MINORITY ALCOHOLISM AND DRUG ABUSE OUTREACH PROGRAM OF LUCAS COUNTY, INC.

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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: Urban Minority Alcoholism and Drug Abuse Outreach Program of Lucas County, Inc.
Ohio Medicaid Number: 3040097 NPI: 1427107317

We examined Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) of Lucas County, Inc. (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation and service authorization related to the provision intensive outpatient services in which more than one unit of service was billed on the same date and service documentation related to the provision of withdrawal management with extended on site monitoring services during the period of January 1, 2018 through June 30, 2018.

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 reimbursements made by Ohio Medicaid. Management of UMADAOP of Lucas County, Inc. is responsible for its compliance with the specified requirements. The accompanying Compliance Examination 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 our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Provider complied, in all material respects, with the specified requirements referenced above. 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. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. Our 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 Adverse Opinion

As described in the attached Compliance Examination Report, the Provider billed using the procedure code for withdrawal management with extended on site monitoring services in 1,150 instances for the provision of room and board in a sober home, which is not a covered Medicaid service. The Provider acknowledged that it had rendered no withdrawal management with extended on site monitoring services during the examination period.

We also examined recipient dates of service in which the Provider billed for two units of intensive outpatient services which is a per diem service. We confirmed for all of these instances that the Provider had improperly billed the second unit of this service.

In addition, after removing the duplicate billings, 29 percent of the intensive outpatient services were not authorized in a treatment plan as required, 68 percent were billed with the incorrect modifier resulting in an overpayment and seven percent had no document to support the payment.

Attestation standards established by the American Institute of Certified Public Accountants require that we request a written statement from UMADAOP of Lucas County, Inc. stating that compliance with the Medicaid Program to which we applied procedures has been accurately evaluated. We requested that that UMADAOP of Lucas County, Inc. provide such a statement but UMADAOP of Lucas County, Inc. declined to do so.

Adverse Opinion

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements withdrawal management with extended on site monitoring services and intensive outpatient services for the period of January 1, 2018 through June 30, 2018.

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 identified improper Medicaid payments in the amount of $496,063. This finding plus interest in the amount of $26,192.81 (calculated as of the date of this report) totaling $522,255.81 is due and payable to the ODM upon its adoption and adjudication of this examination 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.

[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)

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

January 5, 2021

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

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)

Under the provider number 3040097, the Provider is identified as an Ohio Department of Mental Health and Addiction Services (OhioMHAS) licensed treatment program provider and received $816,358 in payments for 6,200 services during the examination period for services to 89 unique recipients.

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 withdrawal management with extended on site monitoring (withdrawal management) and intensive outpatient services as specified below for which the Provider billed with dates of service from January 1, 2018 through June 30, 2018 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. From the total paid services population, we removed all claims paid at zero.

During planning, we noted that 42 percent of the intensive outpatient services (procedure code H0015) were billed with two units even though this code is a per diem rate. Based on this, we extracted all intensive outpatient services with two or more units on a recipient date of service (RDOS). A RDOS is defined as all services for a given recipient on a specific date of service. From the remaining population, we extracted all withdrawal management with extended on site monitoring services (H0012) into a separate file. We selected a simple random sample from each file.

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). The calculated sample sizes are shown in **Table 1**.

Table 1: Sample Sizes

Universe	Population Size	Sample Size	Services Selected
Samples			
Withdrawal Management with Extended on Site Monitoring Services (H0012)	1,150	88	88
RDOS with Greater than One Intensive Outpatient Service (H0015)	369 RDOS	76 RDOS	152
Total			**240**

Purpose, Scope, and Methodology (Continued)

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, personnel related procedures and billing process. During fieldwork, we examined service documentation and personnel records. We sent preliminary results to the Provider and it stated it had no additional documentation to submit for review.

Results

The Provider indicated it billed sober home room and board as withdrawal management services (H0012) after a discussion with an ODM supervisor. The Provider had no support for this discussion or the name of the ODM staff. We inquired with ODM and the Department indicated it had no record of such a conversation. The Provider indicated it billed for room and board using the procedure code for withdrawal management until it became aware that room and board is not a covered service as a result of this examination.

The summary results of the compliance examination are shown in **Table 2.** The noncompliance and basis for the findings is discussed below in more detail.

Table 2: Results

	Services Examined	Non-compliant Services	Non-compliance Errors	Improper Payment
Withdrawal Management with Extended on Site Monitoring Services Sample	88	88	88	$414,414[1]
Greater Than One Unit Intensive Outpatient Services	152	136	156	$81,649[2]
Total	**240**	**224**	**244**	**$496,063**

[1] Due to the 100 percent error rate, the improper payment is equal to the total paid amount for this procedure code for dates of service in the examination period.

[2] The overpayments identified for 76 of the 76 statistically sampled RDOS (136 of the 152 services) were projected to the Provider's population of paid RDOS with greater than one unit of intensive outpatient services resulting in a projected overpayment of $81,649 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $77,274 to $86,023 (+/- 5.31 percent.). A detailed summary of our statistical sample and projection results is presented in the Appendix.

A. Provider Qualifications

Exclusion or Suspension List

Per Ohio Admin. Code § 5160-1-17.2, 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.

A. Provider Qualifications (Continued)

We did not test provider qualifications for withdrawal management services after it was confirmed that the Provider did not render these services.

We identified seven certified practitioners in the service documentation for the selected services and compared their names to the Office of Inspector General exclusion database and the ODM's exclusion or suspension list. We found no matches on the exclusion or suspension list. We also compared identified administrative staff names to the exclusion or suspension list and found no matches.

For the seven certified practitioners, we obtained documentation from the Provider to determine the applicable designation based on education/experience levels. We then compared each individual identified as an unlicensed practitioner to the qualifications contained in Admin. Code § 5160-27-01(A)(6).

We found no errors related to provider qualifications.

B. Service Documentation

Documentation requirements include the date, time of day and duration of the service contact and a description of the service. *See* Ohio Admin. Code § 5160-8-05(F)

Per the ODM Provider Requirements and Reimbursement Manual, effective for dates of service beginning January 1, 2018, practitioner modifiers are required when submitting claims to Ohio Medicaid as they are used to count towards soft limits, price services and adjudicate claims appropriately. For errors where the incorrect modifier was billed, the improper payment was based on the difference between the amount that was reimbursed and the amount that should have been reimbursed.

Withdrawal Management with Extended on Site Monitoring Services Sample

The Provider did not render withdrawal management with extended on site monitoring services. The Provider reported that it used this procedure code to bill for room and board in its sober home. Accordingly, we identified the entire paid amount for this procedure code during the examination period, $414,414, as an improper payment.

RDOS with Greater Than One Unit Intensive Outpatient Service Sample

The 152 services examined contained the following errors:

- 76 instances in which the Provider billed two intensive outpatient services with the same date of service for the same recipient;
- 52 instances in which the incorrect modifier was billed resulting in an overpayment; and
- 5 instances, after accounting for the duplicate services, in which there was no documentation to support the service billed.

In two of the instances in which the Provider billed two intensive outpatient services with the same date of service, there was documentation for a separate group counseling service. We verified that the separate group counseling was not billed and paid under a different procedure code. The improper payment for these two instances was calculated using the difference between the rate paid and rate for group counseling (procedure code H005).

These 133 errors are included in the projected overpayment amount of $81,649. A detailed summary of the statistical sample and projection results is presented in the **Appendix**.

During the entrance conference, the Provider indicated it was unaware of the duplicate billings.

B. Service Documentation (Continued)

Recommendation

The Provider should work with the ODM to identify payments for withdrawal management with extended on site monitoring services billed with dates of service after our examination period and arrange for repayment of these services. In addition, the Provider should implement a review process to ensure that documentation is present, complete and accurate prior to submitting claims for payment. The Provider 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 a month of admissions, whichever is longer, and must specify mutually agreed treatment goals and track responses to treatment. In addition, the record is expected to bear the signature of the person who recorded it. *See* Ohio Admin. Code § 5160-8-05(F)

We did not test authorization to provide withdrawal management services after it was confirmed that the Provider did not render these services.

RDOS with Greater Than One Unit of Intensive Outpatient Service Sample

After removing the duplicate billing from the sample of 152 services, we examined the remaining 76 services for the required treatment plan. Of these 76 services, 22 had no treatment plan to cover the date of service. In addition, of the two services that could have been billed as group counseling, one service had no treatment plan. These 23 errors are included in the projected improper payment amount of $81,649.

Recommendation

The Provider should ensure that all individual treatment plans are completed within the required time frame. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider declined to submit an official response to the results noted above.

APPENDIX

Summary of Sample Record Analysis
RDOS with Greater Than One Unit Intensive Outpatient Service

POPULATION
The population is all paid RDOS with greater than one unit intensive outpatient service (procedure code H0015), net of any adjustments, where the service was performed during the examination period and payment was made by ODM.

SAMPLING FRAME
The sampling frame was paid and processed claims from the ODM's 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 an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	369
Number of Population RDOS Sampled	76
Number of RDOS Sampled with Errors	76
Number of Population Services	740
Number of Population Services Sampled	152
Number of Services Sampled with Errors	136
Total Medicaid Amount Paid for Population	$105,760.28
Amount Paid for Population Services Sampled	$21,891.24
Projected Population Overpayment Amount	$81,649
Upper Limit Overpayment Estimate at 95% Confidence Level	$86,023
Lower Limit Overpayment Estimate at 95% Confidence Level	$77,274
Precision of population overpayment projection at the 95% Confidence Level	$4,375 (5.36%)

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

OHIO AUDITOR OF STATE
KEITH FABER

URBAN MINORITY ALCOHOLISM AND DRUG ABUSE OUTREACH PROGRAM OF LUCAS COUNTY, INC.

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 4/13/2021

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