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CASE REPORT
COUNSELING ASSOCIATES INC

Case Name: Counseling Associates Inc.

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Counseling Associates Inc. (CA). The investigation looked into the Public Consulting Group (PCG) and OptumHealth audits.

According to the PCG audit, in February 2013, the New Mexico Human Services Department (HSD) contracted with PCG to audit fifteen mental health and substance abuse providers statewide. In 2012 these providers constituted approximately 87% of all Core Service Agency spending for Medicaid and non-Medicaid behavioral health services. PCG's audit identified a potential overpayment amount for the period 2009-2012.

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

- 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.
- Consumer case file review: A review of a full year's worth of case file documentation for selected consumers (referred to as longitudinal claims). These findings are not extrapolated, but can be used to identify deficiencies that cannot be identified when reviewing a single claim.

The issues raised by the PCG audit are as follows:

- Staff name missing from the list;
- Practitioners not qualified;
- No documentation of start and end time to support amount of units billed;
- Missing treatment plan, assessments do not include the length of treatment or contain a discharge plan or treatment team not documented;
- Treatment plan is too generic and does not include specific treatment approach; and
- Missing progress notes or other supporting documentation.

OptumHealth also provided a report of their audit of Counseling Associates Inc. with various allegations.

Issues raised in the OptumHealth audit are as follows:

- Individual practitioners billing long hours in one day (8-15);
- Unbundling of bundled services such as Treatment Foster Care, In-patient, Intensive Outpatient, and others;
- Possible up-coding of individual therapy codes;
- Violations of billing code combinations;
- Potential overuse of H0031, H2033, H2017, and H2015;
- Billing for a single consumer on the same date of service at two different providers; and
- Billing of 90862 and H2010 on the same day.

II. APPROACH

We have reviewed and considered the information contained in the OptumHealth and PCG reports to identify the issues set forth in the reports as they apply to CA. Our investigative plan used the results of that review and the issues identified. Our forensic accounting and investigative approach included the following:

A. Forensic analysis of claims data to focus our investigative efforts;

B. The application of analytical procedures to identify and group outlier claims data; and

C. Credentialing analysis focused on the PCG findings.

A. Forensic Analysis of Claims Data

1. Client File Selection

We utilized forensic analysis applied to the individual CA patient claims and processed a number of queries for the CA claims data. The development of and purpose for the forensic data analysis is to identify those clients and related claims that display patterns and are at a higher risk for potential fraud. The selection of queries was based on the findings articulated both in the PCG and OptumHealth reports.

2. Client File Analysis and Investigation Procedures

Our individual client file analysis and investigation procedures were completed to identify patterns that may be evidence of fraud. As a result, the focus was on the verification of the claims data to the underlying client record. This involved the following procedures:

a. Does the date in the claims data worksheet match the service delivery date in the client record;

b. Does the client record contain both a start and stop time;

c. Does the documented duration of time spent with the client match the units associated with the procedure code;

a. Are the progress notes in the client record consistent with the claims file procedure code; and

b. Are there multiple encounters with the client on the same day:

   i. Utilizing the same procedure code - possibly different providers - that may represent duplicate or billed unit discrepancies;

   ii. Utilizing procedure codes that are mutually exclusive; and

   iii. In individual, family and group therapy sessions with start and stop times that overlap.

3. Forensic Data Analysis Results

Of the 2,135 positive query results there were 1,939 with and 196 with no findings. While our focus was on analyzing claims in connection with our forensic analysis, we also looked at other claims filed on the same day to gain a greater understanding of the client record and in that process identified 115 additional claims with findings.

Table 1 summarizes those claims with a finding (query result claims – 1,939 and additional claims – 115) by provider and the claim finding.

Findings:

Table 1 – Summary of Forensic Data Analysis Findings

	Number of claims associated with each finding					
Provider Index	**Code Overlap**	**Missing Documentation**	**Provider/Signature Related**	**Session Time Overlap**	**Duplicate or Unit Billing Discrepancies**	**Total**
2	61	-	-	4	-	65
4	-	1	-	-	-	1
5	1	-	-	-	-	1
6	52	-	-	2	5	59
7	2	-	-	-	-	2
8	4	-	-	-	-	4
9	2	-	-	1	-	3
10	22	6	-	1	7	36
11	387	1	-	7	4	399
12	2	-	-	-	-	2
13	-	-	-	1	-	1
14	-	-	-	2	-	2
15	175	1	-	10	3	189
16	3	-	-	-	-	3
17	-	-	-	1	-	1
18	2	1	-	-	-	3
19	-	-	-	1	-	1
20	-	-	-	1	-	1
21	-	-	-	2	2	4
22	-	1	-	-	2	3
23	-	-	-	1	-	1
24	3	-	-	-	-	3
27	-	-	-	2	1	3
28	-	1	-	6	4	11
29	-	2	-	1	3	6
30	128	1	-	5	-	134
31	-	-	-	-	9	9
32	338	1	-	28	5	372
33	75	-	-	2	-	77
34	307	3	-	10	4	324
35	-	-	13	2	-	15
36	6	1	-	-	-	7
37	57	-	-	1	3	61
38	233	5	-	11	2	251
Total	**1,860**	**25**	**13**	**102**	**54**	**2,054**

A portion of the code overlap findings in Table 1 (45) are related to Alcohol and/or Drug Services Intensive Outpatient Program (IOP- HCPCS H001) and represent when other services are billed on the same day as HCPCS H0015. The New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines (BHS Guidelines) for IOP-HCPCS H0015 provide a list of services that may not be billed in conjunction with the IOP-HCPCS H0015. An analysis of the code overlap in Table 1

indicates some additional services provided to be medication management (HCPCS 90862), alcohol or other drug testing (HCPCS H0031), comprehensive medication services (HCPCS – H2010) and alcohol and/or other drug testing (HCPCS – H0048). These services are not indicated as excluded services. However, the analysis also indicates that psychiatric diagnostic interview examination (HCPCS 90801), individual psychotherapy (HCPCS 90806), and group psychotherapy (HCPCS 90853) services were provided which are indicated as excluded services.

A portion of the code overlap findings in Table 1 (1,788) are related to Comprehensive Medication Services (HCPCS – H2010) and represent when other services are billed on the same day as HCPCS H2010. The BHS Guidelines for HCPCS H2010 requires that the services be delivered by a practitioner with specific qualifications, including a licensed clinical nurse specialist, nurse certified in psychiatric nursing by a national nursing organization. The provider file does not support these requirements. Per communication with HSD, prior experience has been accepted as a substitute for the required certifications. An analysis of the code overlap in Table 1 indicates that the additional services provided were pharmacologic management, including, prescription use and review of medication with no more than minimal medical psychotherapy (HCPCS 90862). Per discussion with HSD, if the client and the prescribing professional are not in the same office it is acceptable for a nurse to be present with the client (and bill H2010) while the client confers with the prescribing professional in another office (who bills 90862). Interviews conducted and our analysis of the code overlap findings support this situation.

A portion of the code overlap findings in Table 1 (12) are related to Comprehensive Community Support Services (HCPCS – H2015) and represent when other services are billed on the same day as HCPCS H2015. The BHS Guidelines for HCPCS H2015 provides a list of services that may not be billed in conjunction with the HCPCS H2015. An analysis of the code overlap in Table 1 indicates that the additional services provided were multi-systemic therapy for juveniles (HCPCS H2033) which are indicated as excluded services.

As described in the preceding paragraphs, the majority of the code overlap findings are not indicated as excluded services under the BHS Guidelines. Those code overlap findings that are indicated as excluded services under the BHS Guidelines do not appear to indicate a pattern of fraud.

The duplicate or billed unit discrepancies, missing documentation, provider/signature related and session time overlap findings do not appear to indicate a pattern of fraud.

B. Application of Analytical Procedures

The specific analytical procedures applied to the CA claims data were based on our review of the reports and findings by OptumHealth and the PCG audit and the observations and findings we identified from our analysis of the claims data identified in our query results. Specific analytical procedures applied to the claims data are set forth below.

1. Session Time Overlap

   Analysis: During our analysis and investigation of the client files to support the claims identified as part of our forensic data analysis, we noted with some frequency situations when individual provider sessions overlapped. These session time overlaps generally occurred if a client was seen by more than three providers on a given day. This issue can only be identified by the analysis and evaluation of individual client medical records. We applied analytical procedures to the claims database to identify claims for further analysis and evaluation. These analytical procedures consisted of the following:

   a. From a subset of all claims detail (subsequent to December 31, 2010; individual as provider rather than entity; Medicaid as funding source), we identified all claims where the clients saw three or more providers on a single day for services;

b. From the claims population identified in a, we summarized the information by provider. We selected those providers where the provider had more than 100 sessions; and

c. For the claims identified in b. associated with CA, we analyzed the client file documentation to determine whether there was evidence of session time overlap.

Findings:

Table 2 – Summary of Session Time Overlaps Identified

Provider Index	Number of Sessions
2	4
6	2
9	1
11	7
13	1
14	2
15	11
17	1
19	1
20	1
21	2
23	1
27	2
28	6
29	1
30	4
31	1
32	28
33	2
34	10
35	2
37	1
38	11
Total	**102**

Our findings resulting from session time overlap review of services provided by CA do not appear to indicate a pattern of fraud.

2. Unbundling of Group Sessions

Analysis: To identify instances where group therapy was potentially billed as individual therapy, we applied analytical procedures to the claims database to identify claims for further analysis and evaluation. These analytical procedures consisted of the following:

a. From a subset of all claims detail (subsequent to December 31, 2010; individual as provider rather than entity; Medicaid as funding source; individual therapy codes versus group therapy codes), we identified all claims where the provider saw the same three clients on a single day for services and the services were charged to the same code;

b. From the claims population identified in a., we identified a subset of claims where the overlap of the same three clients happen on greater than 10 days and where the claims for those 10 days made up greater than 50% of the total claims for the client; and

c. For the claims identified in b. associated with CA, we analyzed the client file documentation to determine if there was evidence of unbundling of group services.

Findings: The unbundling of group sessions analysis was completed for CA and there were no findings.

C. Credentialing Analysis

PCG indicates in its report that auditors requested relevant information related to individual providers, including:

- License to practice;
- Academic or Professional Degrees (GED, High School, Bachelor, Master, Doctorate);
- Certifications;
- Resumes;
- Trainings;
- Supervisor notes (when required); and
- Criminal Background checks (when required).

PCG's credentialing review was aimed at addressing the question whether entity service providers had the requisite education, licensure and training for the services they were billing. PCG used a pass/ fail system in their case file reviews. The table below summarizes the "failed" findings for CA.

Table 3 – Summary of PCG Credential Findings

90806	H2010	H2014	H2015	H2017	T1007	Reason for Fail
1	-	-	-	-	-	Services were billed by one provider but note was signed by another
-	-	-	9	-	-	Staff not qualified (per staff roster)
-	-	-	-	1	-	Staff not on staff roster
-	-	1	6	6	-	Missing provider qualifications
-	-	-	2	-	-	Unable to verify provider qualifications
-	-	1	-	-	-	Qualifications for provider are missing according to the staff roster list
-	-	2	-	-	-	Unable to support medical necessity of units billed based on progress note
-	-	1	-	-	-	Unrealistic, no measurable, "complete remission of symptoms"
-	-	1	13	1	2	Missing documentation (progress note, assessment, treatment plan, etc.) to support claim
-	-	-	5	7	1	Treatment, goals, and/or plan is not specific to client's needs
-	-	-	-	1	-	PSR not on treatment plan
-	-	-	-	1	-	Unable to support units billed based on progress note provided
-	-	-	1	-	-	Location not listed
-	-	-	-	-	2	Discharge plan not quantifiable
-	-	-	-	-	2	Unable to support that an update took place
-	-	-	1	-	-	Potential overbilling
-	1	-	-	-	-	Potential underbilling
1	**1**	**6**	**37**	**17**	**7**	**Total**

1. Provider Selection

From our review of the PCG report, we note that 53.6% of the staff credentialing issues relate to Comprehensive Community Support Services (CCSS) procedure code H2015. Other issues were limited to only a few findings each, and did not indicate any kind of pattern. Our focus will be on the findings related to qualification for the procedure code H2015.

The New Mexico Service Requirements and Utilization Guidelines for CCSS H2015 allow for different billing rates (for services provided under a documented service plan) for individuals who are certified peer or family specialists (or less than a Bachelor degree), Bachelor degree, and Master degree. There are two letter modifiers added to the H2015 procedure code to designate educational

achievement of the individuals providing the service. The higher the educational achievement, the higher the H2015 billing rate. The modifiers are defined as follows:

- HO – Master degree or higher in a human services related field;
- HN – Bachelor degree in human services related field; or
- HM – Certified peer or family specialist or less than a Bachelor degree.

The purpose of our credentialing analysis and investigation procedures was to analyze the provider files and determine if the CCSS H2015 modifiers were appropriately assigned to claims and to identify patterns where individual providers do not meet the requirements for a particular modifier.

2. Provider File Analysis and Investigation Procedures

Our primary focus is to read and analyze the provider file, which included the provider's educational achievement and background. This involved the following procedures:

a. Review the NM service requirements and guidelines for CCSS H2015 procedure code;

b. From a subset of H2015 claims data, filter by entity and provider;

c. Identify individual providers where the claims data indicated that more than one of the HO, HN or HM modifiers were utilized; and

d. From the provider file information received from CA verify that educational achievement, background and certification of the provider supports the highest level of modifier used in the billing process.

Findings:

Table 4 – Credentialing Analysis Summary

Provider Index	IPCD ID	# Lines	Comments
35	H2015HO	878	No support for required credential

Our findings do not appear to indicate a pattern of fraud.

III. CONCLUSION

The findings identified in the investigation and analysis of claims and the result of interviews conducted, as set forth in the report, do not appear to represent a pattern that would indicate fraudulent activity.

The Medicaid Fraud Control Unit has evaluated this matter in accordance with the statutory standards of proof incorporated in the Medicaid Fraud Act Section 30-44-1 et seq., and under New Mexico law. The findings, damages, calculations, and conclusions are not intended to foreclose any administrative or civil action by HSD under its regulatory authority. These findings are not inclusive of and may differ from overpayment calculations or other claims conducted by HSD.