OHIO AUDITOR OF STATE
KEITH FABER

URBAN OUNCE OF PREVENTION BEHAVIORAL HEALTH SERVICE, INCORPORATED
SUMMIT 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: Urban Ounce of Prevention Behavioral Health Services, Incorporated
Ohio Medicaid Number: 3112492 NPI Number: 1679690309

We were engaged to examine Urban Ounce of Prevention Behavioral Health Services, Incorporated (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation and service authorization related to the provision of intensive outpatient program services and individual counseling during the period of January 1, 2018 through June 30, 2018. 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.

We also included in our scope case management services on a single select date, recipient dates of service with greater than 13 units of case management and intensive outpatient services to recipients that received more than one service per day.

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 Urban Ounce of Prevention Behavioral Health Services, Incorporated is responsible for its compliance with the specified requirements. The accompanying Compliance Report identifies the specific requirements examined.

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

As described in the attached Compliance Report, we noted concerns with the authenticity and validity of the Provider's service documentation. As such, we were unable to gain sufficient reliance on the documentation to determine the Provider's compliance with the specified Medicaid requirements. Nor were we able to satisfy ourselves as to the Provider's compliance with these requirements by other examination procedures.

Disclaimer of Opinion

Because of the limitation on the scope of our examination discussed in the preceding paragraph, 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 January 1, 2018 through June 30, 2018.

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.

We identified improper Medicaid payments in the amount of $20,976.91. This finding plus interest in the amount of $1,705.31 (calculated as of May 2, 2021) totaling $22,682.22 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 or 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 Provider, ODM and other regulatory and oversight entities, 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 2, 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 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 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 provider number 3112492, the Provider is identified as an Ohio Department of Mental Health and Addiction Services licensed treatment program and received $936,500 in payments for 9,676 services during the examination period.

Mental Health Services

Under provider number 0320531, the Provider is identified as an Ohio Department of Mental Health provider and received no payments during the examination period.

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 intensive outpatient program (procedure code H0015), case management (H0006), and individual counseling/psychotherapy services (90832, 90834, 90839, 90840, 90837, H0004) 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 and removed all claims paid at zero.

From the total paid services population, we extracted all intensive outpatient program services (H0015). We then extracted all recipient dates of service (RDOS) in which the more than one unit of service was billed. An RDOS is defined as all services for a given recipient on a specific date of service. We selected all 59 services to test in their entirety (RDOS Greater than One Unit Intensive Outpatient Program Service Exception Test). From the remaining intensive outpatient program services, we selected a simple random sample.

We then extracted all case management services (H0006). From this file we extracted all case management services billed with a service date of January 3, 2018 (the date in the population with the highest number of case management services). We selected all 40 services to test in their entirety (Case Management Services on a Single Select Date Exception Test). From the remaining population of case management services, we then extracted all RDOS with greater than 13 units. We selected all 23 RDOS to test in their entirety (RDOS Greater than 13 Units Case Management Exception Test).

Purpose, Scope, and Methodology (continued)

Finally, from the total paid services population, we extracted all individual counseling/psychotherapy services (H0004, 90832, 90834, 90837, 90839 and 90840), summarized by RDOS, and selected a simple random sample. We expanded the services in the sample to ensure representation of all services codes.

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). **Table 1** shows all of the exception tests and samples selected.

Table 1: Exception Test and Sample Sizes

Universe	Population Size	Sample Size	Services Selected
Exception Tests			
Case Management Services on a Single Select Date (H0006)	40		40
RDOS Greater than 13 Units Case Management (H0006)	23 RDOS		54
RDOS Greater than One Unit Intensive Outpatient Program Service (H0015)	59 RDOS		122
Samples			
Intensive Outpatient Program Services (H0015)	1,719	92	92
Individual Counseling/Psychotherapy Services (90832, 90834, 90839, 90840, 90837, H0004)	1,264 RDOS	89 RDOS[1]	153
Total			**461**

[1] Additional 25 services added to the 89 RDOS to ensure all procedure codes included in the sample.

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 reviewed service documentation and personnel records. We sent preliminary results to the Provider and it subsequently submitted additional documentation which we reviewed for compliance prior to the completion of our fieldwork.

Results

We obtained copies of service documentation from the Provider. Upon reviewing the documentation, we noted the following concerns:

- 1 instance of a service overlapping with another service for the same recipient on the same date with the recipient being documented as present on both service documents;
- 1 instance of a cloned note;
- 1 instance in which the documented time did not meet the minimum required to bill intensive outpatient therapy program service and the Provider subsequently submitted a clone of the original document except that the time and clinical supervisor were different;
- 1 instance in which the note repeatedly indicated "his" but the recipient was female;
- 1 instance in which the Provider submitted two documents for the same recipient, date, time, service and practitioner but the narrative in the notes were different;

Results (Continued)

- 1 instance in which the date and case number were manually changed on a note and the description of the recipient appears to describe a different person than described on service narrative for the same recipient for a different service on the same date; and
- Multiple instances in which the Provider re-submitted documentation with a hand written notation indicating a procedure code which contradicted the service check marked on the document.

Due to the aforementioned issues, we were unable to gain assurance over the authenticity and validity of the service documentation and the errors and improper payments noted below reflect a conservative approach. Accordingly, users of this report should be aware that the actual errors and improper payments may be greater.

The summary results of the compliance examination are shown in **Table 2.** While certain services had more than one error, only one improper payment was calculated per service. The noncompliance and basis for the findings is discussed below in more detail.

Table 2: Results

Universe	Services Examined	Non-compliant Services	Non-compliance Errors	Improper Payment
Exception Tests				
Case Management Services on a Single Select Date	40	9	13	$527.58
RDOS Greater than 13 Units Case Management	54	32	32	$3,627.34
RDOS Greater than One Unit Intensive Outpatient Program Service	122	65	65	$8,999.92
Samples				
Intensive Outpatient Program Services	92	16	17	$2,120.52
Individual Counseling/Psychotherapy Services	153	65	70	$5,701.55
Total	**461**	**187**	**197**	**$20,976.91**

A. Provider Qualifications

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.

For the 21 individuals in the service documentation for the selected services we 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 11 certified practitioners and three licensed practitioners, we verified via the Ohio e-License Center website that their certification or license was current and valid on the first date of service found in our selected services and were active during the remainder of the examination period.

A. Provider Qualifications (Continued)

We then compared each individual identified as a certified or licensed rendering practitioner to the qualifications contained in Admin. Code § 5160-8-05(C) and 5160-27-01(A). All of the certified and licensed individuals met the required qualifications for the services rendered.

Exception Test: Case Management Services on a Single Select Date

The 40 services examined contained one instance in which the service documentation did not contain the name of the rendering practitioner. Since we identified no ineligible practitioners, this instance did not result in an overpayment.

B. Service Documentation

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

For errors where units billed exceeded the documented duration, the improper payment was based on unsupported units. For errors where the minimum duration of service was not met for intensive outpatient program services, the improper payment was based on the difference between the payment received and what the payment should have been based on the applicable number of units billed as group counseling.

Exception Test: Case Management Services on a Single Select Date

The 40 services examined contained six instances in which there was no service documentation and three instances in which the units billed exceed the documented duration. These nine errors resulted in an improper payment amount of $527.58.

We also noted three instances in one day in which the start time for one service was the same as the end time of a previous service rendered by the same practitioner. These instances did not result in an overpayment, but do call into question the reliability of the documents.

Exception Test: RDOS Greater than 13 Units Case Management

The 54 services examined contained 28 instances (52 percent) in which there was no service documentation and four instances in which the units billed exceeded the documented duration. These 32 errors resulted in an improper payment amount of $3,627.34.

Exception Test: RDOS Greater than One Unit Intensive Outpatient Program Service

The 122 services examined contained 63 instances (52 percent) in which there was no service documentation and two services in which the minimum duration of service was not met. These 65 errors resulted in an improper payment amount of $8,999.92

Intensive Outpatient Program Services Sample

The 92 services examined contained the following errors:

- 8 instances in which there was no service documentation;
- 4 instances in which the minimum duration of service was not met; and
- 1 instance in which the documented start time of the service overlapped with the end time of a different service for the same recipient on the same date with the recipient being documented as present on both service documents.

B. Service Documentation (Continued)

These 13 errors are included in the improper payment amount of $2,120.52.

Individual Counseling Services Sample

The 153 services examined contained 58 instances (38 percent) in which there was no service documentation and three instances in which the units billed exceed the documented duration. These 61 errors are included in the improper payment amount of $5,701.55.

Recommendation

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 ensure that units billed are supported by documentation. 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 one month of admission, whichever is longer, must specify mutually agreed treatment goals and track responses to treatment and is expected to bear the signature of the professional who recorded it. *See* Ohio Admin. Code § 5160-8-05(F)

We limited our testing of service authorization to the samples.

Intensive Outpatient Program Services Sample

The 92 services examined contained three instances in which there was no treatment plan to cover the date of service and one instance in which the treatment plan was not signed by the practitioner who developed it. These four errors are included in the improper payment amount of $2,120.52

Individual Counseling Services Sample

The 153 services examined contained the following errors:

- 4 instances in which there was no treatment plan to cover the date of service;
- 3 instances in which the treatment plan was not signed by the practitioner who developed it; and
- 2 instances in which the treatment plan did not authorize the service.

These nine errors are included in the improper payment amount of $5,701.55.

Recommendation

The Provider should develop and implement controls to ensure that all individual treatment plans are completed within the required timeframe and are signed by the staff person who developed it. The Provider should address these issues 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.

OHIO AUDITOR OF STATE
KEITH FABER

URBAN OUNCE OF PREVENTION BEHAVIORAL HEALTH SERVICES, INCORPORATED

SUMMIT 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 5/18/2021

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