

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CALIFORNIA CLAIMED AT LEAST  
\$2 MILLION IN UNALLOWABLE  
MEDICAID REIMBURSEMENT FOR A  
SELECTED PROVIDER'S OPIOID  
TREATMENT PROGRAM SERVICES**

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## Report in Brief

Date: January 2021

Report No. A-09-20-02001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

The United States currently faces a nationwide public health emergency due to the opioid crisis. Opioid treatment programs (OTPs) provide medication coupled with counseling services (referred to in this report as “OTP services”) for people diagnosed with an opioid use disorder. This audit is part of OIG’s oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis. To perform an initial assessment of the risk of improper Medicaid reimbursement for OTP services, we selected for audit an OTP provider that received the highest Medicaid reimbursement for OTP services in California for calendar year 2018.

Our objective was to determine whether California claimed Medicaid reimbursement for the selected provider’s OTP services in accordance with Federal and State requirements.

### How OIG Did This Audit

Our audit covered the selected provider’s Medicaid claims for OTP services provided from January 2017 through July 2019 (audit period), with Medicaid reimbursement totaling \$6.5 million (\$4.3 million Federal share).

We reviewed a stratified random sample of 100 beneficiary-months to determine compliance with Federal and State requirements. A beneficiary-month (which we refer to as a “sample item”) included all claims for OTP services provided to a beneficiary in a month.

## California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider’s Opioid Treatment Program Services

### What OIG Found

California did not claim Medicaid reimbursement for the selected provider’s OTP services in accordance with Federal and State requirements. Of the 100 sample items, 1 sample item was allowable, but 99 sample items had services that were unallowable. The deficiencies included, among others, the following: individual counseling sessions were not supported with adequate documentation (99 sample items), take-home medications were not provided in accordance with Federal or State regulations (43 sample items), methadone dosing services were administered without proper authorization (6 sample items), and individual counseling and methadone services were provided without a treatment plan in effect (4 sample items). On the basis of our sample results, we estimated that California claimed at least \$2.4 million in unallowable Federal Medicaid reimbursement for OTP services during our audit period.

These deficiencies occurred because California’s oversight activities did not ensure that OTP services met Federal and State requirements. We also identified deficiencies in two areas in which California could improve the quality of care provided to beneficiaries receiving OTP services.

### What OIG Recommends and California Comments

We recommend that California: (1) refund \$2.4 million to the Federal Government for unallowable OTP services furnished by the selected provider, (2) ensure that the selected provider complies with Federal and State requirements for providing and claiming reimbursement for OTP services, (3) verify that the selected provider implements corrective action plans that were approved by California, (4) perform postpayment reviews to identify disallowances for OTP services that did not comply with State requirements, and (5) work with the selected provider to improve the quality of care provided to beneficiaries by correcting deficiencies.

California agreed with all of our recommendations and provided information on actions that it planned to take to address our recommendations, including conducting a comprehensive postpayment utilization review of the selected provider (which includes monitoring regulatory requirements to identify deficiencies and recovery of overpayments) and reviewing and monitoring for resolution the provider’s corrective action plan to ensure ongoing monitoring of the quality of care provided to beneficiaries receiving OTP services.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The United States currently faces a nationwide public health emergency due to the opioid crisis. The high potential for misuse of opioids has led to alarming trends across the country, including record numbers of people developing opioid use disorders. In 2018 alone, there were nearly 47,000 opioid-related overdose deaths in the United States. Opioid treatment programs (OTPs) provide medication coupled with counseling services (referred to in this report as “OTP services”) for people diagnosed with an opioid use disorder. As part of the Office of Inspector General’s (OIG’s) oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis,<sup>1</sup> we decided to audit OTP services in California. To perform an initial assessment of the risk of improper Medicaid reimbursement for OTP services, we selected for audit an OTP provider that received the highest Medicaid reimbursement for OTP services in California for calendar year 2018.<sup>2</sup>

### OBJECTIVE

Our objective was to determine whether California’s Department of Health Care Services (the State agency) claimed Medicaid reimbursement for the selected provider’s OTP services in accordance with Federal and State requirements.

### BACKGROUND

#### The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

#### Opioid Treatment Program Services

Each State’s Medicaid program may cover substance-use-disorder treatment services, including services provided by OTPs. OTPs provide detoxification and maintenance treatment. During detoxification treatment, a patient receives a narcotic replacement medication, such as

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<sup>1</sup> See the related OIG report *New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries (A-02-17-01021)*, issued February 4, 2020. Appendix B lists additional reports related to opioid treatment and prescription drug monitoring programs.

<sup>2</sup> We plan to conduct an audit of OTP services statewide.

methadone, in decreasing dosages to ease adverse physical and psychological effects caused by withdrawal from long-term use of an opiate, such as heroin. During maintenance treatment, a patient receives narcotic replacement medication in stable and medically determined doses. A patient may be authorized to receive medication for unsupervised, “take-home” use.<sup>3</sup> OTPs must also provide counseling services to each patient as clinically necessary. The purpose of comprehensive maintenance treatment is to reduce or eliminate chronic opiate addiction while the patient is provided a comprehensive range of additional treatment services.

Federal regulations (42 CFR § 8.12) establish treatment standards with which OTPs must comply. As part of these standards, an OTP must maintain a plan as part of its quality assurance program that specifies measures to reduce the possibility of diversion of controlled substances from legitimate treatment use.<sup>4</sup>

### **California’s Opioid Treatment Program Services**

In California, Medicaid is referred to as “Medi-Cal.” The State agency administers the Drug Medi-Cal (DMC) program in California. Under the DMC program, OTP services provided to Medicaid beneficiaries are covered when furnished by providers that have a contract with the State agency. Providers submit claims for OTP services to the State agency. These services may include treatment planning,<sup>5</sup> physician and nursing services related to substance abuse, individual or group counseling, and laboratory tests. However, OTP services under the DMC program do not include detoxification treatment.<sup>6</sup>

The State agency is responsible for implementing applicable statutory and regulatory requirements for licensure and for compliance monitoring of all public and private OTP

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<sup>3</sup> We refer to these medications as “take-home medications.”

<sup>4</sup> 42 CFR § 8.12(c)(2). U.S. Department of Health and Human Services Publication No. PEP15-FEDGUIDEOTP 2015, issued by the Substance Abuse and Mental Health Services Administration, describes “call backs” as an important element of this plan to reduce the possibility of diversion. During callbacks, a provider requires a patient to bring his or her take-home medication to determine whether the medication is being used as ordered and to account for the number of medications outstanding.

<sup>5</sup> Treatment planning refers to the preparation of a treatment plan that includes the patient’s short-term goals, tasks that the patient must perform to complete those goals, and services that the patient needs. The treatment plan must identify the frequency with which these services are to be provided.

<sup>6</sup> Detoxification treatment services are covered under the DMC Organized Delivery System (DMC-ODS) waiver program, which is available in counties that implemented this program. The DMC-ODS is a demonstration project to expand access to substance-use-disorder treatment services through a Medicaid section 1115 waiver. The DMC-ODS requires that counties provide access to a full continuum of services modeled after American Society of Addiction Medicine criteria.

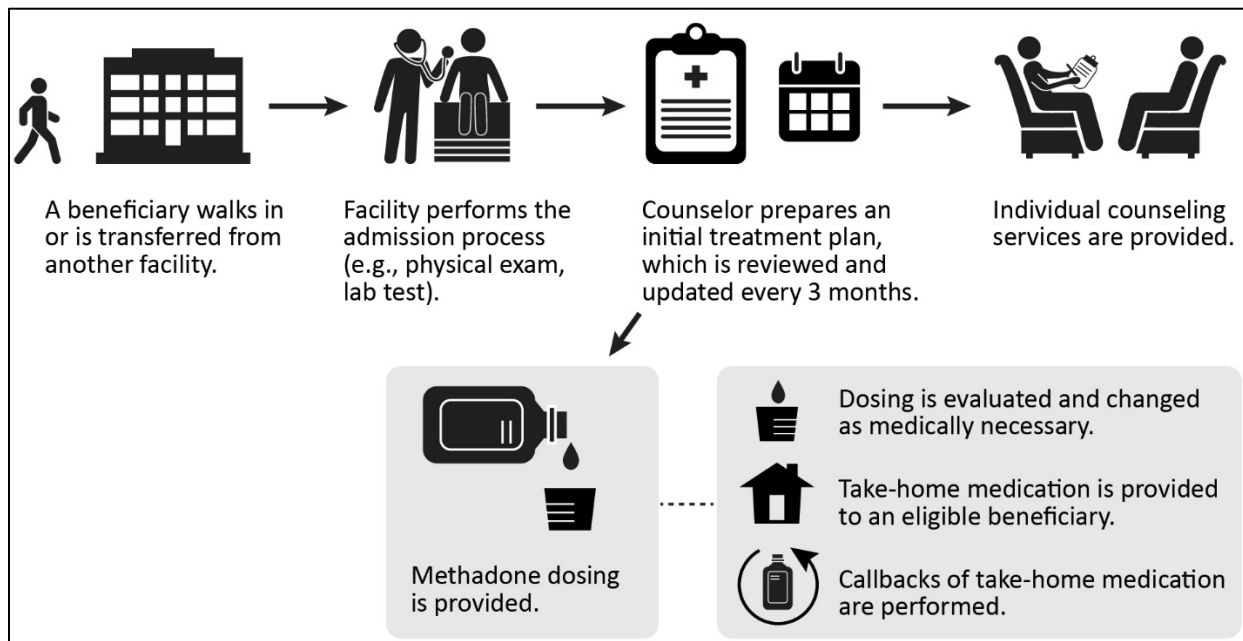


providers in California.<sup>7</sup> It is also responsible for ensuring compliance of DMC-certified programs and services and county compliance with contractual terms and conditions.

### Services Furnished by the Selected Opioid Treatment Program Provider

The State agency contracts directly with the selected provider. The provider furnishes OTP services, which include maintenance treatment services. The figure shows the provider’s general process for providing maintenance treatment services.

**Figure: The Selected Provider’s General Process for Providing Maintenance Treatment Services**



### HOW WE CONDUCTED THIS AUDIT

Our audit covered the selected provider’s Medicaid claims for OTP services provided from January 1, 2017, through July 31, 2019 (audit period). During this period, the provider submitted 57,372 claims for OTP services, consisting of individual counseling services<sup>8</sup> and methadone dosing services,<sup>9</sup> and received Medicaid reimbursement of \$6.5 million (\$4.3 million Federal share).

<sup>7</sup> The purpose of statutory and regulatory requirements is to ensure the safety and well-being of OTP beneficiaries, the community, and the public. As of June 19, 2019, there were 168 OTPs in California.

<sup>8</sup> For individual counseling services, the DMC program reimburses providers based on units of service. A 10-minute interval of service is considered a unit. For example, for State fiscal year (SFY) 2018 (July 1, 2017, through June 30, 2018), the DMC program’s reimbursement rate was \$15.37 per unit.

<sup>9</sup> For methadone dosing services, the DMC program reimburses providers based on a daily dosing rate. For example, for SFY 2018, the DMC program’s reimbursement rate was \$13.11 per day.

After removing potentially duplicate claims, we selected a stratified random sample of 100 beneficiary-months, totaling \$56,533 (\$41,915 Federal share), to determine compliance with Federal and State requirements. A beneficiary-month (which we refer to as a “sample item”) included all claims for OTP services provided to a beneficiary in a month. For example, all claims for services provided to a beneficiary in May 2018 were grouped as one sample item.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

## FINDINGS

The State agency did not claim Medicaid reimbursement for the selected provider’s OTP services in accordance with Federal and State requirements. Of the 100 sample items, 1 sample item was allowable, but 99 sample items had services that were unallowable. Table 1 summarizes the deficiencies and the number of unallowable sample items for each type of deficiency.

**Table 1: Summary of Deficiencies in Sample Items<sup>10</sup>**

Deficiency	Number of Unallowable Sample Items
Individual Counseling Sessions Were Not Supported With Adequate Documentation	99
Take-Home Medications Were Not Provided in Accordance With Federal or State Regulations	43
Methadone Dosing Services Were Administered Without Proper Authorization	6
Individual Counseling and Methadone Dosing Services Were Provided Without a Treatment Plan in Effect	4
Individual Counseling Services Were Provided by a Counselor Who Was Not Registered at the Time of Service	2
Frequency of Individual Counseling Services Provided Exceeded the Frequency Specified in the Treatment Plan	1
Detoxification Treatment Services Provided Were Not Covered Under the Drug Medi-Cal Program	1

<sup>10</sup> The total number of unallowable sample items is more than 99 because 53 sample items had more than 1 deficiency.

On the basis of our sample results, we estimated that the State agency claimed at least \$2.4 million in unallowable Federal Medicaid reimbursement for OTP services during our audit period.<sup>11</sup>

At the provider level, these deficiencies occurred because the selected provider: (1) had a practice of allowing counselors not to document the date when a counseling session note was completed, (2) was not aware of certain regulation changes, and (3) had staff who made errors. In addition, the provider did not explain why some of the deficiencies occurred (e.g., take-home medications were not restricted as required). At the State level, the State agency's oversight activities did not ensure that OTP services met Federal and State requirements.

We also identified deficiencies in two areas in which California could improve the quality of care provided to beneficiaries receiving OTP services:

- The selected provider did not perform callbacks to inventory beneficiaries' self-administered take-home medications (55 sample items).
- The selected provider furnished fewer counseling sessions than were ordered as medically necessary in the treatment plan (nine sample items).

## **THE STATE AGENCY CLAIMED REIMBURSEMENT FOR UNALLOWABLE OPIOID TREATMENT PROGRAM SERVICES**

### **Individual Counseling Services Were Not Supported With Adequate Documentation**

The counselor conducting a counseling session must document information, such as the date and type of the session (e.g., individual or group) and a summary of the session, in the patient's medical record within 14 calendar days of the session. Further, the counselor must document the duration of the counseling session in 10-minute intervals, excluding the time required to document the session.<sup>12</sup>

For 99 sample items, the selected provider did not have adequate documentation to support individual counseling sessions:<sup>13</sup>

- The selected provider did not document the date when the counseling session notes were completed (99 sample items). The counseling session notes included the service

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<sup>11</sup> The total unallowable Federal Medicaid reimbursement claimed was at least \$2,416,900. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

<sup>12</sup> 22 California Code of Regulations (CCR) §§ 51341.1(h)(3)(C) and (m); 9 CCR § 10345(d).

<sup>13</sup> The total number of unallowable sample items for which there was not adequate documentation is more than 99 because 17 sample items had more than 1 deficiency.

date and duration of the session, and the counselors signed the counseling session notes. However, the counselors did not indicate the dates that they signed those notes. The provider's practice was to allow a counselor not to document the date when a counseling session note was completed. Therefore, the provider could not provide support that the counselors documented the counseling sessions in the beneficiaries' medical records within 14 calendar days of the sessions.

- The selected provider's counseling session notes had start and end times that conflicted with the times shown in the counselors' timesheets (15 sample items). Of the 281 counseling session notes, 16 (6 percent) had conflicts. For example, one counselor indicated in her counseling session notes the start time of the counseling session as 10:28 a.m. and the end time as 11:18 a.m. However, the counselor's timesheet showed that she had "clocked out" (ended work) at 11:03 a.m. and "clocked back in" (started work again) at 11:47 a.m., indicating that she could not have provided counseling for the entire time of the session as shown in the counseling session notes. The provider did not explain why there was a discrepancy between the counselor timesheet and the counseling session notes.
- The selected provider did not have counseling session notes that were signed by a counselor (two sample items). Therefore, the provider could not demonstrate that the counselor who had conducted the counseling session had documented the counseling session. For example, a counseling session note for a specific service date was not in the beneficiary's medical records. When we requested the note, the provider printed out the note from its electronic documentation system and provided the copy to us during our site visit. However, this note was not signed by the counselor. According to the provider, the counselor made an error.

### **Take-Home Medications Were Not Provided in Accordance With Federal or State Regulations**

Self-administered take-home medication<sup>14</sup> may be provided to a patient only if the medical director or program physician has determined, in his or her clinical judgment, that the patient is responsible in handling narcotic medications and has documented his or her rationale (e.g., the patient is participating in gainful educational activity, and the patient's daily attendance at the program would be incompatible with such activity) in the patient's medical record.<sup>15</sup>

The medical director or program physician must restrict a patient's take-home privileges if patients submitted at least two consecutive monthly body specimens that have tested:

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<sup>14</sup> Take-home medication refers to the supply of at-home narcotic medication provided for unsupervised use by the patient. It may be authorized for a single day or for a span of multiple days in lieu of having the patient ingest the dose under supervision.

<sup>15</sup> 42 CFR § 8.12(i); 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10370. State regulations (9 CCR § 10385) provided exceptions to section 10370(b); however, these exceptions were later rescinded by California's Department of Alcohol and Drug Programs Bulletin 12-10 because they were less stringent than the Federal regulations.

(1) positive for illicit drugs or (2) negative for the narcotic medication administered or dispensed by the program or (3) both, unless the program physician invalidates the accuracy of the test results.<sup>16</sup>

Any patient in comprehensive maintenance treatment may receive a single take-home dose for a day that a clinic is closed for business, including State and Federal holidays.<sup>17</sup>

For 43 sample items, the selected provider did not provide take-home medications in accordance with Federal or State regulations:<sup>18</sup>

- The selected provider allowed beneficiaries to have take-home medication (methadone) without an adequate rationale (42 sample items). For example, the rationale documented in the medical record for approving a beneficiary to have take-home medications was that the beneficiary did not have transportation to the OTP clinic. The provider was not aware of the regulation change that no longer allowed take-home medications for the reason that the beneficiary did not have transportation.<sup>19</sup>
- The selected provider's medical director or program physician did not restrict beneficiaries' take-home medication as required (three sample items). For example, a beneficiary was still provided take-home medication when his drug test results were positive for illicit drugs for 3 consecutive months. The provider did not explain why take-home medications were not restricted as required.
- The selected provider allowed beneficiaries to have take-home medications for holidays (e.g., Fourth of July) even though the provider was open for business year-round (three sample items). The provider's practice was to allow a beneficiary to have take-home medication on a holiday if the most recent urine test result was negative for illicit drugs even if a physician had not approved the beneficiary for take-home medication. This practice did not comply with Federal and State regulations because the provider was not closed for business.

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<sup>16</sup> 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10390.

<sup>17</sup> 42 CFR § 8.12(i); 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10380.

<sup>18</sup> The total number of unallowable sample items for which the provider did not properly provide take-home medications is more than 43 because 5 sample items had more than 1 deficiency.

<sup>19</sup> See footnote 15.

## **Methadone Dosing Services Were Administered Without Proper Authorization**

Dosing and administration decisions must be made by a program physician.<sup>20</sup> Only the medical director or program physician is authorized to change the patient's medication dosage schedule.<sup>21</sup>

For six sample items, the selected provider administered methadone dosing services to beneficiaries without an authorization by the medical director or program physician. For example, the provider administered to a beneficiary an increased dosage of methadone that the program physician had denied. According to the provider, a dosing nurse made an error.

## **Individual Counseling and Methadone Dosing Services Were Provided Without a Treatment Plan in Effect**

The treatment plan must be reviewed and updated to reflect the patient's: (1) personal history; (2) current needs for medical, social, and psychological services; and (3) current needs for education, vocational rehabilitation, and employment services.<sup>22</sup> The primary counselor is required to evaluate and update the patient's maintenance treatment plan whenever necessary or at least once during each 3-month period from the date of admission to maintenance treatment. The treatment plans must be signed by the primary counselor.<sup>23</sup>

For four sample items, the selected provider furnished individual counseling services and methadone dosing services when there was no treatment plan in effect for the service dates. For three of these sample items, treatment plans were not updated during the 3-month period as required. The provider did not explain why these errors occurred. For the remaining sample item, the treatment plan was not signed by the counselor. Specifically, the signature page from the treatment plan was missing from the beneficiary's medical records. According to the provider, staff made an error.

## **Individual Counseling Services Were Provided by a Counselor Who Was Not Registered at the Time of Service**

Only licensed or certified counselors, or counselors who are registered with a State-approved certifying organization to provide counseling services and who are in the process of obtaining certification or licensure to provide such services, are allowed to provide counseling services. An OTP is required to maintain personnel records for staff who provide counseling services,

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<sup>20</sup> 42 CFR § 8.12(h); 22 CCR §§ 51341.1(b)(28)(B) and (m); 9 CCR § 10110.

<sup>21</sup> 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10355(g).

<sup>22</sup> 42 CFR § 8.12(f)(4); 22 CCR § 51341.1(h)(2)(B) and 9 CCR § 10305.

<sup>23</sup> 22 CCR §§ 51341.1(h)(2)(B) and (m)(3)(B); 9 CCR § 10305(f).

including written documentation of licensure, certification, or registration to obtain certification.<sup>24</sup>

For two sample items, counseling services were provided by a counselor who was not registered with a State-approved certifying organization when she provided services. The counselor did not have a valid registration before November 29, 2017; however, the counselor provided counseling sessions on February 16 and June 15, 2017.<sup>25</sup> The provider did not explain why the services were provided by a counselor who was not registered.<sup>26</sup>

### **Frequency of Individual Counseling Services Provided Exceeded the Frequency Specified in the Treatment Plan**

The frequency of counseling services should not exceed the frequency specified in the treatment plan.<sup>27</sup>

For one sample item, the selected provider furnished individual counseling services at a frequency that exceeded the frequency specified in the beneficiary's treatment plan. The treatment plan stated that the beneficiary would receive individual counseling services four times a month; however, the beneficiary received the services five times a month. The provider did not explain why the counselor provided more counseling services than the frequency specified in the treatment plan.

### **Detoxification Treatment Services Provided Were Not Covered Under the Drug Medi-Cal Program**

An OTP provider's detoxification treatment services are not covered under the DMC program in California.<sup>28</sup>

For one sample item, the selected provider was reimbursed for an individual counseling service and methadone dosing services for 3 days while a beneficiary was in the detoxification program. The beneficiary was admitted to the provider's 21-day detoxification treatment program. After 3 days of treatment, the provider evaluated that the treatment was not working for the beneficiary and transferred the beneficiary to its maintenance treatment

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<sup>24</sup> The State plan, supplement 3 to Attachment 3.1-A, pages 5 and 6, TN No. 13-038; 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10125.

<sup>25</sup> We confirmed with the State agency's certifying body that the counselor did not have a valid registration or certification before November 29, 2017.

<sup>26</sup> The provider confirmed that the counselor was not registered when providing these services.

<sup>27</sup> 22 CCR § 51341.1(m)(4)(C).

<sup>28</sup> 22 CCR §§ 51341.1(a) and (b)(17).

program. These detoxification services were not covered under the DMC program. According to the provider, staff made a data entry error.

### **THE STATE AGENCY'S OVERSIGHT ACTIVITIES DID NOT ENSURE THAT OPIOID TREATMENT PROGRAM SERVICES MET FEDERAL AND STATE REQUIREMENTS**

The State agency's oversight activities did not ensure that OTP services met Federal and State requirements.

The State agency performed annual provider-licensing reviews to determine compliance with licensing requirements, which identified deficiencies related to providing services (e.g., missing treatment plans) and required the selected provider to submit a corrective action plan describing how the provider would address the identified deficiencies. However, after a corrective action plan was submitted, the State agency did not verify that the selected provider corrected the identified deficiencies.

Further, the State agency said that it had not performed any postpayment reviews since 2013 to identify disallowances for services that did not comply with State regulations and State plan requirements.<sup>29</sup>

### **THE STATE AGENCY COULD IMPROVE THE QUALITY OF CARE PROVIDED TO BENEFICIARIES RECEIVING OPIOID TREATMENT PROGRAM SERVICES**

OTPs must provide adequate substance abuse counseling to each patient as clinically necessary.<sup>30</sup> Further, each OTP must develop a set of written rules and instructions that must be provided to all patients receiving services and to applicants for services before the program accepts the applicant as a patient, including requirements for take-home medication privileges.<sup>31</sup>

We identified two deficiencies in the selected provider's: (1) callbacks for take-home medications and (2) implementation of treatment plans. Although these deficiencies may not have affected the allowability of the sample items, addressing these deficiencies may improve the quality of care provided to beneficiaries.

For 55 sample items, the selected provider did not perform callbacks to account for the beneficiary's remaining take-home medications. The provider had a written policy requiring a

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<sup>29</sup> The State agency's "postservice postpayment" utilization review verifies that DMC program services were provided while in full compliance with all the requirements of California's Title 22 regulations. The State agency recovers payments made for services that were not provided in full compliance with the regulations. Federal regulations provide requirements for State agencies' postpayment reviews (42 CFR § 447.45).

<sup>30</sup> 42 CFR § 8.12(f)(5); 22 CCR § 51341.1(h)(2)(B) and 9 CCR § 10305.

<sup>31</sup> 9 CCR §§ 10170(a) and (b)(1).



patient who had received six or more take-home medication doses to have at least one callback within a year from the date when the medications were dispensed to the patient. A patient who had received five or fewer take-home medication doses was required to have at least one callback every 2 years. The clinical director stated that the provider did not follow its own policies and procedures to perform callbacks for all beneficiaries who had received take-home medications. Without performing callbacks, the provider cannot reduce the possibility of diversion of methadone from legitimate treatment use and ensure that the beneficiary is appropriately using take-home medications.

For nine sample items, the selected provider furnished fewer counseling sessions than were ordered as medically necessary in the beneficiary's treatment plan. The medical records did not indicate the reason that fewer counseling sessions were furnished. Furnishing fewer counseling sessions than medically necessary may have an impact on the outcome of the beneficiary's treatment.

### **RECOMMENDATIONS**

We recommend that the California Department of Health Care Services:

- refund \$2,416,900 to the Federal Government for unallowable OTP services furnished by the selected provider,
- ensure that the selected provider complies with Federal and State requirements for providing and claiming reimbursement for OTP services,
- verify that the selected provider implements corrective action plans that were approved by the State agency,
- perform postpayment reviews to identify disallowances for OTP services that did not comply with State regulations and State plan requirements, and
- work with the selected provider to improve the quality of care provided to beneficiaries by correcting deficiencies.

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed with all of our recommendations and provided information on actions that it planned to take to address our recommendations:

- Regarding our first recommendation, the State agency commented that it will coordinate the refund of \$2,416,900 to the Federal Government for unallowable OTP services furnished by the selected provider.

- Regarding our second and fourth recommendations, the State agency commented that it will conduct a comprehensive postpayment utilization review of the provider, which includes monitoring regulatory requirements to identify deficiencies and recovery of overpayments. The State agency said that for each deficiency cited, the provider is required to submit a corrective action plan.
- Regarding our third recommendation, the State agency commented that once the provider audit is completed, the provider's corrective action plan will be reviewed, accepted, and monitored for resolution.
- Regarding our fifth recommendation, the State agency commented that it will continue with annual licensing surveys and implement annual postpayment utilization reviews of the selected provider. The State agency said that the provider's corrective action plan will be reviewed, accepted, and monitored for resolution to ensure ongoing monitoring of the quality of care provided to beneficiaries receiving OTP services from the provider.

The State agency's comments are included in their entirety as Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered the selected provider's Medicaid claims for OTP services provided from January 1, 2017, through July 31, 2019. During this period, the provider submitted 57,372 claims for OTP services consisting of individual counseling services<sup>32</sup> and methadone dosing services<sup>33</sup> and received Medicaid reimbursement of \$6,488,308 (\$4,303,008 Federal share).

After removing potentially duplicate claims, we selected a stratified random sample of 100 beneficiary-months, totaling \$56,533 (\$41,915 Federal share), to determine compliance with Federal and State requirements. A beneficiary-month included all claims for OTP services provided to a beneficiary in a month. For example, all claims for services provided to a beneficiary in May 2018 were grouped as one sample unit.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data provided by the State agency for our audit period.<sup>34</sup> We also established reasonable assurance of the completeness of the data by tracing aggregate claim record amounts to supporting claim schedules and State controller warrant documentation. Further, we matched these totals to supporting documentation used to report amounts on the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

During our audit, we did not assess the overall internal control structure of the State agency or the selected provider. Rather, we limited our review to the State agency's internal controls for monitoring the provider's compliance with Federal and State requirements and claiming reimbursement for the provider's services. To determine the effectiveness of the design and implementation of these internal controls, we:

- reviewed the results of the State agency inspection reports on the selected provider and the selected provider's corrective action plans;
- analyzed State agency claims data and selected for audit a random sample of 100 beneficiary-months from the State agency's claims data;
- interviewed State agency officials; and

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<sup>32</sup> For individual counseling services, the DMC program reimburses providers based on units of service. A 10-minute interval of service is considered a unit. For example, for SFY 2018 (July 1, 2017, through June 30, 2018), the DMC program's reimbursement rate was \$15.37 per unit.

<sup>33</sup> For methadone dosing services, the DMC program reimburses providers based on a daily dosing rate. For example, for SFY 2018, the DMC program's reimbursement rate was \$13.11 per day.

<sup>34</sup> The State agency extracted the data from multiple systems, including the State agency's data warehouse and the Short-Doyle Medi-Cal adjudication system.

- reviewed the State agency’s DMC billing manual, State agency documentation of the claim submission and adjudication cycle, and guidance issued to OTP providers.

We conducted our audit from January to November 2020 and performed fieldwork at the selected provider’s office in Marysville, California.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with officials at the State agency and the selected provider to gain an understanding of OTPs;
- obtained data from the State agency that contained records of Medicaid claims for OTP services furnished by the selected provider;
- verified nurse and counselor qualifications using the publicly available State licensing and certification databases and contacted certifying organizations as appropriate;
- created a sampling frame of 57,372 claims for OTP services furnished by the selected provider to 692 Medicaid beneficiaries during our audit period, totaling \$6,488,308 (\$4,303,008 Federal share);
- used computer programming to identify and exclude 12 potentially duplicate claims<sup>35</sup> in our sampling frame, resulting in 57,360 claims that were grouped into 11,976 beneficiary-months, totaling \$6,487,365 (\$4,302,329 Federal share);
- reconciled the claims data for OTP services with claim schedules’ totals and payments to the selected provider to determine whether the State agency claimed reimbursement on the Form CMS-64 for those services;
- selected a stratified random sample of 100 items from our sampling frame and, for each sample item, reviewed provider and beneficiary medical records to determine whether the State agency claimed OTP services in accordance with Federal and State requirements;
- estimated the total amount of Federal Medicaid reimbursement to the State agency for unallowable OTP services during the audit period; and

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<sup>35</sup> At the conclusion of our audit, we informed the State agency that we determined these claims to be duplicates. Because the claim amounts were immaterial, we did not include this issue as a finding in our report.

- discussed the results of our audit with officials at the State agency and the selected provider.

See Appendix C for our statistical sampling methodology and Appendix D for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Ohio Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<a href="#"><u>A-05-18-00004</u></a>	12/29/2020
<i>Opioid Treatment Programs Reported Challenges Encountered During the COVID-19 Pandemic and Actions Taken To Address Them</i>	<a href="#"><u>A-09-20-02001</u></a>	11/18/2020
<i>Update on Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic</i>	<a href="#"><u>A-09-20-01000</u></a>	10/7/2020
<i>SAMHSA’s Oversight of Accreditation Bodies for Opioid Treatment Programs Did Not Comply With Some Federal Requirements</i>	<a href="#"><u>A-09-18-01007</u></a>	3/6/2020
<i>New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries</i>	<a href="#"><u>A-02-17-01021</u></a>	2/4/2020
<i>California Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<a href="#"><u>A-09-18-01006</u></a>	12/10/2019
<i>New York Achieved Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<a href="#"><u>A-02-18-02001</u></a>	8/8/2019
<i>Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic</i>	<a href="#"><u>A-09-18-01005</u></a>	7/24/2019
<i>The University of Kentucky Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<a href="#"><u>A-04-18-02012</u></a>	5/30/2019
<i>Washington State Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<a href="#"><u>A-09-18-01001</u></a>	4/15/2019
<i>The Substance Abuse and Mental Health Services Administration Followed Grant Regulations and Program-Specific Requirements When Awarding State Targeted Response to the Opioid Crisis Grants</i>	<a href="#"><u>A-03-17-03302</u></a>	3/28/2019
<i>New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds</i>	<a href="#"><u>A-02-17-02009</u></a>	3/20/2019

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of a Microsoft Excel file containing 57,372 claims for OTP services that the selected provider furnished to 692 Medicaid beneficiaries during our audit period, totaling \$6,488,308 (\$4,303,008 Federal share). That State agency extracted data fields for these claims from the State agency's data warehouse and the Short-Doyle Medi-Cal adjudication system.

After excluding 12 claims that we determined were potential duplicate claims, the resulting 57,360 claims were grouped into 11,976 beneficiary-months, totaling \$6,487,365 (\$4,302,329 Federal share). A beneficiary-month consisted of all Medicaid OTP claims for services provided to a beneficiary in a month. A beneficiary was identified using a client index number assigned by the State agency. The month in which a service was considered to have been provided was based on the ending date of service.

### SAMPLE UNIT

The sample unit was a beneficiary-month.

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 2). The strata were based on Federal share amounts for the OTP claims.

**Table 2: Strata**

Stratum	Dollar Range of OTP Claims	Frame Paid Amount	Frame Federal Share	No. of Items in Sampling Frame	Sample Size
1	Less than \$380.50	\$4,194,808	\$2,146,373	7,969	50
2	Greater than or equal to \$380.50	2,292,557	2,155,956	4,007	50
	<b>Total</b>	<b>\$6,487,365</b>	<b>\$4,302,329</b>	<b>11,976</b>	<b>100</b>

### SOURCE OF RANDOM NUMBERS

The source of the random numbers was the OIG, Office of Audit Services (OAS), statistical software.

## **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in each stratum. After generating 50 random numbers for each stratum, we selected the corresponding frame items.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the unallowable Federal Medicaid reimbursement for OTP services for which the State agency claimed reimbursement. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.



**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 3: Sample Details and Results**

Stratum	No. of Items in Sampling Frame	Value of Items in Sampling Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Unallowable Sample Items <sup>36</sup>	Value of Unallowable Sample Items (Federal Share)
1	7,969	\$2,146,373	50	\$13,878	49	\$8,780
2	4,007	2,155,956	50	28,036	50	14,919
<b>Total</b>	<b>11,976</b>	<b>\$4,302,329</b>	<b>100</b>	<b>\$41,914</b>	<b>99</b>	<b>\$23,699</b>

**Table 4: Estimated Value of Unallowable Services in the Sampling Frame (Federal Share)**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$2,594,896
Lower limit	2,416,900
Upper limit	2,772,891

<sup>36</sup> Not all claims within a sample item (a beneficiary-month) were unallowable. We identified the unallowable services in the sampled beneficiary-month that were associated with errors.

## APPENDIX E: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency  
Department of Health Care Services



GAVIN NEWSOM  
GOVERNOR

January 8, 2021

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
Office of Audit Services, Region IX  
90 – 7<sup>th</sup> Street, Suite 3-650  
San Francisco, CA 94103

DRAFT AUDIT REPORT RESPONSE

Dear Ms. Ahlstrand:

The Department of Health Care Services (DHCS) is submitting the enclosed response to the Office of Inspector General (OIG) draft audit report number A-09-20-02001 titled, "California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider's Opioid Treatment Program Services." OIG issued five recommendations for DHCS.

DHCS agrees with all of OIG's recommendations and has prepared corrective action plans for implementation.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any other questions, please contact Internal Audits at (916) 445-0759.

Sincerely,

Will Lightbourne  
Director

Enclosure

cc: See Next Page

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Ms. Ahlstrand  
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January 8, 2021

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## Department of Health Care Services

**Audit:** California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider's Opioid Treatment Program Services

**Audit Entity:** Office of Inspector General  
**Report Number:** A-09-20-02001 (20-08)  
**Response Type:** Draft Audit Report Response

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**Finding 1: The Department of Health Care Services (DHCS) claimed reimbursement for unallowable Opioid Treatment Program (OTP) services.**

**Recommendation 1**

DHCS should refund \$2,416,900 to the Federal Government for unallowable OTP services furnished by the selected provider.

**DHCS Agreement:** DHCS agrees with the recommendation.

**Current Status:** Will Implement

**Estimated Implementation Date:** June 2021

**Implementation Plan:**

DHCS will coordinate refund of \$2,416,900 to the Federal Government for unallowable OTP services furnished by the selected provider. Coordination of the refund will begin upon issuance of the final report. As of the response date, a date for final report issuance has not been provided.

**Finding 2: DHCS' oversight activities did not ensure that OTP services met federal and state requirements.**

**Recommendation 2**

DHCS should ensure that the selected provider complies with Federal and State requirements for providing and claiming reimbursement for OTP services.

**DHCS Agreement:** DHCS agrees with the recommendation.

**Current Status:** Will Implement

**Estimated Implementation Date:** March 2021

**Implementation Plan:**

DHCS will conduct a comprehensive Postservice Postpayment (PSP) utilization review of the contracted provider which includes monitoring regulatory requirements to identify deficiencies and recovery of overpayments based on authority in 22 California Code of

Regulations (CCR) section 51341.1(m)(3)(4) and 22 CCR section 51458.1(a). For each deficiency cited the provider is required to submit a Correction Action Plan (CAP) which is monitored by the Medi-Cal Behavioral Health Division as noted under responses to Recommendations 3 and 5.

**Recommendation 3**

DHCS should verify that the selected provider implements CAPs that were approved by DHCS.

**DHCS Agreement: DHCS agrees with the recommendation.**

**Current Status:** Will Implement

**Estimated Implementation Date:** June 2021

**Implementation Plan:**

Once the provider audit is completed, the CAP will be reviewed, accepted, and monitored for resolution by the Medi-Cal Behavioral Health Division and Behavioral Health Licensing and Certification Division.

**Recommendation 4**

DHCS should perform postpayment reviews to identify disallowances for OTP services that did not comply with State regulations and State plan requirements.

**DHCS Agreement: DHCS agrees with the recommendation.**

**Current Status:** Will Implement

**Estimated Implementation Date:** March 2021

**Implementation Plan:**

DHCS will conduct a comprehensive PSPP utilization review of the contracted provider which includes monitoring regulatory requirements to identify deficiencies and recovery of overpayments based on authority in 22 CCR section 51341.1(m)(3)(4) and 22 CCR section 51458.1(a). For each deficiency cited the provider is required to submit a CAP which is monitored by the Medi-Cal Behavioral Health Division as noted under responses to Recommendation 3 and 5.

**Finding 3: DHCS could improve the quality of care provided to beneficiaries receiving opioid treatment program services.**

**Recommendation 5**

DHCS should work with the selected provider to improve the quality of care provided to beneficiaries by correcting deficiencies.

**DHCS Agreement: DHCS agrees with the recommendation.**

**Current Status:** Will Implement

**Estimated Implementation Date:** December 2021

**Implementation Plan:**

DHCS will continue with the annual licensing surveys and implement annual PSPP reviews of the provider. Once the provider audit is completed, the CAP will be reviewed, accepted, and monitored for resolution by the Medi-Cal Behavioral Health Division and the Behavioral Health Licensing and Certification Division to ensure ongoing monitoring of the quality of care provided to the beneficiaries receiving OTP services from the provider.