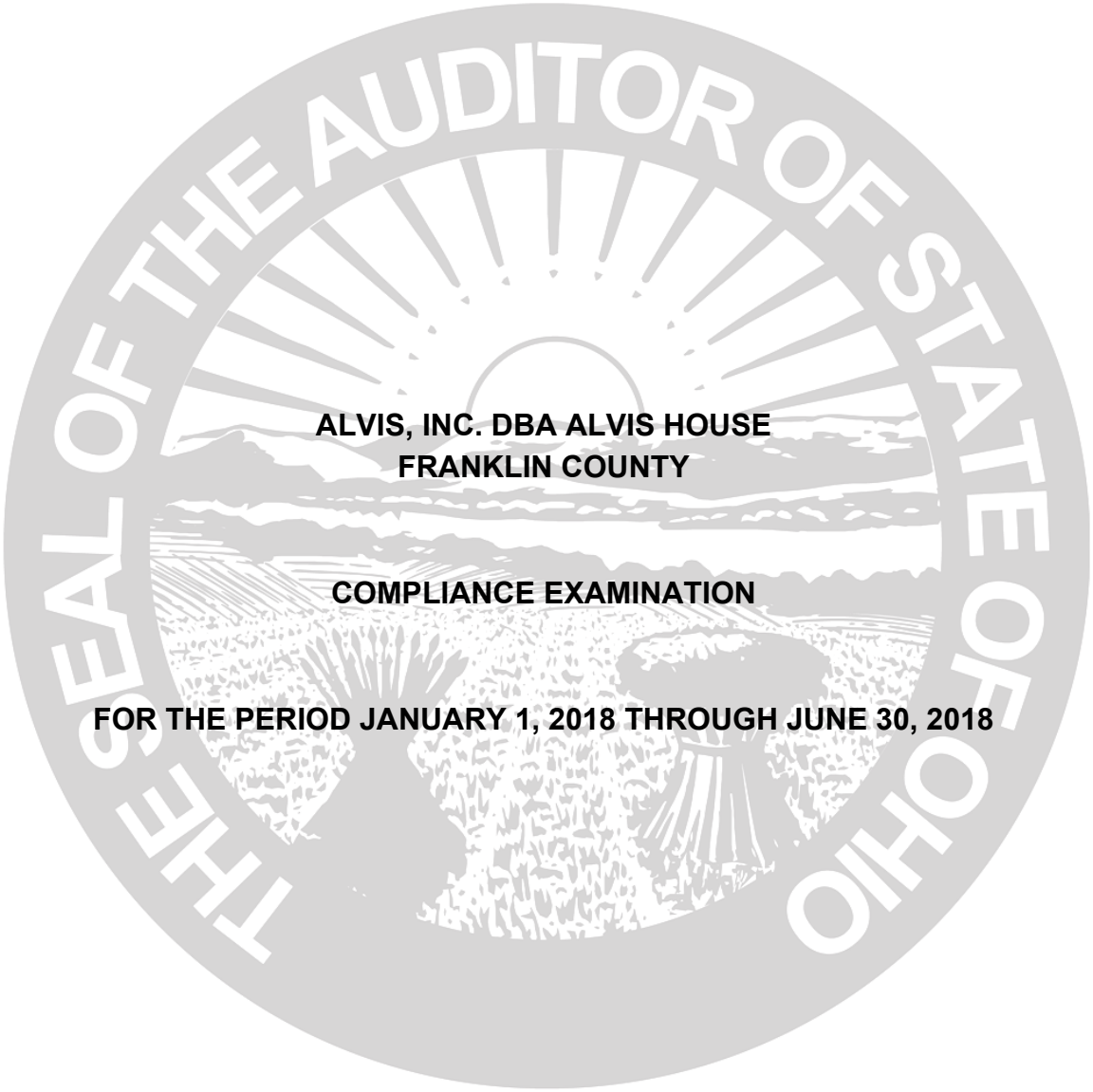

ALVIS, INC. DBA ALVIS HOUSE
FRANKLIN COUNTY

COMPLIANCE EXAMINATION

FOR THE PERIOD JANUARY 1, 2018 THROUGH JUNE 30, 2018

OHIO AUDITOR OF STATE
KEITH FABER

ALVIS, INC. dba ALVIS HOUSE
FRANKLIN COUNTY

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OHIO AUDITOR OF STATE
KEITH FABER

Medicaid Contract Audit
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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: Alvis, Inc. dba Alvis House
Ohio Medicaid Number: 0075755 and NPI Number: 1386993350

We examined Alvis, Inc. (the Provider's) compliance with specified Medicaid requirements for provider qualifications, service documentation and service authorization related to the provision of group counseling and intensive outpatient substance use disorder 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 payments made by Ohio Medicaid. Management of Alvis, 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 Qualified Opinion

Our examination disclosed that, in a material number of instances, the Provider did not have a treatment plan for group counseling services and units billed exceeded the documented duration of service delivery and/or exceeded the allowable limit when billing intensive outpatient services on the same date.

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 for group counseling and intensive outpatient substance use disorder 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 $15,425.35. This finding plus interest in the amount of $741.68 (calculated as of January 8, 2021) totaling $16,167.03 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

This report is intended solely for the information and use of the Provider, 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 8, 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)

Addiction Services

Under the provider number 0075755, the Provider is identified as an Ohio Department of Mental Health and Addiction Services (OhioMHAS) licensed treatment program and received $1,355,503 in payments for 12,302 services during the examination period.

Mental Health Services
Under the provider number 0286992, 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 group counseling and intensive outpatient substance use disorder 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 instances in which other OhioMHAS providers were paid by Ohio Medicaid for the same alcohol and drug addiction service for the same recipient on the same date.

In order to test a selection of these services (Potential Duplicate Services Exception Test), we summarized the unique recipients that received services during the examination period and searched the claims history for services paid to other Medicaid providers for these recipients during our examination period. From the results of this search, we extracted all paid group counseling and intensive outpatient substance use disorder services for the same recipient on the same date of service. There were 13 services in which the Provider was paid for the same recipient on the same date as three other providers[1]. We tested these 13 services in their entirety.

[1] There was a total of 26 services provided by four providers to the same recipients on same date; 13 of the 26 were paid to Alvis, Inc. We compared Alvis, Inc.'s documentation to documentation received from the other three providers.

Purpose, Scope, and Methodology (Continued)

From the remaining population, we extracted all intensive outpatient substance use disorder services (code H0015) with two or more services on a recipient date of service (RDOS) to test as an exception test. A RDOS is defined as all services for a given recipient of a specific date of service.

From the remaining population, we extracted all group counseling services (code H0005) and intensive outpatient substance use disorder services (code H0015) into separate files. We summarized the group counseling services by RDOS and the intensive outpatient substance use disorder services by service.

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 developed a simple random sample for each of the two samples. The calculated sample sizes are shown in **Table 1**.

Table 1: Sample Sizes

Universe	Population Size	Sample Size	Services Selected
Exception Tests:			
Potential Duplicate Services (H0015 and H0005)	13		13
RDOS Greater Than One Unit Intensive Outpatient Services (H0015)	128 RDOS	128 RDOS	257
Samples:			
Group counseling, 15 minute unit (H0005)	2,258 RDOS	57 RDOS	61
Intensive Outpatient Services (H0015)	7,187	58	58
Total			**389**

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

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
Potential Duplicate Services	13	0	0	$0.00
RDOS Greater Than One Unit Intensive Outpatient Services	257	129	135	$14,463.16
Group Counseling, 15 minute unit	61	15	16	$420.35
Intensive Outpatient Services	58	4	5	$541.84
Total	**389**	**148**	**156**	**$15,425.35**

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.

We identified 10 certified practitioners and 25 licensed 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.

Group Counseling and Intensive Outpatient Program Services

For the 10 certified practitioners and 25 licensed practitioners, we verified via the Ohio e-License Center website that their licenses were current and valid on the first date 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 licensed rendering practitioner to the qualifications contained in Admin. Code §§ 5160-8-05(C) and 5160-27-01(A).

All of the licensed and certified individuals met the required qualifications for the services rendered.

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)

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.

The Provider initially submitted supporting documentation that included incorrect practitioner credentials. The Provider explained that it included the credential information as of the date the documentation was printed from the system for this examination rather than the credentials as of the date of service. This resulted in the appearance of practitioners affixing incorrect credentials with their signatures.

Potential Duplicate Services Exception Test

We obtained service documentation from three other providers for the services in which they also received Ohio Medicaid reimbursement for the same recipient on the same date for the same service code as the Provider. We compared times of service delivery and found no overlapping services or other errors.

RDOS Greater Than One Unit Intensive Outpatient Service Exception Test

The 257 services examined contained the following errors:

- 128 instances in which the provider billed two intensive outpatient services with the same date of service for the same recipient;
- 6 services in which the documentation did not contain a description of the service rendered; and

B. Service Documentation (Continued)

- 1 instance in which the provider billed three intensive outpatient services with the same date of service for the same recipient.

These 135 errors resulted in an improper payment amount of $14,463.16.

The Provider indicated that during the examination period, when an error message was received, large batches of claims were resubmitted instead of only resubmitting those with errors which resulted in the duplicate billings. The Provider reported that it has since hired an external billing company to perform their billing process and indicated this new vendor has "a fail-safe to catch duplicate payments."

Group Counseling, 15 minute unit Services Sample

The 61 services examined contained the following errors:

- 3 instances in which intensive outpatient services were billed on the same date as group counseling for the same recipient and the units billed for group counseling exceeded the daily limitation of 4 units;
- 3 instances in which the units billed were greater than the units documented;
- 2 instances in which intensive outpatient services were billed on the same date as group counseling for the same recipient and the documentation did not support the units billed for group counseling; and
- 1 instance in which the documentation did not contain a description of the service rendered.

These nine errors are included in the improper payment amount of $420.35.

Intensive Outpatient Services Sample

The 58 services examined contained one instance in which the documentation did not contain the description of the service rendered and one instance in which the minimum time for this code was not met and, therefore, group counseling should have been billed instead.

These two errors are included in the improper payment amount of $541.84.

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. We also recommend that the Provider ensure correct credential information is submitted for any future examinations, audits or reviews. 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 admission, whichever is longer, must specify mutually agreed treatment goals and track responses to treatment and the medical record 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 Group Counseling and Intensive Outpatient services samples.

C. Authorization to Provide Services (Continued)

Group Counseling, 15 minute unit Services Sample

The 61 services examined contained seven instances in which there was no treatment plan to cover the date of service. These seven errors are included in the improper payment amount of $420.35.

Intensive Outpatient Services Sample

The 58 services examined contained two instances in which the treatment plan was not signed by the staff person who developed it and one service in which there was no treatment plan to cover the date of service. These three errors are included in the improper payment amount of $541.84.

Recommendation:

The Provider should develop and implement controls to ensure that all individual treatment plans are completed within the required timeframe and that each is 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 reiterated that it hired an external billing company on July 1, 2018 and believes any duplicate billing issues should have been resolved by that date. In addition, the provider disagreed with the materiality threshold used in this compliance examination.

Auditor of State Conclusion

Materiality used in a compliance examination is based on auditor judgement. We did not examine the Provider's response and, accordingly, we express no opinion on it.

OHIO AUDITOR OF STATE
KEITH FABER

ALVIS, INC. DBA ALVIS HOUSE

FRANKLIN 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 1/26/2021

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