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New Mexico Human Services Department Behavioral Health Provider Audits

Final Report

CONFIDENTIAL

June 21, 2013



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EXECUTIVE SUMMARY

In February 2013, the New Mexico Human Services Department (HSD) contracted with Public Consulting Group, Inc. (PCG) to audit fifteen (15) mental health and substance abuse providers statewide. In 2012, these providers constituted approximately 87% of all Core Service Agency (CSA) spending for Medicaid and non-Medicaid behavioral health services¹. PCG's audit consisted of three main components:

- 1) *Clinical Case File Audit* – a review of case file documentation, including staffing qualifications and credentials;
- 2) *IT/Billing Systems Audit* – a review of the billing system itself, as well as the protocols and processes employed by the provider; and,
- 3) *Enterprise Audit* – a review of the organization and its key stakeholders, third party contracts, and other stakeholder relationships.

Utilizing an approach developed and refined through auditing behavioral health providers nationally and tailored to New Mexico's payment rules and regulations, PCG's multi-faceted audit arrived at the following findings:

- 1) *Clinical Findings*: Identified **more than \$36.0 million in overpayments** to these 15 providers over a three-year period from 2009-2012. This amounts to nearly 15% of all payments made to these providers. A 2003 Congressional General Accounting Office (GAO) report stated that Medicaid fraud, waste, and abuse is expected to be 3% to 9% of all payments. PCG recommends the collection of these overpayments.
- 2) *IT/Billing System Findings*: No material findings, though PCG did identify **weaknesses in provider billing processes**, including lack of audit trails when it comes to changes made in systems. Generally, PCG recommends that providers tighten billing process controls.
- 3) *Enterprise Findings*: Identified **potential conflicts of interests** of some individuals and some of the audited providers. PCG recommends that the State of New Mexico further review instances of potential conflicts of interest.

¹ Core Service Agencies, or CSAs, are provider organizations that have been designated by the New Mexico Behavioral Health Collaborative to be responsible for clinical coordination of care for children and adults. PCG's audit included 12 of the state's 15 CSAs. Estimated percentage of CSA spending utilized 2009-2012 total spending for each CSA.



Summary of Clinical Audit

PCG's clinical case file review utilized two different methodologies for each provider:

- 1) **Random sampling of provider claims** – Audit of 150 randomly sampled claims that were submitted by the providers. The sampling methodology allows for a statistically valid extrapolation of the findings.
- 2) **Consumer case file review** – A review of a full year's worth of case file documentation for selected consumers. These findings are not extrapolated, but can be used to identify deficiencies that cannot be identified when viewing a single claim.

PCG's clinical case file review revealed moderate to significant levels of non-compliance with state payment rules and regulations. Generally, the providers reviewed in this audit lack many of the appropriate safeguards against overbilling and would benefit from targeted technical assistance. Additionally, PCG's findings reveal deficiencies in accuracy of clinical documentation, which signifies potential quality of care concerns that should be further reviewed by the State of New Mexico.

PCG utilized an audit tool developed and refined through auditing behavioral health providers nationally and tailored to New Mexico's payment rules and regulations. For the randomly sampled claims PCG utilized a statistically significant extrapolation methodology to identify **more than \$33.8 million in overpayments** to these 15 providers over a three-year period from 2009-2012. With the consumer case file, or "longitudinal," reviews PCG identified an **additional \$2.1 million in overpayments** to these 15 providers over the same three year period, for **total estimated overpayments of \$36.0 million** (nearly 15% of claims paid during this period). Below are non-compliance rates and extrapolated overpayments by provider:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
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Provider	Randomly Sampled Claims		Longitudinal Claims		Total Overpayment Amounts
	% Non-Compliance	Extrapolation - Lower Bound	% Claims Failed	\$Value Claims Failed	
Provider A	27.3%	\$4,327,784	59.6%	\$161,843	\$4,489,627
Provider B	40.0%	\$4,128,958	49.7%	\$64,907	\$4,193,865
Provider C	13.3%	\$772,016	27.8%	\$78,854	\$850,870
Provider D	55.3%	\$3,138,735	38.2%	\$55,521	\$3,194,256
Provider E	21.8%	\$3,629,976	70.7%	\$103,063	\$3,733,039
Provider F	3.3%	\$7,856	41.1%	\$14,018	\$21,874
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It is important to note that only the more egregious errors were used to extrapolate the amounts owed across the universe of claims for these providers. A more strict review of the randomly sampled provider claims originally indicated a non-compliance rate of 74%. PCG classified a number of these findings as “poor documentation practices” that should be remedied through a combination of trainings, technical assistance, and clinical and management assistance. These errors included missing signatures, inadequate case note completion, and below standard preparation of plans of care. Had PCG used these errors in the extrapolation, the resulting overpayment amounts would have been much greater.

PCG considers the extent of its findings to be a significant concern for the State of New Mexico. In a 2003 report², the Congressional General Accounting Office (GAO) estimated that fraud, waste, and abuse amounted to between 3% and 9% of total Medicaid spending. Using this GAO study as a base, this audit reveals overpayments that are double what can be expected.

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Summary of IT/Billing Systems Audit

PCG did not identify any specific instances of tampering with the providers' billing systems. This finding must be qualified for several reasons. First, PCG was unable to complete a comprehensive review of all billing systems as one of the billing systems vendors, Anasazi, prohibited providers from sharing system manuals, as they were considered proprietary (noted in an email that PCG viewed from Anasazi to one of the audited providers). Additionally, PCG identified areas of weaknesses in provider practices, including:

- Lack of audit trail for the creation of and changes made to claim records in provider billing systems;
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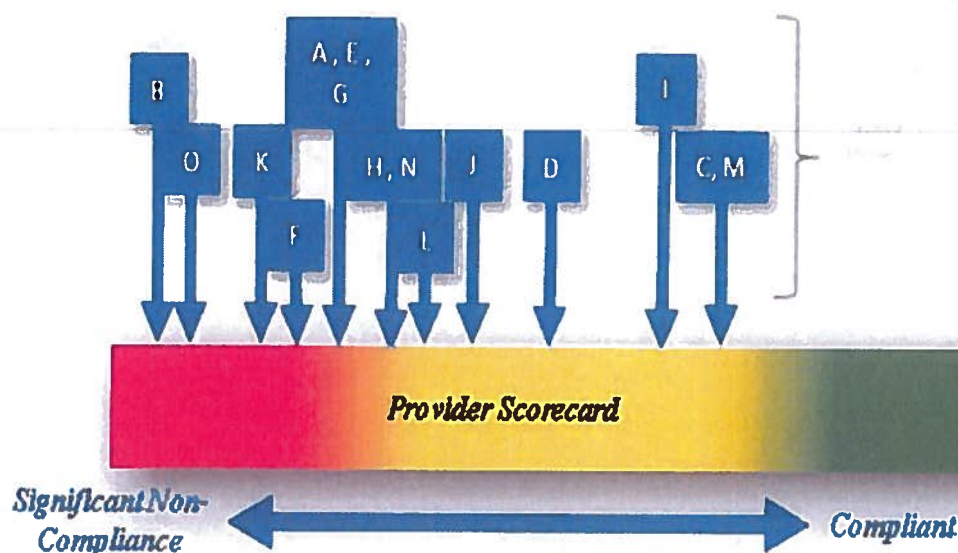
Lastly, PCG's enterprise audit sought to a) provide the state with a clearer view of how its provider system is organized and b) identify any potential appearances of conflicts of interest for the organization and its key board members and employees. The enterprise audit revealed that **some providers may have potential conflicts of interest that should be further reviewed by the State of New Mexico**. Examples of the types of potential conflicts of interest and areas that PCG recommends further research include:

- Unusual compensation and/or benefits to some key stakeholders;
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Scorecard and Risk Tier Results

Based on the clinical case file compliance outcomes and findings related to IT controls, PCG developed, in conjunction with HSD, a "scorecard" for each provider. Below, PCG has

organized the providers' scorecard results in relation to each other. The scorecard ranges from "Significant Non-Compliance" to "Compliant."



PCG then used these provider scorecard ratings to categorize providers into "Risk Tiers," replete with recommended state actions, as follows:

<i>Tier</i>	<i>Types of Findings</i>	<i>Recommended State Actions</i>
1	Findings that include missing documents, etc.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed.
2	Significant volume of findings that include missing documents	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
3	Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. • Potential change in management.
4	Credible Allegation of Fraud	<ul style="list-style-type: none"> • Mandatory change in management.



Based on PCG's scorecard methodology, each of the 15 providers was categorized into a Risk Tier, the results of which are shown below.

<i>Tier</i>	<i>Recommended State Action</i>	<i>Provider</i>
1	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.	
2	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.• Potentially embed clinical management to improve processes.	M, C, I, D, J, L, H, and N
3	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.• Potentially embed clinical management to improve processes. Potential change in management.	E, G, A, F, K, O and B
4	<ul style="list-style-type: none">• Mandatory change in management.	<i>See NOTE, below</i>

NOTE:- Please note that Tier 4: Credible Allegation of Fraud is a determination that can only be made by the State of New Mexico. PCG utilized results from its clinical case file audit and IT/billing system audit to develop the scorecard, which translated into providers being categorized in Tiers 1, 2, and 3. The State of New Mexico may determine that information provided in the case file, IT/billing system, and enterprise audits constitutes a re-categorization of one or more providers into a higher risk tier, including Tier 4.

Background

In February 2013, the New Mexico Human Services Department (HSD) determined the need for a comprehensive clinical and billing audit of select providers within its behavioral health system and engaged Public Consulting Group (PCG) to conduct these audits. Claims data mining by the state's behavioral health vendor revealed a significant number of potential billing abnormalities. These potential billing abnormalities included, but were not limited to, the following data and case file "findings:"



- Cross billing at different locations for the same member potentially overlapping time; uncertainty as to who rendered the service (if rendered at all);
- Insufficient documentation;
- Cross billing multiple codes and double billing (e.g. individual and group therapy);
- Upcoding individual therapy (compared to the average time billed per code in the peer group);
- Excessive billing for psychosocial rehab; including requesting authorization for a consumer on medical leave;
- Suspicious high volume days per one code; overbilling for inappropriate codes; psychosocial rehabilitation billed for large units on a given date to one clinician; excessive hours per day billed by practitioner; excessive hours of service billed per patient per code; billing for services duplicative in nature;
- Identifying Provider as the rendering clinician;
- No medical necessity reviews to determine basis for long-term psychotherapy;
- Forging clinician records to incorporate more time than truly performed;
- Out of home placement services outside norm of service; doubtful medical need;
- Billing outpatient services the same day as bundled services.

Not all of the aforementioned potential billing issues can be addressed with a single audit, particularly when an objective of the audit is to identify recoupable overpayments. In order to recoup across a universe of paid claims, a more comprehensive review is required. Narrowly focusing on one particular suspicious trend in a provider's claims history inhibits the ability of the auditor and the state to extrapolate those results across the entire claims history. Rather than attempting to address each provider's uniquely identified issues, PCG worked with HSD to develop a comprehensive approach that would scrutinize individual providers *holistically* (as opposed to looking at a few aberrant trends that may or may not run afoul of policy even if substantiated) and the system at large. This approach was characterized by three main goals:

- 1) Identify potential credible allegations of fraudulent activity.
- 2) Identify regulatory compliance levels of behavioral health providers.
- 3) Identify areas of weakness that must be strengthened prior to the implementation of Centennial Care.

PCG was tasked with conducting onsite audits of selected providers to examine case files supporting specific claims, IT systems and processes, and adherence with compliance protocols, and to examine existing relationships, financial or other, among providers and other entities. The onsite audits were conducted in February and March and included interviews with relevant



provider staff, collection of hard copy and electronic file documents related to the above mentioned areas, and examination and manual testing of IT systems. The onsite visits were supplemented by desk reviews of collected documentation at a location separate from the provider site. PCG's approach is described in more detail in the body of the full report.

Key Findings

While each provider is unique with respect to clinical findings, PCG identified certain common themes across many of the 15 providers reviewed, which are described below. For each provider, a section is included in the appendix that shows the detailed clinical findings specific to that provider. PCG's findings include:

- **More than \$37.3 million in overpayments** for these 15 providers over a three and a half year period (July 2009-January 2013). This extrapolated overpayment amounts to 15% of total payments from state sources to these providers during this time period.
- **Non-compliance with many New Mexico state rules and regulations.** Pervasive issues that PCG identified across providers include:

Randomly Sampled Claims

- Community Support Workers lacked evidence of completion of the required training per the service definition.
- Assessments (psychosocial/psychiatric evaluations) were not up to date (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
 - Incomplete critical information such as Five Axis diagnosis.
 - Substance abuse history was absent for most consumers with a dual-diagnosis of mental health and substance abuse.
- Treatment plans were not up-to-date and individualized per consumer. Updated treatment plans are necessary to determine any changes to goals/objectives in addition to progress or lack of progress by the consumer. Without continuously updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.
 - Goals/Objectives were not measurable and did not document achievable target dates based on the consumer's needs.
 - Service specific clinical interventions used to reach goals/objectives were absent.



- Discharge plans and estimated length of treatment were not documented for all consumers. Documented discharge plans were rarely individualized.
- Consumer Documentation
 - Consents for medications rendered were absent.
 - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
 - Interventions in the progress notes did not always link to the consumer's treatment plan or support the program definition of the billed service.
 - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
 - Billed units did not match the units documented on the progress notes.
 - Intensive Outpatient Program progress notes did not contain the treatment modalities used as required in the service definition.
 - Documented evidence of the required treatment team was absent for most team services.

Longitudinal File Review Findings

- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
- Treatment plans were not up-to-date and individualized per consumer.
 - Plans contained the same goals/objectives for more than 12 months.
 - Potential overutilization of services without documented justification of the service related to extensive length of stay.
- Consumer Documentation
 - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
 - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
 - Billed units did not match the units documented on the progress notes.
- **Weaknesses identified in providers' billing processes.** PCG identified weaknesses in internal claims processes. PCG was unable to complete a comprehensive review of all billing systems as one particular billing software vendor was unwilling to allow providers to share with PCG important documentation and information about the system.



- **Potential conflicts of interest in selected providers.** PCG identified areas of potential conflicts of interest among some providers, individuals, and related parties. Examples of the types of potential conflicts of interest and areas that PCG recommends further research include:
 - Unusual compensation and/or benefits to some key stakeholders;
 - Key stakeholders' relationships with related parties with financial interests in transactions;
 - Some arrangements with third parties are unclear as to the level of effort and compensation for some executives; and,
 - Non-disclosure of all third party contracts.

Key Recommendations

- **Standardize clinical documentation across providers.** In order to ensure that all critical behavioral health consumer information is gathered and properly documented, PCG recommends that standardized forms be used across all providers. The standardized forms at a minimum would include assessments, treatment plans, and progress notes (daily/weekly/logs). Please refer to Section 4 of the report for specific recommendations.
- **Implement a comprehensive program integrity effort for behavioral health services.** PCG recommends this PI effort be written into MCO contracts and be implemented by the state for non-Medicaid programs. This means more than just post-payment auditing. Traditional “pay and chase” models should be supplemented by pre-payment measures and more proactive provider education, oversight and monitoring efforts to proactively prevent errors from occurring prior to payment.
- **Provide technical assistance** to providers in the areas of clinical best practices and billing processes and procedures.
- **Review and revamp New Mexico’s behavioral health provider billing rules and regulations.** Specifically, PCG recommends certain “best practices” that should be required information. Please refer to Section 4 of the report for recommendations.
- **Enforce payment regulations.** Payment rules and regulations are developed for several reasons, the primary of which is to ensure that consumers receive high-quality care.



- **Maximize the utility of the editing capabilities of claims processing systems to prevent overpayments.** Where functionality is lacking or inadequate to sufficiently vet claims pre-submission to avoid inappropriate billing, providers should engage in discussions with their EMR vendors to identify and implement the requisite safeguards. Thorough training of billing staff on new or previously unused system functionality will further ensure proper front end billing.
- **Complete additional reviews of potential conflicts of interest.**

Beyond the recommendations mentioned above, PCG was asked to provide additional recommendations for the New Mexico behavioral health system, based on the firm's national experience working with behavioral health and other community based providers. PCG recommends the following:

- **Convene stakeholder (state, vendors, and providers) workgroups to develop Outcomes Measures.** Working together, stakeholders can define the particular outcomes that New Mexico chooses to pursue. With specific measures in hand, work can begin on collecting the relevant information and data points, which will spawn fruitful conversations about quality of care and reimbursement reform.
- **Enforce Behavioral Health Providers' important role in Health Care Reform.** A primary argument in favor of health care reform is its potential to achieve cost savings by focusing attention on the small percentage of the population that consumes the largest share of health care services. Better management of care for those individuals can concurrently yield improvements in quality and decreased costs for services. Particularly in the case of publicly funded programs, individuals with chronic illnesses often have a primary or secondary behavioral health diagnosis. Behavioral health providers must be front and center in conversations regarding proactive management of care for this population.

TABLE OF CONTENTS

1. Introduction	1
2. Background and Understanding	
2.1 Purpose of Procurement	7
2.2 Scope of Work	8
3. Audit Approach	
3.1 Preparing and Deploying Audit Teams	
3.2 Establishing protocols for each component of the audit	10
3.3 Onsite data collection	10
3.4 Coordination with State and Managed Care Organization Staff	10
3.5 Production of Final Audit Report	11
4. Case File Reviews	
4.1 Case File Review Methodology	12
4.2 Provider Selection	13
4.3 Claim Selection	15
4.3.1 Random Samples of DOS	15
4.3.2 Longitudinal Reviews	16
4.4 Audit Tool Reviews	16
4.5 Extrapolation Methodology	18
4.6 Key Case File Findings	22
4.7 Key Recommendations	24
5. IT/Billing Systems Reviews	30
Appendices	
Audit Protocols	35
Provider Audit	64
Counseling Associates, Inc., Audit	



Sections 1 - 5

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 - 4.7 Key Recommendations
5. IT/Billing Systems Reviews



1. Introduction



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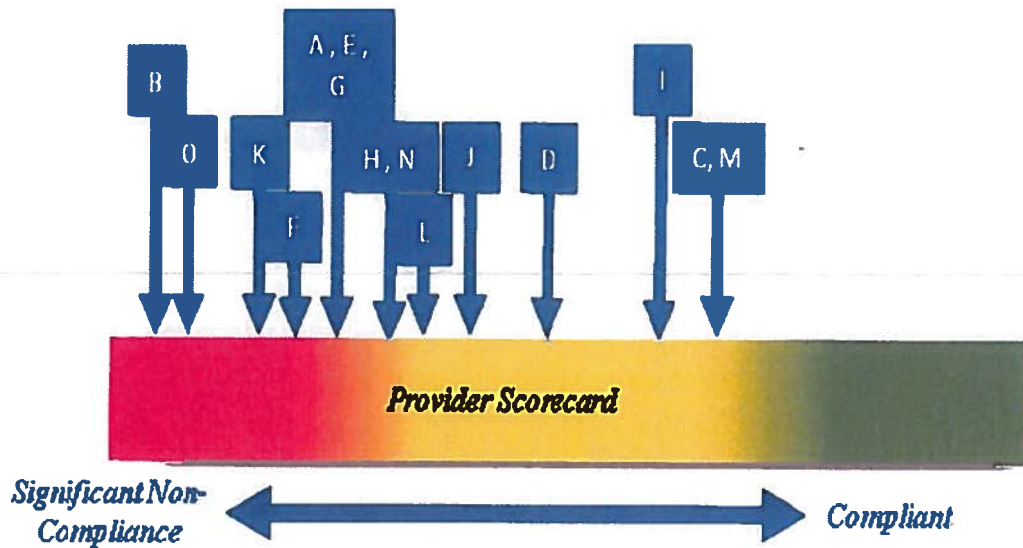
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1	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.	
2	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.• Potentially embed clinical management to improve processes.	M, C, I, D, J, L, H, and N
3	<ul style="list-style-type: none">• Provide trainings and clinical assistance as needed.• Potentially embed clinical management to improve processes. Potential change in management.	E, G, A, F, K, O and B
4	<ul style="list-style-type: none">• Mandatory change in management.	<i>See NOTE, below</i>

NOTE:- Please note that Tier 4: Credible Allegation of Fraud is a determination that can only be made by the State of New Mexico. PCG utilized results from its clinical case file audit and IT/billing system audit to develop the scorecard, which translated into providers being categorized in Tiers 1, 2, and 3. The State of New Mexico may determine that information provided in the case file, IT/billing system, and enterprise audits constitutes a re-categorization of one or more providers into a higher risk tier, including Tier 4.

2. Background and Understanding

2.1 Purpose of Procurement

2.2 Scope of Work

2. BACKGROUND AND UNDERSTANDING

2.1 Purpose of Procurement

In February 2013, the New Mexico Human Services Department (HSD) determined the need for a comprehensive clinical and billing audit of select providers within its behavioral health system and engaged Public Consulting Group (PCG) to conduct these audits. Claims data mining by the state's behavioral health vendor revealed a significant number of potential billing abnormalities. These potential billing abnormalities included, but were not limited to, the following "findings":

- Cross billing at different locations for the same member potentially overlapping time; uncertainty as to who rendered the service (if rendered at all);
- Insufficient documentation;
- Cross billing multiple codes and double billing (e.g. individual and group therapy);
- Upcoding individual therapy (compared to the average time billed per code in the peer group);
- Excessive billing for psychosocial rehab; including requesting authorization for a consumer on medical leave;
- Suspicious high volume days per one code; overbilling for inappropriate codes; psychosocial rehabilitation billed for large units on a given date to one clinician; excessive hours per day billed by practitioner; excessive hours of service billed per patient per code; billing for services duplicative in nature;
- Identifying Provider as the rendering clinician;
- No medical necessity reviews to determine basis for long-term psychotherapy;
- Forging clinician records to incorporate more time than truly performed;
- Out of home placement services outside norm of service; doubtful medical need;
- Billing outpatient services the same day as bundled services.

Not all of the aforementioned potential billing issues can be addressed with a single audit, particularly when an objective of the audit is to identify recoupable overpayments. In order to recoup across a universe of paid claims, a more comprehensive review is required. Narrowly focusing on one particular suspicious trend in a provider's claims history inhibits the ability of the auditor and the state to extrapolate those results across the entire claims history. Rather than attempting to address each provider's uniquely identified issues, PCG worked with HSD to develop a comprehensive approach that would scrutinize individual providers *holistically* (as opposed to looking at a few aberrant trends that may or may not run afoul of policy, even if substantiated) and the system at large. This approach was characterized by three main goals:



- 1) Identify potential credible allegations of fraudulent activity;
- 2) Identify regulatory compliance levels of behavioral health providers; and,
- 3) Identify areas of weakness that must be strengthened prior to the implementation of Centennial Care.

PCG was tasked with conducting onsite audits of selected providers to examine case files supporting specific claims, IT systems and processes, and adherence with compliance protocols, and to examine existing relationships among providers (enterprise audit). The results of the enterprise portion of the audits will be presented in a separate report. The onsite audits were conducted in February and March, and included interviews with relevant provider staff, collection of hard copy and electronic file documents related to the above mentioned areas, and examination and manual testing of IT systems. The onsite visits were supplemented by desk reviews of collected documentation at a location separate from the provider site. PCG's approach is described in more detail in the next section.

2.2 Scope of Work

Under the signed Agreement between HSD and PCG, PCG was engaged to serve as project manager in coordinating audits and analysis of 15 of New Mexico's Medicaid managed care organization (MCO) network of behavioral health providers. The providers were identified by the HSD. PCG's scope of work included three main audit components for each of the 15 providers:

- 1) Clinical Case File Audits to ensure that providers are adhering to New Mexico payment rules and regulations;
- 2) IT/Billing Systems Audit to ensure that systems are being used properly and in accordance with New Mexico payment rules and regulations; and
- 3) Enterprise Audit to ensure that each of the organizations' contractual and business relationships are conducted in accordance with Federal and New Mexico law, rules, and regulations.

PCG's approach and protocols for each of these audit components are described in the subsequent sections of this report.

3. Audit Approach

- 3.1 Preparing and Deploying Audit Teams
- 3.2 Establishing protocols for each component of the audit
- 3.3 Onsite data collection
- 3.4 Coordination with State and Managed Care
Organization Staff
- 3.5 Production of Final Audit Report

3. AUDIT APPROACH

3.1 Preparing and Deploying Audit Teams

Under the Agreement between HSD and PCG, PCG was responsible for the organization of onsite visits and offsite reviews, including preparing audit teams. Each project team was comprised of three to five individuals including the following specific roles:

- **Team Lead:** The Team Lead was responsible for overseeing the general operation of the onsite visits. Specific functions included:
 - Initiating onsite communication with provider staff;
 - Facilitating the entrance discussion, including explaining the purpose of the visit, expectations for provider assistance and actions to be carried out/protocols to be followed by the audit team during onsite time;
 - Coordinating team activities to ensure that team members were connected with the appropriate provider staff members and were able to collect the required information;
 - Conducting interviews with key provider administrative staff; and
 - Facilitating the exit discussion and communicating any additional information/next steps to provider.
- **Administrative Support:** Administrative support staff, which in some cases included team members with clinical experience, had primary responsibility for data collection and storage and provided as needed support to the other team members. Specific functions included:
 - Physically collecting documentation given by the provider, which in some cases included manually extracting documentation from case files;
 - Scanning and/or uploading all collected files;
 - Participating in as needed interviews with provider staff and documenting these interviews;
 - Identifying missing information and working with providers to obtain that information.

- **Information Technology (IT) Lead:** The IT Lead had primary responsibility for working with the provider's IT staff to analyze IT systems, their applications and functionality. Specific functions included:
 - Collecting documentation regarding IT infrastructure and all software systems currently in use, specifically those used for submitting claims to Optum and capturing other relevant clinical information; and
 - As appropriate, manually testing system functionality to determine the link between system inputs and outputs and to identify any areas of concern.

In addition to the above mentioned PCG staff roles, for two weeks of the audit PCG team members were accompanied by State staff acting in administrative support roles. Inclusion of State staff in audit teams reinforced HSD's role as the authorizing entity for the audits and further ensured coordination of onsite audits between HSD and PCG.

3.2 Establishing protocols for each component of the audit

PCG established auditing standards according to HSD's stated needs, with each component of the audit being assigned its own set of procedures, documentation requests and information collection tools. The specific components of the clinical and IT/billing audits and associated protocols are addressed in great detail in sections 4 and 5 of this report.

3.3 Onsite data collection

Upon arriving at each provider site, PCG conducted an entrance conference at which the purpose of the audit was explained and provider staff were given the list of claims (e.g., patient name, service rendered, date(s) of service, etc.) selected for auditing and asked to pull the appropriate medical records for the claims in question. PCG also provided a Document Request List that identified all of the documentation (case file, IT/billing and enterprise) expected to be provided as part of the audit.

The PCG team brought portable scanners to each provider location and any documents provided in hard (paper) copy were scanned and saved on a secure, encrypted laptop. Electronic files that were provided via USB drive or e-mail were also saved on the laptops. At the end of each day of the onsite audits, all files on the laptops were uploaded to a secure, HIPAA-compliant site for safe storage; files were then deleted from the laptops and all USB drives.

3.4 Coordination with State and Managed Care Organization Staff



Throughout the audit process, PCG worked closely with staff from both HSD and Optum, the managed care organization responsible for the administration of all State behavioral health funds, to keep both parties apprised of audit progress and to preemptively identify and discuss concerns related to consumer safety that might arise in relation to the audits.

3.5 Production of Final Audit Report

Upon completion of the data collection, review and analysis processes, PCG was tasked with the development and submission to HSD of a final audit report capturing all components of the audit process and highlighting key findings and recommendations generated by the audits, both at the comprehensive system wide and provider-specific levels. This document serves as that report.

For more details of PCG's audit protocols, please see the Audit Protocols portion of this report.

4. Case File Reviews

4.1 Case File Review Methodology

4.2 Provider Selection

4.3 Claim Selection

4.3.1 Random Samples of DOS

4.3.2 Longitudinal Reviews

4.4 Audit Tool Reviews

4.5 Extrapolation Methodology

4.6 Key Case File Findings

Key Recommendations

4. CASE FILE REVIEWS

Clinical and case file reviews comprised the most significant element of PCG's review. Administrative and clinical staff applied rigorous analysis to all paid claims selected for review. Our methodology focused on providing assurance that payment of claims is consistent with the administrative, credentialing, and clinical requirements set forth in the state's payment regulations.

4.1 Case File Review Methodology

At the start of the onsite audits, PCG presented providers with a notification from HSD identifying the clients whose case files had been randomly selected for audit and requesting that the provider have available all related service documents for review, not limited to:

- Psycho-social assessments
- Psychiatric evaluations
- Treatment plans/person-centered plans
- Service notes/progress notes
- Consents
- Referrals, and
- Authorizations/service orders

During onsite visits, the PCG team lead requested that the provider walk through the layout of the clinical record with the team to identify provider specific documents such as assessments, notes, consents, etc., the purpose of which was to aid PCG's ability to quickly and accurately identify the appropriate documentation within the case files.

In addition to documentation regarding the services provided, PCG requested from the provider personnel documents related to the qualifications for staff that rendered services to selected recipients. This documentation included at a minimum the relevant provider's:

- License to Practice
- Academic/Professional Degrees (Master's, Bachelor's, High School, GED)
- Resumes
- Certifications (Board Certification, Certified Peer Specialist)
- Trainings
- Supervision Notes, if required by service
- Criminal Background Checks (specific to Respite Care, Residential, Foster Care)

In addition to staff-specific information, PCG requested agency documentation related to personnel policies and procedures for maintaining staff qualifications.

The goal of this credentialing review was to address questions including:

- Does the rendering practitioner have a current valid license to practice?
- Did he or she receive the appropriate training to provide the service rendered?
- What is the status of clinical privileges at the institution designated by the service provider as the primary admitting facility, if applicable?
- Does a valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate exist, if applicable?

As with all gathered documentation, all files were scanned, logged, and uploaded to the secure website.

Once the onsite data collection process had concluded and case files had been examined for completeness and accuracy, the reviewing clinicians were notified that case files were ready for clinical review and the documents were downloaded from the secure website. All cases were reviewed using an audit tool containing a broad set of questions specifically geared toward identifying appropriate billing, excessive billing, overutilization, duplicate billing, and upcoding, and examining coordination of care and renderer of service. For certain service types, additional service-specific questions were applied in order to ensure a comprehensive program review that captured the unique facets of that particular service.

4.2 Provider Selection

As stated previously, HSD identified fifteen (15) behavioral health providers in New Mexico for PCG to audit. The table below lists the providers that were audited as part of this process.

Provider Name	Submitted Claims (2009-2012)	Universe Paid (2009-2012)
Border Area Mental Health Services Inc	117,492	\$ 11,081,469
Counseling Associates Inc	117,761	\$ 9,584,483
Families and Youth Inc	71,222	\$ 23,669,210
Hogares Inc	271,467	\$ 30,599,545
Partners in Wellness LLC	24,264	\$ 2,089,889
Pathways Inc	131,785	\$ 7,480,070
Presbyterian Medical Services	413,154	\$ 35,786,267
Easter Seals El Mirador	103,733	\$ 13,978,874

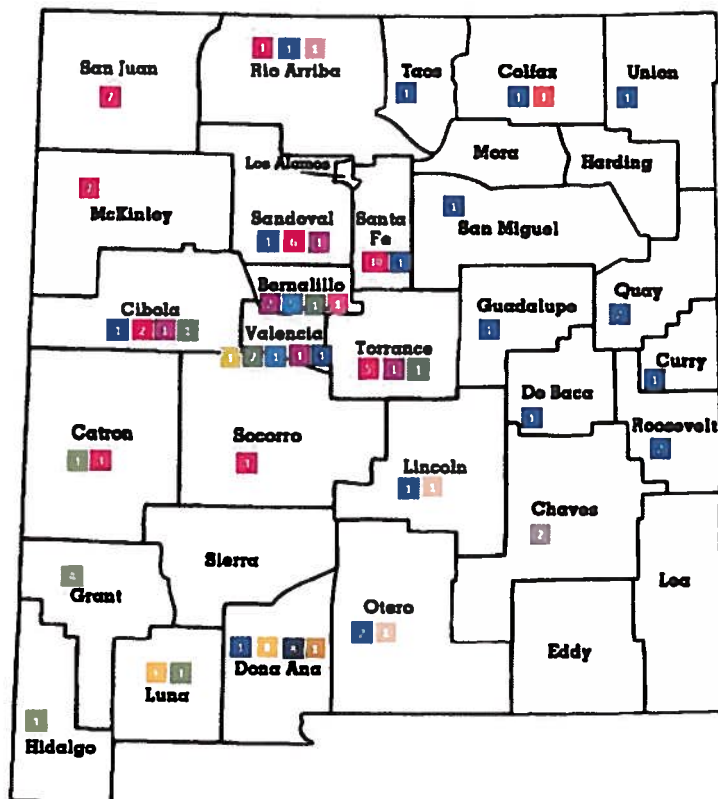
Service Organization for Youth Inc	12,493	\$ 897,468
Southern New Mexico Human Development	52,729	\$ 4,373,845
Southwest Counseling Center Inc	151,769	\$ 14,934,445
TeamBuilders Counseling Services Inc	714,243	\$ 77,493,302
The Counseling Center Inc	78,965	\$ 6,344,152
Valencia Counseling Services Inc	108,047	\$ 9,495,054
Youth Development Inc	26,343	\$ 2,870,455
Totals	2,395,467	\$ 250,678,527

The majority of the selected providers have several facilities located within the state, representing approximately 108 facilities, shown on the map below by county and organization.

STATE OF NEW MEXICO
Behavior Health Audits
Location of BH Facilities

There are 108 facilities scheduled to be audited. They are shown on the map by county and organization.

ORGANIZATION	
Prodytorian Medical Services	1
TeamBuilders	2
Families and Youth, Inc.	3
Border Area Mental Health	4
Hogares	5
Youth Development Inc	6
Valencia Counseling Services Inc	7
Southern New Mexico Human Development	8
The Counseling Center Inc	9
Counseling Associates Inc	10
Pathways	11
Southwest Counseling Center Inc	12
Partners in Wellness	13
Service Organization for Youth	14
Border South El Mirador	15



4.3 Claim Selection

Due to the large volume of claims to analyze, audit sampling was applied. Audit sampling is the application of an audit procedure to less than 100% of the population to evaluate audit evidence within a class of transactions (claims) for the purpose of forming a conclusion concerning the population. The sample size creates a risk that the conclusions may be different from the conclusions that would have been reached based on the whole population.

The most common types of sampling used are systematic sampling and random sampling. Random sampling ensures equal chances of selection, whereas systematic sampling involves using a fixed interval between selections (e.g. every 10th sample; first interval has a random start).

PCG applied random sampling to analyze the data. Sampling documentation includes the source of the population, the sampling method used, sampling parameters, items selected, details of audit tests performed, and conclusions reached.

PCG executed a two-pronged approach to the selection of claims for review – random samples for date of services and longitudinal reviews, both of which are described below.

4.3.1 Random Samples for Date of Service

The first prong was a full, statistically valid random sample of all claims for each provider. PCG randomly selected 150 claims from each provider for a full case file review. It was critical in selecting samples for case file review to ensure randomness so that the review was fair to the provider and was demonstrable as such to impartial parties during the due process phase, as many such reviews might be subject to appeal. During PCG's visit to Optum Health (Optum), Optum staff provided PCG with all paid claims data for providers subject to this review. PCG extracted the claims data and uploaded it into a SQL database for analytical review, validation, and ultimately sample selection. PCG employed RAT-STATs, an Office of Inspector General (OIG) approved statistical sampling package to drive the sample selection for this engagement.

PCG has employed RAT-STATS in multiple engagements and is well-versed in all facets of the program. The program produces a "seed" number to demonstrate the randomness of the sample should a provider appeal on the grounds that claims were selectively targeted and do not represent the entirety of their claim universe. The statistically valid random sample enables PCG to extrapolate any findings over the entire universe of claims for a provider in determining overpayment amounts.

4.3.2. Longitudinal Reviews

The second prong of our approach was to conduct a targeted claim selection process. Through its data analytics process and through tips from whistleblowers, Optum had identified potentially outlying claims for each of the providers under audit. Several of the procedure codes identified as potentially being overbilled are codes billed in 15 minute increments and are billed over an extended period of time. It is often concerning to payers of health care claims when the units of service do not decrease over time within these codes for a given individual and is sometimes a “red flag” that a provider is billing for that service for that individual in an “auto-pilot” mode or that the consumer is not making the desired progress. For these types of trends, it is not possible to diagnose a billing issue by reviewing only a single date of service. In some cases, one may conclude that these trends represent potentially abusive billing and in others that the duration and intensity of services are appropriate for that consumer. One cannot, however, conclude these things by looking at a single point in time.

Through a targeted claim selection process, PCG identified highly utilized codes (as determined by their percentage of total paid claims to the provider) by individual providers. Following the selection of the codes, PCG isolated the consumers for whom the greatest number of units for these procedure codes had been billed over a 12-month period (Calendar Year 2012), removed those claims from the universe of claims subject to random sampling, requested documentation associated with claims submitted on behalf of those consumers and audited the entire length of stay. This allowed our review team to ensure through examination of treatment plans, service authorizations, progress notes, and other documentation that the services were, in fact, taking place and that the high level of service was necessary for that consumer given the diagnosis and goals of the individual. For each provider, PCG identified the 2-3 such procedure codes with the highest spend and selected the 5 consumers with the most units billed. It should be noted that the targeted claim selection process is not statistically valid and cannot be extrapolated to claims other than those claims that are reviewed. It is intended to provide an extensive, thorough review for a small number of consumers so that HSD can determine if a more widespread review is warranted.

4.4 Audit Tool Reviews

The audit tool questions were developed based on both the New Mexico Administrative Code and the New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines. A broad set of questions was employed, coupled with more specific questions tailored for each service sampled.



The broad set of questions in the tool specifically related to excessive billing, overutilization, duplicate billing, coordination of care, upcoding, and renderer of service. Some of the key questions asked about each claim included:

1. Do the units paid match the units of service documented for the sampled procedure code? Was the amount of rendered units appropriate for the recipient? (excessive billing)
2. Was the service delivered medically necessary and appropriate (overutilization)?
3. Does the documentation support, or relate to, the rendered service?
4. Does the procedure code match the documented duration of time spent serving the member for the encounter billed (upcoding)?
5. Were multiple units/encounters billed for the same procedure code for the same recipient in the same day?
6. Were the billed services rendered by qualified staff?

In addition to auditing for excessive billing, overutilization, duplicate billing, coordination of care, upcoding, and inappropriate service delivery as outlined above, a specific set of audit questions developed and utilized for each sampled service type covered the categories below:

- Service Definition
- Target Population
- Program Requirements
- Provider Requirements
- Staff Requirements
- Documentation Requirements
- Service Exclusions
- Admission/Continuing/Discharge Criteria

For each claim, the reviewing clinician provided a response to each clinical question. Possible responses were:

- No/Not Met
- Not Applicable
- Yes/Yes Met

Comments are required for No/Not Met and followed by the New Mexico Administrative Code (NMAC), New Mexico Service Definitions, and Level of Care citation verbiage.

4.5 Extrapolation Methodology

PCG performed both a targeted review and a statistically valid random sample review of all billed behavioral health services procedure codes on behalf of HSD. First, PCG targeted one year's worth of billed high risk procedure codes from the five highest claimed-for recipients at each of the providers and performed an administrative and clinical review of the validity of each billed claim. The resulting overpayment validated by PCG was calculated based on the dollar value of only those paid claims from the universe of claims reviewed found to be out of compliance with New Mexico's clinical and/or billing criteria. The results of these reviews was not extrapolated beyond the specific claims PCG reviewed.

Second, PCG selected a statistically valid random sample of 150 of the remaining claims from the universe of claims paid to each provider paid between July 1, 2009 and January 31, 2013. The resulting overpayment validated by PCG was representative of the universe of claims from which the sample was selected and was extrapolated over the entire universe of claims (excluding those claims selected for targeted review) in compliance with auditing procedure regulations found in New Mexico Administrative Code Title 8, Chapter 351, Part 2.

Targeted Review

The first goal of the review process was to identify a targeted selection of claims based on the procedure codes billed. Those codes include:

Procedure Code	Description
90791	Psychiatric Diagnostic Evaluation
90801	Psychiatric Diagnostic Evaluation
90802	Interactive Psychiatric Evaluation
90804	Outpatient—20-30 minutes
90806	Outpatient—45-50 minutes
90807	Outpatient psychotherapy with E/M 45-50 minutes
90808	Outpatient—75-80 minutes
90812	Interactive Psychotherapy—45-50 minutes
90814	Interactive Therapy—75-80 minutes
90834	Outpatient—45 minutes
90837	Outpatient—60 minutes
90846	Family Therapy
90847	Family Therapy
90849	Outpatient Psychotherapy Services



90853	Group Therapy
90862	Medication Management
99212	Office/Outpatient Visit
99214	Office/Outpatient Visit
H0002	Behavioral Health Screening
H0015	Intensive Outpatient Program
H0019	Transitional Living Services
H0031	Mental Health Assessment
H0039	Assertive Community Treatment
H0041	Foster Care(Shelter)
H0048	Alcohol/Drug Testing
H2010	RN Medication Monitoring
H2011	Crisis Intervention Services
H2014	Behavior Management Services
H2015	HO, HN, HM—CCSS
H2017	Psychosocial Rehabilitation
H2023	Supported Employment Services
H2033	Multi-Systematic Therapy
Q3014	Telehealth Facility Fee/Code
S5145	Treatment Foster Care
S9482	Family Stabilization Services
T1005	Respite Services
T1007	Behavioral Health Treatment Plan Update
T1024	Resource Management Services
T1502	Medication Administration

PCG selected between one and five of these procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid during calendar year 2012. In total, PCG's targeted review included 23,764 claims from 210 of the highest billed-for recipients across 15 providers.

Random Sample Review

Because behavioral health services typically feature high volumes of low-cost claims, PCG selected a statistically valid simple random selection of claims and extrapolated our findings across the claims universe using standards consistent with those used by the U.S. DHHS Office



of Audit Services, endorsed by the Centers for Medicare and Medicaid Services (CMS), and supported by New Mexico Administrative Code. Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population.

All samples consisted of 150 claims per provider and were selected from the entire universe of paid claims for each provider between July 1, 2009 and January 31, 2013. CMS OIG set a minimum standard of 100 claims for use in extrapolation, thus the 150 claim sample size is more than adequate to meet the statistically valid threshold produced by RAT-STATS as well as compliance with the OIG standard. This approach allowed for a comprehensive view of billing practices that was representative of the provider's clinical and billing policy compliance during this period of time. Samples were randomly selected using the OIG-developed statistical sampling software RAT-STATS.

The steps to conduct this sampling process and overpayment extrapolation include:

Step 1 – Define the universe / population

The universe was defined as the total set of claims paid between July 1, 2009 and January 31, 2013 from each reviewed provider minus any claims which were selected for the Targeted Review. PCG pulled these claim extracts (i.e. universes) and retained them in a spreadsheet numbered 1 to (n), where (n) is the total number of claims.

Step 2 – Determine sample size

While the U.S. DDHS Office of Audit Services commonly uses minimum sample sizes of 100 claims, PCG chose to review 150 claims to improve the precision of our samples.

Step 3 – Select the Sample

Random selection of claims is necessary in order to produce a valid sample. In PCG's random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the universe at large. As a result, the sample allows an accurate portrayal of what is occurring across the universe.

PCG used the OIG-developed RAT-STATS random number generator to identify the claim numbers to be selected from the universe spreadsheet. This RAT-STATS random number generation software was extensively tested by the National Bureau of Standards using 13

certification programs to ensure randomness and passed all 13 of these tests. Following this random number generation, RAT-STATS generates a seed number which serves as an auditable reference point should the numbers need to be re-generated at a later date.

The specific steps used for selection of samples in this process include:

1. Using a random number generator (ex: www.random.org), generate a random number to be used as the seed number associated with the sample.
2. Open the RAT-STATS statistical software and navigate to Random Numbers>Single Stage Random Numbers.
3. Select 'yes' to 'Do you want to enter a seed number and input the seed number from above.'
4. Input the desired number of claims for the sample in the Sequential Order Box.
5. Enter the range of values in the Low Number (l) and High Number (n) boxes.
6. Output to an excel file and save as a backup.
7. Using the random numbers spreadsheet, identify the claims from the universe to be included in the audit by selecting those line numbers that were pulled.

Step 4 – Audit the Sample

Each randomly selected claim was reviewed for compliance with New Mexico's clinical and billing policies and to ensure the legitimacy of the state's payment, as described in Section 4.4. The dollar values of any claims validated as non-compliant were classified as overpayments.

Step 5 – Extrapolate the results

The results of PCG's audits were extrapolated using RAT-STATS. PCG first created two spreadsheets; one to record the detailed audit results (i.e. sample item with the difference amount) and one to include the sampling details (i.e. number of items in the universe and number sampled). Once this information has been entered and saved, PCG inputs this information into RAT-STATS. RAT-STATS identifies the overpayment amount using the Lower Bound of the 90% confidence interval, meaning that, in lay terms, there is a 95% chance that the actual overpayment amount (if *all* claims were to be audited) would be *higher than* the estimated overpayment amount.

The specific steps used for extrapolating the results of our findings are as follows:

1. Query the state's claims data to pull the total claims universe for each provider and copy to Spreadsheet #1.
2. Create a Spreadsheet #2 with five columns: Stratum (column A), Paid Amount (B), Examined Amount (C), Sample Size (D), and Universe Size (E).
3. Input the correct information into the appropriate column for each provider.
4. Insert two columns in the spreadsheet columns B and C.
5. Save the spreadsheet using the naming convention [ProviderName]ExtrapolationFile_[YYYYMMDD]
6. Open RAT-STATS and go to Variable Appraisals → Unrestricted
7. Enter the total Universe Value from Spreadsheet #1.
8. Click Specify Input File, choose Excel and choose the Spreadsheet #2.
9. On the next screen, choose Examined and Audited Values, and Output to Text File. Save the text file with the same naming convention as the excel file.
10. Enter the sample size of the case.
11. Click OK twice, and then click Additional Summary Info twice.
12. The recoupment amount is the 90% Lower Limit.

Typically, extremely low rates of noncompliance result in poor precision. Therefore, if both the claims error rate *and* the paid error rate are less than 5%, extrapolation is not used and the overpayment amount is simply the sum of the sample overpayment amounts.

4.6 Key Case File Findings

PCG's Case File Audit did not uncover what it would consider to be credible allegations of fraud, nor any significant concerns related to consumer safety. However, PCG's review revealed a provider system in need of technical assistance, especially considering the seismic shift that the state's behavioral health system will undergo with the transition to Centennial Care in January 2014.

Utilizing a statistically significant extrapolation methodology, PCG identified **more than \$33.8 million in overpayments** to these 15 providers over a three year period from 2009-2012 (13.5% of total payments).



Provider	Universe Paid	# of Non-Compliant Claims	Percentage Non-Compliant Claims	Extrapolation - Lower Bound	Recoupment as a % of Total Payments
Provider A	\$13,978,874	41	27.3%	\$4,327,784	31.0%
Provider B	\$9,495,054	60	40.0%	\$4,128,958	43.5%
Provider C	\$23,669,210	20	13.3%	\$772,016	3.3%
Provider D	\$35,786,267	83	55.3%	\$3,138,735	8.8%
Provider E	\$2,089,889	32	21.8%	\$3,629,976	173.7%
Provider F	\$897,468	5	3.3%	\$7,856	0.9%
Provider G	\$11,081,469	44	29.3%	\$2,046,690	18.5%
Provider H	\$6,344,152	26	17.3%	\$612,663	9.7%
Provider I	\$7,480,070	9	6.0%	\$57,614	0.8%
Provider J	\$2,870,455	27	18.0%	\$228,309	8.0%
Provider K	\$4,373,845	55	36.7%	\$1,304,140	29.8%
Provider L	\$9,584,483	53	35.3%	\$2,757,585	28.8%
Provider M	\$14,934,445	23	15.3%	\$1,028,069	6.9%
Provider N	\$77,493,302	31	21.1%	\$9,262,711	12.0%
Provider O	\$30,599,545	22	14.9%	\$565,309	1.8%
Totals	\$250,678,527	531	23.7%	\$33,868,415	13.5%

While each provider is unique with respect to clinical findings, PCG identified a few common themes across many of the 15 providers reviewed. Each provider has a specific section in the report that provides the detailed clinical findings. Non-compliance with many New Mexico state rules and regulations was common. Provider-specific findings are located within each provider's audit section. Generally, PCG found the following issues across providers:

- Community Support Workers lacked evidence of completion of the required training per the service definition.
- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
- Assessments (psychosocial/psychiatric evaluations) were not up to date (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
 - Incomplete critical information such as Five Axis diagnosis.
 - Substance abuse history was absent for most consumers with a dual-diagnosis of mental health and substance abuse.

- Treatment plans were not up-to-date and individualized per consumer. Updated treatment plans are necessary to determine any changes to goals/objectives in addition to progress or lack of progress by the consumer. Without continuously updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.
 - Plans contained the same goals/objectives for more than 12 months.
 - Potential overutilization of services without documented justification of the service related to extensive length of stay.
 - Goals/Objectives were not measurable and did not document achievable target dates based on the consumer's needs.
 - Service-specific clinical interventions used to reach goals/objectives were absent.
 - Discharge plans and estimated length of treatment were not documented for all consumers. Documented discharge plans were rarely individualized.
- Consumer Documentation
 - Consents for medications rendered were absent.
 - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
 - Interventions in the progress notes did not always link to the consumer's treatment plan or support the program definition of the billed service.
 - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
 - Billed units did not match the units documented on the progress notes.
 - Intensive Outpatient Program progress notes did not contain the treatment modalities used as required in the service definition.
 - Documented evidence of the required treatment team was absent for most team services.

4.7 Key Recommendations

Below, PCG has compiled a list of recommended best practices that New Mexico should include in its payment rules and regulations. Many of these are already included in payment rules and regulations but appear not to always be enforced. PCG recommends that the policies be reviewed and strengthened (i.e., clarified so there is common understanding among HSD and providers) and enforced by all payers (either the state or a contracted MCO). The recommended best practices are divided into case file components: assessments, treatment plans, and progress notes.

Assessments

Type of Information	Description
Identifying Information	<ul style="list-style-type: none"> • The date of initial contact and admission date; • The consumer's name and contact information (including address/phone and emergency contact information); • The consumer's age, self-identified gender & ethnicity, and marital status; • Information about significant others in the consumer's life including guardian/conservator or other legal representatives; • The consumer's school and/or employment information; and, • Other identifying information, as applicable such as Medicaid Identification Number.
Communication	<p><i>Communication needs</i> are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the consumer to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made; if the consumer prefers a family member as interpreter, document that preference. Service-related correspondence with the consumer must be in their preferred language/format.</p>
Relevant physical health conditions	<p><i>Relevant physical health conditions</i> reported by the consumer or by other report must be prominently identified and updated, as appropriate.</p>
Presenting problem/referral reason & relevant conditions	<p><i>Presenting problem/referral reason & relevant conditions</i> affecting the consumer's physical health, mental health status and psychosocial conditions (e.g. living situation, daily activities, social support, etc.). Includes problem definitions by the consumer, significant others and referral sources, as relevant.</p>
Special status situations	<p><i>Special status situations</i> that present a risk to the consumer or to others must be prominently documented and updated, as appropriate. These might include imminent risk of harm, suicidal or homicidal ideations, self-injurious behaviors, or possible elopement. If a risk situation is identified, the Treatment Plan must include how it is being managed.</p>



<i>Consumer's strengths</i>	<i>Consumer's strengths</i> in achieving anticipated treatment goals (e.g., consumer's skills and interests, family involvement and resources, community and social supports, etc.).
<i>Medications</i>	List medications prescribed by an MD employed by the provider, including dose/frequency of each, dates of initial prescriptions & refills. Documentation of informed consent for medications is required. Medications prescribed by an outside MD must be listed as above, per consumer or MD's report; provide the MD's name and telephone number.
<i>Allergies & adverse reactions/sensitivities</i>	Per consumer or by report, to any substances or items, or the lack thereof.
<i>Substance use, past & last use/current</i>	Alcohol, caffeine, nicotine, illicit substances, and prescribed & over-the-counter drugs (as applicable).
<i>Mental health history</i>	<i>Mental health history</i> , including previous treatment dates and providers; therapeutic interventions and responses; sources of clinical data; relevant family information; and results of relevant lab tests and consultation reports (as applicable).
<i>Other history</i>	As relevant, include developmental history; social history; histories of employment/work, living situation, etc.
<i>For consumers under age 18</i>	Include (or document efforts to obtain) pre-natal/ perinatal events, and complete developmental history (physical, intellectual, psychological, social & academic).
<i>Relevant Mental Status Examination</i>	Includes signs and symptoms relevant to determine diagnosis and plan of treatment.
<i>Five-axis diagnosis</i>	<i>Five-axis diagnosis</i> from the most current DSM (or ICD), consistent with presenting problem, history, mental status examination, and/or other assessment data.
<i>Signature/Credentials/Date</i>	<i>Signature/Credentials/Date</i> of the licensed person completing the Assessment. Assessments must be updated at least every 12 months or when there has been a significant change in the consumer's clinical behaviors.

Treatment Plans

Treatment Plans (aka Consumer/Life/Recovery/Care Plans, etc.) are plans for the provision of behavioral health services for consumers who meet the medical necessity criteria. Treatment

Plans must be developed from the Assessment, substantiate ongoing medical necessity, and be consistent with the diagnosis(es) that is the focus of behavioral health treatment. Strength-based and recovery/resiliency focused treatment planning is best practice and strongly recommended.

Type of Information	Description
Timelines	<ul style="list-style-type: none"> • Treatment Plan must be developed within 30 days of admission; • 6-Month Treatment Plan Update: The treatment plan must be updated every 6-months to ensure that the most clinically appropriate interventions are being rendered to the consumer; and, • Other Updates to the Treatment Plan: The Treatment Plan must be updated whenever there are significant changes in the consumer's presentation and/or situation that affect their planned treatment.
Consumer Goals	<ul style="list-style-type: none"> • Stated in own words, when possible.
Mental health goals/objectives	<ul style="list-style-type: none"> • Goals and objectives should be specific and measureable, and linked to the Assessment's clinical analysis and diagnosis (i.e. must be related to mental health barriers to reaching consumer's goals). Provide estimated time frames (target dates) for attainment of both short and long term goals/objectives.
Interventions	<p>Interventions and their focus must be consistent with the behavioral health goals/objectives and must meet the medical necessity requirement that the proposed intervention(s) will have a positive impact on the identified impairments. Providers should indicate:</p> <ul style="list-style-type: none"> • Service Interventions, which are the planned behavioral health services (e.g., Individual Psychotherapy); • Interventions should be appropriate to the consumer's diagnosis, age and intellectual needs; • Documented linkage of interventions to the rendered service definition; and, • "Best practice" to also indicate clinician interventions, which are the provider's actions during services to support the consumer's progress toward goals/objectives (e.g., "Offer stress reduction techniques to reduce anxiety" or "Support consumer to express unresolved grief to reduce depression").



Duration and Frequency	<ul style="list-style-type: none">• Service intervention duration and frequency should be noted, with target dates for each.
Coordination of Care	<ul style="list-style-type: none">• If applicable, it is “best practice” to include an objective in the treatment plan regarding coordination of a consumer’s care with other identified providers.
Estimated Length of Stay/Discharge Plan	<ul style="list-style-type: none">• Should be completed.
Signature/Credentials/Date	<ul style="list-style-type: none">• Should be completed.
Evidence of the consumer’s degree of participation and agreement	<p>Evidence of the consumer’s degree of participation and agreement with the Treatment Plan should be addressed in the following ways:</p> <ul style="list-style-type: none">• The consumer’s (or legal representative’s) dated signature on the Treatment Plan is required;• If the consumer (or legal representative) is unavailable or refuses to sign the Treatment Plan, the Plan must include the provider’s dated/initialed explanation of why the signature could not be obtained, or refer to a specific Progress Note that explains why. In either case, include evidence on the Plan or in Progress Notes of follow-up efforts to obtain the signature; and,• If the provider believes that including the consumer in treatment planning would be clinically contraindicated, the Plan must include the provider’s dated/initialed explanation or refer to a specific Progress Note that explains why, and the reason must be supported by the clinical record’s documentation.
Copy of the Treatment Plan	<ul style="list-style-type: none">• A copy of the Treatment Plan must be provided to the consumer (or legal representative) upon request and a statement to that effect must be either on the Plan or within other documentation signed by the consumer.

Progress Notes

Progress notes (including daily/weekly/monthly logs) are the evidence of a provider’s services to or on behalf of a consumer and relate to the consumer’s progress in treatment. Progress notes must contain the clinical details to support the medical necessity of each claimed service and its relevance to the prescribed treatment plan. In order to receive reimbursement for a service, there must be a complete progress note for that service.



Progress Notes must clearly relate to the behavioral health objectives and goals of the consumer as established in the Treatment Plan (versus, for example, a progress note that focuses on the mental health needs of a depressed mother in a family session, without addressing how her depression impacts the consumer/child's mental health needs.) Each Progress Note must "stand on its own" regarding medical necessity, identifying a clear link to the individualized treatment plan. Progress Notes must be entered into the clinical record within one (1) working day of each service provided. In the infrequent situation when an emergency prevents timely recording of services, the service must be entered in the clinical record as soon as possible. The beginning of the note must clearly identify itself as a late entry for the date of service (e.g. "Late entry for *date of service*"). Signatures for late entries must include the date the note was written.

Below are minimum requirements PCG recommends for Progress Notes:

Type of Information	Description
Dates of Services	<ul style="list-style-type: none"> <i>Date of service</i> on which the service was rendered must be documented.
Service Intervention	<ul style="list-style-type: none"> <i>Service intervention</i> or service code (e.g. psychosocial rehabilitation, collateral, behavior management service, medication management, etc.
Location	<ul style="list-style-type: none"> <i>Location</i> of the service provided (e.g. office, home, community, school, employer, etc.
Time	<ul style="list-style-type: none"> <i>Time</i> spent providing a service. The progress note must contain either a start and stop time or total duration of the rendered service.
Documentation	<ul style="list-style-type: none"> Reason for the contact. Assessment of consumer's current clinical presentation. Specific behavioral health/clinical interventions by provider, per type of service and scope of practice. Consumer's response to interventions. Strengths and limitations in achieving treatment plan goals/objectives. Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Indicate referrals made. Address any issues of risk. If risks are present, a risk assessment or "no harm" agreement must be completed. Signature/Credentials/Date of the person who rendered the service.

5. IT/Billing Systems Reviews

5. IT/Billing Systems Reviews

PCG Information Technology staff accompanied PCG audit teams for on-site audits for 15 New Mexico Behavioral Health Providers in February and March 2013.

As mentioned before, review of information technology (IT) systems included examination of provider IT systems, their inputs, outputs, and claims processing. The purpose of the IT audit was to verify if evidence existed in the IT systems and procedures to support the preliminary audit findings. The IT systems that were reviewed include each provider's:

- Eligibility System
- Prior Authorization System
- Clinical Systems (i.e., Electronic Health Records)
- Rx System (if there is one in place)
- Billing System

Error types

The IT audit examined three main ways in which error could enter the information lifecycle flow:

- Human error in data entry or processing steps
- Unintentional software processing error
- Deliberate action taken to alter the records either by a human or computer so they do not match treatment given

General Controls

Control structure of the provider affects its IT operations. During the onsite audits, audit teams collected documentation in order to evaluate and document:

- Organizational Controls – decision flows within the organization
- Data Center and Network Operations Controls – how is the proper entry of data ensured and what is the procedure for error correction?
- Hardware & Software Acquisition and Maintenance Controls
- Access Security Controls – how is the computer equipment, software, and data protected? What procedures are in place in the event of an unauthorized use?



- Application System Acquisition, Development, and Maintenance Controls – how is the reliability of information processing ensured?
- Managerial controls- are the IT assets protected from unauthorized use?

Systems Documentation

After collection of IT documents, documentation for each of the IT systems was analyzed. The IT Audit focuses on the Billing Lifecycle subset of the Healthcare Delivery Lifecycle:

Healthcare Delivery Lifecycle

This procedure outlines the steps necessary to audit the provider's IT Health care billing system and determine how this fraud/abuse is being perpetrated in the billing lifecycle. The healthcare delivery lifecycle steps include:

- a. Bed facility; office service; products
- b. Pre-admission/admission/office appointment
- c. Inpatient/outpatient/office services performed
- d. Patient discharged/office visit concluded
- e. Medical record assignment of ICD and CPT codes
- f. Bill is processed and submitted
- g. Bill is submitted to TPA/payer for processing
- h. Payment received
- i. Account follow up/collection

IT Billing Lifecycle

The IT Audit should consider the error types listed above for each step of the billing lifecycle. At a high level, the IT billing lifecycle is as follows:

- a. Claim is filled out by human either on a paper form or an electronic record that records information about a health care item delivered to a patient.
- b. An operator enters the claim data into the provider's billing system.
- c. The system validates the entries, checks eligibility and performs actions according to system settings.
- d. The billing system processes the claim, updates the database and generates a bill.

Review of information technology (IT) systems is a vital element of the audit process and included examination of provider IT systems, their inputs, outputs, and processing. The purpose

of the IT audit was to verify if evidence exists in the IT systems and procedures to support the preliminary audit findings.

IT Audit Process

PCG developed an overall understanding of all providers' billing operations and systems. PCG documented the workflow from the provision of the service to the creation of a claim. To achieve this, PCG:

- Analyzed each providers' healthcare information systems. This included all the systems that interact in the claim lifecycle, including intake, eligibility, prior authorization, health records, and billing systems, as well as relevant databases.
- Performed a full review consisting of two major elements:
 - a) Analyzing how the systems and databases work; what rules they use; how they interact; and who and built them, operates them, and maintains them. To this end, PCG requested all documentation regarding the information systems in place.
 - b) Performing end-to-end tests for selected claims. PCG sought to follow claims selected for review across all systems and to compare system inputs and outputs for re-entered claims data in order to verify proper system performance. These claims represented a subset of the claims subject to clinical case review.

These audit steps focused on identifying the following factors that could contribute to the billing irregularities:

- Weak security
- Unauthorized access to data and unauthorized remote access
- Inaccurate information and erroneous or falsified data input
- Misuse by authorized end users
- Incomplete processing and/or duplicate transactions
- Untimely processing
- Communication system failure
- Inadequate training and support

General IT Findings

Generally, providers were helpful in explaining how their systems worked and in providing the requested documentation. However, because of system limitations and apparent software vendors contractual arrangements, there were several providers who could not provide the full range of requested documentation.



The 15 providers audited use systems to handle their intake, eligibility, clinical record creation, billing creation and billing submission. Some providers use more than one system (e.g. a Clinical Records system and a Billing system). The providers use the following systems for their clinical and billing functions:

Anasazi:

- Border Area Mental Health
- Counseling Associates, Inc.
- The Counseling Center, Inc.
- Families and Youth, Inc.
- Partners in Wellness LLC
- Southwest Counseling Center Inc.
- Valencia Counseling Services Inc.

CMCHi:

- Southern New Mexico Human Development

EMR Bear:

- Hogares Inc.
- TeamBuilders
- Pathways

El Perico:

- Youth Development Inc.

MediSoft:

- Santa Maria El Mirador
- Service Organization for Youth Inc.

NextGen:

- Presbyterian Medical Services

Practima:

- Hogares Inc.
- Pathways
- TeamBuilders

Anasazi Software was not able to provide a complete audit record for billing. The software provides an adequate audit trail for the clinical portion, but not for billing. PCG staff was informed, through providers, that Anasazi Software would not provide any system documentation, claiming that it is proprietary. This includes:

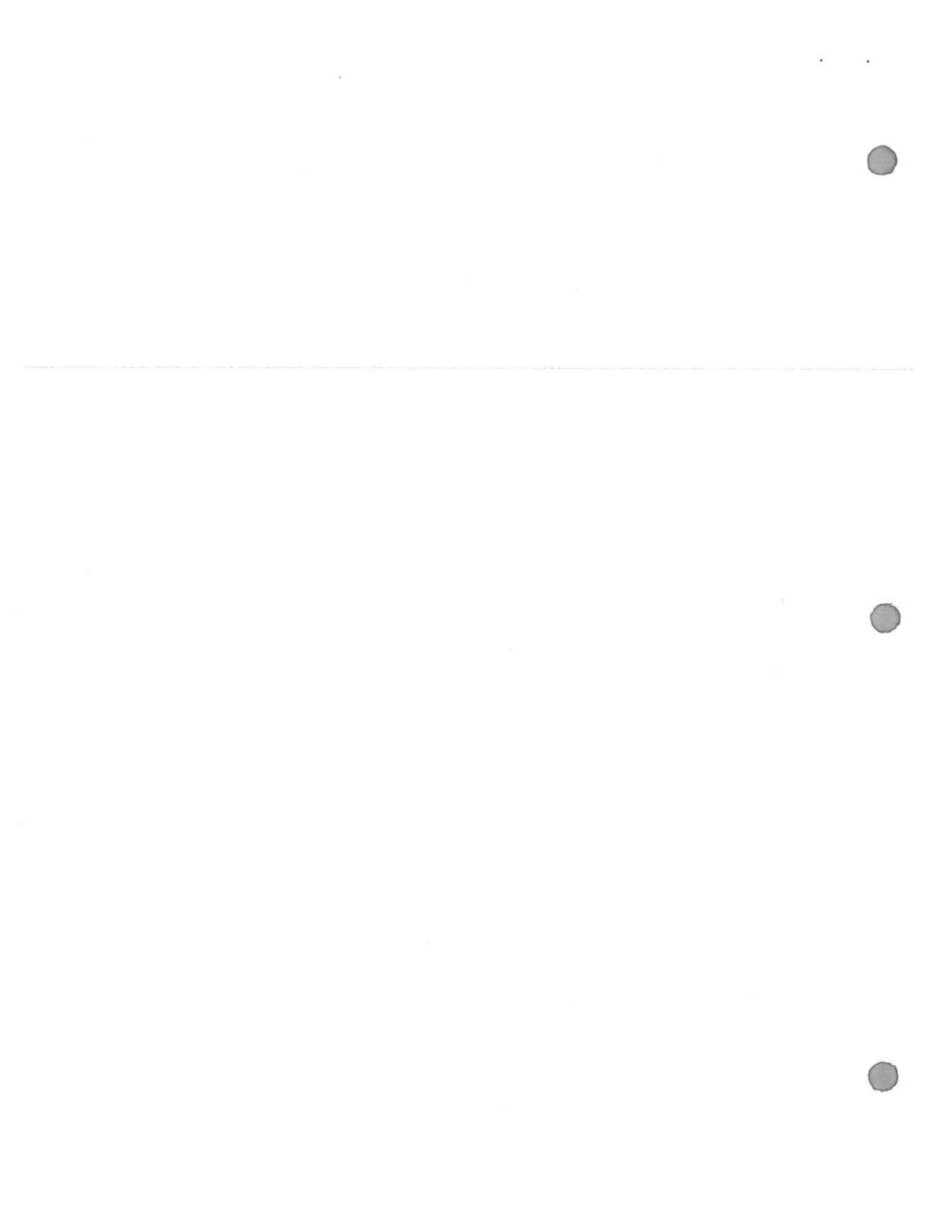
- User instructions/manuals/guides



- User training materials
- Installation Instructions
- System maintenance guides
- System development documentation

All providers utilize the Optum portal for authorizations, eligibility, and billing entry, and all providers use Optum Netwerkes as their ACH – Automated Clearing House.

PCG evaluated all the IT controls involved in the billing process from intake through to submission of the Claim during our audit. PCG found that the sophistication and controls in place were greater for the larger organizations. Some organizations they were more reliant on manual processes and institutional knowledge that had been built up over time. The size of the IT departments varies depending on the size of the provider and the number of sites they support. The sophistication of the training for clinical areas and IT areas also varies between providers.



Appendices

Audit Protocols
Provider Audit





Audit Protocols

New Mexico Human Services Department Behavioral Health Provider Audit and Policy Review

February 26, 2013



Contents

1. Background	37
2. Project Teams	42
3. Communications	43
4. Clinical and Case File Review Procedures	44
4.1. Claim Sample Selection Methodology	44
4.2. Claim Review Methodology	45
5. IT Audit Procedures	48
5.1. Systems to Review	48
5.2. Error types	48
5.3. General Controls and System Documentation	48
5.4. Sampling	49
5.5. IT Audit Processes	49
Appendix 1 – Case File Review Questions	51
Appendix 2 – IT System Audit Checklist	53



1. Background

The New Mexico Human Services Department (HSD) has engaged Public Consulting Group (PCG) to conduct audits of a select group of behavioral health providers. Preliminary reviews and reports indicate potential service or coding issues. As a result, HSD has requested a comprehensive medical record and credentialing audit.

Specifically, the following items have been identified for further exploration:

- Cross billing at different locations for the same member potentially overlapping time; uncertainty as to who rendered the service (if rendered at all);
- Insufficient documentation;
- Cross billing multiple codes and double billing (e.g. individual and group therapy);
- Upcoding individual therapy (compared to the average time billed per code in the peer group);
- Excessive billing for psychosocial rehab; incl. requesting authorization for a consumer on medical leave;
- Suspicious high volume days per one code; overbilling for inappropriate codes; psychosocial rehab billed for large units on a given date to one clinician; excessive hours per day billed by practitioner; excessive hours of service billed per patient per code; billing for services duplicative in nature;
- Identifying Provider as the rendering clinician;
- No medical necessity reviews to determine basis for long-term psychotherapy;
- Forging clinician records to incorporate more time than truly performed;
- Out of home placement services outside norm of service; doubtful medical need;
- Billing outpatient services the same day as bundled services.

As a result of the preliminary findings, PCG has been tasked with conducting onsite audits of selected providers to examine case files, IT systems and processes, and adherence with compliance protocols, and to examine existing relationships among providers. The onsite visits are expected to entail interviews with relevant provider staff, collection of hard or electronic copy documents related to the above mentioned areas, review of clinical data and examination and manual testing of IT systems.

The onsite visits will be supplemented by desk reviews at a location separate from the provider site. Findings resulting from desk reviews may necessitate follow up communication with providers to clarify and/or request additional information.

The documentation findings will be provided in a final report to the Department of Human Services. The final report will state the nature, timing, and extent of the audit work performed, as well as the findings, conclusions, and recommendations and any reservations, qualifications or limitations of scope that IT audit team has with respect to the audit.

Provider Obligations

Several documents outline provider responsibilities regarding the provision of access to facilities, systems, and files and other documentation. These documents include:

- New Mexico Medicaid Provider Participation Agreement
- UBH Facility Participating Provider Agreement
- Optum Health New Mexico Provider Manual

The relevant sections from each document are excerpted below.

New Mexico Medicaid Provider Participation Agreement

Excerpted from Article 1, Obligations of the Provider, which states that the Provider shall:

1.19. Furnish immediately to the DEPARTMENT or its AUTHORIZED AGENTS, the U.S. Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested and any information regarding payments claimed by the PROVIDER for furnishing services to eligible recipients.

1.20. Permit announced and unannounced inspection of facilities or the PROVIDER'S offices and other locations used in the provision of services for billing and to eligible recipients by the U.S. Secretary of Health and Human Services, the Medicaid Fraud Control Unit, and the DEPARTMENT and its AUTHORIZED AGENTS. Failure to comply with this provision constitutes a violation of federal and state law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the PROVIDER



shall furnish the records within two (2) to ten (10) business days of the receipt of the request or as provided in the request.

1.21. Assist and cooperate in any review, inspection or audit conducted in conformity with the terms of this AGREEMENT.

UBH Facility Participating Provider Agreement

Excerpted from the New Mexico Statewide Behavioral Health Program Funded by the Behavioral Health Collaborative Regulatory Requirements Appendix, Section 4: Optum Health Requirements:

4.7 OptumHealth may periodically conduct a review, such review to include an audit, of Provider's records to determine Provider's compliance with State and Federal codes, rules, regulations and requirements, as well as with the Agreement. Provider agrees that Provider shall cooperate as necessary in any such review, which may include, but are not limited to, the following:

- (1) Federal and State audits;
- (2) Encounter Validation Studies - Provider shall participate in any required Center for Medicaid and Medicare Services ("CMS") and/or OptumHealth data validation studies and other validation studies as may be required. Any and all Covered Services may be validated as part of the studies;
- (3) Review of Financial Statements and Other Documents - Provider shall supply annual financial audits, A-133 audits, periodic financial statements, and other documents as requested by OptumHealth; and/or
- (4) OptumHealth and State will regularly audit and monitor financial stability of Provider, requests for additional funds, or requests for funds as a result of claims reimbursement issues.

Optum Health New Mexico Provider Manual

Excerpted from the section entitled "Audits: On-site, Treatment Records, Financial Records":

OptumHealth representatives visit practice locations and facilities to conduct a variety of on-site audits, including but not limited to, routine clinical quality audits, environmental site audits, quality of care audits (to address concerns identified through Critical Incident reporting or consumer complaints, for example) and financial viability audits. Environmental audits may be conducted



as part of the routine quality audit processor, for facilities without national accreditation or state certification it may be part of the credentialing and recertification process. Any facility, regardless of accreditation, may be subject to an On-site Audit for any potential quality of care concerns brought to the attention of OptumHealth.

During an On-site Audit, charts are reviewed for documentation of diagnosis, treatment plan, verification of services provided to members and other elements. You are expected to maintain adequate medical records on all consumers. Prior to a scheduled audit visit, you will be notified of the specific types of charts that will be reviewed. Failure to document services and/or dates of services may lead to a request for a Corrective Action Plan.

Financial viability audits include a review of specific records to assess financial stability with a goal of strengthening the viability for the long-term. Some examples of records that are reviewed as part of the financial audit are income statements and balance sheets. As with any audit, you will be notified of the specific requirements prior to the review.

Audit tools are based on standards set forth by the State of New Mexico, National Committee on Quality Assurance (NCQA), The Joint Commission (formerly JCAHO) an independent, not-for-profit organization that evaluates and accredits more than 16,000 health care organizations and programs in the United States, HIPAA and OptumHealth. Audit tools are available for reference on optumhealthnewmexico.com.

Treatment Record Documentation Requirements

In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing and/or national certification board standards.

In order to perform required utilization management and quality improvement activities, OHNM may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested



records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to OHNM and its Payors, customers, clinicians, and facilities.

OHNM may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to OHNM for review. An On-Site Audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities without national accreditation such as The Joint Commission, CARF or other
- agency approved by OHNM
- Audits of high-volume clinicians
- Routine random audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues identified by OHNM or brought to OHNM's attention by
- members, family members or their representatives
- Audits of clinicians with a home office
- Audits related to a member complaint regarding the physical environment of an office or facility

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records. OHNM has established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP.

Guidelines contained in this section are subject to change.

2. Project Teams

Each project team is expected to be comprised of three to five individuals including the following specific roles:

- **Team Lead:** The team lead will be responsible for overseeing the general operation of the onsite visits. Specific functions include:
 - Initiating onsite communication with provider staff
 - Facilitating the entrance discussion, including explaining the purpose of the visit, expectations for provider assistance and actions to be carried out/protocols to be followed by the audit team during onsite time
 - Coordinating team activities to ensure that team members are connected with the appropriate provider staff members and are able to collect the required information
 - Conducting interviews with key provider administrative and clinical staff
 - Facilitating exit discussion and communicating any additional information/next steps to provider
- **Administrative Support:** Administrative support staff will have primary responsibility for data collection and storage and will provide as needed support to the other team members. Specific functions include:
 - Physically collecting documentation given by the provider, which may include pulling case files
 - Scanning, logging and uploading all collected files
 - Participating in interviews with provider staff and documenting these interviews
- **Information Technology Lead:** The IT lead will have primary responsibility for working with the provider's IT staff to analyze IT systems, their applications and functionality. Specific functions include:
 - Collecting documentation regarding IT infrastructure and all software systems currently in use, specifically those used for submitting claims to Optum and capturing other relevant clinical information
 - As appropriate, manually testing system functionality to determine the link between system inputs and outputs and to identify any areas of concern

3. Communications

Providers identified for audits will not be given advance notice of the audits; rather, the team will arrive on site on the scheduled day unannounced. The team lead will request to speak with the Executive Director or other designee and will request an immediate entrance conference, at which the team lead will present a letter from HSD explaining the purpose of the audit and provider expectations regarding compliance.

Along with the letter, the team lead will provide documentation containing the identities of the randomly selected recipients (including service type and dates of service) as well as a list of documents that the provider will be required to make available to the audit team. Requested documents pertaining to the individual components of the audit are outlined in subsequent sections.

Once onsite, the team lead shall ensure the appropriate level of communication with provider staff. Upon arrival, the team lead will conduct an entrance conference with the designated provider representative (or his or her designee) and other relevant provider staff. The items to be covered in the entrance conference include:

- Provide hard copy of letter of authority to conduct audit
- Provide claims list for review
- Discuss scope of audit--recipient and staff records review to ensure policy/regulation compliance
- Request staff files related to recipients/claims identified for review
- Discuss space needs and estimated time onsite
- Establish provider contact for questions onsite

As appropriate, the team lead will address provider questions related to the nature, purpose and scope of the audit. Information shared in this regard will adhere to HSD guidance on this issue, and questions that cannot be addressed by the team lead will be referred to the appropriate HSD contact.

The team lead shall ensure that specific audit team members are connected with the proper staff to address their specific component of the audit process.

All audit documentation collected onsite will be scanned or saved to a secure laptop and logged, including but not limited to the above mentioned documents as well as session and supervisory notes, manuals, reports, flowcharts, correspondence, observations, plans, test results, meeting minutes, computer records, and data files. PCG has developed a detailed system for logging all

information collected onsite and ensuring that the necessary documentation is seamlessly captured and recorded.

Prior to departing the provider site at the conclusion of the onsite portion of the audit, the team lead will hold an Exit Conference to validate that PCG has received all requested documents and will be reviewing them for compliance through the desk review process. As appropriate, any next steps for the provider will be communicated at this point.

4. Clinical and Case File Review Procedures

Clinical and case file reviews will be a major part of PCG's audit process. Our administrative and clinical staff will apply rigorous analysis to all paid claims selected for review. Our methodology will seek to provide assurance that paid claims are consistent with administrative, credentialing, and clinical requirements set forth in the state's Medicaid regulations. Upon arriving at provider sites, PCG will present provider staff with the list of claims (e.g., patient name, service rendered, date(s) of service, etc.) and ask staff to pull the appropriate medical records for the claims in question. The PCG team will bring portable scanners to provider locations and upload the appropriate documents to a secure, HIPAA-compliant database from which the appropriate reviewer will download the documents for review.

4.1. Claim Sample Selection Methodology

PCG will execute a two-pronged approach to the selection of claims for review. The first prong will be a full, statistically valid random sample of all claims for each provider. PCG will randomly select 150 claims from each provider for a full case file review. It is critical in selecting samples for case file review to ensure randomness so that the review is fair to the provider and is demonstrable as such to impartial parties during the due process phase as many such reviews are subject to appeal. During PCG's visit to Optum Health, Optum staff provided PCG with all paid claims data for providers subject to this review. PCG extracted the claims data and uploaded it into a SQL database for analytical review, validation, and ultimately sample selection. PCG will employ RAT-STATs, an Office of Inspector General (OIG) approved statistical sampling package to drive the sample selection for this engagement.

PCG has employed RAT-STATS in multiple engagements and is well-versed in all facets of the program. The program produces a "seed" number to demonstrate the randomness of the sample should a provider appeal on the grounds that claims were selectively targeted and do not represent the entirety of their claim universe. **The statistically valid random sample will**



enable PCG to extrapolate any findings over the entire universe of claims for a provider in determining overpayment amounts.

The second prong of our approach will be to conduct a targeted claim selection process. Through its data analytics process and through tips from whistleblowers, OptumHealth has identified potentially outlying claims for each of the providers under audit. Several of the procedure codes identified as potentially being overbilled are codes billed in 15 minute increments and are billed over an extended period of time. It is often concerning to payers of health care claims when the units of service do not decrease over time within these codes for a given individual. It is sometimes a red flag that a provider is billing for that service for that individual in an “auto-pilot” mode or that the consumer is not making the desired progress. For these types of services, it is often difficult to diagnose a billing issue by reviewing only a single date of service.

Through a targeted claim selection process, PCG has isolated the consumers for whom the most units have been billed of these procedure codes over a 12-month period (Calendar Year 2012), removed those claims from the universe of claims subject to random sampling, and will request documentation associated with claims submitted on behalf of those consumers and audit the entire length of stay. This will allow our review team to ensure through examination of treatment plans, service authorizations, progress notes, and other documentation that the services are, in fact, taking place and the high level of service is necessary for that consumer given the diagnosis and goals of the individual. For each provider, we have identified the 2-3 such procedure codes with the highest spend and have selected the 5 consumers with the most units billed. **It should be noted that the targeted claim selection process is not statistically valid and cannot be extrapolated to claims other than those claims that are reviewed. It is intended to provide an extensive, thorough review for a small number of consumers so that HSD can determine if a more widespread review is warranted.**

4.2. Claim Review Methodology

Case Files

As stated above, the notification from HSD to providers will identify the clients whose case files have been randomly selected for audit and request that the provider have available all related service documents for review not limited to:

- Psycho-social assessments
- Psychiatric evaluations
- Treatment plans/person-centered plans
- Service notes/progress notes

- Consents
- Referrals, and
- Authorizations/service orders

The team lead and clinical lead will request the provider walk through the layout of the clinical record with the team to identify provider specific documents such as assessments, notes, consents etc. and will conduct interviews with key clinical staff and practitioners as necessary.

Provider Credentialing

In addition to documentation regarding the services provided, PCG will request from the provider personnel documents related to the qualifications for staff that rendered services to selected recipients. This documentation will include at a minimum the relevant provider's:

- License to Practice
- Academic/Professional Degrees(Master's, Bachelor's, High School, GED)
- Resumes
- Certifications (Board Certification, Certified Peer Specialist)
- Trainings
- Supervision Notes, if required by service
- Criminal Background Checks(specific to Respite Care, Residential, Foster Care)

In addition to staff-specific information, PCG will request agency documentation related to personnel policies and procedures for maintaining staff qualifications.

The goal of this credentialing review is to address questions including:

- Does the rendering practitioner have a current valid license to practice?
- Did he or she receive the appropriate training to provide the service rendered?
- What is the status of clinical privileges at the institution designated by the service provider as the primary admitting facility, if applicable?
- Does a valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate exist, if applicable?

As with all gathered documentation, all files will be scanned, logged and uploaded to the secure website.

Desk Audit Steps

Once the onsite data collection process has been concluded and case files have been examined for completeness and accuracy, the reviewing clinician will be notified that case files are ready



for review. The documents will be pulled down from the secure website for clinical review. All cases will be reviewed using an audit tool containing a broad set of questions specifically related to excessive billing, overutilization, duplicate billing, coordination of care, upcoding, and renderer of service. In addition to the areas above, certain service types will contain specific questions in order to ensure a comprehensive program review.

Examples of specific questions are outlined in Appendix I although the list is not exhaustive as each claim's review will be driven by the specific procedure code for that claim and the questions asked will be unique to requirements for billing under that procedure code. Some of the key questions that will be asked of each claim include:

1. Do the units paid match the units of service documented for the sampled procedure code? Was the amount of rendered units appropriate for the recipient? (excessive billing)
2. Was the service delivered medically necessary and appropriate (overutilization)?
3. Does the documentation support, or relate to, the rendered service? i.e. Does the documentation match the description of the services associated with the procedure code?
4. Does the procedure code match the documented duration of time spent serving the member for the encounter billed (upcoding)?
5. Were multiple units/encounters billed for the same procedure code for the same recipient in the same day?

For each claim, the reviewing clinician will provide a response to each clinical question. Possible responses are:

- No/Not Met
- Not Applicable
- Yes/Yes Met

Comments are required for No/Not Met and will be followed by the NMMAC Regulations, NM Service Definitions, and Level of Care citation verbiage.

5. IT Audit Procedures

Review of information technology (IT) systems is a vital element of the audit process and will include examination of provider IT systems, their inputs, outputs, and processing. The purpose of this IT audit is to verify if evidence exists in the IT systems and procedures to support the preliminary audit findings. Upon the completion of the IT audit, a report will be provided.

5.1. Systems to Review

The IT systems that should be reviewed include provider's:

- Eligibility System
- Prior Authorization System
- Clinical Systems (i.e., Electronic Health Records)
- Rx System (if there is one in place)
- Billing System

5.2. Error types

Error could enter the information lifecycle flow through three main ways. These must all be accounted for in the audit procedures for all of the systems listed above:

- Human error in data entry or processing steps
- Unintentional software processing error
- Deliberate action taken to alter the records either by a human or computer so they do not match treatment given

5.3. General Controls and System Documentation

General Controls

Control structure of the provider affects its IT operations. The following should be evaluated and documented:

- Organizational Controls – decision flows within the organization
- Data Center and Network Operations Controls – how is the proper entry of data ensured and what is the procedure for error correction?
- Hardware & Software Acquisition and Maintenance Controls

- Access Security Controls – how is the computer equipment, software, and data protected? What procedures are in place in the event of an unauthorized use?
- Application System Acquisition, Development, and Maintenance Controls – how is the reliability of information processing ensured?
- Managerial controls- are the IT assets protected from unauthorized use?

Systems Documentation

Documentation for each of the IT systems should be gathered and analyzed. Appendix 2 provides a checklist for systems documentation.

5.4. Sampling

Due to the possibly large volume of claims to analyze, audit sampling may be applied when necessary. Audit sampling is the application of an audit procedure to less than 100% of the population to evaluate audit evidence within a class of transactions (claims) for the purpose of forming a conclusion concerning the population. The sample size creates a risk that the conclusions may be different from the conclusions that would have been reached based on the whole population.

The most common types of sampling used are systemic sampling and random sampling. Random sampling ensures equal chances of selection, whereas systematic sampling involves using a fixed interval between selections (e.g. every 10th sample; first interval has a random start).

The sampling objectives and methods should be documented. Documentation should include the source of the population, the sampling method used, sampling parameters, items selected, details of audit tests performed, and conclusions reached.

5.5. IT Audit Processes

The audit steps protocol and checklists in Attachment 2. The information below provides additional background on the healthcare delivery lifecycle and the IT billing lifecycle.

Healthcare Delivery Lifecycle

This procedure outlines the steps necessary to audit the provider's IT Health care billing system and determine how abuses might be perpetrated in the billing lifecycle. The healthcare delivery lifecycle steps include:

- a. Bed facility; office service; products
- b. Pre-admission/admission/office appointment



- c. Inpatient/outpatient/office services performed
- d. Patient discharged/office visit concluded
- e. Medical record assignment of ICD and CPT codes
- f. Bill is processed and submitted
- g. Bill is submitted to TPA/payer for processing
- h. Bill is received
- i. Account follow up/collection

IT Billing Lifecycle

The IT Audit should consider the error categories listed in Section 3.1 for each step of the billing lifecycle. At a high level, the IT billing lifecycle is as follows:

- a. Claim is filled out by human either on a paper form or an electronic record that records information about a health care item delivered to a patient
- b. An operator enters the claim data into the provider's billing system
- c. The system validates the entries, checks eligibility and performs actions according to system settings
- d. The billing system processes the claim, updates the database and generates a bill.

Review of information technology (IT) systems is a vital element of the audit process and will include examination of provider IT systems, their inputs, outputs, and processing. The purpose of this IT audit is to verify if evidence exists in the IT systems and procedures to support the preliminary audit findings. Upon the completion of the IT audit, a report will be provided.

Case File Review Questions

Below is an incomplete list of questions utilized in the audit tool:

Questions	Responses: Yes/No/NA	Comments
Was a psychosocial assessment/psychiatric evaluation completed as appropriate (i.e. contains a treatment history whether substance abuse, mental health, or both)?		
Does the psychosocial assessment/psychiatric evaluation contain all five DSM-IV axes and is it signed by a licensed clinician?		
If the identified treatment is for mental health, is a mental health screening present and complete?		
If the identified treatment is for substance abuse, is a history of smoking, alcohol use, and substance use documented? This must include present and past use, frequency and duration of use, administration method, as well as any abuse of medications, whether prescribed or over the counter.		
Does the record document a risk assessment appropriate to the level of care and population served which includes the presence or absence of suicidal or homicidal risk?		
Was there documentation of continuity of care, consultation, and referral (i.e. prior providers, consultants, Probation/Parole Officers, Employee Assistance Programs, housing, employers, Courts, Department of Vocational Rehabilitation, ancillary and other non-behavioral health providers?)		
Was the treatment plan signed by a treatment team licensed practitioner?		
Was the treatment plan individualized per person including the specific service provided with appropriate goals and objectives?		
Does the treatment plan estimate the length of treatment and contain a discharge plan?		
Are the treatment interventions consistent with the individualized treatment plan?		



Was the service delivered medically necessary and appropriate (overutilization/length of stay)?		
Were the delivered interventions appropriate to the diagnosis, age, and intellectual needs?		
Does the service note document progress or lack of progress toward treatment goals/objectives?		
Does the documentation support, or relate to, the rendered service (service definition)?		
Were multiple units/encounters billed for the same procedure code for the same recipient in the same day?		
Are the encounters billed supported by documentation of medical necessity in appropriate amount, duration and scope?		
Were the billed services rendered by qualified practitioners? If so, was the practitioner identified as rendering the service (instead of providers/TIN)?		
Does the procedure code match the documented duration of time spent serving the member for the encounter billed (up coding)?		
Was the amount of rendered units appropriate for the recipient?		
Were medication codes billed appropriately and non-duplicative?		
Do the psychiatric notes reflect target symptoms, rationale for medications, treatment recommendations, and response to medications?		
Was the written informed consent for psychotropic medication documented?		
Is there evidence of an evaluation of the recipient's response to the prescribed medications and adjustments made as needed?		
Does the record document what medications have been prescribed, the dosages of each, and the dates of initial prescriptions or refills?		



Appendix 2 – IT System Audit Checklist

To be filled out for each audit site separately

Section I: Audited entity information	
Name	
Address	
ID# (SSN, DEA etc)	
Organization	

Section II: Audit team information		
Name	Date	Signature



Section III: Documentation gathered

No	Document name	(Y/N)	Comments
• <i>Process documentation of development and maintenance, including:</i>			
1.	Plans, schedules, reports used in the development/ customization process		
2.	Process quality documents		
3.	Organizational and project standards		
• <i>Documentation of current system settings, including:</i>			
1.	System architecture (also for each program in the system)		
2.	Description of components and their functionalities		
3.	Rules		
4.	Logic and automatic actions applied to data entries/claims		
5.	System maintenance guide		
6.	Validation and how it related to the requirements		

• Documentation of system factory settings			
1.	[document 1]		
2.		
• End-user documentation (e.g. manuals)			
1.	[document 1]		
2.	...		
• System administrator documentation			
1.	Functional description		
2.	System installation document		
3.	Introductory manual		
4.	System reference manual		
5.	System administrator's guide		
6.	...		
• Other documentation			
1.	[document 1]		
2.	...		

Section IV: IT Hardware & Software System information

Fill in the following IT system information to be gathered from documentation and interviews. Can do initial pass pre-visit from documentation.

- Make a full list of all servers and all PCs at a location using the following format for each machine.**

Inventory ID:		Location:		Type (server/PC) and name:	
Staff who can access:				Access level description:	
1.	[name 1]				
2.	...				
Hardware: [description]					
Software installed (incl. anti-virus)				Version and licensing info	
1.	[item 1]				
2.	...				
Services exposed to the Internet				Reason for exposure	
1.	[service 1]				
2.	...				
Make a full list of network equipment					
Firewall/switch		Firmware version	Configuration info	Network access permissions <i>What's allowed into the network</i>	
1.	[item 1]				



2.	...			
• Document network connections				
1.	[description]			

Section V: Audit steps

The audit steps focus on identifying the following factors that could contribute to the billing irregularities:

- Weak security
- Unauthorized access to data and unauthorized remote access
- Inaccurate information and erroneous or falsified data input
- Misuse by authorized end users
- Incomplete processing and/or duplicate transactions
- Untimely processing
- Communication system failure
- Inadequate training and support

For each of the IT systems below execute the full set of audit steps:

- a) Eligibility System
- b) Prior Authorization System (PAS)
- c) Clinical Systems (i.e., Electronic Health Records)
- d) Rx System (if there is one in place)
- e) Billing System



AUDIT STEPS PROTOCOL

IT System: [name and type – billing, eligibility, PAS, etc.]

No	Audit Step	Completion Date	Person Responsible	Notes
1.	Compare paper or electronic claims to the submitted bill and any intermediate reports created by the system. Record the claims that are compared and make copies of any discrepancies. On a more general scale, compare the input to the system and the output from the system for correctness			
2.	Verify that the training material, courses and instruction practice good processing. Identify the training procedures to train employees on the system use			
3.	Verify that any user modifiable setting is correct on the billing system. Especially settings might change final billing amounts			
4.	List all system components and processes that can interact with the database of record			
5.	Identify system user authentication/login procedures and what is currently implemented			
6.	Identify system administration capabilities and what is currently implemented			



7.	Identify backup procedures and what was implemented			
8.	List Disaster Recovery procedures. Identify if it has ever happened			
9.	Analyze Audit trails/logs generated by system. Identify if any of them relate to the potential billing discrepancies			
10.	Identify if any batch processes that are used to upload data			
11.	Determine if any media is stored offsite and document it			
12.	Identify and interview company (s) that developed and maintained the IT billing system. Ask the following questions:			
a.	Does the system offer the ability for users to modify billing amount calculations?			
b.	Do the users of the system have access to source code?			
c.	Do the users of the system have ability to modify any portion of the database including SQL, stored procedures, report tools, software responsible for creating billing statements or reports?			
13.	Interview person or people who use or manage the billing system and ask the following questions:			



a.	Who has access to alter system settings?			
b.	Who has the ability to change the source code?			
c.	Who has the ability to change the data in the database?			
d.	Does everyone have their own login?			
e.	Are logins shared?			
f.	Is there a log of users who sign in and use the system?			
g.	Is there a database transaction log?			
h.	Is there an application transaction log?			
i.	Is everyone who enters data into the system required to go through a training course?			
j.	How are data entry errors detected by the system?			
k.	Is there a data entry error log?			
l.	Is there documentation that explains the data entry validations implemented by the system?			
14.	Identify the programmers and support staff that have access and can modify the billing system			
Additional audit steps				



If there is direct online access to the provider billing system additional audit steps can be performed:

15.	Verify that the billing system process and screens matches the documented functionality			
16.	Verify that the billing program security features work as planned and only authorized users can make entries or changes to the IT system			
17.	Verify source code controls			
18.	Verify any online reports generated match the database values			
19.	Verify IT system controls in the processing of the claim and ensure the completeness and accuracy of the transaction processing, authorization and validity. These include:			
a.	Data Capture Controls – ensures that all transactions are recorded in the application system, transactions are recorded only once, and rejected transactions are identified, controlled, corrected, and reentered into the system			
b.	Data Validation Controls – ensures that all transactions are properly valued			
c.	Processing Controls – ensures the proper processing of transactions			



d.	Error Controls – ensures that errors are corrected and resubmitted to the application system at the correct point in processing			
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Section VI: Audit step execution documentation

When discrepancies are identified they should be documented and attached to this document. The person generating the documentation should date and sign the attachments.

1. For instance, if an input claim form for a patient does not match the submitted bill, then a copy of the original claim and a screen shot of the billing information should be captured.
2. Images for portions of audit trails that show an unauthorized change should be captured.
3. Any tests that identify that the user actions are not being stored properly in the database of record should be documented and screen shots should capture the process utilized.

No	Document description	Date	Person Responsible	Notes

...



Border Area Mental Health Services

Clinical Narrative
IT Narrative
Enterprise Narrative



BORDER AREA MENTAL HEALTH

Case File Audit

Dates of Onsite Review	March 6 – 13, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$2,046,690
Actual Longitudinal Overpayments	\$179,903
Total Overpayment Amount	\$2,226,593

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
71%	35%



This scorecard result translates to the following Risk Tier:

Risk Tier	Types of Findings	Recommended State Action
3	Significant findings, including significant	<ul style="list-style-type: none"> Provide trainings and clinical assistance as needed.



quality of care
findings.

- Potentially embed clinical management to improve processes.
- Potential change in management.

Provider Overview

Border Area Mental Health Services is the largest provider of behavioral health services in southwest New Mexico and has seven locations across the region. Within these locations, Border Area delivers behavioral health services including outpatient services, family programs, substance abuse services, comprehensive community support services/case management, and community correction program services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	1,228,308	4,727,240
CYFD	85,398	478,450
Medicaid FFS	48,927	229,135
Medicaid MCO	1,460,105	5,069,573
NMCD	15,598	120,357
Other	243,511	727,869
Grand Total	3,081,847	11,352,623

Audit Team Observations

- An entrance conference was held approximately 30 minutes after PCG arrived onsite at Border Area Mental Health Services (BAMHS). [REDACTED] [REDACTED] was out of the office on the day PCG arrived and our entrance conference was held with [REDACTED] and [REDACTED].
- [REDACTED] assumed responsibility for the coordination of the document collection and worked with administrative and clinical staff.
- PCG began to receive case files on the second day of our visit.

- BAMHS staff provided PCG with hard copies of documentation and PCG scanned the files and saved them to a laptop.
- [REDACTED] supplied PCG with documents related to the BAMHS billing system and procedures and did an informal demonstration of the system.
- Initially, BAMHS provided a user guide to Anasazi but upon consultation with the licensor requested that PCG sign a document that we would not distribute or view the document for competitive reasons. PCG purged the document from our files.
- BAMHS was cooperative throughout the process but was disorganized in their collection of documents. PCG received multiple copies of many of the documents and many documents were not submitted.
- Clinical Reviewers noted the following general findings:
 - For Foster Care and Treatment Foster Care, time sheets were often the only documents verifying placement of a child – no progress notes or other goal-tracking documentation was received for review.
 - Safety/Risk Assessments were not completed or up-to-date for multiple consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were incomplete of critical information.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:



Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	5	561	0	0	0.0%
90804	Outpatient—20-30 minutes	2	87	0	0	0.0%
90806	Outpatient—45-50 minutes	29	2,028	0	0	0.0%
90808	Outpatient—75-80 minutes	1	79	0	0	0.0%
90847	Family Therapy	1	80	0	0	0.0%
90853	Group Therapy	14	347	0	0	0.0%
90862	Medication Management	6	411	0	0	0.0%
H0015	Intensive Outpatient Program	6	705	0	0	0.0%
H0031	Mental Health Assessment	5	1,783	0	0	0.0%
H0041	Foster Care(Shelter)	12	1,200	0	0	0.0%
H2010	RN Medication Monitoring	2	138	0	0	0.0%
H2011	Crisis Intervention Services	1	112	0	0	0.0%
H2015	HO, HN, HM—CCSS	36	2,417	34	2,272	94.4%
H2017	Psychosocial Rehabilitation	5	615	2	291	40.0%
H2033	Multi-Systematic Therapy	8	1,740	0	0	0.0%
S5145	Treatment Foster Care	3	480	0	0	0.0%
S9482	Family Stabilization Services	5	270	0	0	0.0%
T1007	Behavioral Health Treatment Plan Update	9	1,019	8	909	88.9%
Grand Total		150	14,073	44	3,471	29.3%

Specific Random Sample Review Findings

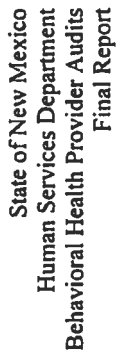
For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing document: Psychosocial assessment. [redacted] unable to determine qualification to provide service based on information in file.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing documentation: [redacted] education. [redacted] not qualified per staff roster.
H2015		Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Unable to read signature of provider on psychiatric evaluation. Missing documentation: [redacted] education.
H2015		Fail	Fail	Fail	Fail	N/A	Fail	N/A	N/A	N/A	Missing documentation: no treatment plan in file. No safety risk assessment documented on progress note. [redacted] is not on staff roster, she has documents in staff file. [redacted] is not on staff roster or in staff file. [redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing documentation: education [redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Fail	N/A	Fail	N/A	N/A	N/A	Billing indicates three units, and per progress note, the duration of this was 0:15 min=1 unit. Missing documentation [redacted] education. Not qualified per staff roster [redacted].
H2015		Pass	Pass	Pass	Fail	N/A	Fail	N/A	N/A	N/A	No risk assessment on progress note. Missing documentation: [redacted] not on staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing documentation: [redacted] education. [redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[redacted] resume states "no degree". [redacted] not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Per comprehensive, consumer has been in treatment since

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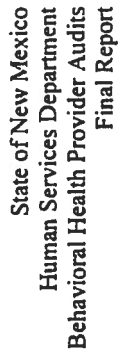
Page 69



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	not qualified per staff roster.
H2015		Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing documentation: psychosocial assessment. unable to determine qualifications to provide service from information in file.
H2015		Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	and is not qualified per staff roster. is the provider on progress note and is not qualified per staff roster.
H2015		Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing documentation: not on staff roster or in staff qualifications file. not qualified per staff roster.
H2015		Fail	Fail	Fail	Fail	N/A	Fail	N/A	N/A	N/A	Missing documentation: No comprehensive assessment found in file. Missing documentation: No treatment plan in file.
H2015		Fail	Fail	Fail	Fail	N/A	Fail	N/A	N/A	N/A	Missing documentation Progress note documents Suicidal intent expressed in session and homicidal intent expressed in session but there is no new safety risk assessment in file. Client shot and killed prior to this date. Missing documentation: education
H2015		Pass	N/A	N/A	Fail	N/A	Fail	N/A	N/A	N/A	Suicidal intent is documented as being expressed, progress note does not indicate that the service plan, danger assessment or the safety prevention plan was addressed.
H2015		Pass	Fail	Pass	Pass	N/A	Fail	N/A	N/A	N/A	not qualified per staff roster.
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Unable to determine qualifications based on file
H2015		Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	resume states "no degree".
H2015		Fail	Pass	Pass	Fail	N/A	Fail	N/A	N/A	N/A	Disclaimer indicates that client refused to complete the assessment for substance abuse. Missing document:

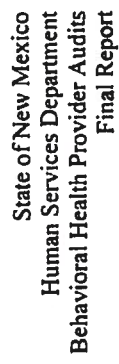
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Page 71



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015	[REDACTED]	Fail	Pass	Fail	Fail	N/A	Fail	N/A	N/A	N/A	[REDACTED] not qualified per staff roster. No support services documented as being provided on date of service. Progress note documents telephone call. No interventions documented on progress note. No safety assessment documented on progress note. Nothing in the progress note demonstrates medical necessity for this billing. Missing documentation: [REDACTED] not on staff roster.
H2015	[REDACTED]	Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[REDACTED] not qualified per staff roster.
H2015	[REDACTED]	Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition).
H2015	[REDACTED]	Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	Missing Document: [REDACTED] Provider, is not found in the list or in provider file.
H2015	[REDACTED]	Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[REDACTED] not qualified per staff roster.
H2015	[REDACTED]	Fail	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	[REDACTED] not qualified per staff roster. [REDACTED] unable to open file.
H2015	[REDACTED]	Pass	Fail	Fail	Pass	N/A	Fail	N/A	N/A	N/A	Missing document: treatment plan. Not qualified per staff roster.
H2015	[REDACTED]	Pass	Pass	Pass	Pass	N/A	Fail	N/A	N/A	N/A	.Provider [REDACTED], CSW does not meet qualifications.
H2017	[REDACTED]	Pass	Pass	Pass	Pass	Fail	Fail	N/A	N/A	N/A	H2017—Psychosocial Rehabilitation—(NMAC 8.315.3; Service Definition); CSW [REDACTED] IN STAFF LIST AS NOT MEETING ALL REQUIREMENTS: H2017—Psychosocial Rehabilitation (NMAC 8.315.3; Service Definition); CSW [REDACTED] in staff list as not meeting all requirements.



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Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame-Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Border Area Mental Health Services	
Sample Size	150
Total Paid for Sample	\$14,073
Sampling Frame Size	117,492
Number of Sample Claims with Overpayments	44
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$2,046,690

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:



Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2015	HO, HN, HM—CCSS	5	317	27,678	317	27,678	100.0%
H2017	Psychosocial Rehabilitation	5	993	127,886	352	41,843	35.4%
H2033	Multi-Systematic Therapy	5	517	110,775	515	110,383	99.6%
Grand Total		15	1,827	266,339	1,184	179,903	64.8%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	12
FFS	1
Therapist	25
Nurse	3
Psychiatrist	2
Psychosocial Rehabilitation	2
Unknown/Other	7
Total Staff Reviewed	52

IT/Billing Systems Audit

System Overview

Border Area Mental Health utilizes the Anasazi System for most of its medical records and billing. The system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Most agencies in the Rio Grande system stay one to three updates behind the most recent. Each site generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

Anasazi would not allow Border Area Mental Health (nor any provider) to disclose any training or systems documentation to our auditors, claiming it was proprietary.

Bill Processing

On a simple level, after services are provided to the client, the clinician updates the file with notes and the time and date of encounter. The Anasazi software processes this information and calculates the number of units that the service should be billed for, and what HCPCS/CPT code should be assigned to the service, using the service provided and start and stop times of the service.

The service is processed by the Anasazi system and transformed into an 837 billing format, which is uploaded to Optum health through the Optum Networkes system.

IT Contacts and roles

- [REDACTED]



Application Controls - System Walkthrough

Administration and Segregation of Duties

User Roles

System Admin Group: Can add users and configure data sheets for health plans and services.

Administrative Group: Can configure data sheets for health plans and services.

Medical Records and Intake Groups: Records Clerks and Intake Staff have appropriate administrative levels of access to records (primarily administrative and demographic records and read only for clinical information).

Clinical Group: All clinicians who bill are in the Clinical Group. They can enter clinical service provision to the system.

COI Group: QI Manager is in this group.

Clinical Supervisors Group: Clinical Supervisors.

Rio Grande Supervisors Group:

Supervisory staff from Rio Grande Behavioral Health Services are provided with supervisory roles due to the management services agreement with Border Area:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]

Auditors Group: No staff at Border Area currently have the Auditor Role, but Border Area has established four Auditor accounts should auditors need access.

Strengths and Weaknesses

Strengths:

- The Anasazi software offers sequestration of clinical information so that users' roles determine the kind of information each user may have access to on a *per client* basis. For example, a front office clerk may have access to certain demographic information.
- Each clinician enters his own billing information.
- Anasazi software allows for members of a group therapy session to arrive and leave at different times, allowing for more accurate billing of group services.

- The Anasazi system that the provider uses records and tracks clinical records.
- The audit trail for the clinical record portion of the system is extremely complete and easy to generate.
- Have extensive training and training videos for Anasazi system. Have a training database set up separate from the production database.
- The IT department has written 50-100 reports to check different medical field billing value accuracy that they run on all entered bills before they are submitted for payment.
- There is an audit trail for their IT-helpdesk issues that have been resolved.
- Have a disaster recovery plan. Border Area Mental Health experience a fire a couple of years ago that destroyed the majority of their paper records. Since then they have instituted a strong disaster recovery plan.

Weaknesses:

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. The 837 can be changed when connected to Optum Networkes. The person uploading the 837 can make any changes to billing with no audit trail.
- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered
- The Anasazi system does not report on the audit trail for the billing part of the system.
- There is no complete audit trail of the entire clinical and billing transaction that is guaranteed to correspond to what is billed to Medicaid

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Border Area Mental Health Services (BAMHS). PCG began by locating BAMHS's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on BAMHS.

PCG located and reviewed BAMHS's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Because of the closely interrelated companies, PCG reviewed BAMHS and two other related companies simultaneously – Mimbres Regional Mental Health (provides administrative staffing to BAMHS) and Mimbres Properties (leases real estate to BAMHS).

Audit Observations

Border Area Mental Health consists of three related exempt organizations:

- Border Area Mental Health Services (BAMHS);
- Mimbres Regional Mental Health (MRMH); and
- Mimbres Properties.

Of the three, BAMHS is the provider organization; MRMH is an organization that provides administrative staffing to BAMHS; and Mimbres Properties leases real estate to BAMHS. In addition to leasing real estate to BAMHS, Mimbres Properties has significant unrelated business income in the form of rental income.

BAMHS publishes the least transparent financial documents of all the organizations reviewed. There is extremely weak disclosure of pertinent information for evaluation purposes.

These three organizations are governed by three separate boards of trustees, however, with small exception; the trustees are the same individuals. These individuals do not appear to have financial connections with the organizations.

Key Staff

Border Area Mental Health		
Frank	Van Gundy	Director
Patricia	Chavez	Secretary/ Treasurer
Margaret	Vesper	Director
Sam	Tapia	President
Claire	Leonard	Vice President
Mimbres Regional Mental Health		
Patricia	Chavez	Secretary/ Treasurer
Margaret	Vesper	Director
Sam	Tapia	President
Claire	Leonard	Vice President
Mimbres Properties		
Jeannette Helton	Helton	Director
Claire	Leonard	Secretary/Treasurer
Margaret	Vesper	Director
Sam	Tapia	President
Patricia	Chavez	Vice President

Financial Relationships

All three organizations have significant transactions with a local company, Atlas Resources, although there is some variance in annual reporting with this contractor. Atlas Resources is an employee leasing organization, NMSCC 1570209 located at 2009 Eubank NE, Albuquerque, NM and owned by Jimmy Daskalos and Nick Kapnison. Both men are involved in a number of companies and restaurants in the Albuquerque area and have a number of real estate holdings. They purchased the former Lovelace Hospital property and have subsequently leased the



property. At one point, local media reported that the facility would be leased to physician practice groups.

BAMHS contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources. Unlike other provider organizations, amounts paid by the organization to RGBHS for these services are not disclosed. Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While Rio Grande Behavioral Health Services receives monthly fees from its members, RGBHS has also distributed various grants back to its members.

In addition, BAMHS may contract with Rio Grande Management, LLC (RGM), for management services, although it is not disclosed in financial documents. These likely include legal services, and the provision of executive management. Providence Service Corporation fully owns Rio Grande Management Services. Providence is a large, for profit, national, corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. Typically, the executive director of this organization would be an employee of Providence Service Corporation. Kathleen Hunt is the Executive Director of BAMHS. She is also a director of RGBHS which is typical for members of the Rio Grande provider group. For these reasons, we believe that she is likely to be employed by Providence Service Corporation and that BAMHS contracts with RGM for her services as well as the aforementioned management services.

Summary of Findings and Recommendations

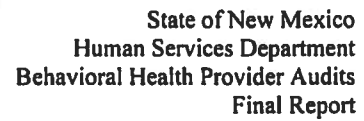
Findings	Recommendations
Because staffing is paid by Atlas Resources, compensation is not disclosed in reports that exempt organizations typically file.	<p>This is highly unusual and it is recommended that MBRMH be required to disclose significant compensation by individual leased through Atlas Resources. Those individuals should be reviewed for associations with other organizations and individuals.</p> <p>It is further recommended that Mimbres Properties disclose detailed source information for unrelated rental income, including tenants, leases, and cash receipts.</p>
Major contracts, such as those with Rio Grande Behavioral Health Services and Rio	Full disclosure of all significant contracts should be reported on the organization's Form



Grande management are presumed, but not fully disclosed.	990.
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List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2012, 2011
Federal Tax Filings	2012, 2011



2010

Cash and equivalents	\$ 2,908,484.00
Grants and Contracts Receivable	\$ 691,246.00
Note Receivable	\$ 628,456.00
Furniture and Fixtures	\$ 580,578.00
Less depreciation	\$ (474,750.00)

Liabilities

Total Liabilities	\$ 1,497,090.00
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Total Liabilities and Net Assets	\$ 4,334,014.00
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Income Statement

2010

Revenue

Behavioral Health Services Division	\$ 1,297,302.00
Children Youth and Families Dept.	\$ 653,818.00
Local Grants and Contracts	\$ 1,021,364.00
Program Fees	\$ 1,881,641.00
Interest Income	\$ 12,172.00
Net Asset release	\$ -
Total Revenue	\$ 4,866,297.00

Expenses

Program Services	\$ 4,509,619.00
Total Expenses	\$ 4,509,619.00

Change in Net Assets **\$ 356,678.00**

Net Assets, beginning of year **\$ 2,480,246.00**

Net Assets, end of year **\$ 2,836,924.00**

Counseling Associates Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



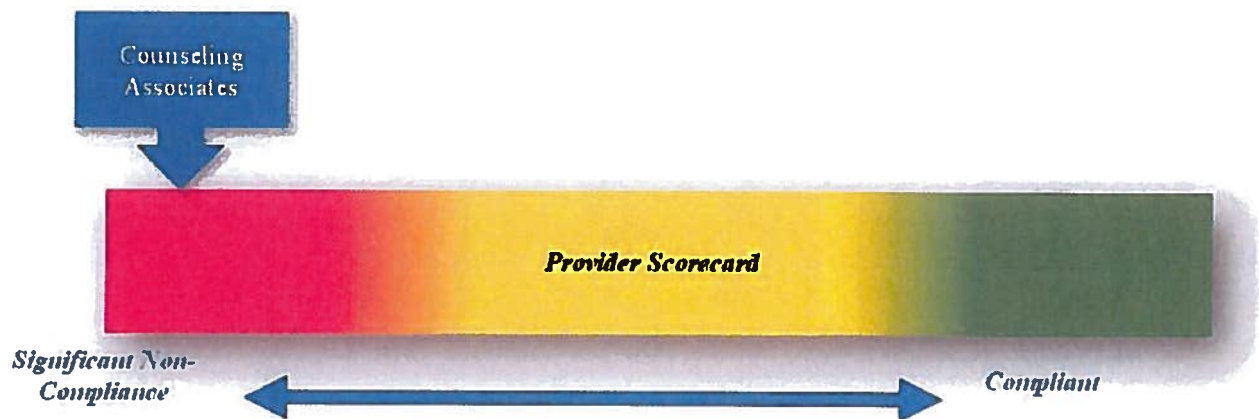
COUNSELING ASSOCIATES BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6-12, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$2,757,585
Actual Longitudinal Overpayments	\$210,548
Total Overpayment	\$2,968,133

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
65%	15%



This scorecard result translates to the following Risk Tier:

Risk Tier	Types of Findings	Recommended State Action
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3	Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. • Potential change in management.
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Provider Overview

Counseling Associates, Inc. is the largest provider of behavioral health services in Chaves and Eddy County, New Mexico. Within these locations, Counseling Associates delivers behavioral health services including; outpatient services, comprehensive community support services (CCSS), multi-systemic treatment (MST) community correction program services and substance abuse services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	1,257,643	4,211,298
CYFD	64,477	245,513
Medicaid FFS	39,333	181,107
Medicaid MCO	1,692,032	5,052,958
NMCD	22,174	147,755
Other	2,581	3,517
Grand Total	3,078,240	9,842,147

Audit Team Observations

- Upon PCG's arrival at 9 a.m., [REDACTED] was at CAI's Carlsbad site. The PCG audit lead was notified that [REDACTED] was traveling back to Roswell immediately. The entrance conference took place late morning.
- CAI staff immediately began to compile the documents. PCG received its first documents in the afternoon of Day 1, and received documents steadily during the onsite audit.

- Clinical Reviewers noted the following general findings:
 - Safety Assessments were not always completed for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
 - Safety/crisis plans were often completed months after the initial assessment when the concern for safety was revealed.
 - Diagnostic Reviews often showed conflicting dates (difference of several months) related to completion and authorization signatures by clinician and supervisor.
 - Comprehensive Clinical Assessments appear not to be up to date with current information.
 - Treatment plans were not up to date and individualized per consumer.
 - Progress Notes/Recipient Documents were inconsistent across staff and programs.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	1	137	0	0	0.0%
90806	Outpatient—45-50 minutes	19	1,324	0	0	0.0%
90847	Family Therapy	3	238	0	0	0.0%
90853	Group Therapy	13	324	0	0	0.0%
90862	Medication Management	11	749	0	0	0.0%
99214	Office/Outpatient Visit	1	79	0	0	0.0%
H0015	Intensive Outpatient Program	7	528	0	0	0.0%
H0031	Mental Health Assessment	3	664	0	0	0.0%
H2010	RN Medication Monitoring	28	1,044	0	0	0.0%



H2014	Behavior Management Services	4	528	4	528	100.0%
H2015	HO, HN, HM—CCSS	24	1,614	24	1,614	100.0%
H2017	Psychosocial Rehabilitation	18	1,726	18	1,726	100.0%
H2023	Supported Employment Services	1	34	0	0	0.0%
H2033	Multi-Systematic Therapy	8	1,143	0	0	0.0%
Q3014	Telehealth Facility Fee/Code	2	45	0	0	0.0%
T1007	Behavioral Health Treatment Plan Update	5	625	5	625	100.0%
T1024	Resource Management Services	2	20	2	20	100.0%
Grand Total		150	10,818	53	4,512	35.3%

Specific Random Sample Review Findings

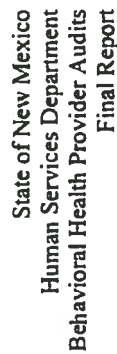
For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



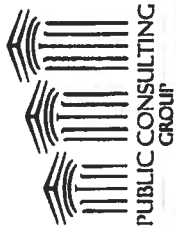
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Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
90806		Pass	NA	NA	Pass	Fail	Pass	NA	NA	NA	The services were billed by [REDACTED] but, the note was signed by [REDACTED]
H2010		Pass	Pass	Fail	Fail	Fail	Pass	NA	NA	NA	Progress note documents receipt and filing of lab results. When added up the number of units billed for three sessions on this dos 11/12/2012 adds up to 14 unit or 15 units- seems like an under billing for these services.
H2014		Pass	Fail	NA	Pass	NA	Fail	NA	NA	NA	Progress note documents receipt and filing of lab results.
H2014		Fail	Fail	NA	Fail	NA	Pass	NA	NA	NA	The treatment plan is not specific for this client on this date of service. The qualifications for the provider, [REDACTED] are missing according to the staff roster list.
H2014		Fail	Fail	NA	Pass	NA	Pass	NA	NA	NA	A more in depth safety assessment was warranted but not documented. Only one intervention by BMS worker is documented in over 6 hours. Unable to support medical necessity of units billed based on progress note.
H2014		Fail	Fail	NA	Pass	NA	Pass	NA	NA	NA	Documentation of SI and attempts at suicide documented in 1/12/2010 assessment, stating attempts "earlier this year". Assessment narrative does not document talking to parent about safety issues with consumer. Crisis plan is not documented until 6/10/12. Unrealistic, no measurable, "complete remission of symptoms."
H2014		Fail	Fail	NA	Fail	NA	Fail	NA	NA	NA	Missing any none documented continuity of care services. No documentation of parents or guardians being included in interventions. No length of time documented to achieve goals of, "improved attention, behavioral control, pro social behaviors for one year." Unable to support the medical necessity of units billed based on the progress note. Missing document qualifications for [REDACTED]
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	No safety assessment documented. Review of staff roster

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												resulted in [REDACTED] being designated as not meeting qualification requirements.
H2015	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	NA	NA	A review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements.
H2015	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	NA	NA	Review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements.
H2015	Fail	Fail	Fail		NA	Fail	NA	NA	NA	NA	NA	The assessment does have boxes checked regarding SI HI; a no harm contract was documented, narrative states consumer does not currently have SI, HI thoughts. There are no specific CCSS goals, objectives or interventions documented on treatment plan. Documentation reflects office visit. No safety assessment is documented. Progress note states service as discharge coordination; there is not another progress note for initial intake, one hour after this session. Unable to support CCSS services prior to intake and creation of treatment plan. [REDACTED] is shown as not meeting qualifications per review of staff roster and related support documents.
Proc Code	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments		
H2015	Pass	Fail	Fail	Pass	NA	Pass	NA	NA	NA	A team meeting was documented in the progress note as well as a telephone call with the consumer. The treatment plan is not specific to this client's needs.		
H2015	Fail	Fail	Fail	Fail	NA	Pass	NA	NA	NA	Unable to discern if the contact with the hospital staff is in person or on the phone, according to the documentation. The documentation does not support the units billed based on the information supplied. Assessment is outdated by more than a year. Goals are not specific to the treatment plan.		
H2015	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing documented qualifications for [REDACTED] to perform CCSS work. Missing document qualifications for [REDACTED] to perform CCSS work.		

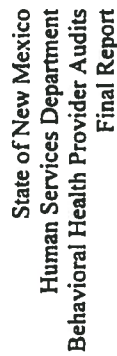


State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Does not list location.
H2015	Pass	Fail	Pass	Pass	NA	Fail	NA	NA	NA	Missing document Qualifications for [REDACTED] Plan is non-specific as to CCSS interventions and goals.
H2015	Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing documentation of a progress note unable to support service billed on the DOS. Review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements.
H2015	Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	There are no documents other than a progress note dated for 12/10/2012, not the dos which was 12/14/2012. Telephoned the discharge information to another agency. Discharge coordination is documented. Review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements.
H2015	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Can not verify the qualification of the provider on this DOS.
H2015	Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	There is no progress note documented for this DOS.
H2015	Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	There is no progress note documented for this DOS. Missing qualifications for [REDACTED] Missing qualifications for [REDACTED] The assessment documents that the consumer has present HI, and had SI the prior week, with a serious attempt at suicide in the past. A crisis plan is not documented until 2 months later. Also no follow on HI related to duty to warn. A specific CCSS needs were not documented for this dos.
H2015	Fail	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing documentation qualifications for [REDACTED] unless that is an aka for [REDACTED] The ASI MV are documented, but the tool is not documented.



Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Fail	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Unable to determine from the documentation if the consumer was present during this meeting. There is a concern as to whether other attendees at meeting also billed for their services. Review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements. At date of assessment, 8/24/2010, documentation states consumer had active SI. There is no documentation of a no harm plan, a crisis plan or follow up on the SI. A crisis plan was signed on 3/25/2011.
H2015		Pass	Fail	Fail	Pass	NA	Pass	NA	NA	NA	The client's discharge was coordinated via the phone and a computer with another facility. Missing a treatment plan.
H2015		Fail	NA	Fail	Fail	NA	Fail	NA	NA	NA	No documentation of any documents for this consumer. No qualifications are documented for [REDACTED]
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	No safety assessment. Missing document qualifications for [REDACTED]
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	A progress note for this date of service was not documented.
H2015		Fail	Fail	Fail	Fail	NA	Pass	NA	NA	NA	A treatment plan was not documented. Progress note documents a phone call to another facility re: consumer discharge from hospital. Unable to support number of units billed based on documentation. Assessment documents hospitalization for SI, a crisis plan is not documented.
H2015		Fail	Pass	Pass	Fail	NA	Fail	NA	NA	NA	There is no safety assessment documented for this DOS. Review of staff roster resulted in [REDACTED] being designated as not meeting qualification requirements. The assessment does not have boxes related to SI, HI filled in; narrative describes child who runs into traffic. A crisis plan was initiated.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Verification of experience needed for staff providing services.



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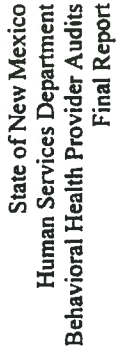
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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report


Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2017		Pass	Fail	Pass	Pass	Fail	Pass	NA	NA	NA	Assessment diagnoses is Alcohol Dependence, with no treatment goals to maintain sobriety are in the Treatment Plan. Intervention described as, "skills training to promote more effective personal." Missing documentation qualifications for effective personal. There is non-specific service, not individualized for the client. Objective is stated as "therapeutic recreation to influence mood."
H2017		Fail	Fail	Fail	Fail	Fail	Fail	NA	NA	NA	The client has a history of traumatic brain injury and epilepsy this supports the medical need for PSR. The PSR is not on the treatment plan. The PSR is not on the treatment plan. The PSR is not on the treatment plan. Progress note documents CCSS services in the home. Progress note documents CCSS services in the home. Progress note documents CCSS services in the home. Progress note documents CCSS services in the home. Progress note documents CCSS services in the home. The PSR is not on the treatment plan.
H2017		Pass	Fail	Pass	Pass	Fail	Pass	NA	NA	NA	This plan is only consistent with generic intervention, "Skills training in a group format by a rehabilitation specialist or other staff to promote more effective personal functioning and/or community involvement." Unable to support units billed with documentation. Unable to discern what, "participate in Independence day" means. is not on Staff Roster. The treatment plan does not contain specific objectives a generic goal was established 10/11/2010.
H2017		Pass	Fail	Fail	Pass	Fail	Pass	NA	NA	NA	There is no documentation and no case note in the file. There is no documentation and no case note in the file that addresses the appropriate interventions.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	There is no documentation of education of licensure for

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T1024		Pass	Fail	NA	Fail	NA	Pass	NA	NA	NA	NA	NA	Treatment plan does not document resource management. Treatment plan update dates 4/30/2012, all goals are dated 1/1/2011 with no updates on progress toward reaching goals. Missing the monthly attendance reports, transition plan. The client's non-compliance is addressed in this dos unplanned group progress report..
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Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Counseling Associates Inc.	
Sample Size	150
Total Paid for Sample	\$10,818
Sampling Frame Size	117,761
Number of Sample Claims with Overpayments	53
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$2,757,585

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2015	HO, HN, HM—CCSS	5	282	20,148	282	20,148	100.0%
H2017	Psychosocial Rehabilitation	5	965	130,590	765	102,572	79.3%
H2033	Multi-Systematic Therapy	5	455	104,805	392	87,828	86.2%
Grand Total		15	1,702	255,543	1,439	210,548	84.6%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	7
Therapist	22
Nurse	7
BMS	1
MST	1
Psychiatrist	3
Peer Support	1
Psychologist	1
Psychosocial Rehabilitation	3
Unknown/Other	8
Total Staff Reviewed	54



IT Billing Systems Audit

System Overview

Counseling Associates utilizes the Anasazi System for most of its medical records and billing. The system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Most agencies in the Rio Grande system stay one to three updates behind the most recent. Each site generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

The software is actually installed on the Counseling Associates Microsoft Window Network but it is primarily accessed through the Citrix system, which allows all administrative and clinical staff to access the system from any computer.

Anasazi would not allow Counseling Associates (nor any provider) to disclose any training or systems documentation to our auditors, claiming it was proprietary.

Bill Processing

After services are provided to the client, the clinician updates the file with notes and the time and date of encounter. The Anasazi software processes this information and calculates the number of units that the service should be billed for, and what HCPCS/CPT code should be assigned to the service, using the service provided and start and stop times of the service.

The service is processed by the Anasazi system and transformed into an 837 billing format, which is uploaded using the Optum Netwerkes ACH system.

IT Contacts

- [REDACTED]
- [REDACTED]

- [REDACTED]

Application Controls - System Walkthrough

Administration and Segregation of Duties

There are two systems that users access: the Microsoft Windows Network and the Anasazi System. The Anasazi system is accessible both through the Windows network and through any computer that is connected to the internet through the Citrix system. For that reason, PCG will only discuss Anasazi access in this report; the Windows network users are held in audit documentation collected by PCG for any required future reference.

User Roles

System Admin Group: Can add users and configure data sheets for health plans and services.

1. [REDACTED]

Administrative Group: Can configure data sheets for health plans and services.

1. [REDACTED]

2. [REDACTED]

Medical Records and Intake Groups: Records Clerks and Intake Staff have administrative levels of access to records; primarily administrative and demographic records and read only for clinical information.

Clinical Group: All clinicians who bill are in the Clinical Group. They can enter clinical service provision to the system.

Rio Grande Supervisors Group: Staff from Rio Grande Behavioral Health Services have a supervisory user role per their management services agreement with Counseling Associates.

Auditors Group: No staff at Counseling Associates currently have the Auditor Role, but they have established Auditor accounts should outside auditors need access.



IT Strengths and Weaknesses

Strengths:

- Counseling Associates' Anasazi applications are available from any computer connected to the internet via Citrix, which make for ease of use from any computer and maintains a uniformly enforced security policy.
- Users do not share login accounts.
- The Anasazi software offers sequestration of clinical information so that users' roles determine the kind of information each user may have access to on a *per client* basis. For example, a front office clerk may have access to certain demographic information, but
- Each clinician enters his/her own billing information.
- Each clinician does not know what CPT/HCPCS codes are used for billing the service provided, he/she only knows what service is being provided.
- In cases of time duration-based billing units, Anasazi software calculates units billed based on start and end times recorded by the clinician.
- Anasazi software allows for members of a group therapy session to arrive and leave at different times, allowing for more accurate tracking group services, and therefore billing.

Weaknesses:

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. The 837 can be changed when connected to Optum Networkes. The person uploading the 837 can make any changes to billing with no audit trail.
- Training is done mostly on an *ad hoc* basis.

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Develop formalized training system for all users who create charge entry and billing.

Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Counseling Associates, Inc. (CAI). PCG began by locating CAI's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on CAI.

PCG located and reviewed CAI's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Key Staff

First Name	Last Name	Position
Marti	Everitt	Exec Director
Waylene	Haley	Fiscal Director
Bari	Bellicini	President
Kathleen	Wells	VP
Cory	Woodbury	Treasurer
Sally	Gonzales	Secretary
Armando	Lopez	Director
Howard	Hicks	Director
Paula	Marshal	Director
Henry	Dickson	Director
Syed	Nazirpour-Caloor	Nurse Practitioner

Financial Relationships



Counseling Associates contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources functions. The organization paid RGBHS \$197,000 in 2009¹ for these services. Rio Grande is a provider-sponsored network and each organization's board members serve as rotating members of the RGBHS board. While Rio Grande Behavioral Health Services receives monthly fees from its members, RGBHS has also distributed various grants back to its members.

In addition, CAI contracts with Rio Grande Management, LLC (RGM) paying \$182,000 (2009) for management services. These include legal services and the provision of executive management. Providence Service Corporation fully owns RGM. Providence is a large, for profit, national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada.

CAI's Executive Director, Martha Everitt, is an employee of Providence Service Corporation and was paid \$102,000 from this related organization in 2010.

Summary of Findings and Recommendations

Findings	Recommendations
<p>In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable.</p> <p>On the surface, the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure and may have the effect of masking excessive compensation or</p>	<p>Full disclosure of executive effort, compensation, and benefits should be revealed for this organization and for its services to Providence Service Corporation.</p>

¹ Most recent year for which representative payments for both behavioral health and management services were reported.



benefits.	
In addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.	

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010, 2009
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2012, 2011, 2010
Contracts	

Balance Sheet	2009	2010
Assets		
Cash & cash equivalents	\$ 770,696.00	\$ 412,334.00
Contracts receivable and other, net of allowance of \$53,746 (2009); \$92,726 (2010)	\$ 307,498.00	\$ 289,866.00
Prepaid expenses	\$ 31,536.00	\$ 23,289.00
Leasehold improvements	\$ 165,642.00	\$ 165,642.00
Computer equipment & software	\$ 331,258.00	\$ 331,258.00
Office equipment	\$ 133,145.00	\$ 138,486.00
Vehicles	\$ 103,862.00	\$ 103,862.00
Less accumulated depreciation	\$ (604,632.00)	\$ (663,782.00)
Total Assets	\$ 1,239,005.00	\$ 800,955.00
Liabilities		
Accounts Payable	\$ 55,142.00	\$ 52,763.00
Accrued Expenses	\$ 559,115.00	\$ 577,376.00
Contract revenue not yet earned	\$ 1,950.00	\$ 4,450.00



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Due to others	\$	44,292.00	\$	5,133.00
Deferred rents	\$	75,327.00	\$	63,494.00
Total Liabilities	\$	735,826.00	\$	703,216.00
Net Assets	\$	503,179.00	\$	97,739.00
Total Liabilities and Net Assets	\$	1,239,005.00	\$	800,955.00

Income Statement	2009	2010	2011
Revenue			
Grants & Contract	\$ 3,854,276.00	\$ 3,543,018.00	
Contributions & fees	\$ 3,770.00	\$ -	
Interest income	\$ 5,590.00	\$ 549.00	
Total Revenues and Support	\$ 3,863,636.00	\$ 3,543,567.00	\$ -
Expenses			
Program Expenses	\$ 3,589,294.00	\$ 3,551,216.00	
Admin Expenses	\$ 449,522.00	\$ 376,880.00	
Fundraising	\$ 24,606.00	\$ 20,912.00	
Total Expenses	\$ 4,063,422.00	\$ 3,949,008.00	\$ -
Change in Net Assets	\$ (199,786.00)	\$ (405,441.00)	\$ -
Net Assets, beginning of year	\$ 702,965.00	\$ 503,179.00	\$97,738.00
Net Assets, end of year	\$ 503,179.00	\$ 97,738.00	\$97,738.00

Families and Youth Inc.

Clinical Narrative
IT Narrative
Enterprise Narrative



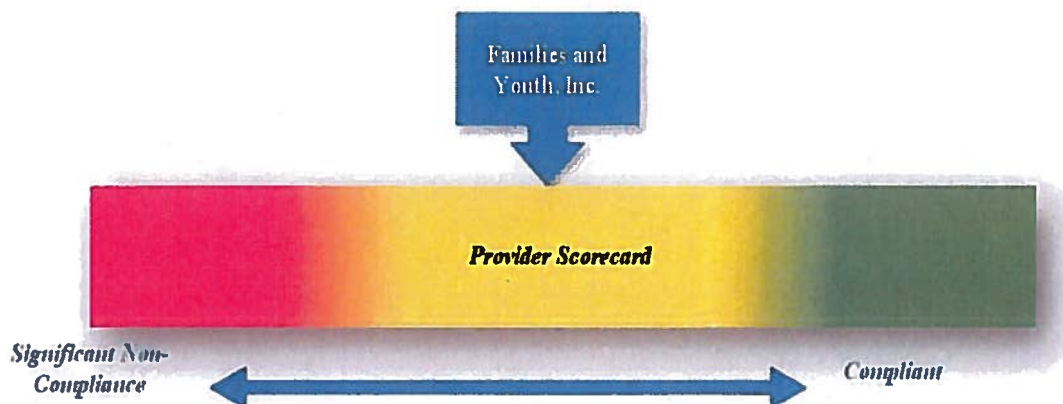
FAMILIES AND YOUTH, INC. BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6-13, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$565,309
Actual Longitudinal Overpayments	\$291,436
Total Overpayments	\$856,745

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
85%	64%



This scorecard result translates to the following Risk Tier:

Tier	Types of Findings	Recommended State Actions
2	Significant volume of findings that include missing documents	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.



Provider Overview

Families and Youth Inc provides behavioral health services in southwest New Mexico and has locations across the region. Within these locations, Families and Youth Inc, delivers behavioral health services including; AmeriCorps program services, behavioral management services, child and adult care food program, consumer benefits and eligibility, family programs, substance abuse services, comprehensive community support services, therapy programs, residential services, treatment foster care, youth employment programs and community correction program services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	0	42
CYFD	426,290	1,772,589
Medicaid FFS	206,436	1,016,794
Medicaid MCO	5,252,161	20,456,244
NMCD	0	0
Other	133,827	778,187
Grand Total	6,018,714	24,023,856

Audit Team Observations

- Upon arrival, PCG was immediately escorted to the office of [REDACTED]. [REDACTED] named [REDACTED], [REDACTED] as the primary point of contact for PCG and also introduced the PCG team to [REDACTED]
- Other FYI clinical staff, including [REDACTED] were introduced and charged with responding to PCG questions throughout the course of the audit.
- Hard copy case files were provided to PCG almost immediately.
- From time to time it was necessary to ask for certain documents that were not included in the case files; these were provided promptly.

- All case files followed a consistent organizational format.
- Documents such as training records and credentials were retrieved and delivered separately.
- Clinical Reviewers noted the following general findings:
 - Safety Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessment was many years prior to the dates of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Discharge plans were not always complete or individualized to the consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and forty-eight (148) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	9	983	0	0	0.0%
90804	Outpatient—20-30 minutes	6	258	0	0	0.0%
90806	Outpatient—45-50 minutes	17	1102	0	0	0.0%
90846	Family Therapy	3	323	0	0	0.0%
90847	Family Therapy	18	1376	0	0	0.0%
90853	Group Therapy	5	121	0	0	0.0%
90862	Medication Management	15	1117	0	0	0.0%



H0015	Intensive Outpatient Program	4	249	0	0	0.0%
H0031	Mental Health Assessment	1	404	0	0	0.0%
H0041	Foster Care(Shelter)	7	3299	0	0	0.0%
H2010	RN Medication Monitoring	1	34	0	0	0.0%
H2011	Crisis Intervention Services	3	294	0	0	0.0%
H2014	Behavior Management Services	11	866	10	804	90.9%
H2015	HO, HN, HM—CCSS	12	1039	11	974	91.7%
H2033	Multi-Systematic Therapy	15	3245	0	0	0.0%
S5145	Treatment Foster Care	8	19248	0	0	0.0%
T1005	Respite Services	10	734	0	0	0.0%
T1007	Behavioral Health Treatment Plan Update	3	331	1	111	33.3%
Grand Total		148	35,023	22	1,889	14.9%

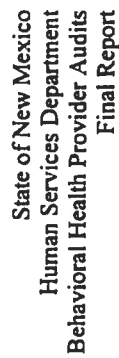
Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



Proc Ccde	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2014	[REDACTED]	Pass	Fail	NA	Fail	NA	Fail	NA	NA	NA	A treatment plan was not submitted/Missing document. Documentation is not clear on what interventions were provided. Documentation does not support the medical necessity for units billed/A treatment plan was not submitted/Missing document. [REDACTED] not on staff list provided/missing credentials/Missing document.
H2014		Pass	Pass	NA	Fail	NA	Pass	NA	NA	NA	Progress note documents BMS worker attending team meeting with school, case workers and step mom to discuss suspension of consumer from school.
H2014		Pass	Fail	NA	Pass	NA	Fail	NA	NA	NA	No projected date of discharge located. [REDACTED] name is not on the staff list provided/missing credentials/missing documents.
H2014		Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	No documentation of specific interventions related to goals and objectives. 4 hours at a client's home is questionable and the note documents this was a face to face at the client's home. If it was also at the school it was not documented as such. [REDACTED] is not on the staff roster for FYI.
H2014		Fail	Fail	NA	Fail	NA	Pass	NA	NA	NA	No discharge plan intervention of BMS services is not documented. BMS intervention was not documented. [REDACTED] was not included on staff roster. A treatment plan was not documented, there is a 30 day interim treatment plan but it does not include BMS.
H2014		Fail	Fail	NA	Fail	NA	Fail	NA	NA	NA	Out of home placement risk is not documented/There is no psychosocial assessment/psych eval submitted/Missing documents. This was a day out for an activity-no interventions regarding reinforcement/redirection, time outs or verbal de-escalation were noted or addressed. [REDACTED] is not on

[illegible]



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Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	review of staff roster as not meeting qualifications. [REDACTED] is depicted on review of staff roster as not meeting qualifications. [REDACTED] is depicted on review of staff roster as not meeting qualifications. No documentation of Substance Abuse assessment. There is a crisis plan for 11/18/2008 - but no updated one for 2009.
H2015		Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Not addressed on this PN. Review of staff roster depicted [REDACTED] as not meeting qualifications. No psychosocial or psych eval submitted/Missing documents. No documentation of treatment plan/Missing documents. Limited information on the PN by practitioner- document relates client's mother is requesting help other than the current services as the mother does not feel her daughter is getting the help that she needs. Qualifications review for [REDACTED] resulted in depicting her as not meeting requirements for a CSW/missing credentials/missing documents.
H2015		Fail	Pass	Pass	Fail	NA	Fail	NA	NA	NA	None noted or addressed. [REDACTED] and [REDACTED] are not on the staff list provided. Qualifications were not submitted for [REDACTED]. Qualifications were not submitted for [REDACTED].
H2015		Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Documentation was not submitted for review. None of the following were submitted: treatment plan, Assessment, Diagnosis, progress note. Unable to support that services were rendered. Qualifications were not submitted for [REDACTED].
T1007		NA	Fail	NA	NA	NA	Fail	NA	NA	NA	[REDACTED] was depicted as not meeting required qualifications during the staff roster review. Note was countersigned by [REDACTED] who is qualified. Also signed by [REDACTED] who is also qualified.

Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 148 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Families and Youth Inc.	
Sample Size	148
Total Paid for Sample	\$35,023
Sampling Frame Size	71,222
Number of Sample Claims with Overpayments	22
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$565,309

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2033	Multi-Systematic Therapy	5	269	73,192	54	15,393	20.1%
S5145	Treatment Foster Care	5	66	281,455	65	276,043	98.5%
Grand Total		10	335	354,647	119	291,436	35.5%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	4
BMS	4
RTC	1
TFC	2
TLP	1
Therapist	25
Milieu Counselor	2
Psychiatrist	2
Unknown/Other	3
Total Staff Reviewed	44



IT/Billing Systems Audit

System Overview

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IT Contacts

- [REDACTED]
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PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

A separate entity – Resources for Children and Youth – was founded for the benefit of FYI. Both organizations were reviewed simultaneously.

Key Staff

First Name	Last Name	Position
Felipe	Peralta	Chairman
Reese	Carson	Vice Chairman
Dr Ivan Alexandre	De La Rosa	Sec/Treasurer
Lisa	Dalton	Board Member
Dr John	Patton	Board Member
Joe J	Martinez	Board Member
Bill	Stickles	Board Member
Bill	Stickles	Board Member
Jeannine	Apodaca	Board Member
Karen	Wootton	Board Member
Maria C	Gutierrez	Board Member



Natasha	Fulbright	Board Member
Omar	Montoya	Board Member
Barbara Y	Myers	Board Member
Barry	Irons	Psychiatrist
Jose	Frietze	Exec Director/CEO
Mickey	Curtis	Clinical Director
Renee	Curtis	CEO
Sharon	Tariol	Nurse
Brian	Hodges	Program Director
Madelon	Winters	Program Director
Dexter	Sandoval	CFO

Financial Relationships

Families and Youth, Inc. contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources. The organization pays RGBHS approximately \$475,000 annually (2009¹) for these services. Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While Rio Grande Behavioral Health Services receives monthly fees from its members, RGBHS has also distributed various grants back to its members.

In addition, Families and Youth, Inc. contracts with Rio Grande Management, LLC (RGM) paying approximately \$572,000 (2009) for management services. These include legal services and the provision of executive management. Providence Service Corporation fully owns Rio Grande Management Services. Providence is a large, for profit, national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. The Executive Director of this organization is an employee of Providence Service Corporation.

In 2011, the Executive Director, Jose Frietze, was paid approximately \$212,000, and Rio Grande CFO Dexter Sandoval was paid 15 hours per week from this related organization. Mr. Sandoval is also the CFO of RGBHS.

¹ Most recent year for which representative payments for both behavioral health and management services were reported.



Summary of Findings and Recommendations

Findings	Recommendations
In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable. On the surface, the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure may have the effect of masking excessive compensation or benefits. In addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.	Full disclosure of executive effort, compensation and benefits should be revealed for this organization and for its services to Providence Service Corporation.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010, 2009
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	



Balance Sheet	2009	2010
Assets		
Cash & cash equivalents	\$ 2,493,154.00	\$ 2,476,185.00
Investments - certificate of deposits	\$ 552,419.00	\$ 469,033.00
Accounts & grants receivable, less allowance for doubtful accounts of \$72,327; \$195,139 (2010)	\$ 1,385,468.00	\$ 1,016,234.00
Prepaid expenses	\$ 53,196.00	\$ 46,135.00
Interest receivable from affiliate	\$ 14,139.00	\$ 1,751.00
Storage building	\$ 26,584.00	\$ 26,584.00
Furniture & equipment	\$ 820,542.00	\$ 823,729.00
Improvements	\$ 806,592.00	\$ 806,592.00
Vehicles	\$ 219,109.00	\$ 285,184.00
Less accumulated depreciation	\$ (1,325,019.00)	\$ (1,433,627.00)
Note receivable from affiliate, long-term portion	\$ 649,612.00	\$ 174,612.00
Deposits	\$ 1,200.00	\$ 1,200.00
Total Assets	\$ 5,696,996.00	\$ 4,693,612.00
Liabilities		
Accounts Payable	\$ 1,585,024.00	\$ 142,310.00
Deferred revenues	\$ 153,633.00	\$ 236,787.00
Accrued liabilities	\$ 97,457.00	\$ 93,055.00
Accrued salaries	\$ 161,453.00	\$ 161,476.00
Accrued compensated absences	\$ 149,435.00	\$ 362,408.00
Due to Officer	\$ 45,117.00	\$ -
Total Liabilities	\$ 2,192,119.00	\$ 996,036.00
Net Assets	\$ 3,504,877.00	\$ 3,697,576.00
Total Liabilities and Net Assets	\$ 5,696,996.00	\$ 4,693,612.00



Income Statement	2009	2010	2011
Revenue			
Federal Funds	\$ 5,281,613.00	\$ 4,937,387.00	
State Funds	\$ 1,928,983.00	\$ 1,665,465.00	
Local Funds	\$ 2,107,156.00	\$ 2,862,829.00	
Service fees - Medicaid	\$ 5,261,360.00	\$ 5,182,002.00	
Contributions	\$ 36,419.00	\$ 39,566.00	
Interest income	\$ 41,454.00	\$ 39,410.00	
Unrealized gain on investment	\$ 10,973.00	\$ (49,491.00)	
Miscellaneous	\$ 266.00	\$ -	
Total Revenues and Support	\$ 14,668,224.00	\$ 14,677,168.00	\$ -
Expenses			
Program Expenses	\$ 13,973,000.00	\$ 14,169,251.00	
Admin Expenses	\$ 197,346.00	\$ 215,926.00	
Fundraising	\$ 84,344.00	\$ 99,292.00	
Total Expenses	\$ 14,254,690.00	\$ 14,484,469.00	\$ -
Change in Net Assets	\$ 413,534.00	\$ 192,699.00	\$ -
Net Assets, beginning of year	\$ 3,091,343.00	\$ 3,504,877.00	\$ 3,697,576.00
Net Assets, end of year	\$ 3,504,877.00	\$ 3,697,576.00	\$ 3,697,576.00

Hogares Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



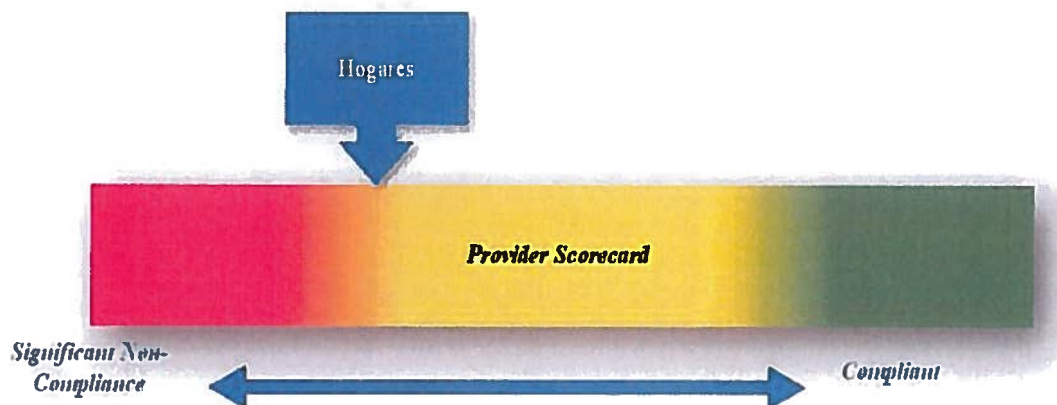
HOGARES, INC. BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	February 27 – March 8, 2013
Main Point of Contact at Facility	[REDACTED]
Extrapolated Date of Service Overpayments	\$3,629,976
Actual Longitudinal Overpayments	\$103,063
Total Overpayments	\$3,733,039

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
78%	29%



This scorecard result translates to the following Risk Tier:

Tier	Types of Findings	Recommended State Actions
2	Significant volume of findings that include missing documents	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.



Provider Overview

Hogares Inc provides behavioral health services in Bernalillo, Cibola, Sandoval, Torrance and Valencia counties. Within these locations, Hogares delivers behavioral health services including access and intake services, therapeutic outpatient intervention services, comprehensive community support services, treatment foster care, behavior management services, transition living services and respite care services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	37,423	40,714
CYFD	352,441	951,461
Medicaid FFS	775,304	2,656,520
Medicaid MCO	8,257,434	27,089,835
NMCD	0	0
Other	0	0
Grand Total	9,422,603	30,738,530

Audit Team Observations

- On Wednesday, February 27th, PCG conducted an entrance conference upon arriving onsite. [REDACTED] was offsite so [REDACTED] was designated to serve as the team's point of contact. Michelle Comeaux explained the reason why PCG was there, what we needed to review, and the anticipated sequence of events, in addition to answering any questions.
- PCG received their first case file within 15 minutes and reviewed the file with [REDACTED] to ensure PCG understood the documentation in the records.
- Hogares staff pulled all the requested consumer and staff documentation. All requested consumer documents were consistently being brought to PCG staff to be scanned. Some of the files were electronic; however, Hogares staff printed hard copies for PCG to scan.



- The majority of the consumer and staff documents were provided over ten days. A few of the requested files were provided later because they had to be retrieved from storage.
- On Wednesday, February 27th, PCG's IT Lead, Mike Dieter, met with [REDACTED] to review their billing and clinical systems, including inputs, outputs and audit trails.
- Hogares staff was always prompt in responding to audit team requests for clarification or additional information.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments did not always support medical necessity for the billed service or the provided assessments were incomplete of critical information for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Submitted treatment plans did not always cover the dates of service under review.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and forty seven (147) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	5	489	0	0	0.0%
90804	Outpatient—20-30 minutes	1	43	0	0	0.0%
90806	Outpatient—45-50 minutes	13	872	0	0	0.0%
90847	Family Therapy	13	990	0	0	0.0%
90853	Group Therapy	3	61	0	0	0.0%
90862	Medication Management	2	146	0	0	0.0%
H0019	Transitional Living Services	10	1590	0	0	0.0%

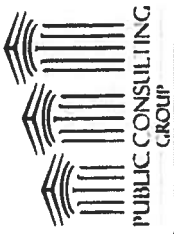


H2014	Behavior Management Services	19	1932	9	1203	47.4%
H2015	HO, HN, HM—CCSS	33	2321	23	1699	69.7%
Q3014	Telehealth Facility Fee/Code	5	112	0	0	0.0%
S5145	Treatment Foster Care	33	5234	0	0	0.0%
T1005	Respite Services	10	685	0	0	0.0%
Grand Total		147	14,474	32	2,902	21.8%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2014	[REDACTED]	Fail	Fail	NA	Fail	NA	Pass	NA	NA	NA	No documentation of support for BMS services. Comp Assessment dated 4/30/12. Recommendation for CCSS services. CCSS Recovery & Resiliency Plan dated 6/20/1 only. No BMS Tx Plan, only CCSS interventions. Documentation does not support 16 units. No documentation of BMS services nor recommendation. Recommendation for CCSS services only. No BMS Tx Plan. No BMS Tx Plan.
H2014	[REDACTED]	Fail	Pass	NA	Fail	NA	Fail	NA	NA	NA	Reviewer examined the Psychiatric Evaluation and Enhanced Assessment which did not list behaviors that could potentially lead member to an out of home placement NMAC 8.322.3. Documentation does not support units billed NMAC 8.322.3. The qualified staff identified as rendering the service was Hogares Inc. NMAC 8.322.3. Tx plan rarely includes parents/family and are focused towards the school environment. NMAC 8.322.3. The agency is addressing Autism/Pervasive Developmental Disorder and the diagnosis is not listed on the Enhanced assessment or Psychiatric evaluation as one of the member's diagnosis. NMAC 8.322.2.
H2014	[REDACTED]	Pass	Fail	NA	Fail	NA	Fail	NA	NA	NA	No documentation to support the billed service of BMS. Practitioner not listed to determine qualifications. Documentation is related to TFC. Documentation is related to TFC.
H2014	[REDACTED]	Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	Units being billed are 23. Time listed is 0955 to 3:40pm Each unit is equal to 15 minutes of time. [REDACTED] is the provider listed. There is a [REDACTED] on the provider list however there is no last name added.
H2014	[REDACTED]	Pass	Fail	NA	Pass	NA	Pass	NA	NA	NA	Names are listed [REDACTED] and [REDACTED] providers are not found on provider list.



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2014		Pass	Pass	NA	Fail	NA	Pass	NA	NA	NA	NA	NA	NA	At the top of this DOS 5/20/11 are listed two times starting with 0845 end time of 11:45 then 1600 start time with an end time of 1700. Units billed are for 25. Each 15 minute interval is equal to 1 unit.
H2014		Pass	Pass	NA	Pass	NA	Pass	NA	NA	NA	NA	NA	Fail	No documentation of progress or lack of.
H2014		Pass	Pass	NA	Pass	NA	Pass	NA	NA	NA	NA	NA	Fail	BMS Note appears to be more a list of activities done with consumer, rather than a clinical look at progress and the activities relation to goals.
H2014		Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	NA	NA	NA	No interventions documented for billed date of 1/19/2012.

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	No documentation of client's risk assessment. [REDACTED] is highlighted in red on provider list. [REDACTED] is highlighted in red on provider list.
H2015		Pass	Fail	NA	Fail	NA	Fail	NA	NA	NA	CSW went to discuss with JPPO team dose of client file as client has not been found. CSW also discussed with JPPO team that if client is found how services for Comprehensive Community support can be reiterated. CSW went to meet with JPPO team at JPPO office. Client is missing and CSW is discussing with them closing the case and if Client should be found how to have services reiterated. [REDACTED] is highlighted in Red on provider list. HN modifier is the correct code identified with this service date. [REDACTED] is highlighted on provider list. [REDACTED] is highlighted on provider list in red. No Treatment Plan evidenced in the record.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	[REDACTED] is highlighted in red on provider sheet. in regard to record license and experience as well as trainings. HN code is the proper code.
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	No documentation of client's risk assessment.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	CODE is for H2015HN must identify the Provider not the facility for billing with this code.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Do not see [REDACTED] list on provider list.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Right modifier appears on claims data sheet however [REDACTED] is highlighted in red on providers list. [REDACTED] is highlighted in red on provider list. [REDACTED] is highlighted in red on provider list.



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	No on-going risk assessment during this date of service. Staff does not meet the minimum qualifications for CSW. Staff does not meet the minimum qualifications for CSW. Staff does not meet the minimum qualifications for CSW.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	is highlighted in red on providers list.
H2015		Pass	Pass	NA	Fail	NA	Pass	NA	NA	NA	is highlighted in red on providers list.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Documentation that CCSS had no contact with parent and child/client, parent requested closure.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	is highlighted in red on the provider list.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	is highlighted in red on provider list.
H2015		Fail	Pass	Pass	Pass	NA	Pass	NA	NA	NA	billed services rendered by DO not see this individual listed on provided list therefore unable to note if qualified staff rendered this service.
H2015		Fail	Pass	Pass	Pass	NA	Pass	NA	NA	NA	The Comprehensive assessment dated 12/29/2009 shows an Axis I of Adj. D/O (elementary school to middle school) as the only diagnosis, with a GAF of 79. Yet consumer was recommended to BMS, CCS, Individual and Family therapies. Additionally, "Client's mo.
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	No documentation of risk assessment per progress note.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Signatures are present however unable to read handwriting and therefore uncertain if qualified to render the service requirements. There is a listed on provider sheet but this It looks as if the first letter is either an S or G but not.
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Assessment of risk for child not mentioned although intervention involved father who was identified as past abuser against child consumer. 11 units for a preparation discussion with father of upcoming court appearance in Family Court, self-care, and

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Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 147 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Hogares Inc.	
Sample Size	147
Total Paid for Sample	\$14,474
Sampling Frame Size	271,467
Number of Sample Claims with Overpayments	32
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$3,629,976

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2014	Behavior Management Services	5	855	104,457	579	75,233	67.7%
H2015	HO, HN, HM—CCSS	5	321	34,527	252	27,830	78.5%
Grand Total		10	1,176	138,984	831	103,063	70.7%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	35
Therapist	32
Community Support Worker Supervisor	1
Psychiatrist	4
BMS	1
Residential, BMS, Respite, Other	55
TFS staff	2
Therapeutic Foster Care Staff	13
Unknown/Other	16
Total Staff Reviewed	159

IT/Billing Systems Audit

System Overview

Hogares uses EMR Bear as their Electronic Health Record and Practima as their billing system. They interface with the Optum Networkes ACH to submit their bills for processing and payment. EMR Bear is accessed remotely to allow progress note updates. Practima is used for case tracking and billing. Practima is based on industry-standard Microsoft technology and the database is MS SQL Server, also an industry standard. Emdeon is 3rd party system used to check eligibility. Networkes is used for the billing clearinghouse.

IT Contacts

- [REDACTED]
- [REDACTED]

Strengths and Weaknesses

Strengths:

- Have an EHR system that they use to record and track clinical records
- All users are trained on the software system.
- Direct access to software system author, [REDACTED] for issues or questions.
- [REDACTED] is a strong developer and very knowledgeable about this subject area. Very qualified to write software for case tracking and billing process for behavioral related claims.
- Have a process for backing up the system database.
- Have strong eligibility checking process, training and system (uses Emdeon).
- Have strongly documented intake process for new patients
- Have strongly documented process for submitting billing claims in batch process on regular basis to avoid duplicate billing.
- Have strong system reporting capabilities to review payments, population treated and other clinical activity across population cross sections.
- Have a hard connection between EHR system and billing system. Data entered into the EHR system is uploaded into the billing system on a nightly basis.
- Have a strong process for adding new employees and deleting employees that have been terminated.



- System appears to be a strong application for submitting claims correctly with accurate pricing. System does contain reports and open database to corroborate billings with progress notes.

Weaknesses:

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. While this has not been observed, it is a considerable weakness.
- [REDACTED] is the only programmer and is the only person who knows the software system from beginning to end. Hogares has no backup for [REDACTED]. They are looking at alternatives to [REDACTED] to support their report requests.
- The process for checking that the data transmitted from the EHR system to the billing system is correct is weak. A file from EMR Bear is created and loaded into Practima. There is no report or comparison done to ensure that everything that was taken from EMR Bear was transferred into Practima precisely.

Recommendations

- Should develop regular process or reports to verify that data moved from EHR to billing system is always correct.
- Need to find alternate source for supporting system in addition to the only staff member who has the necessary know-how.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Hogares, Inc. PCG began by locating Hogares' legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on Hogares.

PCG located and reviewed Hogares' audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Audit Observations

Hogares is a long standing New Mexico non-profit providing services for troubled youths and their families. The organization provides residential and outpatient services, foster care and adoption services as well as transitional living skills.

At 6/30/2010, the organization had audit findings related to internal controls; these were resolved at 6/30/2011.

Key Staff

First Name	Last Name	Position
Bill	Herman	President
Tito	Chaves	Treasurer
Pamela	Gooden	Secretary
Katy	Brazier	Board member
Trey	Hammond	Board member
Herb	Hughes	Board member
Loretta	Lopez	Board member



Edwin Jr	Reyes	VP
Joan	Staveley	Board member
Rosalie	Perea	Board member
Jeff	Peters	Board member
Nancy Jo	Archer	CEO
Larry	Leyva	Fiscal Officer
Nestor	Baca	Board member
Kris	Carrillo	Board member
Matthew	Glickman	Board member
Eric	Burgmaier	Board member

Financial Relationships

The organization has a service agreement for child psychiatry with TeamBuilders Counseling Services.

The organization paid Zia Behavioral Health approximately \$151,000 in 2010; \$148,000 in 2011; and \$231,000 in 2012. Zia Behavioral Health is owned by Shannon and Lorraine Freedle, the Chief Executive Officer and Chief Clinical Officer, respectively, of Teambuilders.

Summary of Findings and Recommendations

Findings	Recommendations
None	

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011, 2010
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	
Third party contracts	
Independent contractor agreements	



Balance Sheet	FY2009	FY2010	FY2011	FY2012
Assets				
Cash & cash equivalents	\$ 1,776,055.00	\$ 2,334,547.00	\$ 1,344,205.00	\$ 1,528,308.00
Accounts receivable, net	\$ 721,921.00	\$ 749,307.00	\$ 934,869.00	\$ 857,617.00
Contribution receivable	\$ -	\$ 38,700.00	\$ 45,000.00	\$ 54,450.00
Prepaid expenses	\$ 61,942.00	\$ 90,999.00	\$ 51,128.00	\$ 78,667.00
Certificate of Deposit	\$ -	\$ -	\$ -	
Property, furniture & equipment, net	\$ 2,799,486.00	\$ 2,692,819.00	\$ 3,241,621.00	\$ 3,077,937.00
Funds held in trust	\$ 14,407.00	\$ 15,789.00	\$ 17,684.00	\$ 8,547.00
Total Assets	\$ 5,373,811.00	\$ 5,922,161.00	\$ 5,634,507.00	\$ 5,605,526.00
Liabilities				
Accounts Payable	\$ 189,067.00	\$ 204,655.00	\$ 165,410.00	\$ 203,546.00
Deferred revenues	\$ 1,000.00	\$ -	\$ 45,435.00	\$ 10,186.00
Accrued expenses	\$ 24,718.00	\$ 1,256,347.00	\$ 698,385.00	\$ 779,221.00
Notes payable, current portion	\$ -	\$ 127,199.00	\$ 1,178,879.00	\$ 1,104,010.00
Notes payable, less current portion	\$ 1,557,567.00	\$ 1,475,976.00	\$ 862,309.00	\$ 783,948.00
Accrued salaries, vacation & benefit	\$ 455,768.00	\$ -	\$ -	\$ -
Medicaid advance payments	\$ 185,035.00	\$ -	\$ -	\$ -
Current maturities of long-term debt	\$ 112,521.00	\$ -	\$ -	\$ -
Funds held in trust for client	\$ 14,407.00	\$ 15,789.00	\$ 17,684.00	\$ 8,547.00
Total Liabilities	\$ 2,540,083.00	\$ 3,079,966.00	\$ 2,968,102.00	\$ 2,889,458.00
Net Assets	\$ 2,833,728.00	\$ 2,842,195.00	\$ 2,666,405.00	\$ 2,716,068.00
Total Liabilities and Net Assets	\$ 5,373,811.00	\$ 5,922,161.00	\$ 5,634,507.00	\$ 5,605,526.00



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Income Statement	FY2009	FY2010	FY2011	FY2012
Revenue				
Contributions - public support	\$ 23,513.00	\$ 17,731.00	\$ 74,938.00	\$ 94,138.00
State Funds	\$ 742,181.00	\$ 1,003,221.00	\$ -	
Medicaid	\$ 7,480,278.00	\$ 8,126,370.00	\$ 8,859,145.00	\$ 8,568,931.00
Private insurance	\$ 40,302.00	\$ 94,070.00	\$ -	
Bernalillo County	\$ 122,000.00	\$ 122,000.00	\$ -	
City of Albuquerque	\$ 93,925.00	\$ 93,988.00	\$ -	
Other	\$ 33,888.00	\$ 82,721.00	\$ 42,913.00	\$ 62,378.00
Interest	\$ 10,018.00	\$ 24,939.00	\$ 9,518.00	\$ 14,042.00
Federal funding	\$ 28,953.00	\$ 27,211.00	\$ -	
Sandoval County	\$ 22,845.00	\$ 6,871.00	\$ -	
Valencia County	\$ 13,783.00	\$ 9,383.00	\$ -	
Rent	\$ 26,302.00	\$ 27,348.00	\$ 37,913.00	\$ 29,854.00
APS Mental Health	\$ 73,172.00	\$ 86,057.00	\$ -	
Expansion grant funding	\$ 304,128.00	\$ -	\$ -	
United Way funding	\$ 43,999.00	\$ 60,000.00	\$ -	
Other funding	\$ 38,305.00	\$ 38,127.00	\$ -	
Grants	\$ -	\$ -	\$ 52,725.00	
Contracts	\$ -	\$ -	\$ 994,461.00	\$ 1,033,916.00
Total Revenues and Support	\$ 9,097,592.00	\$ 9,820,037.00	\$ 10,071,613.00	\$ 9,803,259.00
Expenses				
Residential treatment	\$ 2,533,056.00	\$ 2,051,189.00		
Foster care & adoption services	\$ 2,391,823.00	\$ 2,571,153.00		
Outpatient services	\$ 3,236,251.00	\$ 3,509,847.00		
Transitional living services	\$ 294,245.00	\$ 589,370.00		
Management & general	\$ 1,378,493.00	\$ 1,068,408.00	\$ 1,151,694.00	\$ 1,080,024.00
Program services (combined)			\$ 9,095,709.00	\$ 8,673,572.00
Total Expenses	\$ 9,833,868.00	\$ 9,789,967.00	\$ 10,247,403.00	\$ 9,753,596.00
Change in Net Assets (unrestricted)	\$ (736,276.00)	\$ 30,070.00	\$ (175,790.00)	\$ 49,663.00
Change in Net Assets (temp restricted)	\$ (84,933.00)	\$ (21,603.00)	\$ -	\$ -
Change in Net Assets (Total)	\$ (821,209.00)	\$ 8,467.00	\$ (175,790.00)	\$ 49,663.00
Net Assets, beginning of year	\$ 3,654,937.00	\$ 2,833,728.00	\$ 2,842,195.00	\$ 2,666,405.00
Net Assets, end of year	\$ 2,833,728.00	\$ 2,842,195.00	\$ 2,666,405.00	\$ 2,716,068.00



Partners in Wellness LLC.

Clinical Narrative

IT Narrative

Enterprise Narrative



PARTNERS IN WELLNESS BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	February 27 – March 6, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$57,614
Actual Longitudinal Overpayments	\$22,736
Total Overpayments	\$80,350

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
94%	3%



This scorecard result translates to the following Risk Tier:

3	Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> Provide trainings and clinical assistance as needed.
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- Potentially embed clinical management to improve processes.
- Potential change in management.

Provider Overview

Partners in Wellness is located in the Albuquerque metropolitan area. Within this location, Partners in Wellness delivers behavioral health services including substance abuse treatment services, mental health support services and community support services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	629,556	1,621,900
CYFD	11,420	18,062
Medicaid FFS	17,703	34,334
Medicaid MCO	235,159	356,345
NMCD	71,265	82,544
Other	0	0
Grand Total	965,103	2,113,185

Audit Team Observations

- An entrance conference was held with [REDACTED] immediately upon the audit team's arrival onsite.
- [REDACTED] Anasazi "super user" (backup for their primary IT staff person who is located in Hawaii), walked the team through the clinical records according to name and DOS and explained the format of the records.
- The majority of documentation was provided electronically via transfer of files to a thumb drive that was provided to the audit team.
- Clinical files were provided in a combination of paper and electronic format due to signed consents that are documented on paper and then moved to an electronic format.

- Client signatures on treatment plans were done on a hard copy. Staff didn't have time to pull the hard copies and noted that at times the electronic signature pad was down and clients couldn't use it.
- The team did not have access to records for employees who were originally stationed at the Carlsbad provider site.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were not up to date for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90791	Psychiatric Diagnostic Evaluation	1	90	0	0	0.0%
90801	Psychiatric Diagnostic Evaluation	12	1224	0	0	0.0%
90804	Outpatient—20-30 minutes	2	82	0	0	0.0%
90806	Outpatient—45-50 minutes	14	926	0	0	0.0%
90808	Outpatient—75-80 minutes	2	153	0	0	0.0%
90847	Family Therapy	1	78	0	0	0.0%
90853	Group Therapy	33	841	0	0	0.0%
90862	Medication Management	5	361	0	0	0.0%
H0015	Intensive Outpatient Program	53	7009	0	0	0.0%



H2015	HO, HN, HM—CCSS	23	1941	7	565	30.4%
T1007	Behavioral Health Treatment Plan Update	4	509	2	289	50.0%
Grand Total		150	13,214	9	855	6.0%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	see below, see below, see below.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing staff: [REDACTED] is not on the provided staff list, [REDACTED] is missing credentials per the staff list. missing staff.
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation: 1.5 hours billed for a face to face where the progress note does not indicate and progress or application of interventions, it appears to be one sentence, "I asked if she had maintained her recovery". Missing staff: [REDACTED] is not found on the provided list.
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	6 units not justified by note.
H2015		Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	No documentation received for 10/24/2012.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Was not held in the community was in the Office CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6.
H2015		Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	Cient did not show up for his appointment on 2/20/12
T1007		NA	Fail	NA	NA	NA	Fail	NA	NA	NA	Report from provider stating unable to access documentation for 8/16/2010.
T1007		NA	Fail	NA	NA	Fail	Pass	NA	NA	NA	Documentation was not submitted showing the need for continued therapy. Discharge planning with projected discharge date. No other progress notes for that day were submitted. Will need to check claims.



Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Partners in Wellness	
Sample Size	150
Total Paid for Sample	\$13,214
Sampling Frame Size	24,264
Number of Sample Claims with Overpayments	9
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$57,614

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2015	HO, HN, HM—CCSS	5	265	23,296	258	22,736	97.4%
Grand Total		5	265	23,296	258	22,736	97.4%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	2
Therapist	6
Clinical Supervisor	1
Psychiatrist	1
Community Support Services Coordinator(CSSC)	1
Community Support Worker(CSW)	1
Total Staff Reviewed	12

IT/Billing System Audit

System Overview

Partners in Wellness (PIW) uses the Anasazi application which provides a wide array of components in a flexible display. Anasazi data resides on a Windows-based Server that exists in a firewalled subnet on an internal LAN. Client Data in real time which allowing for streamlined quality of care.

The Anasazi system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Most agencies in the Rio Grande system stay one to three behind the most recent release. Each site generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

In most situations, staff may choose the Anasazi data they wish to display, and may make changes to this display on-the-fly. Broad functionality is included that provides staff with ready access to information regarding the Client to aid him/her in preparing for different sessions. Application also covers functionality that is common to all of the assessment and treatment plan, assignments, client billing, client payments).

Clinician's Home Page functionality:

- Clinical management complexities all solved in a single screen
- Over twenty different views to choose from, including client photos
- Special supervisor access to monitor staff productivity

Client Data System functionality:

- Service Test Recalculation Utility
- Robust Reporting
- 837P & 837I Claim Submission

- 835 Electronic Remittance Advice
- Automated Billing Modality and Service Code Assignment

Anasazi would not allow PIW (nor any provider) to disclose any training or systems documentation to our auditors, claiming it was proprietary.

IT Contacts:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Application Controls - System Walkthrough Administration and Segregation of Duties

Agency Administrator Role: Can add users and configure data sheets for health plans and services.

- [REDACTED]

Administrative Group: Can configure data sheets for health plans and services.

- [REDACTED]

Billing Administrator Role: Can convert clinical information into billing information

- [REDACTED], [REDACTED]

Staff Supervisor Role: Can see clinical records of clients served by clinical subordinates.

- [REDACTED], [REDACTED]

Service Provider Role: All clinicians who bill and are on the payroll have the Service Provider Role.

Auditor Role: No staff at PIW Counseling Services currently have the Auditor Role.

IT Strengths and Weaknesses

Strengths:

- PIW clinical and billing system uses the Windows-based Servers that house both the presentation and database layers of the Anasazi system are dynamically updated weekly to ensure the most current Operating System is in place. The Anasazi DB, and related software, is updated and maintained on an as requested/required basis.

- PIW uses Intrusion Prevention Services (IPS) which are provided by the NSA 2400 firewall that separates the Anasazi Subnet from the rest of the LAN and Internet. These database signatures are dynamically updated on a daily basis to ensure industry standard currency is obtained.
- Anasazi Software has a single-source-code system to allow for ongoing customizations and enhancements.
- PIW presented disaster recovery plans for the application hosting server and electronic records.

Weaknesses:

- Currently PIW IT staff have little knowledge of the application transaction and database transaction logs.
- The point of entry to Optum Netwerkes provides the ability to change any billing from what the clinician entered.

Recommendations

- Work with Anasazi vendor to understand the database and application transaction log.
- Should develop appropriate accounting controls for charge entry/billing in Optum Portal and Optum Networks.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Partners in Wellness, LLC (PIW). PCG began by locating PIW's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on PIW.

PCG located and reviewed PIW's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Audit Observations

The organization was formed in 2009 and is "dedicated to providing behavioral healthcare and other administrative and managerial services to health care providers in the State of New Mexico." The organization is a partnership between Presbyterian Medical Services, Carlsbad Mental Health Center, and Teambuilders.

Key Staff

First Name	Last Name	Position
Steve	Hansen	Director
Doug	Smith	Director
John	Bain	Director
Noel	Clark	Director
Shannon	Freedle	Manager
Lorraine	Freedle	Manager

Financial Relationships



Each organization paid in capital to form the company and has been receiving a share of the net income.

Carlsbad Mental Health Center has received the following payments from the organization: approximately \$333,000 in 2010 and \$732,000 in 2011.

Summary of Findings and Recommendations

These services are primarily funded through Medicaid and the State of New Mexico.

Findings	Recommendations
One member, Carlsbad Mental Health Center, notified the organization that it planned to withdraw after agencies of the State of NM alleged that there were billing irregularities in its own business and subsequently suspended payments to Carlsbad. Carlsbad provided billing, IT support, and staffing for PIW. Because of this, the other members asked Carlsbad to withdraw. Management has determined that billing errors were possible due to programming errors which may be a material liability in excess of 100k.	Adequate internal controls over billing should be implemented.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010
Form 990 (Nonprofit filing)	2011



Balance Sheet		2011
Assets		
Cash & cash equivalents	\$	383,888.00
Contract billings receivable, net of allowances	\$	126,672.00
Program, office equipment	\$	29,532.00
Less accumulated depreciation	\$	(4,799.00)
Prepaid expenses	\$	4,510.00
Software license	\$	51,195.00
Less accumulated amortization	\$	(17,065.00)
Total Assets	\$	573,933.00
Liabilities		
Accounts Payable	\$	6,408.00
Total Liabilities	\$	6,408.00
Net Assets	\$	567,525.00
Total Liabilities and Net Assets	\$	573,933.00



Income Statement		2011
Revenue		
Governmental exchange contracts	\$	878,096.00
Medicaid fees	\$	117,879.00
Other service fees	\$	16,497.00
Contributions, in kind	\$	376,500.00
Rental income	\$	9,936.00
Other income	\$	720.00
Total Revenues and Support	\$	1,399,628.00
Expenses		
Program services	\$	1,053,778.00
Management & general	\$	274,034.00
Total Expenses	\$	1,327,812.00
Change in Net Assets	\$	71,816.00
Net Assets, beginning of year	\$	495,709.00
Net Assets, end of year	\$	567,525.00

Pathways Inc.

Clinical Narrative
IT Narrative
Enterprise Narrative



PATHWAYS BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	February 27 – March 12, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$3,138,735
Actual Longitudinal Overpayments	\$55,521
Total Overpayments	\$3,194,256

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
45%	62%



This scorecard result translates to the following Risk Tier:

3 Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
--	---



- Potential change in management.

Provider Overview

Pathways Inc, Mental Health Services is located in the Albuquerque metropolitan area; it has two Locations in Bernalillo County. Within these locations, Pathways delivers behavioral health services including counseling and psychotherapy services for individuals, families or groups, psychiatric medication prescription services, medication support services, comprehensive community support services, psycho-social rehabilitation groups, and crisis services for adults. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	316,780	1,419,434
CYFD	0	0
Medicaid FFS	45,651	169,953
Medicaid MCO	1,935,208	6,033,921
NMCD	0	0
Other	0	0
Grand Total	2,297,639	7,623,308

Audit Team Observations

- On Wednesday, February 27th, PCG conducted an entrance conference with the [REDACTED], upon arriving onsite, explaining the reason we were there, what we needed to review, and the anticipated sequence of events, in addition to answering her questions.
- PCG received their first case file within 15 minutes and reviewed the file with [REDACTED] to ensure all requested documentation was present. The file was provided in physical format and was supplemented with additional requested documents within 30 minutes of the initial receipt of the file.



- Following a 3 hour wait for additional documentation, PCG approached [REDACTED] to request additional documentation. [REDACTED] informed PCG that she was working on gathering documentation but would not have any additional documentation until the following day.
- On Thursday, February 28th, PCG waited until 3 pm and had yet to receive any additional documentation, despite several requests. PCG approached [REDACTED] and the [REDACTED] of Pathways/Team Builders, [REDACTED], and reasserted their need to see documentation. At that point [REDACTED] informed PCG that it would be 10 business days before we would be able to receive any supporting documentation for the requested claims. PCG's audit team lead was told that we would need to speak to their CEO if wanted documents sooner than that. PCG's audit lead informed the [REDACTED] that PCG would be contacting the State and Pathways' CEO. PCG's team has left the provider site for the day.
- PCG's audit team lead reported a Trigger Event (#2 - "After Entrance Conference, decline participation") to the PCG project manager, who then reported this to the state at 5:33 pm on the 28th.
- On the morning of Friday, March 1st, the PCG audit team lead who was onsite at TeamBuilders spoke with their [REDACTED], who indicated that there was no reason for PCG to have to wait 10 days to receive the requested documentation.
- Shortly thereafter PCG's audit team lead at Pathways received a call from [REDACTED], who was very apologetic and said that it was not their intention to keep things from PCG but that "things were a mess" at Pathways and that she was trying to make sure she can find everything that was requested.
- At 11 am on the 1st, PCG submitted another HSD letter to [REDACTED] and [REDACTED] which required them to begin turning over documentation by 1 pm that day.
- By 12:45 pm, PCG had received an additional 3 files electronically and was promised at least 20 more by the end of the day.
- On the afternoon of Friday, March 1st, PCG met with the Pathways billing manager who walked PCG through the adjudication of clinical notes with billing outputs. Later that afternoon, PCG met with the Pathways HR manager who updated PCG on the status of pulling staff records and walked PCG through the process of pulling each record from their system.

- On Monday, March 4th, PCG's [REDACTED], [REDACTED], met with [REDACTED] and [REDACTED] to review their billing and clinical systems, including inputs, outputs and audit trails.
- By Monday, March 11th, Pathways had provided the rest of the requested documentation in a neat, well-organized electronic format.
- Clinical Reviewers noted the following general findings:
 - Safety Assessments were frequently missing for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were incomplete of critical information for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90804	Outpatient—20-30 minutes	1	43	0	0	0.0%
90806	Outpatient—45-50 minutes	1	67	0	0	0.0%
90808	Outpatient—75-80 minutes	1	80	0	0	0.0%
90846	Family Therapy	1	67	0	0	0.0%
90847	Family Therapy	2	155	0	0	0.0%
90853	Group Therapy	1	24	0	0	0.0%



90862	Medication Management	2	128	0	0	0.0%
H0031	Mental Health Assessment	2	808	0	0	0.0%
H2010	RN Medication Monitoring	22	1,094	0	0	0.0%
H2015	HO, HN, HM—CCSS	88	5,002	76	4,123	86.4%
H2017	Psychosocial Rehabilitation	29	1,056	7	219	24.1%
Grand Total		150	8,525	83	4,343	55.3%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2010	[REDACTED]	Pass	Pass	Pass	Fail	Pass	Pass	Fail	NA	NA	Missing informed consent documents found in file. Missing information: last record of his list of medications is in documentation from 2010, no psychiatrist documents found, only dates of service documents are medication assistance with an RN.
H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Telephone call from client to staff at the community mental health center. Missing credentials for [REDACTED]
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Staff made telephone call to a housing resource for application.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Staff worked on Treatment Plan--inappropriate billing. Staff worked on Treatment Plan--inappropriate billing. Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED]
H2015		Fail	Pass	Pass	Fail	NA	Pass	NA	NA	NA	Missing documentation of client's risk assessment.
H2015		Fail	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation of client's risk assessment. Missing documentation of end time to support amount of units billed. Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	CSW did not document assessment of safety / monitoring of at risk situations. [REDACTED] is not credentialed according to the provider list.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Telephone call. Missing documentation of client's risk assessment. Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	[REDACTED] is not credentialed according to the provider list.

CONFIDENTIAL



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	Telephone contact w/client. ██████████ is not credentialed according to the provider list.	
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	Telephone contact w/patient. Missing documentation of client's risk assessment. ██████████ is not credentialed according to the provider list.	
H2015		Pass	Pass	Fail	Fail	NA	Pass	NA	NA	Billed units for comprehensive assessment, not any CCSS services	
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	Missing progress note for this date of service.	
H2015		Fail	Pass	Pass	Fail	NA	Fail	NA	NA	Missing documentation of client's risk assessment. Missing credentials for ██████████. Missing documentation of a risk assessment .	
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	██████████ is not credentialed according to the provider list.	
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015	██████████	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation of client's risk assessment. Missing credentials for ██████████
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	No contact with client, staff worked on crisis plan for client.
H2015		Pass	Fail	Pass	Pass	NA	Pass	NA	NA	NA	Missing: No initial treatment plan found. Just an updated recovery plan.
H2015	██████████										The note for this DOS does not pertain to said client. The

CONFIDENTIAL



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Telephone call. [REDACTED] is highlighted in red on providers list and unknown written across the page for qualifications.
H2015		Pass	Fail	Fail	Fail	NA	Fail	NA	NA	NA	1 unit billed for transporting client--inappropriate billing. [REDACTED] is not credentialed according to the provider list.
H2015		Fail	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Client made contact with staff via telephone to reschedule appointment. No documentation to assess client's risk. Documentation does not support amount of time spent on phone call. [REDACTED] is not credentialed according to the provider list. No documentation to assess client's risk.
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation to support client's progress or lack of progress. Missing credentials for [REDACTED]
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Staff updated crisis plan w/o client. Staff updated crisis plan w/o client. [REDACTED] is not credentialed according to the provider list.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing progress note for this date of service.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	[REDACTED] is not credentialed according to the provider list.
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Client called CSW to request individual session.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing qualifications for [REDACTED]
H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Client call CSW at community mental health center. [REDACTED] is not credentialed according to the provider list.
H2015		Fail	NA	NA	NA	NA	Pass	NA	NA	NA	Missing all documentation for this client.

CONFIDENTIAL



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015	Pass	Pass	Pass	Notes			NA	Fail	NA	NA	NA	Missing documentation of risk assessment done on this date. Missing credentials for [REDACTED]
				Pass	Fail	NA						
H2015	Fail	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documentation for this client.
H2015	Fail	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documentation for this client.
H2015	Pass	Pass	Fail	Fail	NA	NA	NA	Fail	NA	NA	NA	Client made telephone contact w/secretary. 1 unit billed is not supported by documentation by secretary who received phone call from client requesting name of CCSS worker. secretary of facility received call from staff.
H2015	Fail	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documentation for this client.
H2015	Fail	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Missing documentation for this client.
H2015	Pass	Pass	Pass	Pass	Pass	NA	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED]
H2015	Pass	Pass	Pass	Pass	Pass	NA	NA	Fail	NA	NA	NA	[REDACTED] is not on the provider list.
H2015	Pass	Pass	Fail	Fail	NA	NA	NA	Fail	NA	NA	NA	Telephone call from client to provider. No documentation of client's risk assessment. [REDACTED] is not credentialed according to the provider list.
H2015	Pass	Pass	Pass	Pass	Fail	NA	NA	Pass	NA	NA	NA	Staff updated client's crisis plan w/o client, billed 1 unit. Missing documentation of client's current risk assessment. Missing credentials for [REDACTED]
H2015	Pass	Pass	Pass	Pass	Fail	NA	NA	Fail	NA	NA	NA	Missing documentation of client's risk assessment. Missing: Provider [REDACTED] is not credentialed according to the provider list for this agency.
H2015	Pass	Pass	Fail	Pass	Pass	NA	NA	Pass	NA	NA	NA	Client called CSW at the Community Mental Health Center.



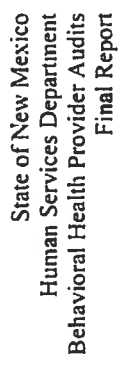
State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015	Pass	Pass	Fail	Fail	Pass	Fail	NA	Fail	NA	NA	NA	NA	Telephone contact by CSW to change appointment. Missing documentation of client's risk assessment. Documentation does not support the 2 units billed for a phone call to change appointment. Missing credentials for [REDACTED]
H2015	Pass	Pass	Fail	Fail	Pass	Pass	NA	Fail	NA	NA	NA	NA	Progress note states that the intake and assessment were completed at this time. Missing credentials for [REDACTED]
H2015	Pass	Pass	Fail	Fail	Pass	Pass	NA	Fail	NA	NA	NA	NA	Contact made through a phone call from the consumer. [REDACTED] is not credentialed according to the provider list.
H2015	Pass	Pass	Fail	Fail	Pass	Fail	NA	Fail	NA	NA	NA	NA	contact made by telephone call. 10 Units billed is not supported by documentation in note dated 10/18/2010 for 2 units. Missing credentials for [REDACTED]. Missing credentials for [REDACTED]
H2015	Pass	Pass	Fail	Fail	Pass	Fail	NA	Pass	NA	NA	NA	NA	Unknown how contacted but it was not face to face. 3 units billed not supported by documentation of the phone call.
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments		
H2015	[REDACTED]	Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Telephone call made with no contact. Missing credentials for [REDACTED]		
H2015	[REDACTED]	Fail	NA	NA	NA	NA	NA	NA	NA	NA	No documentation found for this client.		
H2015	[REDACTED]	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation of clients risk assessment. Missing documentation of end time for activities, therefore, unknown how many units were used and should be billed. Missing credentials for [REDACTED].		
H2015	[REDACTED]	Fail	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documentation for this client.		
H2015	[REDACTED]	Fail	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documents for this client.		
H2015	[REDACTED]	Fail	NA	NA	NA	NA	NA	NA	NA	NA	Missing all documentation for this client.		

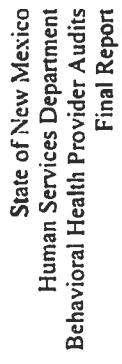
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Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Pass	Pass	Fail	Fail	NA	Pass	NA	NA	NA	Telephone contact documented. Missing documentation of client's risk assessment.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED] Missing credentials for [REDACTED]
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Telephone contact with client to reschedule appointment.
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Client called CSW at office.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing: Service date note is of a Psychiatric Diagnostic Interview by another provider. No documentation of a CCSS service. Missing: Service date note is of a Psychiatric Diagnostic Interview by another provider. Another staff completed the diagnostic interview.
H2015		Pass	Pass	Fail	Fail	NA	Pass	NA	NA	NA	Missing progress note for this date of service.
H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Unknown where the contact was made. Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	[REDACTED] is not credentialed according to the provider list.
H2015		Pass	Pass	Pass	Pass	NA	Pass	NA	NA	NA	Minimal documentation.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing credentials for [REDACTED]
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	Missing documentation of client's risk assessment.



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H2017			Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	Missing documentation of client's risk assessment.
H2017			Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	Missing documentation of client's risk assessment.
H2017			Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	Psych eval is not signed.



Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Pathways	
Sample Size	150
Total Paid for Sample	\$8,525
Sampling Frame Size	131,785
Number of Sample Claims with Overpayments	83
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$3,138,735

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2010	RN Medication Monitoring	5	673	35,768	395	19,782	58.7%
H2015	HO, HN, HM—CCSS	5	448	26,788	429	25,564	95.8%
H2017	Psychosocial Rehabilitation	5	1,541	80,682	192	10,175	12.5%
Grand Total		15	2,662	143,238	1,016	55,521	38.2%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	19
Therapist	8
RN	2
PhD	1
Psychosocial Rehabilitation	8
Unknown/Other	1
Total Staff Reviewed	39

IT/Billing System Audit

System Overview

Pathways uses El Perico as their Electronic Health Record and Practima as their billing system for their 18 sites. They interface with the Optum portal to submit their bills for processing and payment. The IT department at Pathways supports 18 different sites. Both El Perico and Practima are supported by their respective vendors at Pathways. [REDACTED] coordinates system administration.

El Perico is a program management system designed and developed by ECS, a software development company. The system is hosted and maintained at a data center managed by Synergetic Systems Management. They are responsible for system backups and system uptime.

The Practima billing system is used by less than 10 providers in the NM area. The product is supported full time by the creator of the Practima billing system. Practima has basic checks for coding inconsistencies. It also is able to generate and audit trail. However it is not tied to the Optum Networkes portal which is a common theme at all providers audited. There is a handoff between the intake, eligibility, EHR, billing system, and Optum. At any one of these points errors could be introduced even with the human double checking processes that Pathways has instituted.

The systems at Pathways are not well integrated which increases potential for data entry errors between the data intake system and the billing system.

Bill process

The process from data intake to billing was described to be the following:

- 1) Data intake information and progress notes are entered into the El Perico system.
- 2) After the progress notes are approved they are printed out and scanned into Intact, a document management system.
- 3) After scanning the printed data from El Perico is used to enter the information necessary for billing into Practima.
- 4) Practima interfaces with Emdeon (a widely used eligibility system) to verify eligibility.
- 5) Practima interfaces with Optima Networkes to submit the requests for payments using the 837P format.

Pathways has a fully documented training system for all levels of staff and standard treatment paths that the clinicians will face. At every step of the intake thru to the billing process, every step is double checked for accuracy.

IT Contacts and roles

- [REDACTED]
- [REDACTED]

Application Controls - System Walkthrough

Administration and Segregation of Duties

User Roles: [REDACTED] is able to set login privileges for staff members to restrict access to patient's information. She also is the manager who is able to set login privileges for staff members to appropriately restrict access to parts of the Practima system.

Strengths and Weaknesses

Strengths:

- Have an EHR system that they use to record and track clinical records.
- Have extensive training for every type of employee and diagnosis. Have initial training and training updates.
- Each step of the billing process from intake to submission is double checked by at least one other person.
- Have a disaster recovery plan.
- Have strong eligibility checking process, training and system.
- Have strongly documented intake process for new patients.
- Have strongly documented process for submitting billing claims in batch process on regular basis to avoid duplicate billing.
- Have an internal audit person who monitors billing trends by region, diagnosis and providers to identify inefficiencies or outliers that could be fraudulent.

Weaknesses:

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered.
- Both the data intake and billing systems log database and application information. But due to the amount of transactional information in the logs it might be difficult to find a singular log entry responsible for a questionable transaction.



- There is no direct connection between the EHR system and the billing system which could lead to human error in transcribing.
- Did not have a thorough termination plan for employees and their computer system access privileges.
- There is no complete audit trail of the entire clinical and billing transaction that is guaranteed to correspond to what is billed to Medicaid

Recommendations

- Should develop appropriate accounting controls for charge entry/billing in Optum Portal.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Pathways, Inc. PCG began by locating Pathways' legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on Pathways.

PCG located and reviewed Pathways' audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

This provider had a multi-year connection with Teambuilders Counseling Services. In a complex and evolving relationship, Pathways, Inc., is now controlled by Teambuilders. PCG simultaneously compared reporting from both entities.

Key Staff

First Name	Last Name	Position
Nancy	Colella	President
Steve	Pino	Treasurer
Debbie	Dziak	Director
Joy	Schick-Southwick	Consumer Rep
Patricia	Reedy	Consumer Rep
Donald	Naranjo	Exec Director
Gabriel	Campos	Board member
Shannon	Freedle	President/CEO

Financial Relationships



During FY 2011, TeamBuilders Counseling Services provided an unsecured mortgage to Pathways payable over 3 years at 5% interest. In FY 2012, this loan changed, becoming a line of credit secured by the organization's assets. A second line of credit was established for \$80,000 and is also secured by the organization's assets. During FY12, Pathways paid \$87,000 to TeamBuilders officers.

Summary of Findings and Recommendations

Findings	Recommendations
In FY12, Pathways paid TeamBuilders officers as follows: <ul style="list-style-type: none"> • Shannon Freedle, CEO – \$29,207 • Lorraine Freedle, CCO - \$14,844 • Ben Lucas, CFO - \$13,182 • Sun Vega, COO - \$24,157 	These officers should be evaluated for conflict of interest, inurement, excess benefit or private benefit based upon these transactions. These individuals should be evaluated to determine if they are disqualified persons.
At 6/30/2012, Pathways contracted with a Texas-based audit firm, Salmon, Sims for their audited financial statements and with a Kerrville, TX firm (where TeamBuilders' CEO's brother is a partner) for preparation of the organization's tax returns.	These new accounting firms should be evaluated for private benefit.
At 6/30/12, the loan balance to TeamBuilders was listed at \$290,000. Invoices from Teambuilders were listed at \$185,000.	These transactions to and from Teambuilders should be evaluated for conflict of interest, inurement, excess benefit or private benefit.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011, 2010,
Form 990 (Nonprofit filing)	2011
Third-party contracts	
Service agreements	
Org charts	



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Balance Sheet	2009	2010	2011	2012
Assets				
Cash & cash equivalents	\$ 28,366.00	\$ 578,398.00	\$ 131,310.00	\$ 149,327.00
Accounts receivable	\$ 121,820.00	\$ 210,168.00	\$ 134,388.00	\$ -
Prepaid expenses	\$ 11,276.00	\$ 3,878.00	\$ 6,645.00	\$ 5,736.00
Cash equivalents - reserved for long-term use	\$ 61,452.00	\$ 61,458.00	\$ -	\$ -
Property, furniture & equipment, net	\$ 2,387,996.00	\$ 2,266,907.00	\$ 2,161,112.00	\$ 1,263,520.00
Other assets	\$ 2,179.00	\$ 2,179.00	\$ 63,645.00	\$ -
Service fees receivable				\$ 106,372.00
Land				\$ 794,218.00
Investment				\$ 2,179.00
Total Assets	\$ 2,613,089.00	\$ 3,122,988.00	\$ 2,497,100.00	\$ 2,321,352.00
Liabilities				
Accounts Payable	\$ 34,776.00	\$ 48,001.00	\$ 89,282.00	\$ 114,203.00
Accrued expenses	\$ 116,808.00	\$ 654,762.00	\$ -	\$ 87,917.00
Notes payable, current portion	\$ 141,905.00	\$ 75,443.00	\$ 77,959.00	\$ 1,666,355.00
Notes payable, less current portion	\$ 1,713,603.00	\$ 1,735,039.00	\$ -	\$ -
Accrued pension contribution			\$ 29,519.00	\$ -
Accrued compensated absences			\$ 41,935.00	\$ -
Accrued payroll			\$ 46,617.00	\$ -
Accrued payroll taxes			\$ 11,973.00	\$ -
Notes payable, long-term portion			\$ 1,919,596.00	\$ -
Lines of credit due to related party				\$ 290,000.00
Total Liabilities	\$ 2,007,092.00	\$ 2,513,245.00	\$ 2,216,881.00	\$ 2,158,475.00
Net Assets	\$ 605,997.00	\$ 609,743.00	\$ 280,219.00	\$ 162,877.00
Total Liabilities and Net Assets	\$ 2,613,089.00	\$ 3,122,988.00	\$ 2,497,100.00	\$ 2,321,352.00



Income Statement	2009	2010	2011	2012
Revenue				
Professional service contracts	\$ 1,758,777.00	\$ 1,837,956.00	\$ 2,005,730.00	\$ 2,344,404.00
Grant revenue	\$ 307,011.00	\$ 459,840.00	\$ 371,790.00	\$ -
Contributions	\$ 16,555.00	\$ 1,348.00	\$ -	\$ -
Investment income	\$ 3,919.00	\$ 2,947.00	\$ 785.00	\$ -
Miscellaneous/Other support & revenue	\$ 2,190.00	\$ 420.00	\$ 5,274.00	\$ 2,427.00
Gain on disposal of assets	\$ 2,893.00	\$ -	\$ -	\$ -
Total Revenues and Support	\$ 2,091,345.00	\$ 2,302,511.00	\$ 2,383,579.00	\$ 2,346,831.00
Expenses				
Program services	\$ 1,878,125.00	\$ 1,494,146.00	\$ 1,668,652.00	\$ 1,808,309.00
Management & general	\$ 553,931.00	\$ 804,619.00	\$ 1,044,451.00	\$ 655,864.00
Total Expenses	\$ 2,432,056.00	\$ 2,298,765.00	\$ 2,713,103.00	\$ 2,464,173.00
Change in Net Assets	\$ (340,711.00)	\$ 3,746.00	\$ (329,524.00)	\$ (117,342.00)
Net Assets, beginning of year	\$ 946,708.00	\$ 605,997.00	\$ 609,743.00	\$ 280,219.00
Net Assets, end of year	\$ 605,997.00	\$ 609,743.00	\$ 280,219.00	\$ 162,877.00

Service Organization for Youth Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



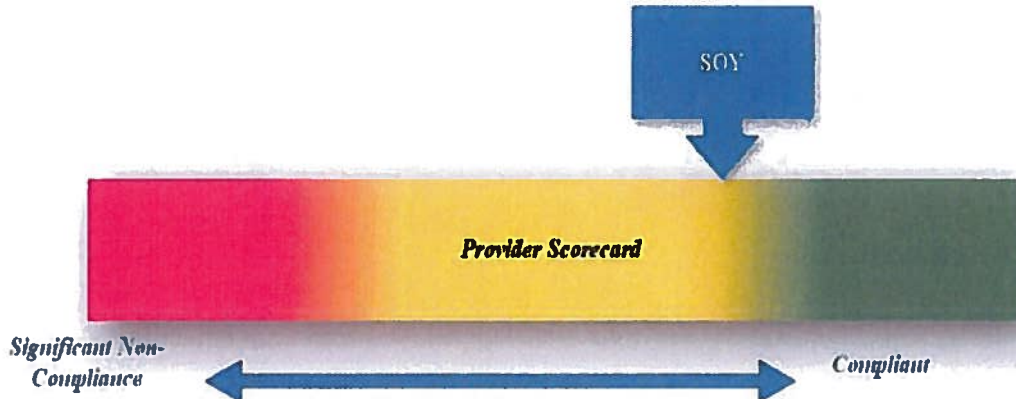
SERVICE ORGANIZATION FOR YOUTH BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 13 – 19, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$7,856
Actual Longitudinal Overpayments	\$14,018
Total Overpayments	\$21,874

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
97%	59%



This scorecard result translates to the following Risk Tier:

2	Significant volume of findings that include missing documents	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
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Provider Overview

Service Organization for Youth provides behavioral health services in Raton, New Mexico. Within these locations, Service Organization for youth, delivers behavioral health services including counseling therapy for groups, individuals and families, prevention services, family services (CYFD/protection services referral required), Juvenile-community correction services (CYFD/juvenile justice referral required), treatment services for youth and their families) and the summer food program for youth employment. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	42,811	100,201
CYFD	76,053	289,064
Medicaid FFS	5,601	17,524
Medicaid MCO	209,476	536,283
NMCD	0	0
Other	0	0
Grand Total	333,940	943,073

Audit Team Observations

- An entrance conference was held with [REDACTED] within minutes of the audit team's arrival onsite.
- SOY is in the process of merging with Easter Seals El Mirador. Once that transaction is complete, certain functions will be shared among the two organizations and Easter Seals will provide QI, personnel and most other types of support. Easter Seals will also act as the main billing provider, using their own billing management system, through which SOY would license their program and load billing.
- Since SOY does not use EHR, all clinical files were provided in paper format. The files were well organized. All files were provided by [REDACTED] with assistance from his clinical and administrative staff.



- [REDACTED] provided hard copy originals from the files that were subsequently scanned by PCG onsite staff. The files were well organized.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were incomplete of critical information for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	1	108	0	0	0.0%
90804	Outpatient—20-30 minutes	22	948	0	0	0.0%
90806	Outpatient—45-50 minutes	44	2,905	0	0	0.0%
90807	Outpatient psychotherapy with E/M 45-50 minutes	1	88	0	0	0.0%
90808	Outpatient—75-80 minutes	4	295	0	0	0.0%
90846	Family Therapy	14	920	0	0	0.0%
90847	Family Therapy	22	1,664	0	0	0.0%
90849	Outpatient Psychotherapy Services	1	24	0	0	0.0%
90853	Group Therapy	21	1,541	0	0	0.0%



H0015	Intensive Outpatient Program	7	926	0	0	0.0%
H0031	Mental Health Assessment	4	520	1	130	25.0%
H2015	HO, HN, HM—CCSS	2	95	2	95	100.0%
S9482	Family Stabilization Services	5	600	0	0	0.0%
T1007	Behavioral Health Treatment Plan Update	2	220	2	220	100.0%
Grand Total		150	10,854	5	445	3.3%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H0031		Pass	Fail	NA	NA	NA	Pass	NA	NA	NA	H0031—Mental Health Assessment—(NMAC 8.310.8; Service Definition)—INITIAL TX PLAN WITHOUT A DISCHARGE PLAN.,
H2015		Pass	Fail	Fail	Fail	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)— Missing document: PRACTITIONER: DUP [REDACTED]—biller's modifier not indicated.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition), PRACTITIONER: [REDACTED]
T1007		NA	Fail	NA	NA	NA	Fail	NA	NA	NA	T1007—Behavioral Health Treatment Plan Update—(Service Definition). Treatment plan update states date of 11/10/11. This claim indicates 10/18/11.
T1007		NA	Fail	NA	NA	Fail	Fail	NA	NA	NA	T1007—Behavioral Health Treatment Plan Update—(Service Definition)—missing document. T1007—Behavioral Health Treatment Plan Update—(Service Definition)—incomplete, the estimated length of stay not included.



Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Service Organization for Youth	
Sample Size	150
Total Paid for Sample	\$10,854
Sampling Frame Size	12,493
Number of Sample Claims with Overpayments	5
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$7,856

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90806	Outpatient—45-50 minutes	5	229	15,420	115	7,778	50.2%
S9482	Family Stabilization Services	5	182	21,600	54	6,240	29.7%
Grand Total		10	411	37,020	169	14,018	41.1%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Psychologist	2
Therapist	9
Total Staff Reviewed	11



IT/Billing Systems Audit

System Overview

SOY uses Medisoft software for their billing. Medisoft is a 3rd party, cloud based billing system based on Microsoft technology. Medisoft uses Optum Networkes ACH and Optum Portal to submit their bills for processing and payment. All PCs are encrypted

Bill process

Data intake forms are entered into the Medisoft system and electronically scanned and stored on a secure file server. Raton sends data intake forms and progress notes to Taos office for billing. Taos office receives forms, scans paper documents and stores them on a file server and then data is keyed into Medisoft. Raton uses an older secondary billing system to manage adult service billing and will convert over all billing to Medisoft later this year. Fee rates come from Optum and the State and are hand keyed into the system.

Raton is currently sending Outpatient Service billing to the Taos office and is processing Foster Care house services through the old billing system.

IT Contacts

- [REDACTED]

Application Controls - System Walkthrough

All data intake information collected on paper and encounter data is entered into the Medisoft 3rd party system. The paper forms are keyed in by a small number of staff. The claims are billed on a monthly basis.

The El Mirador office is the central accounting office for both Raton and Taos. After claims are submitted by Taos and Raton a spreadsheet of their billings are sent to [REDACTED] and [REDACTED] for review. Both of them analyze the billings and review the data for increases or decreases.

IT Strengths and Weaknesses

Strengths:

- The Medisoft software application is provided by a division of McKesson, a \$123 billion dollar health company.
- The Medisoft software is a cloud based, practice management software application that is secure and backed up on a regular basis.
- Medisoft user names and passwords are not shared and are distributed to individual users.
- Claims and remittances are sent and received electronically through Networks ACG clearing house.
- The system has reports to reconcile billings and remittances.
- None of the staff have access to the billing system source code.
- Formal training to use the system is provided to the users.
- Visual inspection of latest rates and corresponding procedure codes that were in the system was done by examining application screens and the data was correct.

Weaknesses:

The weaknesses identified below are common among all the providers we audited especially the three groups that are organized under El Mirador because they all use the same system and owned and managed by the same central corporation; El Mirador, Taos and Raton.

Application controls may be compromised by the following application risks:

- All data forms are keyed into the application by a few individuals.
 - Despite the application's data entry edits there is opportunity for data entry error. There should be a periodic audit of the stored electronic form and the corresponding data that is stored online (e.g. compare # of units and procedures) to see if differences exist.
- There is opportunity for clerical staff to create and manage fictitious clients and providers. Independent audits on a periodic basis are needed to verify both the provider and patient and the patient's condition exists.

Recommendations

- Develop a procedure to verify that billing data in 837s and remittance data in 835s balance out using the Medisoft accounting reports or other available reports.



- Develop a procedure to confirm that billings and remittances match to progress notes and billing data in the Medisoft system.
- Create a process to verify that patient treatment documentation stored as an image on the image server matches what is in the Medisoft database on a monthly or quarterly basis to prevent data entry mistakes.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Service Organization for Youth (SOY). PCG began by locating SOY's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on SOY.

PCG located and reviewed SOY's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Audit Observations

Service Organization for Youth (SOY) is a small non-profit organization administering services to youth and their families to provide crisis intervention, educational assistance, and placement or referral of youth who need alternative living arrangements.

Key Staff

First Name	Last Name	Position
Karen	Murray	President
Loretta	Encinas	Vice President
Mark	Bayliss	Member
Suzanne	Baze	Secretary/Treasurer
Ferman	Ulibarri	Executive Director
Serena	Lannon	Financial Manager
Terry	Baca	Member



Financial Relationships

A local service agency contributes space for SOY to operate in Raton, New Mexico. SOY is in the process of merging with Easter Seals.

Summary of Findings and Recommendations

Findings	Recommendations
In 2010, SOY's auditor noted that there were problems with billing and collecting from Optum Health and recommended more training for staff.	SOY is planning to merge with Easter Seals which will optimize administrative services and transfer billing responsibilities to Easter Seals. SOY's denials should be reviewed for possible appeal and recapture of lost revenue.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2010, 2009
Form 990 (Nonprofit filing)	2011, 2010, 2009
Third party contracts	
Org charts	



Balance Sheet

2009

Assets

Cash & cash equivalents	\$ 38,250.00
Receivables - grants, contracts	\$ 52,081.00
Furniture, fixtures & equipment	\$ 263,088.00

Less accumulated depreciation	\$ (170,050.00)
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Total Assets	\$ 183,369.00
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Liabilities

Accounts Payable	\$ 3,588.00
Retirement withholdings payable	\$ 1,330.00
Payroll taxes payable	\$ 3,002.00
Deferred revenue	\$ 25,451.00
Notes payable	\$ 62,619.00
Notes payable	\$ 975.00

Operating	\$ (6,634.00)
Capital assets	\$ 93,038.00

Total Liabilities	\$ 96,965.00
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Net Assets	\$ 86,404.00
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Total Liabilities and Net Assets	\$ 183,369.00
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Income Statement	2009
Revenue	
Other contributions-in-kind	\$ 68,040.00
Special events	\$ 7,949.00
Interest	\$ 1,149.00
Net assets released from restrictions	\$ 812,056.00
Total Revenues and Support	\$ 889,194.00
Expenses	
Community Based Services	\$ 173,540.00
Facility Program - Total Community Approach	\$ 104,085.00
Time Limited Reunification	\$ 34,816.00
Summer Food Program	\$ 140,656.00
Juvenile Community Corrections	\$ 70,706.00
Mid-Level Family Preservation	\$ 83,907.00
Juvenile Drug Court	\$ 87,240.00
Tobacco Use Prevention	\$ 90,876.00
Other	\$ 9,534.00
Fundraising	\$ 4,558.00
Management & general	\$ 81,867.00
Total Expenses	\$ 881,785.00
Change in Net Assets (unrestricted)	\$ 7,409.00
Change in Net Assets (temp restricted)	\$ 6,000.00
Total change in Net Assets	\$ 13,409.00
Net Assets, beginning of year	\$ 73,195.00
Prior-period adjustments	\$ (200.00)
Net Assets, end of year	\$ 86,404.00

Southern New Mexico Human Development

Clinical Narrative

IT Narrative

Enterprise Narrative



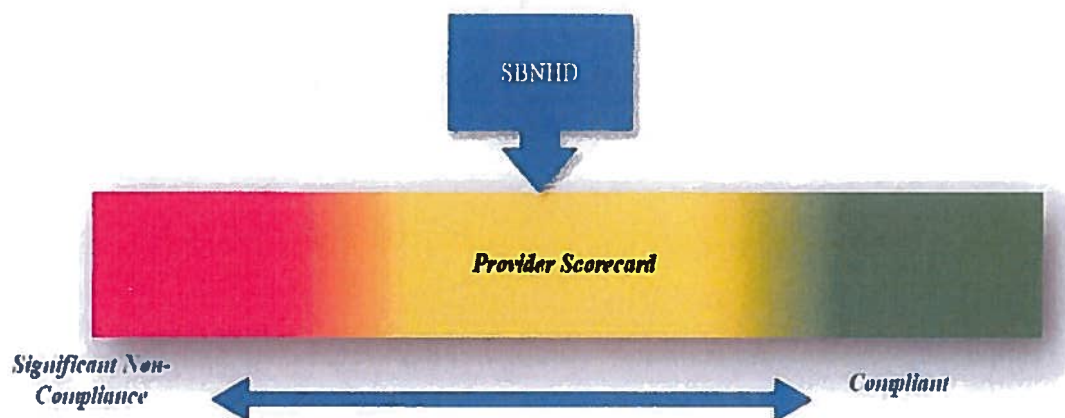
SOUTHERN NEW MEXICO HUMAN DEVELOPMENT BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6-14, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$1,304,140
Actual Longitudinal Overpayments	\$44,239
Total Overpayments	\$1,348,379

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
63%	65%



This scorecard result translates to the following Risk Tier:

<p>2 Significant volume of findings that include missing documents</p>	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
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Provider Overview

Southern New Mexico Human Development serves the community of Anthony and Sunland Park. Within these locations Southern New Mexico Human Development delivers behavioral health services including counseling and outreach for children and adults, alcohol and substance abuse outpatient services, 24-hour crisis intervention emergency services, evaluation and diagnostic services and specialized outpatient services.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	382,223	1,362,569
CYFD	83,107	301,130
Medicaid FFS	4,856	24,954
Medicaid MCO	681,090	2,838,199
NMCD	0	0
Other	0	0
Grand Total	1,151,275	4,526,852

Audit Team Observations

- An entrance conference was held with [REDACTED] shortly after the team's arrival onsite. She stressed the importance of the team understanding their recordkeeping system and how records are kept to ensure that all available documentation is captured.
- [REDACTED] arrived late to the entrance conference and asked questions related to the selection criteria, scope and time frame of the audit, all of which were explained by the audit team.
- [REDACTED] noted that the EHR system does not contain any documents with signatures (e.g. consent forms) and noted that all patients sign consents separate from the electronic form. He also expressed concern about administrative support staff being spread thin.

- All billing and clinical records are maintained electronically in a single CMHC-EMR system, so clinical records were extracted from their EMR system and provided via flash drive.
- Supervision notes and HR files were provided partly in electronic and partly in paper format.
- It was noted that SNMHD has only one contracted therapist at this point in time – all other practitioners are employed full time – so third party contracts provided would be minimal.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were not up to date for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	4	408	0	0	0.0%
90804	Outpatient—20-30 minutes	3	131	0	0	0.0%
90806	Outpatient—45-50 minutes	23	1,596	0	0	0.0%
90808	Outpatient—75-80 minutes	2	153	0	0	0.0%
90846	Family Therapy	1	69	0	0	0.0%
90847	Family Therapy	2	138	0	0	0.0%



90862	Medication Management	9	661	0	0	0.0%
99212	Office/Outpatient Visit	1	37	0	0	0.0%
H0002	Behavioral Health Screening	1	40	0	0	0.0%
H0031	Mental Health Assessment	5	1,487	2	536	40.0%
H2014	Behavior Management Services	14	613	7	341	50.0%
H2015	HO, HN, HM—CCSS	22	1,797	8	670	36.4%
H2017	Psychosocial Rehabilitation	57	5,053	35	3,000	61.4%
T1007	Behavioral Health Treatment Plan Update	6	709	3	375	50.0%
Grand Total		150	12,893	55	4,922	36.7%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

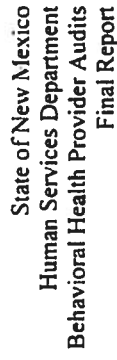
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H0031		Pass	Pass	NA	NA	NA	Fail	NA	NA	NA	Missing staff from the provider list: [REDACTED]
H0031		Pass	Pass	NA	NA	NA	Fail	NA	NA	NA	Missing staff from staff list: [REDACTED]
H2014		Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	No documentation of start and end time to support amount of units billed. Staff is not on the provider list.
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	Staff is not qualified per list.
H2014		Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	No documentation of start and end time for BMS activity. Staff is listed as unqualified.
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	Staff is listed as Not Qualified.
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	Staff is listed as Not Qualified.
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	Staff is listed as Not Qualified.
H2014		Pass	Fail	NA	Pass	NA	Pass	NA	NA	NA	CCSS/BMS assessment does not document length of treatment or contains a discharge plan.
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	No documentation of how much time was spent w/client, no time in and time out on progress note. CSW does not meet the qualification/trainings.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Staff is listed as not qualified.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing staff from provider list: [REDACTED]
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Staff is listed as Not Qualified.

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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015		Pass	Fail	Pass	Pass	Pass	NA	Fail	NA	NA	Missing staff from provider list: ██████████ CCSS is not addressed in the Treatment Plan.
H2015		Pass	Fail	Pass	Pass	Pass	NA	Fail	NA	NA	Missing credentials for ██████████ Q8: Missing Treatment Plan in file.
H2015		Pass	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	Missing staff on provider list: ██████████
H2015		Pass	Fail	Pass	Pass	Pass	NA	Fail	NA	NA	Staff is listed as Not Qualified. No documentation of a treatment plan in file.
H2017		Pass	Pass	Pass	Pass	Pass		Fail	NA	NA	Documentation does not support 6 units billed. No documentation of starting time or ending time nor is there anything on the progress note of how much was for group, or individual. No documentation nor evidence of what or whom comprises the treatment team. Staff is not qualified or met the required trainings. .
H2017		Pass	Pass	Pass	Pass	Pass		Fail	NA	NA	Missing start and end time for activities, therefore, unknown how many units were used and should be billed. Missing documentation of PSR treatment team members. ██████████ is not on the provider list. Another staff provided the actual group session.
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2017	██████████	Fail	Fail	Fail	Fail	Fail	Pass	NA	NA	NA	Missing documentation supporting: PSR not recommended. PSR not on the Treatment Plan. Identified tx goals were Cannabis use, Oppositional Defiant D/O and Prevention Program. No documentation supporting PSR nor recommended. PSR not on the Treatment Plan. Identified tx goals were Cannabis use, Oppositional Defiant D/O and Prevention Program. No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed. Missing credentials for ██████████ Client not appropriate for

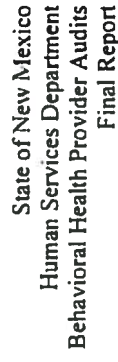


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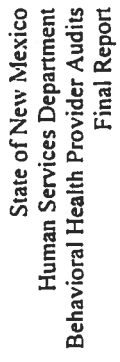


State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed. Staff is listed as not qualified.
H2017		Fail	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Missing Assessment. Missing start and end time for activities, therefore, unknown how many units were used and should be billed. Missing Assessment. Missing credentials for [REDACTED]
H2017		Fail	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Missing Assessment. Missing start and end time for activities, therefore, unknown how many units were used and should be billed. Missing staff from provider list: [REDACTED]
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Documentation does not support the 24 units billed. No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed. Staff is not listed in provider's list.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	22 units billed inappropriately as documentation supports 20 units per progress note.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Missing start and end time for activities, therefore, unknown how many units were used and should be billed. Staff, [REDACTED] M.A.C., is not on provider's list.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Inappropriate billing of 22 units as no documentation of start and end time to support amount of units billed. Missing staff from provider list: [REDACTED]
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Missing staff from provider list: [REDACTED]
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed.
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	No documentation of start and end time for activities, therefore, unknown how many units were used and should be billed.



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Page 240

Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Southern New Mexico Human Development

Sample Size	150
Total Paid for Sample	\$12,893
Sampling Frame Size	52,729
Number of Sample Claims with Overpayments	55
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$1,304,140

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90806	Outpatient—45-50 minutes	5	171	11,749	104	7,092	60.8%
H2015	HO, HN, HM—CCSS	5	224	17,551	176	13,863	78.6%
H2017	Psychosocial Rehabilitation	5	899	123,707	170	23,284	18.9%
Grand Total		15	1,294	153,007	450	44,239	34.8%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	5
Therapist	9
Prevention Specialist	1
Psychiatrist	2
Psychosocial Rehabilitation	9
BMS	2
Unknown/Other	3
Total Staff Reviewed	29



IT/Billing Systems Audit

System Overview

Southern New Mexico Human Development is the only provider audited that uses the system CMHC, a product by MSHealth. They do not use the most recent web version (CMHCi), they use version 5.5 for Windows. They have been using this system for many years and find that it does the basic steps required to support their business. They have approached and interviewed other vendors such as Anasazi but the purchase price is not within their budget and the additional functionalities would, in their opinion, not be worth the investment. However, they understand that as soon as MSHealth stops supporting CMHC Windows product, they will have to switch to another product and/or vendor. CMHC does not include an EHR capability but just handles basic billing functions.

The intake process and the eligibility process are all handled manually. There is a set of paper forms that a new patient fills out as part of the intake process. The clinical director is informed when there is a new client and decides what therapist is going to see them. Then the clinical director schedules an intake appointment. This intake appointment is created on their calendar software. After intake, the patient is assigned to an individual therapist. Each member of the staff only has system access to their own activities.

Bill process

Accounts Receivable (AR) generates an EDI file for submission. Billing is submitted to Optum Netwerkes twice a month. They upload the billing information to Netwerkes and go to the Netwerkes portal to check on processing results. If there is a problem with a claim being rejected by Optum, they first change the claim at Southern New Mexico Human Development and then upload the changed claim to Netwerkes.

They are able to generate an audit trail of the actual bill that was entered and modified within the CMHC system. The IT manager has created a set of validation reports to ensure billing accuracy since CMHC does not have many internal checks and is a bare bones system.

IT Contacts

[REDACTED]

Application Controls - System Walkthrough

Administration and Segregation of Duties

There is just one IT person who handles all IT and helpdesk functions for Southern New Mexico Human Development. There are settings within the CMHD system to handle restricted access to files at the therapist level. The IT manager has "supervisor" login level privileges that allow him to change any field in the billing system for any therapist's case including progress notes. The IT manager can delete progress notes. Currently, the IT manager removes the ability to delete progress notes after the first month a case is established.

Strengths and Weaknesses

Strengths:

- They have created a set of validation reports to help ensure accuracy of the billing information as CMHC is a very basic package without many internal checks.
- The audit trail for the progress notes and billing information can be generated.
- Have only a rudimentary disaster recovery plan.

Weaknesses:

- Very reliant on one person to keep the billing system operational. The IT manager is crucial to the operation of this provider and does not have a backup.
- There is no ability for an electronic signature in the CMHC system. The staff member types in their name into the notes section at the bottom of the clinical record and then selects the "x" to complete and submit the form.
- There are some fields in the CMHC product that are dependent on each other but the dependencies are not documented. They are just known by the IT manager who also functions as the helpdesk IT manager for the billing staff.
- The CMHC product does not have that many clients and is a product that is not going to be supported at all in the near future. Right now support is minimal.
- There is no complete audit trail of the entire clinical and billing transaction that is guaranteed to correspond to what is billed to Medicaid

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Reconsider upgrading or replacing the CMHC system



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Southern New Mexico Human Development (SNMHD). PCG began by locating SNMHD's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on SNMHD.

PCG located and reviewed SNMHD's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Audit Observations

Southern New Mexico Human Development is a small non-profit organized to provide mental health, alcohol, and drug abuse services.

Key Staff

First Name	Last Name	Position
Vincent	Ortega	Exec Director
Ed	Saenz	Member
Ralph	Gallegos	Chairperson
John	Holguin	Member
Elisa	West	Member
David	Garcia	Vice Chairperson
Demetrious	Giovas	Member
Maria	Saenz	Chairperson/Secretary/Treasurer

Financial Relationships



Services are received from Rio Grande Behavioral Health Services and Rio Grande Management/Providence. Services are listed, but payments are not detailed (presumably because they are below the threshold of \$100,000). The Executive Director is an employee of Providence and received compensation of \$128,000 from this related party for the years 2009 through 2011.

SNMHD contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources functions. The organization does not disclose what it pays RGBHS for these services. Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While Rio Grande Behavioral Health Services receives monthly fees from its members, RGBHS has also distributed various grants back to its members.

In addition, SNMHD and RGBHS contract with Rio Grande Management, LLC (RGM), paying an undisclosed amount for management services. These include legal services and the provision of executive management. Providence Service Corporation fully owns RGM. Providence is a large, for profit, national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. The Executive Director of this organization is an employee of Providence Service Corporation.

Summary of Findings and Recommendations

Findings	Recommendations
In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable. On the surface, the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure and may have the effect of masking excessive compensation or benefits. In	Full disclosure of executive effort, compensation and benefits should be revealed for this organization and for its services to Providence Service Corporation.



addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011, 2010
Form 990 (Nonprofit filing)	2012, 2011, 2010
Professional services contracts	

Balance Sheet	2009	2010	2011
Assets			
Cash & cash equivalents	\$ 620,976.00	\$ 242,763.00	\$ 62,466.00
Certificate of deposit	\$ 101,951.00	\$ 102,764.00	\$ 103,163.00
Accounts receivable, net	\$ 143,973.00	\$ 129,244.00	\$ 112,963.00
Prepaid expenses	\$ 34,014.00	\$ -	\$ -
Property & equipment, net	\$ 2,456,905.00	\$ 2,494,936.00	\$ 2,336,138.00
Accumulated depreciation	\$ (1,064,778.00)	\$ (1,140,581.00)	\$ (1,039,254.00)
Loan fees, net of amortization	\$ 4,921.00	\$ 3,847.00	\$ 2,773.00
Total Assets	\$ 2,297,962.00	\$ 1,832,973.00	\$ 1,578,249.00
Liabilities			
Accounts Payable	\$ 332,836.00	\$ 33,500.00	\$ -
Accrued annual leave	\$ 57,608.00	\$ 61,907.00	\$ 52,850.00
Accrued interest payable	\$ -	\$ 807.00	\$ 609.00
Current portion of long-term debt	\$ 72,481.00	\$ 77,335.00	\$ 182,515.00
Long-term Liabilities	\$ 302,316.00	\$ 224,948.00	\$ 142,772.00
Total Liabilities	\$ 765,241.00	\$ 398,497.00	\$ 378,746.00
Net Assets	\$ 1,532,721.00	\$ 1,434,476.00	\$ 1,199,503.00
Total Liabilities and Net Assets	\$ 2,297,962.00	\$ 1,832,973.00	\$ 1,578,249.00



Income Statement	2009	2010	2011
Revenue			
Grants/contracts	\$ 813,357.00	\$ 847,171.00	\$ 525,924.00
Client fees	\$ 974,801.00	\$ 910,661.00	\$ 905,304.00
In-kind	\$ 52,000.00	\$ 66,000.00	\$ 66,000.00
Miscellaneous income	\$ 42,099.00	\$ 35,144.00	\$ 18,206.00
Interest income	\$ 9,137.00	\$ 5,981.00	\$ 4,550.00
Total Revenues and Support	\$ 1,891,394.00	\$ 1,864,957.00	\$ 1,519,984.00
Expenses			
Program expenses	\$ 1,462,969.00	\$ 1,549,188.00	\$ 1,375,713.00
Admin expenses	\$ 337,030.00	\$ 354,359.00	\$ 322,943.00
Fundraising	\$ 56,128.00	\$ 59,655.00	\$ 56,302.00
Total Expenses	\$ 1,856,127.00	\$ 1,963,202.00	\$ 1,754,958.00
Change in Net Assets	\$ 35,266.00	\$ (98,245.00)	\$ (234,973.00)
Net Assets, beginning of year	\$ 1,497,455.00	\$ 1,532,721.00	\$ 1,434,476.00
Net Assets, end of year	\$ 1,532,721.00	\$ 1,434,476.00	\$ 1,199,503.00



addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.

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Prepaid expenses	\$ 34,014.00	\$ -	\$ -
Property & equipment, net	\$ 2,456,905.00	\$ 2,494,936.00	\$ 2,336,138.00
Accumulated depreciation	\$ (1,064,778.00)	\$ (1,140,581.00)	\$ (1,039,254.00)
Loan fees, net of amortization	\$ 4,921.00	\$ 3,847.00	\$ 2,773.00
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Liabilities			
Accounts Payable	\$ 332,836.00	\$ 33,500.00	\$ -
Accrued annual leave	\$ 57,608.00	\$ 61,907.00	\$ 52,850.00
Accrued interest payable	\$ -	\$ 807.00	\$ 609.00
Current portion of long-term debt	\$ 72,481.00	\$ 77,335.00	\$ 182,515.00
Long-term Liabilities	\$ 302,316.00	\$ 224,948.00	\$ 142,772.00
Total Liabilities	\$ 765,241.00	\$ 398,497.00	\$ 378,746.00
Net Assets	\$ 1,532,721.00	\$ 1,434,476.00	\$ 1,199,503.00
Total Liabilities and Net Assets	\$ 2,297,962.00	\$ 1,832,973.00	\$ 1,578,249.00

Southwest Counseling Center Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



SOUTHWEST COUNSELING CENTER BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6 – 21, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$1,028,069
Actual Longitudinal Overpayments	\$437,537
Total Overpayments	\$1,465,606

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
85%	1%



This scorecard result translates to the following Risk Tier:

3	Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed.
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- Potentially embed clinical management to improve processes.
- Potential change in management.

Provider Overview

Southwest Counseling Center serves a mixed urban-rural area of southern New Mexico; it serves the community of Dona Ana County. Within these locations, Southwest Counseling Center delivers behavioral health services including comprehensive community support services, psychosocial rehabilitation services, residential treatment services, child and adolescent services and assertive community treatment services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	1,599,314	6,179,388
CYFD	0	87
Medicaid FFS	81,681	330,326
Medicaid MCO	2,317,393	8,434,939
NMCD	105301	430852.02
Other	0	3932.72
Grand Total	4,103,688	15,379,526

Audit Team Observations

- On Monday, March 4th, PCG held an entrance conference with Southwest Counseling's [REDACTED], upon arriving onsite, explaining the reason we were there, what we needed to review, and the anticipated sequence of events, in addition to answering her questions.
- PCG began receiving well-organized physical files almost immediately and throughout the remainder of the day.



- On Tuesday, March 5th, PCG met with [REDACTED] and Southwest Counseling's [REDACTED] to once again explain the reason we were there, what we needed to review, and the anticipated sequence of events, in addition to answering their questions. During this meeting, [REDACTED] expressed frustration with the state's audits and indicated that [REDACTED] in [REDACTED] and [REDACTED] were both committing fraud. [REDACTED] also stated that [REDACTED] was actively committing fraud because they were diagnosing anyone who came in as needing mental health services. [REDACTED] stated that he was aware of several patients (typically kids) that Southwest Counseling declined to give a mental health diagnosis who [REDACTED] than accepted. He stated that several of the for-profit BH providers in NM bill for clients they never treated.
- PCG continued to receive well-organized physical documentation from Southwest Counseling for the remainder of the week.
- On Monday, March 11th, PCG's [REDACTED], met with [REDACTED] to review their billing and clinical systems, including inputs, outputs and audit trails.
- By Thursday, March 21st, PCG had received all of the requested documentation from Southwest Counseling.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were not up to date for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
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90801	Psychiatric Diagnostic Evaluation	2	242	0	0	0.0%
90804	Outpatient—20-30 minutes	3	132	0	0	0.0%
90806	Outpatient—45-50 minutes	23	1,578	0	0	0.0%
90847	Family Therapy	4	313	0	0	0.0%
90853	Group Therapy	21	521	0	0	0.0%
90862	Medication Management	9	573	0	0	0.0%
H0019	Transitional Living Services	8	960	0	0	0.0%
H0031	Mental Health Assessment	2	833	1	416	50.0%
H0039	Assertive Community Treatment	33	5,843	0	0	0.0%
H2010	RN Medication Monitoring	6	450	0	0	0.0%
H2011	Crisis Intervention Services	2	241	0	0	0.0%
H2015	HO, HN, HM—CCSS	13	799	8	516	61.5%
H2017	Psychosocial Rehabilitation	13	1,270	5	364	38.5%
T1007	Behavioral Health Treatment Plan Update	7	793	5	568	71.4%
T1024	Resource Management Services	1	10	1	10	100.0%
T1502	Medication Administration	3	45	3	45	100.0%
Grand Total		150	14,601	23	1,919	15.3%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H0031		Fail	Fail	NA	NA	Pass	Fail	NA	NA	NA	Documentation Missing NMAC 8.310.8; Service Definition; Reviewer unable to read, scanning process did not copy entire document, scanning process did not copy entire document. Practitioner not on agency roster NMAC 8.310.8; Service Definition.
H2015		Pass	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Documentation Missing NMAC 8.315.6. Documentation Missing NMAC 8.315.6. Progress note states to see hard copy no copy in file. NMAC 8.315.6. Documentation does not support units billed NMAC 8.315.6. Provider was not listed on the staff roster submitted. NMAC 8.310.8. Documentation Missing NMAC 8.315.6.
H2015		Fail	Pass	Pass	Fail	NA	Pass	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Documentation does not support units billed NMAC 8.315.6. Treatment plan contains an assessment each time plan is updated. Missing Axes IV.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing documentation, please see note below NMAC 8.315.6. Documentation in the Anazazi note states there was travel time/transportation time. Provider is not on the agency roster NMAC 8.315.6.
H2015		Pass	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Missing Documentation for CCSS treatment/service plan. There is no treatment plan prior to this DOS; NMAC 8.315.6; LOC 8.315.69; Service Definition. Practitioner's qualifications were not submitted. There is no treatment plan prior to this DOS; NMAC 8.315.6; LOC 8.315.69; Service Definition. Practitioner's qualifications were not submitted. There is no treatment plan prior to this DOS; NMAC 8.315.6; LOC 8.315.69; Service Definition.
H2015		Pass	Fail	Fail	Pass	NA	Pass	NA	NA	NA	Missing Documentation: CCSS service/treatment plan there is a treatment plan however it does not have CCSS goals and

CONFIDENTIAL

												objectives they do mention CCSS as an intervention NMAC 8.315.6.
H2015		Pass	Fail	Fail	Fail	Pass	NA	Pass	NA	NA		8 min phone call between the CSW and member; NMAC 8.315.6. Tx plan uses the CSW as an intervention to help the member be med compliant, provide skill training in budget development and money management skills.
H2015		Fail	Pass	Fail	Fail	Pass	NA	Fail	NA	NA		Session was face to face, progress note states Provided at Center, CCSS in office NMAC 8.315.6; LOC 8.315.69; Service Definition. Reviewer unable to read, scanning process did not copy entire document. NMAC 8.315.6; LOC 8.315.69; Service Definition. Provider is not listed on the agency roster NMAC 8.315.6; LOC 8.315.69.
H2015		Pass	Pass	Fail	Fail	Pass	NA	Fail	NA	NA		Session with member took place in the CCSS office. NMAC 8.315.6. [REDACTED] not on staff roster, he has a file in the staff folder, unable to determine qualifications for providing this service.
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments	
H2017		Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	NA	Missing documentation NMAC 8.315.3. Missing documentation NMAC 8.315.3.	
H2017		Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Practitioners qualifications were not submitted [REDACTED]	
H2017		Fail	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Missing documentation NMAC 8.315.6. Start time 11:30 am Stop time 2:00 duration 2.30 hrs or 10 units. Claims shows 14 units NMAC 8.315.3; Service Definition. Missing documentation NMAC 8.315.6. Missing documentation NMAC 8.315.6.	
H2017		Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	NA	Missing documentation NMAC 8.315.3; Service Definition.	
H2017		Fail	Pass	Pass	Pass	Pass	Pass	NA	NA	NA	Missing assessment.	

T1007		NA	Fail	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	Missing document: treatment plan that was formulated ON date of service.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	NA	No signature on the tx plan submitted NMAC 8.315.6.
T1007		NA	Fail	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	Missing documentation T1007—Behavioral Health Treatment Plan Update—(Service Definition).
T1007		NA	Fail	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	No discharge planning or projected discharge date on treatment plan. [REDACTED] not on staff roster, he has a file in the staff roster, unable to determine if he is qualified to render this service.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	NA	AXIS I reads none.: Member did not sign treatment plan.
T1024		Pass	Pass	NA	NA	Fail	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	Documentation Missing. Service Definition. [REDACTED] is not on the agency roster. [REDACTED] has been practicing with agency for many years)Service Definition.
T1502		Pass	NA	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	[REDACTED] is on progress note, she is not on the staff roster but she has a file in staff folder, unable to determine if she is qualified to render service.
T1502		Fail	NA	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	Progress noted dated 10/20/09 10:15 - 10:45 Service: TM Medication Inj Prolixin progress note reads see hard copy, hard copy not submitted. Service Definition; Progress noted dated 10/20/09 10:15 - 10:45 Service: TM Medication Inj Prolixin progress note reads see hard copy, hard copy not submitted.
T1502		Pass	NA	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	NA	[REDACTED] is not on staff roster, she has a file in the staff folder, unable to determine qualifications to render this service.



Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Southern New Mexico Human Development

Sample Size	150
Total Paid for Sample	\$14,601
Sampling Frame Size	151,769
Number of Sample Claims with Overpayments	23
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$1,028,069

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid

during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H0039	Assertive Community Treatment	5	1,363	304,900	1,327	297,356	97.4%
H2015	HO, HN, HM—CCSS	5	259	20,230	259	20,230	100.0%
H2017	Psychosocial Rehabilitation	5	976	119,951	976	119,951	100.0%
Grand Total		15	2,598	445,080	2,562	437,537	98.6%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	6
Therapist	8
Nurse	1
Psychosocial Rehabilitation	3
Unknown/Other	3
Total Staff Reviewed	21



IT/Billing Systems Audit

System Overview

Southwest Counseling Center utilizes the Anasazi System for most of its medical records and billing. The system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Most agencies in the Rio Grande system stay one to three updates behind the most recent. Each site generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

The software is actually installed on the Southwest Counseling Center Microsoft Window Network but it is primarily accessed through the Citrix system, which allows all administrative and clinical staff to access the system from any computer that is connected to the internet.

Anasazi would not allow Southwest Counseling Center (nor any provider) to disclose any training or systems documentation to our auditors, claiming it was proprietary.

Bill Processing

After services are provided to the client, the clinician updates the file with notes and the time and date of encounter. The Anasazi software processes this information and calculates the number of units that the service should be billed for, and what HCPCS/CPT code should be assigned to the service, using the service provided and start and stop times of the service.

The service is processed by the Anasazi system and transformed into an 837 billing format, which is uploaded using the Optum Network's ACH system.

IT Contacts

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

- [REDACTED]

Application Controls - System Walkthrough

Administration and Segregation of Duties

There are two systems that SW Counseling users access: the Microsoft Windows Network and the Anasazi System. The Anasazi system is accessible both through the Windows network and through any computer that is connected to the internet through the Citrix system. For that reason, PCG will only discuss Anasazi access in this report; the Windows network users are held in audit documentation collected by PCG for any required future reference.

User Roles

System Admin Group: Can add users and configure data sheets for health plans and services.

- [REDACTED]

Administrative Group: Can configure data sheets for health plans and services.

- [REDACTED]

Medical Records and Intake Groups: Records Clerks and Intake Staff have appropriate administrative levels of access to records; primarily administrative and demographic records and read only for clinical information.

Clinical Group: All clinicians who bill are in the Clinical Group. They can enter clinical service provision to the system.

Rio Grande Supervisors Group: Staff from Rio Grande Behavioral Health Services have a supervisory user role per their management services agreement with Southwest Counseling Center.

Auditors Group: No staff at Southwest Counseling Center currently have the Auditor Role, but they have established Auditor accounts should outside auditors need access.

IT Strengths and Weaknesses

Strengths:

- Southwest Counseling Center's Anasazi applications are available from any computer connected to the internet via Citrix, which make for ease of use from any computer and maintains a uniformly enforced security policy.
- Users do not share login accounts.
- The Anasazi software offers sequestration of clinical information so that users' roles determine the kind of information each user may have access to on a *per client* basis. For example, a front office clerk may have access to certain demographic information, but
- Each clinician enters his/her own billing information.
- Each clinician does not know what CPT/HCPCS codes are used for billing the service provided, he/she only knows what service is being provided.
- In cases of time duration-based billing units, Anasazi software calculates units billed based on start and end times recorded by the clinician.
- Anasazi software allows for members of a group therapy session to arrive and leave at different times, allowing for more accurate tracking group services, and therefore billing.

Weaknesses:

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. The 837 can be changed when connected to Optum Networkes. The person uploading the 837 can make any changes to billing with no audit trail.
- Training is done mostly on an *ad hoc* basis.

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Develop formalized training system for all users who create charge entry and billing.



Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Southwest Counseling Center, Inc. (Southwest). PCG began by locating Southwest's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on Southwest.

PCG located and reviewed Southwest's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

The organization has an economic interest in its affiliate, Southern Rio Grande Mental Health Foundation. The foundation owns and leases real estate to Southwest Counseling Center, Inc. The economic interest of each organization in the other is sufficient to allow the pooled financial reporting to be presented as a consolidated organization. We reviewed the consolidated results. Based on this consolidated structure, PCG reviewed consolidated financial documents.

Key Staff

First Name	Last Name	Position
Idella	Cantrell	President
Marla J.	Cooper	President Elect
Frima	Marquez	Past President
Felipe	Salcido, Jr	Secretary/Treasurer
Joyce	Montes	Member at large
Elwood M.	Powell	Director
Roque	Garcia	Acting CEO
Dexter	Sandoval	COO

Financial Relationships

Southwest contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources functions, for which Southwest paid RGBHS \$140,000 in 2010¹.

Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While RGBHS receives monthly fees from its members, it has also distributed various grants back to its members.

In addition, Southwest contracts with Rio Grande Management, LLC (RGM), paying \$195,000 (2010) annually for management services. These include legal services and the provision of executive management. RGM is fully owned by Providence Service Corporation, a large, for profit, national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. The Executive Director of this organization is an employee of Providence Service Corporation.

In 2010, Director Joyce Montes was paid \$162,000; acting CEO Roque Garcia was paid \$135,000; and Dexter Sandoval, COO, was paid \$86K from RGM.

Summary of Findings and Recommendations

Findings	Recommendations
In 2010 and 2011, Roque Garcia (CEO of RGBHS) served as Acting CEO of Southwest Counseling. Additional compensation was provided for use of an airplane owned by Mr. Garcia. In 2010 and 2011, Dexter Sandoval (CFO of RGBHS) served as COO of Southwest Counseling.	These transactions should be evaluated to determine if these individuals are disqualified persons and if any part of the transactions rise to the level of excess benefit.
In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by	Full disclosure of executive effort, compensation and benefits should be revealed for this organization and for its services to Providence Service Corporation.

¹ Most recent year for which representative payments for both behavioral health and management services were reported.



Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable. On the surface, the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure may have the effect of masking excessive compensation or benefits. In addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010, 2009
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	
Service agreements	
Org Charts	



Balance Sheet

2009

Assets

Cash & cash equivalents	\$ 1,171,353.00
Accounts receivable, less allowance for doubtful accts of \$26,839	\$ 1,092,860.00
Inventory	\$ 76,914.00
Prepaid expenses	\$ 30,958.00
Land	\$ 190,037.00
Building & improvements	\$ 4,837,149.00
Origination fees	\$ 6,790.00
Office equipment	\$ 917,518.00
Library	\$ 4,928.00
Vehicles	\$ 348,758.00
Less accumulated depreciation	\$ (1,890,129.00)
Restricted cash	\$ 49,505.00
Deposits	\$ 675.00

Total Assets

\$6,837,316.00

Liabilities

Accounts Payable	\$ 140,292.00
Payroll taxes & other payables	\$ 14,150.00
Accrued wages	\$ 95,024.00
Accrued annual leave	\$ 155,785.00
Custodial accounts	\$ 49,505.00
Due to others	\$ 56,978.00
Deferred revenues	\$ 1,026,297.00
Notes payable-current portion	\$ 115,565.00
Notes payable, net of current	\$ 3,466,407.00

Total Liabilities

\$5,120,003.00

Net Assets

\$1,717,313.00

Total Liabilities and Net Assets

\$6,837,316.00



Income Statement		2009
Revenue		
State contracts	\$	3,943,617.00
Service fees	\$	1,524,530.00
Local funds	\$	26,540.00
In-kind revenues	\$	121,792.00
Interest income	\$	4,178.00
Miscellaneous income	\$	105,085.00
Total Revenues and Support		\$5,725,742.00
Expenses		
Program expenses	\$	4,061,450.00
Admin expenses	\$	1,597,220.00
Fundraising	\$	45,440.00
Total Expenses		\$5,704,110.00
Change in Net Assets	\$	21,632.00
Net Assets, beginning of year		\$1,695,681.00
Net Assets, end of year		\$1,717,313.00



Teambuilders Counseling Services Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



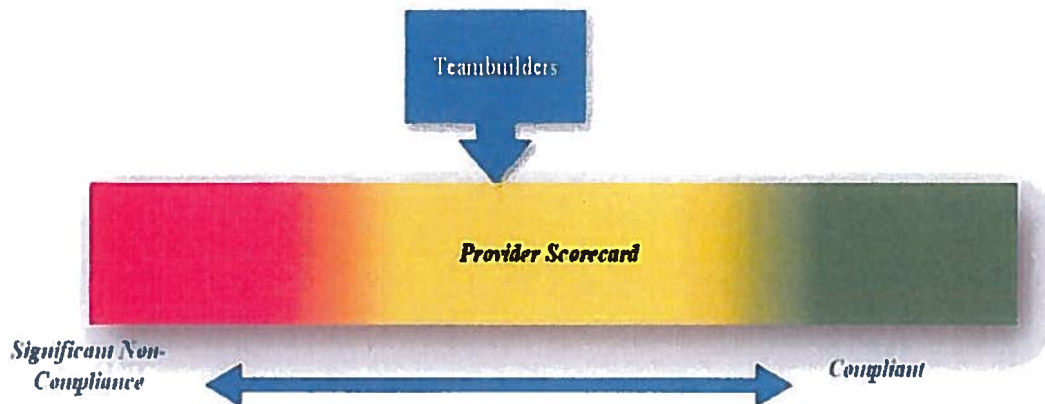
TEAMBUILDERS COUNSELING SERVICES BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite-Review	February-27 – March 7, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$9,262,711
Actual Longitudinal Overpayments	\$335,833
Total Overpayments	\$9,598,544

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
79%	40%



This scorecard result translates to the following Risk Tier:

<p>2 Significant volume of findings that include missing documents</p>	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
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Provider Overview

TeamBuilders Counseling Services has facilities in fifty two locations, in seventeen counties in New Mexico. Within these locations, TeamBuilders delivers behavioral health services including behavior management services, comprehensive community support services, individual and family counseling, multi-systemic therapy, psychiatric services, residential treatment/group home care, sandplay therapy, treatment foster care, support groups and other services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	474	1,290
CYFD	941,909	2,492,459
Medicaid FFS	1,307,843	4,541,860
Medicaid MCO	22,297,150	70,782,727
NMCD	15,079	155,020
Other	3,633	210,777
Grand Total	24,566,087	78,184,133

Audit Team Observations

- An entrance conference was held approximately 90 minutes after PCG arrived onsite. Prior to the arrival of [REDACTED], TeamBuilders [REDACTED], PCG spoke briefly with [REDACTED] and [REDACTED], [REDACTED] about the purposes of the audit. When [REDACTED], PCG conducted the formal entrance conference.
- [REDACTED] introduced PCG to various staff members from his programs teams and his administration functions who would be assisting us with the documentation collection.
- Case files began to arrive at approximately 1:00 pm on the day after PCG's arrival onsite.
- TeamBuilders chose to make copies of all documentation that they submitted to PCG and was very organized and provided PCG with complete case files (e.g., service authorizations, treatment plans, case notes) for the dates of service in the claims sample

on a flash drive. The files were clearly labeled and each file had an index of what was included.

- Human Resources staff produced documentation regarding staff credentials, training, and supervisory logs approximately four business days after our arrival. Like the case files TeamBuilders produced, the staff files were orderly and submitted electronically.
- PCG interviewed [REDACTED], [REDACTED], about claims documentation and submission. [REDACTED] reported that he believed the internal controls to be strong and effective at TeamBuilders.
- TeamBuilders staff was cooperative and transparent throughout our time onsite.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and forty-seven (147) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	1	90	0	0	0.0%
90802	Interactive Psychiatric Evaluation	1	145	0	0	0.0%
90806	Outpatient—45-50 minutes	17	1,131	0	0	0.0%
90834	Outpatient—45 minutes	1	68	0	0	0.0%
90837	Outpatient—60 minutes	1	71	0	0	0.0%
90846	Family Therapy	5	337	0	0	0.0%



90847	Family Therapy	8	626	0	0	0.0%
90862	Medication Management	6	429	0	0	0.0%
H0041	Foster Care(Shelter)	2	200	0	0	0.0%
H2014	Behavior Management Services	32	3,398	6	692	18.8%
H2015	HO, HN, HM—CCSS	33	2,542	24	1,882	72.7%
H2017	Psychosocial Rehabilitation	2	238	1	102	50.0%
H2033	Multi-Systematic Therapy	6	2,795	0	0	0.0%
Q3014	Telehealth Facility Fee/Code	6	135	0	0	0.0%
S5145	Treatment Foster Care	17	2,726	0	0	0.0%
T1005	Respite Services	9	435	0	0	0.0%
Grand Total		147	15,366	31	2,675	21.1%

Specific Random Sample Review Findings

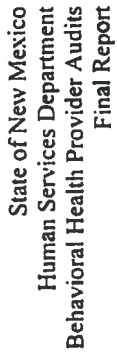
For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



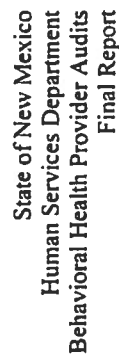
State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	H2014—Behavior Management Services(NMAC 8.322.3; LOC 745.2) MISSING DOCUMENT: [REDACTED]
H2014		Pass	Pass	NA	Fail	NA	Pass	NA	NA	NA	TIME INDICATED IN THE NOTE: 08:30 TO 11:45AM=9 UNITS BILLING ABOVE INDICATES 13 UNITS. H2014—Behavior Management Services (NMAC 8.322.3; LOC 745.2).
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	MISSING DOCUMENT: for CSW—[REDACTED]
H2014		Fail	Pass	NA	Pass	NA	Pass	NA	NA	NA	no Axis III appears patient does have seasonal allergies listed.
H2014		Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	MISSING DOCUMENTATION: Unable to read the practitioner's name.
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)—need to improve and include specific risk assessment.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)—rendering provider not qualified as per list.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition) not qualified as per staff list.
H2015		Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)—NOT QUALIFIED PER STAFF LIST.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition).
H2015		Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)—PER NOTE THIS IS A TELEPHONE CALL.
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition) H2015HO, HN, HM—CCSS—(NMAC 8.315.6; LOC 8.315.69; Service Definition)—PER LIST, PRACTITIONER

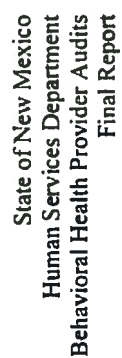
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Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 147 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

TeamBuilders	
Sample Size	147
Total Paid for Sample	\$15,366
Sampling Frame Size	714,243
Number of Sample Claims with Overpayments	31
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$9,262,711

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2014	Behavior Management Services	5	1,214	146,555	300	35,789	24.7%
H2015	HO, HN, HM—CCSS	5	315	25,310	217	18,881	68.9%
H2033	Multi-Systematic Therapy	5	489	251,910	68	25,524	13.9%
S5145	Treatment Foster Care	5	1,768	267,056	1,694	255,639	95.8%
Grand Total		20	3,786	690,831	2,279	335,833	60.2%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	23
BMS	57
Case Manager	1
Clinical Supervisor	1
Therapist	39
DO	1
Psychiatrist	6
Youth Care Specialist	1
MST Supervisor	7
Total Staff Reviewed	136

IT/Billing Systems Audit

System Overview

TeamBuilders uses EMR Bear as their Electronic Health Record and Practima as their billing system. They interface with Optum Networkes to submit their bills for processing and payment. The IT department at TeamBuilders supports 18 different sites. There is one person who is in charge of the EMR Bear implementation and he is an expert who handles upgrades and usage as his full time job. There is one person who is in charge of the Practima billing system and handles upgrades and issues as his full time job.

EMR Bear is a product that was designed by a Behavioral Health professional. It does not have a very large footprint and it is very popular among the staff members of TeamBuilders. They are able to efficiently use it to create their case files for patient treatment. TeamBuilders spent a 2 year IT investment in another product that turned out to not be reliable and interfered with staff members performing their duties of recording patient treatment. TeamBuilders concluded that it was better to switch back to EMR Bear which does not do everything they wish it did, but is, in their opinion, reliable.

The Practima billing system is used by less than 10 providers in the NM area. The product is supported full time by the creator of the Practima billing system. Practima has basic checks for coding inconsistencies. It also is able to generate an audit trail. However it is not tied to the Optum Networkes portal which is a common theme at all providers audited. There is a handoff between the intake, eligibility, EHR, billing system, and Optum. At any one of these points errors could be introduced even with the human double checking processes that TeamBuilders has instituted.

TeamBuilders also has an intake and eligibility system. They have a fully documented training system for all levels of staff and standard treatment paths that the clinicians will face. At every step of the intake thru to the billing process, every step is double checked for accuracy.

IT Contacts and roles



Application Controls - System Walkthrough

Administration and Segregation of Duties

The EHR manager is able to set login privileges for staff members to restrict access to patient's information. The IT billing manager is able to set login privileges for staff members to appropriately restrict access to parts of the Practima system.

Strengths and Weaknesses

Strengths:

- EHR system that they use to record and track clinical records
- Provide extensive training for every type of employee and diagnosis. Have initial training and training updates.
- Each step of the billing process from intake to submission is double checked
- Disaster recovery plan in place
- Strong eligibility checking process, training and system
- Strongly documented intake process for new patients
- Strongly documented process for submitting billing claims in batch process on regular basis to avoid duplicate billing
- TeamBuilders has invested in EHR systems and put out an RFP for bid a couple of years ago. TeamBuilders appears to keep abreast of new developments in the EHR space.
- An internal audit person monitors billing trends by region, diagnosis and providers to identify inefficiencies or outliers that could be fraudulent.

Weaknesses:

- The point of entry to Optum Networkes provides the ability to change any billing from what the clinician entered.
- EMR Bear is not configured to easily provide an audit trail of the events of an encounter
- There is no direct connection between the EHR system and the billing system which could lead to human error in transcribing
- Did not have a thorough termination plan for employees and their computer system access privileges
- There is no complete audit trail of the entire clinical and billing transaction that is guaranteed to correspond to what is billed to Medicaid



Recommendations

- Develop appropriate accounting controls for charge entry/billing in Optum Portal and Optum Networkes.

Enterprise Audit

Provider Specific Methodology

In conducting the standard enterprise review of TeamBuilders Counseling Services (TB), an extraordinary number of unusual financial relationships and related party transactions were discovered. Accordingly, PCG researched the organization's finances as far back as possible (to 2003), reviewed ownership of properties and researched a number of limited liability companies owning properties that TB rents. Most of these companies are owned by TB executives and their families.

PCG also looked at other non-profit providers that had linkages to TB and organizations associated with or compensating these executives. Finally, any financial transactions that appeared unusual were examined. For example, a construction contract with unusually beneficial terms to the contractor prompted contact with the local building department, through which PCG was able to trace the construction company back to an address in Texas owned by the TB CEO and his brother.

Audit Observations

Teambuilders has an excessive number of related party transactions for a non-profit and a substantial portion of the organization's funds are being used to benefit the executive team, their families, or companies closely held by these same parties. It is unusual that so many of these relationships exist in a 501 (c) (3) organization, which is a special status granted by the IRS with significant regulations to insure that these kinds of charities earn a public trust.

In granting this special status, the IRS prohibits inurement; meaning that the assets or income of a non-profit organization cannot be used to benefit an individual who has a close relationship with the organization or is able to exercise control over the organization. This prohibition is found in the language of Internal Revenue Code 501 (c) (3):

"A section 501(c)(3) organization must not be organized or operated for the benefit of private interests, such as the creator or the creator's family, shareholders of the organization, other designated individuals, or persons controlled directly or indirectly by such private interests. No part of the net earnings of a section 501(c)(3) organization may inure to the benefit of any private shareholder or individual."



Key Staff

First Name	Last Name	Position
Gay	Wellborn	Director
Robert	Pacheco	Director
Carlos	Romero	Director
Jim	Hilber	Director
Emmett	Breen	Director
Charlie	Sandoval	Director
Jacob	Caldwell	Director
Shannon	Freedle	President
Lorraine	Freedle	Vice President
Ben	Lucas	CFO
Sun	Vega	COO
William	Johnson	Psychiatrist
Jim	Heneghan	Psychiatrist

Financial Relationships

Company	Type of Company	Description
Plain View Properties, LLC	Limited liability corporation – exempt	This company leases real estate to TeamBuilders
Full Circle Holdings, LLC	Limited liability corporation – exempt	This company leases real estate to TeamBuilders
Yellow Brick Properties, LLC	Limited liability corporation – exempt	This company leases real estate to TeamBuilders
Oso Doso Properties, LLC	Limited liability corporation – exempt	This company leases real estate to TeamBuilders
Zia Behavioral Health	Domestic Professional Corporation	Providers of behavioral health services
Community Wellness Center	501(c)(3)	This organization addresses challenges of unintended teen pregnancies in Taos County
Partners in Wellness	501(c)(3)	This organization networks administrative and behavioral health services



Pathways Youth & Family Services, Texas	501(c)(3)	This organization provides social services for Texas children and families
Pathways Inc, New Mexico	501(c)(3)	This organization provides case management, psycho-social intervention, and substance abuse counseling
Habilitative Homes, Texas	501(c)(3)	This organization is held by Pathways, TX and provides rehabilitative homes in Texas
Davidson, Freedle, Espenhover, & Overby, Kerrville, Texas	Domestic Professional Corporation	Providers of financial, accounting, and tax services

Summary of Findings and Recommendations

Findings	Recommendations
<p>Leases paid to limited liability companies owned by TeamBuilders' CEO and family:</p> <ul style="list-style-type: none"> • 2012 - \$1,217,416 • 2011 - \$910,170 • 2010 - \$685,482 • 2009 - \$551,030 • 2008 - \$618,516 • 2007 - \$446,156 • 2006 - \$ 97,046 <p>These payments total \$3,308,400 through 2011 with additional commitments through 2021 of an estimated \$10,682,731.</p> <p>In 2007, TeamBuilders entered into a ten year lease agreement with Plainview Properties, LLC for property to be built at 121 Towngate in Clovis, NM. TeamBuilders agreed to pay fees of:</p> <ul style="list-style-type: none"> • \$65K during the construction process • 100% of the architect's fees of \$45K • \$50,000 in leasehold improvements • \$29K in security deposit for this location. • Rental payments for the ten year lease total \$1,979,928. • Plainview Properties, LLC is owned in whole or in part 	<ul style="list-style-type: none"> • Payments from the related party LLCs should be audited for conflict of interest. Additional leasehold and other capital purchases made by TeamBuilders should be reviewed to determine if additional benefits have accrued to the owners of these properties in the form of capital improvements.
<p>In 2007, TeamBuilders entered into a ten year lease agreement with Plainview Properties, LLC for property to be built at 121 Towngate in Clovis, NM. TeamBuilders agreed to pay fees of:</p> <ul style="list-style-type: none"> • \$65K during the construction process • 100% of the architect's fees of \$45K • \$50,000 in leasehold improvements • \$29K in security deposit for this location. • Rental payments for the ten year lease total \$1,979,928. • Plainview Properties, LLC is owned in whole or in part 	<ul style="list-style-type: none"> • Officers and directors of TeamBuilders should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions. • Plainview Properties, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations. • RCH Inc., the contractor that built the Clovis, NM property should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.

<p>by the CEO and his family.</p> <p>According to building permits filed with the City of Clovis, NM this facility was constructed by RCH, Inc. of 222 Sidney Baker Suite 635, Kerrville, TX - a property owned by the CEO and/or his brother, Patrick Freedle. The address is the same as Patrick Freedle's accounting firm -- Davidson, Freedle, Espenhover & Overby. The contractor's phone is listed as 830-257-3951 which is TeamBuilders' headquarters in Santa Fe. Estimated construction costs paid were \$1.75M.</p>	
<p>TeamBuilders leases property in Clayton, NM from Plainview Properties LLC. This NM Corporation (NMSCC 2740801) is classified as exempt and listed as a related party. TeamBuilders' CEO is listed as both organizer of the company and its agent. Lease payments from 2006 to 2016 are estimated at \$139K.</p>	<ul style="list-style-type: none"> • Officers should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions. • Plainview Properties, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.
<p>TeamBuilders leases property in Santa Fe, NM from Yellow Brick Properties, LLC. This NM Corporation (NMSCC 2671733) is classified as exempt and listed as a related party. TeamBuilders' CEO is listed as organizer of the company and TeamBuilder's COO, Sun Vega, is listed as its agent. TeamBuilders spent \$215K on leasehold improvements and a security deposit of \$56,460. Lease payments from 2007 to 2017 are estimated at \$4,012,900.</p>	<ul style="list-style-type: none"> • Officers should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions. • Yellow Brick Properties, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.



<p>TeamBuilders leases property in Tucumcari, NM from Full Circle Holdings, LLC. This NM Corporation (NMSCC 2671725) is classified as exempt and listed as a related party.</p> <p>TeamBuilders' CEO is listed as both organizer of the company and its agent. Lease payments from 2007 to 2017 are estimated at \$1,060,795.</p>	<ul style="list-style-type: none"> • Officers should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions. • Full Circle Holdings, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.
<p>TeamBuilders leases property in Riudoso, NM from Oso Doso Properties, LLC. In 2011 TeamBuilders' COO, Sun Vega, filed articles of incorporation in NM as agent and organizer of the corporation. Oso Doso Properties, LLC. (NMSCC 4428934) is classified as exempt and listed as a related party. TeamBuilders has lease commitments of approximately \$1,575,359 from 2011 to 2021 for use of this property. The property was purchased by this related organization for \$322K in 2011. Several other businesses list addresses at his location and may be paying rent as well.</p>	<ul style="list-style-type: none"> • In light of the decision made by officers to purchase the building for themselves and lease it to TeamBuilders, officers and trustees should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit. • Oso Doso Properties, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.
<p>TeamBuilders had sufficient capital to purchase this property outright in 2011 and would have saved \$1,253,359 in lease payments had it been purchased for \$322K. If there are other tenants in the building, TeamBuilders could have received the benefit of unrelated business income.</p>	
<p>TeamBuilders leases property in Las Vegas, NM from Yellow Brick Properties, LLC. This NM Corporation (NMSCC 2671733) is classified as exempt and listed as a related party.</p>	<ul style="list-style-type: none"> • Officers should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions.

TeamBuilders' CEO is listed as organizer of the company and TeamBuilders' COO, Sun Vega, is listed as its agent. Lease payments from 2009 to 2019 are estimated at \$591K.	<ul style="list-style-type: none"> Yellow Brick Properties, LLC should be evaluated to determine if it is a "disqualified person" under excess benefit regulations.
In 2011, TeamBuilders entered into a related party lease with Cielo Azul Holding, LLC for a facility in Taos, NM for 5 years beginning 1/1/2011 and paying annual rent of \$232K per annum. Cielo Azul Holding is owned in whole or in part by TB CEO and his family.	<ul style="list-style-type: none"> Officers should be evaluated for conflict of interest, inurement, excess benefit, and/or private benefit based upon these transactions.
Officer's compensation. In FY12, Shannon Freedle was granted a \$104K raise of 71%, bringing his compensation as CEO to \$252K. Lorraine Freedle was granted a \$64K raise of 46%, bringing her compensation as VP to \$203K. Combined with estimated income from related transactions, this family's income from the non-profit is estimated as high as \$1.5M per year. Shannon Freedle also serves as CEO of The Community Wellness Center and received compensation in FY10 of \$12,913.	<ul style="list-style-type: none"> Total compensation and related income should be examined for all officers of TeamBuilders.
<p>Unrelated officers.</p> <ul style="list-style-type: none"> Ben Lucas, TeamBuilders' CFO, serves as manager at two other LLCs – Quiet Oasis, a Texas corporation and Kerrville 415, also a Texas Company at the same address as Davidson, Freedle, etc., TeamBuilders' tax advisors and brother of the CEO. Mr. Lucas serves as CFO for Community Wellness Center and received compensation of \$12K in FY10. In 	<ul style="list-style-type: none"> Total compensation and related income should be examined for all officers of TeamBuilders. Other organizations should be examined to determine if they meet the test for disqualified persons.

<p>2012, Mr. Lucas received compensation from Pathways, TX of \$18K and from Pathways, NM of \$13K, substantially increasing his compensation.</p> <ul style="list-style-type: none"> • Ms. Sun Vega serves as COO for Community Wellness Center and has received similar compensation to Mr. Lucas. In 2012, Ms. Vega received compensation from Pathways, TX of \$7K and from Pathways, NM of \$24K, substantially increasing her compensation. • Ms. Vega, TeamBuilders' COO has filed as agent for several other exempt NM corporations: <ul style="list-style-type: none"> ◦ Oso Doso LLC (NMSCC (4428934)) ◦ Yellow Brick Properties, LLC (NMSCC 2671733) ◦ Highland Sipapu LLC (NMSCC 4660625) • All of these corporations list TeamBuilders' Headquarters, 2504 Camino Entrada, Santa Fe, NM as headquarters. • Ms. Vega also serves as COO of the Community Wellness Center and receives compensation of \$12K in FY10. In 2012, she received compensation from Pathways, TX and Pathways, NM. 	
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<p>Pathways, Inc. Texas.</p> <ul style="list-style-type: none"> At 12/31/11, TeamBuilders lent Pathways, Inc. of Texas \$500K in cash and guaranteed a loan of \$530K. TeamBuilders now has a controlling interest in the organization. Shannon Freedle became CEO/President and Ben Lucas became CFO. Also in 2011, Pathways TX became a tenant of property at 222 Sidney Baker, Kerrville, TX paying \$47K in annual lease payments. The property is owned by Kerrville 415, LLC. Shannon Freedle, Ben Lucas, and others have an interest in Kerrville 415. This building is also the site of Freedle's brother's CPA firm. In 2011, Habilitative Homes of Texas was acquired and became a tenant of a related party paying rent of \$42K per annum. 	<ul style="list-style-type: none"> These transactions should be audited to determine if excess benefit in the form of rent has inured to the CEO, CFO, and any other owners of Kerrville 415, LLC as a result of loaning and risking TeamBuilders' assets.
<p>Miscellaneous:</p> <ul style="list-style-type: none"> In 2010 TeamBuilders entered into a "business combination" with True North Consulting. In 2007, two \$10K grants were given to Golden Willow Retreat, owned and operated by an employee of TeamBuilders, Ted Wiard and governed by a member of TeamBuilders' Board, Jacob Caldwell. From 2003 to 2005, TeamBuilders paid an officer approximately \$9K per year for office rental in Colorado. 	<ul style="list-style-type: none"> Each of these transactions was identified as unusual from financial statements, tax returns, or other sources. While the amounts noted are relatively small, it is recommended that they be reviewed if a full financial audit is done.

<ul style="list-style-type: none"> • 2011 investment is noted in Sendero Ranch. This is an unusual investment for a non-profit. • Highland Sipapu LLC (NMSCC 4660625) was organized by Sun Vega, COO and lists TeamBuilders' Santa Fe headquarters as its address. However, no further information was available. 	
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List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2003 - 2012
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2003 - 2012
Third-party Contracts	



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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

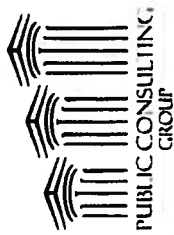
Balance Sheet	2003	2004	2005	2006	2007	2008	2009	2010	2011
Assets									
Cash	\$ 442,403	\$ 325,122	\$ 188,546	\$ 464,447	\$ 353,627	\$ 1,369,695	\$ 3,433,672	\$ 5,243,390	\$ 3,555,038
Investments	\$ 415,863	\$ 510,581	\$ 540,810	\$ 686,633	\$ 820,732	\$ 610,051	\$ 437,164	\$ 1,084,996	\$ 3,540,452
A/R	\$ 235,698	\$ 520,623	\$ 428,369	\$ 533,948	\$ 648,097	\$ 1,342,873	\$ 1,091,712	\$ 1,948,947	\$ 2,640,064
A/R - employees	\$ 1,710	\$ 2,200	\$ 9,150	\$ 3,831	\$ 2,822	\$ 3,579	\$ 8,714	\$ 10,301	\$ 9,145
Related party receivable					\$ 31,782	\$ 5,777	\$ 5,777	\$ 7,471	\$ 317,925
Property & Equipment	\$ 178,882	\$ 201,342	\$ 369,457	\$ 452,275	\$ 715,830	\$ 1,213,994	\$ 1,416,169	\$ 1,746,059	\$ 3,787,525
Promised use of facilities/current				\$ 24,828	\$ 24,828	\$ 24,828	\$ 24,828	\$ 21,725	
Promised use of facilities/long term				\$ 96,209	\$ 71,381	\$ 46,553	\$ 21,725		
Land Held for future expansion	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696	\$ 54,696
Other Assets	\$ 2,035	\$ 57,103	\$ 10,855	\$ 21,219	\$ 126,508	\$ 95,484	\$ 264,245	\$ 220,461	\$ 360,161
Goodwill						\$ 45,000	\$ 63,000	\$ 63,000	\$ 63,000
Long term security deposits						\$ 100,175	\$ 100,175	\$ 111,745	\$ 193,794
Total Assets	\$ 1,331,287	\$ 1,671,667	\$ 1,601,883	\$ 2,338,086	\$ 2,850,303	\$ 4,912,705	\$ 6,921,877	\$ 10,512,791	\$ 14,521,800
Liabilities									
Accounts Payable	\$ 11,738	\$ 21,121	\$ 46,244	\$ 14,806	\$ 74,516	\$ 386,631	\$ 233,519	\$ 293,955	\$ 687,967
Accrued Expenses	\$ 143,050	\$ 139,276	\$ 182,059	\$ 293,859	\$ 460,144	\$ 615,712	\$ 750,958	\$ 1,025,332	\$ 1,433,503
Notes payable	\$ 44,073	\$ 15,041	\$ 14,056	\$ 12,816	\$ 10,872	\$ 9,478	\$ 7,549	\$ 5,548	\$ 3,328
Line of Credit									\$ 530,000
Total Liabilities	\$ 198,861	\$ 175,438	\$ 242,359	\$ 321,481	\$ 545,532	\$ 1,011,821	\$ 992,026	\$ 1,324,835	\$ 2,654,798
Net Assets	\$ 1,132,426	\$ 1,496,229	\$ 1,359,524	\$ 2,016,605	\$ 2,304,771	\$ 3,900,884	\$ 5,929,851	\$ 9,187,956	\$ 11,867,002
Total Liabilities and Net Assets	\$ 1,331,287	\$ 1,671,667	\$ 1,601,883	\$ 2,338,086	\$ 2,850,303	\$ 4,912,705	\$ 6,921,877	\$ 10,512,791	\$ 14,521,800

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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Income Statement	2003	2004	2005	2006	2007	2008	2009	2010	2011
Revenue									
Program & Service Fees	2,401,096	2,982,342	3,451,919	6,077,164	8,129,781	13,184,064	17,236,353	21,681,771	24,107,894
Contributions				121,037	85,720	75,491	85,478	81,008	57,824
Investment Income	2,831	109,682	35,560	65,649	156,737	(87,761)	(161,322)	27,778	485,438
In-kind contributions									65,878
Special events									114,905
Other revenue				3,723	1,988	53,159	21,535	101,898	305,321
Net asset release									
Total Revenues and Suppo	2,403,927	3,092,024	3,487,479	6,267,573	8,374,226	13,224,953	17,182,044	21,892,455	25,137,260
Expenses									
Program Services	1,683,763	2,412,454	3,166,203	4,809,657	6,601,167	10,518,971	13,377,231	16,380,905	19,910,897
Supporting Services	598,062	315,707	457,981	800,835	1,484,893	1,538,832	1,775,846	2,253,445	3,349,274
Total Expenses	2,281,825	2,728,161	3,624,184	5,610,492	8,086,060	11,857,803	15,153,077	18,634,350	23,260,171
Inherent contribution from Pathways TX									801,957
Change in Net Assets	122,102	363,863	(136,705)	657,081	288,166	1,367,150	2,028,967	3,258,105	2,679,046
Net Assets, beginning of y	1,010,264	1,132,366	1,496,229	1,359,524	2,016,605	2,533,734	3,900,884	5,929,851	9,187,956
Net Assets, end of year	1,132,366	1,496,229	1,359,524	2,016,605	2,533,734	3,900,884	5,929,851	9,187,956	11,867,002



Excess Benefits Table

This table estimates the total benefit per year paid to the CEO and his family.

- Columns 1 and 2 represent direct compensation paid to Dr. and Mr. Freedle.
- Column 3 represents 40% of payments made to a behavioral health organization 40% owned by the CEO and his family.
- Column 4 shows lease payments made to holding companies owned in full or in part by the CEO, his family, and other officers of TeamBuilders.*
- Column 5 represents payments made to the CEO's brother's Texas accounting firm as well as lease payments to a holding company at the same address.

*Because details on the extent of officer ownership in the limited liability holding companies is not fully disclosed, it is possible that some unrelated parties receive a portion of this rental income.

Year	Shannon Freedle	Lorraine Freedle	Zia	Leases	Related parties	Accounting Firm/Texas rent	Total
2012		<i>Data Not Available</i>		\$ 1,217,416		\$ 125,000	\$ 1,342,416
2011	\$ 357,389	\$ 299,159	\$ 31,000	\$ 910,170		\$ 102,000	\$ 1,699,718
2010	\$ 147,710	\$ 139,309	\$ 401,000	\$ 685,482	\$ 117,529	\$ 54,000	\$ 1,545,030
2009	\$ 151,405	\$ 143,407	\$ 240,800	\$ 551,030	\$ 24,084	\$ 36,000	\$ 1,146,726
2008	\$ 124,981	\$ 129,321	\$ 201,600	\$ 618,516	\$ 11,755	\$ 35,000	\$ 1,121,173
2007	\$ 103,282	\$ 120,026	\$ 82,800	\$ 446,156		\$ 35,000	\$ 787,264
2006	\$ 101,398	\$ 91,599	\$ 207,000	\$ 97,046		\$ 24,000	\$ 521,043
2005	\$ 101,263	\$ 79,092	\$ 84,000		\$ 93,000	\$ 20,000	\$ 377,355
2004	\$ 93,417	\$ 69,721			\$ 9,000	\$ 24,000	\$ 196,138
2003	\$ 84,269	\$ 69,221			\$ 9,300	\$ 13,000	\$ 175,790
Total	\$ 1,265,114	\$ 1,140,855	\$ 1,248,200	\$ 3,308,400	\$ 264,668	\$ 343,000	\$ 7,570,237

Rental Income

This table portrays the significant, cumulative impact of multi-year leases between Teambuilders and multiple related parties in the form of limited liability corporations organized and owned by Teambuilders' officers (CEO, CFO, COO, etc.) and members of their families. These commercial property leases with multiple holding companies typically span ten years. PCG has estimated the established duration of these commitments without assuming lease renewal at the end of ten years, although renewal is likely. It is noteworthy that while the organization invested in land for expansion in Quay County with the intention of building a facility, it continues to hold this land and instead entered into leases and construction contracts with related party holding companies to develop property that it would never own. PCG considers this significant because more than \$1M per year in Teambuilders assets is diverted to its officers and their families. While prosperous from its state contracts, Teambuilders does not own a single piece of real estate that it occupies. Teambuilders has essentially built a sizeable real estate portfolio for its officers.



Excess Benefits

Site	2006	2007	2008	2009	2010	2011	2012	2013	2014
Santa Fe		\$ 338,760	\$ 338,000	\$ 219,000	\$ 351,000	\$ 361,000	\$ 371,830	\$ 382,985	\$ 394,474
Clayton	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600	\$ 12,600
Clovis			\$ 172,800	\$ 177,984	\$ 178,600	\$ 188,000	\$ 193,640	\$ 199,449	\$ 205,433
Ruidoso						\$ 123,000	\$ 135,000	\$ 139,050	\$ 143,222
Las Vegas				\$ 46,000	\$ 47,712	\$ 49,000	\$ 50,470	\$ 51,984	\$ 53,544
Tucumcari #1	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446	\$ 84,446
Tucumcari #2		\$ 10,350	\$ 10,670	\$ 11,000	\$ 11,124	\$ 11,124	\$ 12,000	\$ 12,360	\$ 12,731
Kerrville, TX						\$ 81,000	\$ 83,430	\$ 85,933	\$ 88,511
San Antonio, TX							\$ 42,000	\$ 43,260	\$ 44,558
Taos, NM							\$ 232,000	\$ 238,960	\$ 246,129
Totals	\$ 97,046	\$ 446,156	\$ 618,516	\$ 551,030	\$ 685,482	\$ 910,170	\$ 1,217,416	\$ 1,251,027	\$ 1,285,647

Site	2015	2016	2017	2018	2019	2020	2021	2022	Total Lease
Santa Fe	\$ 406,309	\$ 418,498	\$ 431,053						\$ 2,757,049
Clayton	\$ 12,600	\$ 12,600							\$ 113,400
Clovis	\$ 211,596	\$ 217,944	\$ 224,482						\$ 1,315,906
Ruidoso	\$ 147,518	\$ 151,944	\$ 156,502	\$ 161,197	\$ 166,033	\$ 171,014	\$ 176,144		\$ 540,272
Las Vegas	\$ 55,150	\$ 56,804	\$ 58,509	\$ 60,264	\$ 62,072				\$ 298,710
Tucumcari #1	\$ 84,446	\$ 84,446							\$ 760,014
Tucumcari #2	\$ 13,113	\$ 13,506							\$ 91,359
Kerrville, TX	\$ 91,166	\$ 93,901	\$ 96,718	\$ 99,620	\$ 102,608	\$ 105,687	\$ 108,857		\$ 338,874
San Antonio, TX	\$ 45,895	\$ 47,271	\$ 48,690	\$ 50,150	\$ 51,655	\$ 53,204	\$ 54,800	\$ 56,444	\$ 129,818
Taos, NM	\$ 253,513	\$ 261,118	\$ 268,952	\$ 277,020	\$ 285,331	\$ 293,891	\$ 302,707	\$ 311,789	\$ 717,089
Totals	\$1,321,305	\$ 1,358,033	\$ 1,298,816	\$ 648,251	\$ 667,699	\$ 623,796	\$ 642,509	\$ 368,233	\$ 7,062,490



Compensation

Year	Employee	Compensation	Other	Non taxable Benefits	Total
2012	estimated use previous year's compensation				
2011	Shannon Freedle	\$ 236,284	\$ 105,365	\$ 15,740	\$ 357,389
	Lorraine Freedle	\$ 189,153	\$ 95,596	\$ 14,410	\$ 299,159
	Adrian Chavarria				\$ -
	Ben Lucas	\$ 102,889	\$ 16,797		\$ 119,686
	Sun Vega	\$ 105,837	\$ 19,344		\$ 125,181
	William Johnson, MD	\$ 181,674	\$ 13,744	\$ 13,764	\$ 209,182
	Jim Heneghan, MD	\$ 252,552			\$ 252,552
2010	Shannon Freedle	\$ 135,587	\$ 132,419	\$ 12,123	\$ 280,129
	Lorraine Freedle	\$ 127,703	\$ 99,694	\$ 11,606	\$ 239,003
	Adrian Chavarria	\$ 60,505	\$ 12,115		\$ 72,620
	Ben Lucas	\$ 79,686	\$ 20,912		\$ 100,598
	Sun Vega	\$ 62,699	\$ 23,051		\$ 85,750
2009	Shannon Freedle	\$ 133,937	\$ 185,468	\$ 17,468	\$ 336,873
	Lorraine Freedle	\$ 125,451	\$ 181,233	\$ 17,956	\$ 324,640
	Adrian Chavarria	\$ 60,213		\$ 9,971	\$ 70,184
	Ben Lucas	\$ 73,999		\$ 1,998	\$ 75,997
	Sun Vega	\$ 63,466		\$ 21,101	\$ 84,567
2008	Shannon Freedle	\$ 112,600	\$ 76,000	\$ 12,381	\$ 200,981
	Lorraine Freedle	\$ 116,814	\$ 67,136	\$ 12,507	\$ 196,457
	Ben Lucas	\$ 52,999		\$ 7,781	\$ 60,780
	Sun Vega	\$ 67,691		\$ 8,471	\$ 76,162
	Paul McQuaid	\$ 53,243		\$ 4,762	\$ 58,005
	Theodore Wiard	\$ 45,547		\$ 5,012	\$ 50,559
	Adrian Chavarria	\$ 52,999		\$ 10,593	\$ 63,592



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Year	Employee	Compensation	Other	Non taxable Benefits	Total
2007	Shannon Freedle	\$ 92,804	\$ 61,333	\$ 10,478	\$ 164,615
	Lorraine Freedle	\$ 109,108	\$ 69,225	\$ 10,918	\$ 189,251
	Adrian Chavarria	\$ 42,296		\$ 8,914	\$ 51,210
	Ben Lucas	\$ 63,395		\$ 2,318	\$ 65,713
	Sun Vega				\$ -
2006	Shannon Freedle	\$ 98,445		\$ 2,953	\$ 101,398
	Lorraine Freedle	\$ 88,931		\$ 2,668	\$ 91,599
	Adrian Chavarria	\$ 40,188		\$ 1,206	\$ 41,394
	Ben Lucas	\$ 61,051		\$ 1,832	\$ 62,883
					\$ -
2005	Shannon Freedle	\$ 101,263			\$ 101,263
	Lorraine Freedle	\$ 79,092			\$ 79,092
	Adrian Chavarria	\$ 37,885			\$ 37,885
	Ben Lucas	\$ 61,276			\$ 61,276
2004	Shannon Freedle	\$ 93,417			\$ 93,417
	Lorraine Freedle	\$ 69,721			\$ 69,721
	Adrian Chavarria	\$ 24,039			\$ 24,039
	Ben Lucas	\$ 42,566			\$ 42,566
2003	Shannon Freedle	\$ 84,269			\$ 84,269
	Lorraine Freedle	\$ 69,221			\$ 69,221
	Adrian Chavarria	\$ 41,807			\$ 41,807
	Ben Lucas	\$ 14,500			\$ 14,500

Valencia Counseling Services Inc.

Clinical Narrative
IT Narrative
Enterprise Narrative



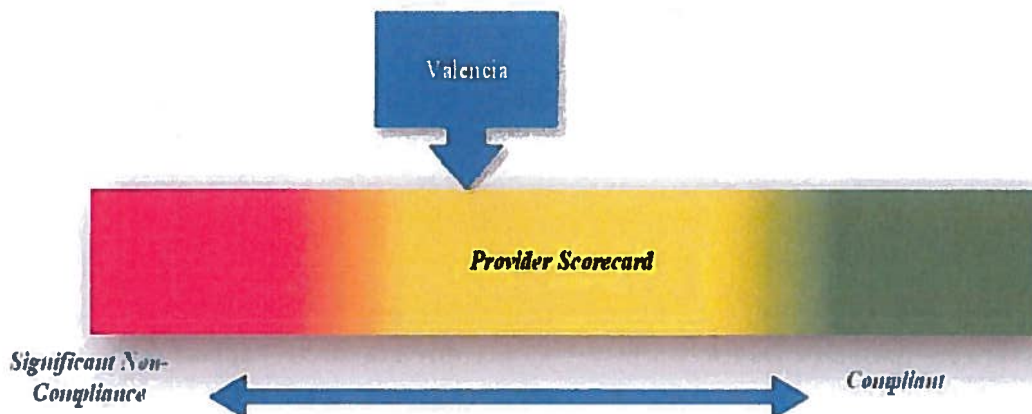
VALENCIA COUNSELING SERVICES BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6 – 14, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$4,128,958
Actual Longitudinal Overpayments	\$64,907
Total Overpayments	\$4,193,865

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
60%	50%



This scorecard result translates to the following Risk Tier:

- | | |
|---|---|
| <p>2 Significant volume of findings that include missing documents</p> | <ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management |
|---|---|



to improve processes.

Provider Overview

Valencia Mental Health Services provides behavioral health services in four counties in New Mexico; Sandoval, Bernalillo, Valencia, and Cibola. Within these locations, Valencia delivers behavioral health services including psychosocial rehabilitation, childcare food program services, DWI school services and housing services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	1,058,085	4,344,262
CYFD	67	67
Medicaid FFS	47,705	236,472
Medicaid MCO	1,309,341	5,055,694
NMCD	5,497	5,497
Other	0	0
Grand Total	2,420,695	9,641,993

Audit Team Observations

- On Wednesday, March 4th, PCG held an entrance conference with Valencia Counseling Services [REDACTED] upon arriving onsite, explaining the reason we were there, what we needed to review, and the anticipated sequence of events, in addition to answering any questions.
- Case files began to arrive within an hour of the conclusion of the entrance conference. Valencia does utilize the Anasazi system, however, hard copy files were provided to PCG.
- All case and staff files were provided in paper format and the PCG audit team manually pulled the necessary documents from the case files.
- The majority of consumer and staff files were provided over 14 business days. A few of the requested documents were provided electronically later as they were offsite.

- PCG's [REDACTED], [REDACTED], met with Valencia IT systems staff to review their billing and clinical systems, including inputs, outputs and audit trails.
- Valencia staff was slow in responding to audit team requests for clarification or additional information.
- Clinical Reviewers noted the following general findings:
 - Safety Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were incomplete of critical information for the date of service under review.
 - Treatment plans were missing, difficult to interpret and track progress, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claim s Failed	\$ Value Claims Failed	% Claims Failed
90791	Psychiatric Diagnostic Evaluation	1	87	0	0	0.0%
90801	Psychiatric Diagnostic Evaluation	8	654	0	0	0.0%
90804	Outpatient—20-30 minutes	7	307	0	0	0.0%
90806	Outpatient—45-50 minutes	39	2,731	0	0	0.0%
90808	Outpatient—75-80 minutes	1	79	0	0	0.0%
90847	Family Therapy	1	78	0	0	0.0%



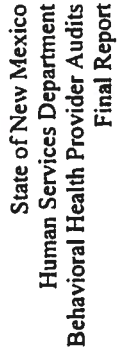
90853	Group Therapy	4	147	0	0	0.0%
90862	Medication Management	14	944	0	0	0.0%
H0015	Intensive Outpatient Program	3	397	0	0	0.0%
H2011	Crisis Intervention Services	4	222	0	0	0.0%
H2015	HO, HN, HM—CCSS	22	1,354	20	1,286	90.9%
H2017	Psychosocial Rehabilitation	24	4,018	23	3,926	95.8%
T1007	Behavioral Health Treatment Plan Update	22	2,536	17	1,975	77.3%
Grand Total		150	13,554	60	7,188	40.0%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:

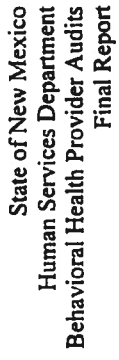


Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015		Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Consumer diagnosis does not meet SMI definition. No progress note was located to support services. No progress note was located to support services. Treatment plan does not provide specific support services needed.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Progress note states "talking to public servants" unable to document any service was delivered to consumer. Progress note states "talking to public servants" unable to document any service was delivered to consumer. [REDACTED] is missing credentials per staff list.
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	No specific interventions were documented in progress note. The progress note does not support the units billed.
H2015		Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	The progress note does not support the units billed.
H2015		Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	No assessment or treatment plan were submitted for review. Dispensing meds is out of scope for CSW. Dispensing meds is out of scope for CSW. No safety assessment. This a CSW dispensing medications. Dispensing meds is out of scope for CSW.
H2015		Fail	Fail	Pass	Fail	NA	Pass	NA	NA	NA	No assessment or treatment plan were submitted for review. No documentation of specific intervention. No safety assessment.
H2015		Fail	Pass	Pass	Fail	NA	Pass	NA	NA	NA	Originally assessed in 2008, consumer continues to receive CCSS for same objectives and goals that were set in 2008. Cannot support medical necessity of units billed.
H2015		Fail	Fail	Pass	Fail	NA	Pass	NA	NA	NA	The assessment did not include a 5 access diagnosis, therefore, unable to determine if consumer meets SMI requirement. The progress note documents consumer picking up medication samples. Safety concern that CSW is explaining meds to consumer. No progress noted. Documentation does not support consumer.

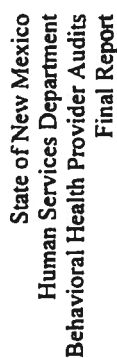


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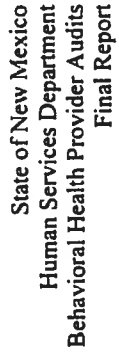
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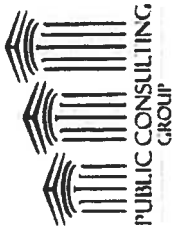
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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

T1007		NA	Fail	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	Unable to determine with the limited documents see below. See below. See below. See below.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	No consumer signature. No signature page submitted.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	An updated treatment plan was not submitted, signature page is dated 1/19/2012 but there is not Treatment Plan bearing that date.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	Treatment plan dated in August of 2010 was not submitted. Treatment plan submitted is for date 5/27/2010.
T1007		NA	Fail	NA	NA	NA	NA	NA	Fail	NA	NA	NA	NA	NA	NA	
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	No treatment plan was submitted for review.
T1007		NA	Fail	NA	NA	NA	NA	Pass	Pass	NA	NA	NA	NA	NA	NA	Consumer signed care plan which is electronically dated 11/8/2011. Care plan itself has no updates on 11/8/2011.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	No consumer signature.
T1007		NA	Fail	NA	NA	NA	NA	Fail	Fail	NA	NA	NA	NA	NA	NA	A treatment Plan was not submitted for review.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	Documentation supports an initial assessment not an update. Lacking in discharge planning.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	Mental Health Assessment was not submitted for review. Treatment Plan has goals going back to 2006. No documentation of any updates to treatment plan other than date at top of page.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	According to the progress note, the update occurred 10/13/2010, the updated treatment plan was not submitted for review.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	Treatment plan submitted is dated 12/21/2011, one year AFTER this DOS.
T1007		NA	Fail	NA	NA	NA	NA	NA	Pass	NA	NA	NA	NA	NA	NA	No evidence of discharge planning, goals and target behaviors, just to "review in 90 days". See below.

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State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

T1007		NA	Fail	NA	NA	NA	NA	Fail	NA	NA	NA	NA	An updated treatment plan was not submitted, the last update was 9/19/2011.
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Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Valencia Mental Health Services	
Sample Size	150
Total Paid for Sample	\$13,554
Sampling Frame Size	108,047
Number of Sample Claims with Overpayments	60
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$4,128,958

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H2015	HO, HN, HM—CCSS	5	228	18,228	217	17,384	95.2%
H2017	Psychosocial Rehabilitation	5	866	126,215	327	47,523	37.8%
Grand Total		10	1,094	144,443	544	64,907	49.7%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	5
Therapist	28
Nurse	3
Peer Specialist	1
Rehab Coordinator	2
Psychologist	1
Psychiatrist	2
Psychosocial Rehabilitation	3
Total Staff Reviewed	49

IT/Billing Systems Audit

System Overview

The Anasazi system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Each provider generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

The software is installed on the Valencia Microsoft Window Network and is primarily accessed through the Citrix system, which allows all administrative and clinical staff to access the system from any computer.

Anasazi would not allow any provider to disclose any training or systems documentation to our auditors, claiming it was proprietary.

Bill Processing

On a simple level, after services are provided to the client, the clinician updates the file with notes and the time and date of encounter. The Anasazi software processes this information and calculates the number of units that the service should be billed for, and what HCPCS/CPT code should be assigned to the service, using the service provided and start and stop times of the service. The service is processed by the Anasazi system and transformed into an 837 billing format, which is uploaded to Optum health through the Optum Networkes system.

IT Contacts

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]



Application Controls - System Walkthrough

There are two systems that Valencia users access: the Microsoft Windows Network and the Anasazi System. The Anasazi system is accessible both through the Windows network and through any computer that is connected to the internet. For that reason, PCG will only discuss Anasazi access in this report; the Windows network users are held in audit documentation collected by PCG for any required future reference.

Administration and Segregation of Duties

Agency Administrator Role: Can add users and configure data sheets for health plans and services.

- [REDACTED]

Administrative Group: Can configure data sheets for health plans and services.

- [REDACTED]

Billing Administrator Role: Can convert clinical information into billing information

- [REDACTED]

Staff Supervisor Role: Can see clinical records of clients served by clinical subordinates.

- [REDACTED]

Service Provider Role: All clinicians who bill and are on the payroll have the Service Provider Role.

Auditor Role: No staff at Valencia Counseling Services currently have the Auditor Role.

IT Strengths and Weaknesses

Strengths:

- Valencia's billing applications are available from any computer connected to the internet via Citrix, which make for ease of use from any computer and maintains a uniformly enforced security policy.
- Valencia uses Intrusion Prevention Services (IPS) which are provided by the NSA 2400 firewall that separates the Anasazi Subnet from the rest of the LAN and Internet. These database signatures are dynamically updated on a daily basis to ensure industry standard currency is obtained.
- Users do not share login accounts.
- The Anasazi software offers sequestration of clinical information so that users' roles determine the kind of information each user may have access to on a *per client* basis. For example, a front office clerk may have access to certain demographic information, but
- Each clinician enters his own billing information.
- Each clinician does not know what CPT/HCPCS codes are used for billing the service provided.
- Anasazi software calculates units billed based on start and end times recorded by the clinician.
- Anasazi software allows for members of a group therapy session to arrive and leave at different times, allowing for more accurate tracking group services, and therefore billing.

Weaknesses:

- System super user creates the password for everyone but passwords never expire.
- Disaster Recovery – Valencia presented no disaster recovery plans for the application hosting server and electronic records.
- Currently Valencia IT staff have no knowledge of the application transaction and database transaction logs.
- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. The 837 can be changed when connected to Optum Netwerkes. The person uploading the 837 can make any changes to billing with no audit trail.
- Training is done mostly on an *ad hoc* basis.

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Develop formalized training system for all users who create charge entry and billing.



- Develop Disaster Recovery Plan to manage electronic and paper client records.

Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Valencia Counseling Services, Inc. (Valencia). PCG began by locating Valencia's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on Valencia.

PCG located and reviewed Valencia's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Valencia is a member of the Rio Grande Provider Network and was evaluated simultaneously with Rio Grande Behavioral Health Services and Rio Grande Management.

Audit Observations

Valencia Counseling Services, Inc. provides counseling services to adults, families, and children having difficulties with their personal lives, relationships with others, alcohol and drug abuse, and social learning problems.

Key Staff

First Name	Last Name	Position
Sam	Vigil	Executive Director
Joe	Castillo	President
Leo	Chavez	Treasurer
Ernestina	Morlan	Secretary
Javier	Vera	Psychiatrist
Terri	Sturgis	Director
Carol	Long	Director
Glenna	Giles	Employee

Financial Relationships

Valencia contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources. The organization paid RGBHS \$210,000 for these services in 2011¹. Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While RGBHS receives monthly fees from its members, it has also distributed various grants back to its members.

In addition, Valencia contracts with Rio Grande Management, LLC (RGM), paying \$188,000 for management services (2011). These include legal services and the provision of executive management. Providence Service Corporation fully owns RGM. Providence is a large, for-profit national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. The Executive Director of this organization is an employee of Providence Service Corporation.

In 2012, Sam Vigil, Executive Director, was paid \$152,000 from this related organization.

In 2012, the organization merged another non-profit, La Buena Vida, into the organization and is now operating as a single mental health clinic.

Summary of Findings and Recommendations

Findings	Recommendations
The Executive Director has had an unusual financial arrangement that began in 2002, was amended in 2009, and converted existing funding to a single premium immediate annuity plan. \$244,000 was added to the plan and brought the organization's investment in the plan to \$605,000. The amended plan provides \$50,000 in annual payments to the director immediately for 17 years with an additional single payment of \$100,000 upon	These transactions are unusual for a non-profit organization and should be evaluated to determine if excess benefit was provided to this individual. The executive director should be evaluated to determine if he is a disqualified person.

¹ Most recent year for which representative payments for both behavioral health and management services were reported.



retirement. Upon his death, his beneficiary receives the balance less any retirement benefits already received.	
In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable. On the surface, the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure and may have the effect of masking excessive compensation or benefits. In addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.	Full disclosure of executive effort, compensation and benefits should be revealed for this organization and for their services to Providence Service Corporation.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011, 2010
Form 990 (Nonprofit filing)	2011, 2010, 2009
Third-party contracts	
Organizational charts	
Interviews	



Balance Sheet	2010	2011	2012
Assets			
Cash & cash equivalents	\$ 1,707,823.00	\$ 1,031,791.00	\$ 251,812.00
Investments - certificate of deposits	\$ 1,118,764.00	\$ 1,121,472.00	\$ 1,122,832.00
Accounts & grants receivable, less allowance for doubtful accounts	\$ 425,277.00	\$ 271,378.00	\$ 197,646.00
Due from related party			\$ 55,254.00
Other Receivables	\$ 2,492.00	\$ 4,410.00	\$ 2,442.00
Prepaid Expenses	\$ 40,443.00	\$ 40,971.00	\$ 67,610.00
Total current assets	\$ 3,294,799.00	\$ 2,470,022.00	\$ 1,697,596.00
Property and Equipment			
Land, building, furniture, and equipment	\$ 1,899,868.00	\$ 1,928,387.00	\$ 1,943,155.00
Accumulated depreciation	\$ (905,026.00)	\$ (957,506.00)	\$ (1,008,689.00)
Total property and equipment	\$ 994,842.00	\$ 970,881.00	\$ 934,466.00
Other Assets			
Single premium annuity	\$ 557,653.00	\$ 533,305.00	\$ 507,837.00
Due from related party	\$ 44,415.00	\$ 46,973.00	\$ 49,150.00
Deposits	\$ -	\$ 825.00	\$ 825.00
Total other assets	\$ 602,068.00	\$ 581,103.00	\$ 557,812.00
Total Assets	\$ 4,891,709.00	\$ 4,022,006.00	\$ 3,189,874.00
Liabilities			
Accounts Payable	\$ 74,576.00	\$ 60,933.00	\$ 65,312.00
Accrued expenses	\$ 71,810.00	\$ 67,091.00	\$ 85,198.00
Other current liabilities	\$ 963,117.00	\$ 373,960.00	\$ 413,479.00
Notes Payable, current portion	\$ 3,864.00	\$ 4,093.00	\$ 4,216.00
Deferred compensation payable	\$ 24,348.00	\$ 25,468.00	\$ 26,640.00
Deferred revenue			\$ 1,400.00
Total Current Liabilities	\$ 1,137,715.00	\$ 531,545.00	\$ 596,245.00
Long Term Liabilities			
Deferred compensation payable	\$ 533,305.00	\$ 507,837.00	\$ 481,197.00
Note payable, long term	\$ 10,948.00	\$ 17,633.00	\$ 13,418.00
Total long-term liabilities	\$ 544,253.00	\$ 525,470.00	\$ 494,615.00
Total Liabilities	\$ 1,681,968.00	\$ 1,057,015.00	\$ 1,090,860.00
Net Assets	\$ 3,209,741.00	\$ 2,964,991.00	\$ 2,099,014.00
Total Liabilities and Net Assets	\$ 4,891,709.00	\$ 4,022,006.00	\$ 3,189,874.00



Income Statement	2010	2011	2012
Revenue			
Program Revenue and Fees	\$ 3,541,926.00	\$ 3,282,967.00	\$ 3,036,704.00
Interest	\$ 36,271.00	\$ 43,561.00	\$ 37,204.00
Other	\$ 204,354.00	\$ 224,602.00	\$ 184,138.00
Total Revenues and Support	\$ 3,782,551.00	\$ 3,551,130.00	\$ 3,258,046.00
Expenses			
Program Services	\$ 2,617,153.00	\$ 2,742,147.00	\$ 3,506,703.00
Management and General	\$ 1,418,916.00	\$ 1,053,733.00	\$ 617,320.00
Total Expenses	\$ 4,036,069.00	\$ 3,795,880.00	\$ 4,124,023.00
Change in Net Assets	\$ (253,518.00)	\$ (244,750.00)	\$ (865,977.00)
Net Assets, beginning of year	\$ 3,463,259.00	\$ 3,209,741.00	\$ 2,964,991.00
Net Assets, end of year	\$ 3,209,741.00	\$ 2,964,991.00	\$ 2,099,014.00



Youth Development Inc.

Clinical Narrative

IT Narrative

Enterprise Narrative



YOUTH DEVELOPMENT INC. BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	February 27 – March 5, 2013
Main Point of Contact at Facility	
Extrapolated Date of Service Overpayments	\$228,309
Actual Longitudinal Overpayments	\$68,661
Total Overpayments	\$296,970

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
82%	3%



This scorecard result translates to the following Risk Tier:

<p>3 Significant findings, including significant quality of care findings.</p>	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. • Potential change in management.
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Provider Overview

Youth Development Inc has six locations in the Albuquerque metropolitan area. Within these locations, Youth Development delivers behavioral health services including tutoring, after-school activities, gang intervention, drop-out prevention, family counseling services, emergency teen shelter, youth sports, internships, scholarships, parenting skills, leadership development, public housing assistance, community corrections, GED studies, early childhood education via Head Start centers, substance abuse and AIDS education and other services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	\$ Claims Paid FY12	\$ Claims Paid Audit Period
BHSD	8,822	8,822
CYFD	448,971	1,034,640
Medicaid FFS	42,776	93,681
Medicaid MCO	523,431	1,049,054
NMCD	0	0
Other	17,958	758,308
Grand Total	1,041,959	2,944,506

Audit Team Observations

- An entrance conference was held within two hours of the team's arrival onsite. [REDACTED] was offsite so [REDACTED] was designated to serve at the team's point of contact at the site. Also participating in the entrance conference was [REDACTED]
- Case files began to arrive within an hour of the conclusion of the entrance conference. The majority of files were provided within two business days. A number of files were provided later because they had to be retrieved from storage. Two case files could not be located.
- All case files and supervision logs were provided in paper format and the PCG audit team manually pulled the necessary documents from the case files. Personnel files were provided in electronic format.

- Case files had a defined organizational format that was observed in the majority of case files reviewed.
- YDI staff was prompt in responding to audit team requests for clarification or additional information.
- Clinical Reviewers noted the following general findings:
 - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were incomplete of critical information for the date of service under review.
 - Treatment plans were missing, not up to date, and/or not individualized per consumer.
 - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	\$ Value Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	4	350	0	0	0.0%
90804	Outpatient—20-30 minutes	6	266	0	0	0.0%
90806	Outpatient—45-50 minutes	44	2,884	1	60	2.3%
90808	Outpatient—75-80 minutes	13	972	0	0	0.0%
90846	Family Therapy	4	254	0	0	0.0%
90847	Family Therapy	16	1,198	0	0	0.0%
90853	Group Therapy	16	383	0	0	0.0%
H0041	Foster Care(Shelter)	13	6,728	0	0	0.0%
H2011	Crisis Intervention Services	7	318	0	0	0.0%



H2015	HO, HN, HM—CCSS	27	2,055	26	1,922	96.3%
Grand Total		150	15,408	27	1,982	18.0%

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:



Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
90806		Pass	NA	NA	Pass	Fail	Pass	NA	NA	NA	Practitioner is not on agency roster NMAC 8.310.8.
H2015		Pass	Fail	Fail	Fail	NA	Pass	NA	NA	NA	Missing Documentation treatment plan. Missing Documentation treatment plan. CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Missing Documentation treatment plan.
H2015		Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Practitioners qualifications were not submitted NMAC 8.315.6. Agency listed themselves as practitioner
H2015		Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Practitioners qualifications were not submitted NMAC 8.315.6. Although there was a service note provider is ineligible to provide services.
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Session occurred at the agency offices NMAC 8.315.6. Met with member to sign consent paper work did not document if she assessed for safety issues or at risk situations. NMAC 8.315.6. Practitioner did not meet qualifications.
H2015		Fail	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation Psychosocial assessment. Documentation by the CSW does not indicate that she and the member worked on skill building or accessing services or skills that would help member improve his life at home or at school. Documentation does not support units billed NMAC 8.315.6. Missing documentation Psychosocial assessment. [REDACTED] not qualified per staff roster.
H2015		Fail	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing documentation psychosocial assessment. Documentation states that CSW went by members home and no one was there. NMAC 8.315.6. Documentation states that CSW went by members home and no one was there. NMAC 8.315.6. [REDACTED] not qualified per staff roster.



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015		Pass	Fail	Fail	Pass	NA	Fail	NA	NA	No estimated length of treatment or discharge plan noted in crisis treatment plan. [REDACTED] not qualified per staff roster. No specific community support services noted in crisis plan.	
H2015		Pass	Pass	Fail	Fail	NA	Fail	NA	NA	Documentation does not state why mom wanted this meeting with JPO and CSW. NMAC 8.315.6. Documentation does not state why mom wanted this meeting with JPO and CSW. NMAC 8.315.6. Documentation does not support units billed NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6.	
H2015		Fail	Pass	Fail	Fail	NA	Fail	NA	NA	Missing Documentation psychosocial assessment. CSW did not meet with the member. Transcript was picked up by CSW at his school. This should have been a parent duty. NMAC 8.315.6. CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. [REDACTED] not qualified per staff roster. [REDACTED] not qualified per staff roster.	
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015	[REDACTED]	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6.
H2015	[REDACTED]	Pass	Fail	Fail	Fail	NA	Fail	NA	NA	NA	Missing Documentation NMAC 8.315.6. [REDACTED] not qualified per staff roster. [REDACTED] not qualified per staff roster
H2015	[REDACTED]	Fail	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Missing documentation Psychosocial assessment NMAC 8.315.6. [REDACTED] not qualified per roster.
H2015	[REDACTED]	Pass	Fail	Pass	Fail	NA	Fail	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Documentation does not support units billed NMAC 8.315.6. Practitioner doesn't meet standard [REDACTED] NMAC 8.315.6. No support service needs documented on safety/crisis plan dated 10-6-11.

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H2015	Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	NA	NA	Documentation did not state what was done at the home visit. Csw visited with member nmac 8.315.6. Csw did not state what she worked on with the client nmac 8.315.6. Csw did not document assessment of safety /monitoring of at risk situations. Nmac 8.315.6. Practitioners qualifications were not submitted
H2015	Fail	Fail	Pass	Fail	NA	Fail	NA	NA	NA	NA	NA	Missing documentation NMAC 8.315.6. Service Plan for CCSS was not submitted, only service plan for Amistad Crisis Shelter NMAC 8.315.6. CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Missing documentation NMAC 8.315.6. [REDACTED] not qualified per staff roster. CCSS service plan NMAC 8.315.6.
H2015	Pass	NA	Pass	Fail	NA	Fail	NA	NA	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6; Missing documentation: education for [REDACTED] Missing document: [REDACTED] not on staff roster, file not complete. Listed facility as the practitioner. NMAC 8.315.6; LOC 8.315.69; Service Definition.
H2015	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	NA	NA	Documentation does not support units billed NMAC 8.315.6. Practitioner is on the company roster but did not have appropriate qualifications. NMAC 8.315.6; LOC 8.315.69.
H2015	Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	NA	NA	Assessment was dated 2/15/08 service date for member is 10/16/09 assessment is out dated NMAC 8.315.6. Plan or revision done by service date 10/16/09 CSW did not document progress or lack of progress toward treatment goals/objectives NMAC 8.315.6. Last treatment plan update was 7/1/09 no new tx plan or revision done by service date 10/16/09 NMAC 8.315.6. CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. CSW did the intervention at school, unable to read documentation clearly. Treatment plan had not been updated. NMAC 8.315.6. Q2: Diagnostic Impressions dated diagnostic review had not been completed since 2/15/08 NMAC 8.315.6. Agency was used as the rendering the service



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015	[REDACTED]	Fail	Pass	Fail	Fail	NA	Fail	NA	NA	NA	instead of csw. NMAC 8.315.6. Agency was used as the rendering the service instead of csw. NMAC 8.315.6. Old diagnosis 305.20 and 305.00 no new assessment submitted. NMAC 8.315.6. Assessment need to be updated not valid NMAC 8.315.6.
H2015	[REDACTED]	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing documentation NMAC 8.315.6. Two separate contact telephone notes. One was to the member's sister and the other was to [REDACTED] at OHNM regarding discharge meeting total phone time 1.5 hrs or 6 units NMAC 8.315.6. 60% of CCSS must be in vivo. The documentation that was submitted all interventions were done via telephone. Practitioners qualifications were not submitted NMAC 8.315.6.
H2015	[REDACTED]	Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Documentation does not support units billed NMAC 8.315.6. Practitioners qualifications were not submitted NMAC 8.315.6.
H2015	[REDACTED]	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	Missing Documentation NMAC 8.315.6. Provider is not on the agency roster NMAC 8.315.6.
H2015	[REDACTED]	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	CSW did not document assessment of safety /monitoring of at risk situations. NMAC 8.315.6. Practitioners did not meet qualifications NMAC 8.315.6.
H2015	[REDACTED]	Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing document: progress note for billed service. Progress note documents individual psychotherapy. [REDACTED] did not meet qualifications for a CSW.
H2015	[REDACTED]	Pass	Pass	Fail	Fail	NA	Fail	NA	NA	NA	Missing Documentation progress note for date of service 12/7/09. NMAC 8.315.6. [REDACTED] is not listed as a CSW to do CCSS. Practitioners qualifications are unknown if they meet standards for CSW, NMAC 8.315.6.

CONFIDENTIAL



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

H2015		Fail	Pass	Fail	Fail	NA	Fail	NA	NA	NA	NA	Missing documentation NMAC 8.315.6. Practitioner's name is not on agency roster NMAC 8.315.6.
H2015		Fail	Fail	Pass	Fail	NA	Fail	NA	NA	NA	NA	Missing Documentation psychosocial assessment. No in or out time on progress note. Missing documentation not on staff roster or staff folder. No specific community support needs noted on treatment plan.



Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Youth Development	
Sample Size	150
Total Paid for Sample	\$15,048
Sampling Frame Size	26,343
Number of Sample Claims with Overpayments	27
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	\$228,309

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid



during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	\$ Claims Reviewed	# Claims Failed	\$ Value Claims Failed	% Claims Failed
H0041	Foster Care(Shelter)	5	53	44,356	46	39,258	86.8%
H2015	HO, HN, HM—CCSS	5	253	29,695	251	29,403	99.2%
Grand Total		10	306	74,051	297	68,661	97.1%

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Community Support Worker	7
Therapist	13
Residential Worker	14
Intervention Specialist	1
Unknown/Other	16
Total Staff Reviewed	51



IT/Billing Systems Audit

System Overview

For most of its billing, YDI uses El Perico, a clinical and billing system that integrates intake, clinical notes and billing. While YDI does have a Microsoft network system, it is used only as file server and does not contain any billing or clinical information. All billing is performed on three separate systems that process information in the cloud:

- El Perico, their main billing system. All billing that is billed hourly or for the service is billed through El Perico.
- Optum Netwerkes, on-line EDI clearinghouse. El Perico creates the 837 and it is uploaded through Optum Netwerkes.
- Optum Provider Portal – on-line portal is used to bill services that are billed at day rates – shelters, etc.
- [REDACTED] reports that Optum Health recommended El Perico to YDI. She cannot recall which staff member(s) made the recommendation.

IT Contacts:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Application Controls - System Walkthrough

Administration and Segregation of Duties

User Roles

Agency Administrator Role: Can create new users and set up new payers/insurance plans.



- [REDACTED]
- Billing Administrator Role:** Can create new services and generate billing.
- [REDACTED]
- Staff Supervisor Role:** Can access clinical records of staff that is supervised by each supervisor.
- [REDACTED]
- [REDACTED]
- [REDACTED] Community Support Workers (CSW)

Service Provider Role: All clinicians who bill and are on the payroll have the Service Provider Role, which can add clinical services to clients assigned to them.

Auditor Role: No staff at YDI currently have the Auditor Role.

IT Strengths and Weaknesses

Strengths:

- YDI's billing applications are in the cloud, which make for ease of use from any computer and uniformly enforced security policy.
- Users do not share login accounts; new passwords are required every 90 days.
- Each clinician enters her own charges.

Weaknesses:

Application controls may be compromised by the following application risks.

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered:
 - In El Perico, the 837 can be changed when connected to Optum Networkes. The person uploading the 837 can make any changes to billing with no audit trail.
 - In Optum Portal, the clinicians can report a certain number of days, but both the source documents and what is entered in the portal can be changed by staff entering the information.
- Training done mostly on an *ad hoc* basis. Without a formal training and tracking system, uniform direction as to the use of the system cannot be guaranteed or tracked.
- Disaster Recovery – El Perico demonstrated adequate disaster recovery plans through its application hosting service arrangement, but YDI presented no disaster recovery plans for all of the paper client records in its possession.



Recommendations

- When and if financially feasible, migrate to Electronic Health Records to integrate the health record with the billing system, to have tight controls between clinical and billing processes.
- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Develop appropriate accounting controls for charge entry/billing in Optum Portal.
- Develop Disaster Recovery Plan to manage paper client records.
- Develop formalized training system for all users who create charge entry and billing.

Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Youth Development, Inc. (YDI). PCG began by locating YDI's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on YDI.

PCG located and reviewed YDI's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Youth Development Inc. is a member of Partners in Wellness which was reviewed simultaneously. Youth Development Inc. has a related organization, YDI Foundation, Inc. that exists to collect, manage, and distribute funds and properties for the benefit of the organization. The financial interests of both organizations are pooled in consolidated financial statements.

Audit Observations

Youth Development Inc. provides services to youth of New Mexico including residential care, youth employment and education, counseling, outreach, substance abuse prevention, gang prevention and community corrections programs.

Key Staff

First Name	Last Name	Position
Robert J	Avila	Chair
Joe	Bowdich	Vice Chair
Priscilla	Gonzales	Secretary
Andres	Trujillo	Member



Debra	Singletary	Member
Grace	Chavez	Member
Judge Diane	Dal Santo	Member
Ramona	Sanchez	Member
Judge Violet	Otero	Member
Michael	Padilla	Member
Patrick A	Baldonado	Treasurer
Johnise Monae	Pena	Member
Conrad E	Candelaria	Member
Mary Rose	Holtry	Member
Augustine C	Baca	CEO
John	Melendez	CFO
Stephen	Fortress	COO
Debra L	Baca	VP/Headstart
Ryan Patrick	Griego	Member
Ramona	Padilla	Member

Financial Relationships

The president of YDI is also the President and CEO of YES Housing. YDI leases office space to YES and YDI leases commercial office space from YES.

Summary of Findings and Recommendations

Findings	Recommendations
None	

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010, 2009
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	
Org Charts	



Balance Sheet	2009	2010	2011	2012
Assets				
Cash & cash equivalents	\$ 62,346	\$ 54,828	\$ 21,940	\$ 147,121
Grants receivable	\$ 2,331,392	\$ 2,800,782	\$ 2,462,300	\$ 2,137,768
Other receivables	\$ 157,973	\$ 208,456	\$ 196,671	\$ 32,977
Other current assets	\$ 6,745	\$ 7,335	\$ 7,337	\$ 21,103
Land	\$ 786,440	\$ 786,440	\$ 786,440	\$ 786,440
Buildings	\$ 6,063,382	\$ 6,137,548	\$ 6,137,548	\$ 6,137,546
Equipment	\$ 2,515,559	\$ 2,600,402	\$ 2,548,404	\$ 2,543,620
Vehicles	\$ 1,450,728	\$ 1,680,562	\$ 1,846,190	\$ 1,825,289
Furniture & fixtures	\$ 480,978	\$ 483,362	\$ 483,363	\$ 483,363
Accumulated depreciation	\$ (5,312,771)	\$ (5,830,558)	\$ (6,346,296)	\$ (6,716,902)
Other long-term assets				\$ 152,810
Total Assets	\$ 8,542,772	\$ 8,929,157	\$ 8,143,897	\$ 7,551,135
Liabilities				
Cash overdraft	\$ 82,271	\$ 94,617	\$ 165,758	\$ 201,344
Accounts Payable	\$ 570,849	\$ 665,809	\$ 1,000,957	\$ 374,629
Accrued liabilities & compensated absences	\$ 677,733	\$ 868,425	\$ 1,182,304	\$ 1,127,451
Deposits held for others	\$ 220,259	\$ 201,099	\$ 8,795	\$ -
Line-of-credit	\$ 661,132	\$ 1,363,096	\$ 237,382	\$ 266,344
Current portion of long-term debt	\$ 76,700	\$ 76,700	\$ 164,200	\$ 725,968
Deferred revenue	\$ 255,603	\$ 153,560	\$ 1,026,880	\$ 1,614,810
Long-term debt, net of current portion	\$ 799,371	\$ 722,675	\$ 558,270	\$ -
Total Liabilities	\$ 3,343,918	\$ 4,145,981	\$ 4,344,546	\$ 4,310,546



Net Assets	\$	5,198,854	\$	4,783,176	\$	3,799,351	\$	3,240,589
Total Liabilities and Net Assets	\$	8,542,772	\$	8,929,157	\$	8,143,897	\$	7,551,135
Income Statement		2009		2010		2011		2012
Revenue								
Grant income	\$	22,949,820	\$	24,145,624	\$	25,055,423	\$	25,712,622
Contributions	\$	402,953	\$	561,591	\$	125,725	\$	249,637
In-kind donations	\$	781,462	\$	769,667	\$	830,326	\$	607,371
Other income	\$	462,038	\$	218,261	\$	481,616	\$	141,819
Net assets released from restrictions	\$	-	\$	-	\$	-	\$	-
Total Revenues and Support	\$	24,596,273	\$	25,695,143	\$	26,493,090	\$	26,711,449
Expenses								
Residential care	\$	625,175	\$	596,996	\$	543,925	\$	535,641
Youth employment & education	\$	16,307,340	\$	17,804,029	\$	17,967,738	\$	17,297,534
Counseling & community outreach	\$	3,103,664	\$	3,036,805	\$	4,162,117	\$	4,969,133
Substance abuse prevention	\$	170,527	\$	84,080	\$	83,500	\$	83,500
Community correction & gang intervention	\$	1,447,902	\$	1,282,187	\$	1,153,714	\$	1,123,056
Health issues	\$	441,845	\$	229,081	\$	206,113	\$	122,906
Management & general	\$	3,084,769	\$	3,077,643	\$	2,748,291	\$	2,710,505
Total Expenses	\$	25,181,222	\$	26,110,821	\$	26,865,398	\$	26,842,275
Change in Net Assets	\$	(584,949)	\$	(415,678)	\$	(372,308)	\$	(130,826)
Depreciation Expense					\$	(611,517)	\$	(427,936)
Change in Net Assets (+ depreciation expense)			\$	(983,825)	\$	(558,762)		



State of New Mexico
Human Services Department
Behavioral Health Provider Audits
Final Report

Net Assets, beginning of year	\$	5,783,803	\$	5,198,854	\$	4,783,176	\$	3,799,351
Net Assets, end of year	\$	5,198,854	\$	4,783,176	\$	3,799,351	\$	3,240,589