OFFICE OF THE ATTORNEY GENERAL OF NEW MEXICO
MEDICAID FRAUD & ELDER ABUSE DIVISION
CONFIDENTIAL INVESTIGATIVE REPORT

[X] Case Report **[ ] Supplemental Report**

Case Name: Easter Seals El Mirador
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Case Number: 13-088

Synopsis

On June 24 2013 MFEAD received a referral from Human Services Department (HSD), Program Policy and Integrity Bureau. The following allegations were listed in the report issued by Public Consulting Group (PCG) on June 21, 2013: missing documents, insufficient documentation of services, no medical necessity for the services, billing discrepancies, services provided by unqualified staff. Also included in the referral was a report generated from OptumHealth which identified numerous irregularities.

On June 24, 2013 the New Mexico Humans Services Department issued a letter to Easter Seals El Mirador stating that payments from Medicaid program have been suspended due to credible allegations of fraud.

An investigation was conducted by the Medicaid Fraud Control Unit at the Attorney General Office into potentially fraudulent activities of Easter Seals El Mirador (Provider). The investigation looked at the Public Consulting Group audit, the OptumHealth New Mexico (OptumHealth) audit, and three separate complaints that came from private individuals regarding the Provider.

Background

Public Consulting Group Report: see Supplemental Report, case 13-088, pages 2-13.

Public Consulting Group utilized two different methodologies for the Provider:

1) Random sampling of provider claims. The sampling methodology allows for a statistically valid extrapolation of the findings.
2) Longitudinal review of claims. This review included consumers' complete file review: a review of a full year's worth of case file documentation for selected consumers; these findings are not extrapolated.

Random Sampling Review

The Audit Report generated by PCG stated that 150 random dates of service claims were reviewed for a period from July 1, 2009 through January 31, 2013. PCG found that 20 claims were not in compliance with behavioral program standards. Upon review by the MFEAD investigative staff it was determined that 4 of 20 failed claims did not have sufficient documentation to justify billing the claims. Total amount associated to this finding was $368.28; see Table 1, Line 2.

Follow up investigation was conducted on these 4 claims to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate

attempt to bill Medicaid for services that were not provided.

Longitudinal Review

PCG performed a complete review of 5 consumers who received services billed for skills training and development and treatment foster care during calendar year 2012. PCG stated that 640 of 2,301 claims were not in compliance with behavioral program standards. It was noted that number of claims that were referred to MFEAD for noncompliance was 646 claims. Upon review by the MFEAD investigative staff it was determined that 39 of these 646 claims did not have sufficient documentation to justify billing the claims. Total amount associated to this finding was $4,752.03; see Table 1, Line 1.

Follow up investigation was conducted on these 39 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Independent of the longitudinal and random review conducted by PCG the MFEAD investigative staff reviewed additional claims related to 6 consumers who received behavioral services from the Provider. A review of these claims resulted in a finding of additional 58 claims for which documentation was lacking. Total amount associated to this finding was $5,722.15; see Table 1, Line 3.

Follow up investigation was conducted on these 58 claims to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

MFEAD investigative staff determined that amount of findings associated with allegations from PCG totals to $10,842.46; see Table 1, Line 4.

OptumHealth Report: see Supplemental Report, case 13-088, pages 13-17.
OptumHealth issued the Program Integrity Referral Detail Report in June 2013. The report listed potential program integrity issues; these issues were identified by OptumHealth through analysis of claims and records (desk review). The purpose of the OptumHealth's desk review was to condense various issues into corresponding summary for pre-audit. OptumHealth did not review patient files.

OptumHealth identified the following irregular billing patterns: unbundling bundled services, cross-billing and excessive billing of specific codes.

MFEAD investigative staff conducted an investigation to determine if the irregular billing patterns identified in the OptumHealth report were the result of fraudulent activity.

Unbundling bundled services

Claims for Medicaid payments for the treatment of patients in the areas of Treatment Foster Care, In-patient, Intensive Outpatient, and RTC (Residential Treatment Centers) were referred to the MFEAD for investigation.

8,531 claims were analyzed for the possible unbundling bundled services. It was noted that 62 of these 8,531 claims were billed with an additional procedure code which could present an opportunity for unbundling of a bundled service. Of these 62 claims 5 were categorized as improperly billed.

Follow up investigation was conducted by MFEAD investigative staff to determine if the unbundling of these 5 claims was the result of fraudulent activity. After a review of documents and claims it was determined that MFEAD staff could discern no pattern of a deliberate attempt to bill Medicaid as result of unbundling bundled services.

Total overbilling for unbundling bundled services was $330.00. Associated with the above finding the MFEAD investigative staff identified additional $1,774.71 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $2,104.71; see Table 2, Line 4.

Cross Billing

110,453 claims were reviewed to determine if the Provider was improperly billing for multiple services in one day. The claims analysis was performed to verify whether Provider was reimbursed for services that are not allowed to be billed on the same day (cross billing).

143 claims for services billed for individual psychotherapy were examined for cross billing. MFEAD investigative staff determined that individual psychotherapy and skills training and development services were billed inappropriately 2 times. Total overbilling for individual psychotherapy services was $137.64. Associated with this finding the MFEAD staff identified additional $7,936.56 in claims which did not have sufficient documentation to support the claims; see Table 2, Line 1.

40 claims for services billed for family psychotherapy and multiple family group psychotherapy were analyzed and found to be billed inappropriately 21 times. Total overbilling of family psychotherapy and multiple family group psychotherapy services was $1,033.77. Associated with this finding the MFEAD staff identified additional $1,727.07 in claims which did not have sufficient documentation to support the claims; see Table 2, Line 2.

MFEAD staff could discern no pattern of a deliberate attempt to bill Medicaid as result of cross billing for services.

MFEAD investigative staff determined that total overbilling for claims associated with cross billing was $10,835.04 (8,074.20+2,760.84); see Table 2, Line 1 and Line 2.

Excessive billing for skills training and development

Procedure code for skills training and development was examined to determine if this code was utilized to treat adolescents whose behavior assessments did not warrant this level of therapy. Upon examination of the claims the MFEAD staff determined that utilization of this code fell within the guidelines established by the Behavioral Collaborative for the use of this code.

Excessive billing for psychosocial rehabilitation services

Procedure code for psychosocial rehabilitation services was examined to determine if this code was utilized to treat clients whose behavior assessments did not warrant this level of therapy. Upon review of these claims the MFEAD staff could not determine an overuse of this code.

Excessive billing for foster care therapeutic services

Procedure code for foster care therapeutic services was examined to determine if the length of stay in out of home placement services billed by Provider was excessive. MFEAD staff examined the claims of 55 foster placement children to determine if their out of home placement was excessive. MFEAD staff could find no evidence to suggest that this code was used in an excessive manor.

Duplicate Billing

Through the course of investigating length of stay in out of home placement, MFEAD staff expanded the investigation to include the possibility of duplicate billing for treatment foster care and treatment foster care with step-down level of care.

8,469 claims were analyzed for fraudulent billing. It was noted that 34 of the 8,469 claims were billed as duplicate billing. This resulted in duplicate billing of $6,905.00. Associated with the above finding the MFEAD investigative staff identified additional $1,801.00 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $8,706.00; see Table 2, Line 3.

Follow up investigation was conducted on these 34 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and communications with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Double Billing

Independent of the OptumHealth report the MFEAD investigative staff expanded the inquiry to include an analysis of group psychotherapy and skills training and development for double billing occurring at the same time on the same day.

86,831 claims for group psychotherapy and skills training and development were analyzed. It was determined that 29 claims were result of double billing and should not have occurred. These 29 instances of double billing totaled to $325.12. Associated with the above finding the MFEAD investigative staff identified additional $1,312.86 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $1,637.98; see Table 2, Line 5.

Follow up investigation was conducted on these 29 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and communications with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Referral from a private citizen (Complainant) dated August 6, 2013: see Supplemental Report, case 13-088, pages 18-25.

The referral contained following allegations:

1. Billing for ICFMR residential services while consumers were attending summer camp.
2. Billing for medication management services not provided by psychiatrist.
3. Billing for adult rehabilitation day care (dayhab) services not provided.
4. Billing for occupational therapy services not provided by therapist.
5. Behavioral therapy was provided by unlicensed personnel.
6. Interest income was improperly accounted in the cost reports.
7. Expenses were improperly accounted in the cost reports.
8. Provider forced employees to commit fraud by inducing them into wrongful actions, or preventing them from correct actions.

Each of these allegations was investigated by MFEAD.

1. An analysis of claims for the individual client who was attending summer camp revealed that Medicaid was billed for 6 days in August 2011 for ICFMR (Intermediate Care Facilities for individuals with Mental Retardation) services. This billing correctly reflected the time when consumer was not receiving services from Provider.

2. A review of the medical file of the individual client did not support the allegation that medication management services were not provided by the psychiatrist. Complainant was interviewed regarding this allegation. MFEAD staff found that the services described by Complainant were appropriate for the medication management services. Upon review of the claims the MFEAD staff determined that medication management was billed correctly as part of ICFMR services.

3. Complainant was interviewed regarding allegations that dayhab were billed without services provided. The services which Complainant described were found to be appropriate for the category of dayhab services. Upon review of the claims the MFEAD staff determined that dayhab was billed correctly as part of ICFMR services.

4. Complainant was interviewed regarding allegations that occupational therapy was billed without services provided. The services which Complainant described were found to be appropriate for the category of occupational therapy. Upon review of the claims the MFEAD staff determined that occupational therapy was billed correctly as part of ICFMR services.

5. Behavioral therapy was provided by unlicensed personnel. Proof of licensure of therapists who provided behavioral therapy was obtained by MFEAD investigative staff.

6. Cost reports prepared by accounting firm Myers and Stauffer LC CPA were reviewed by MFEAD staff to identify whether the interest income from trust accounts were reflected properly in cost reports for fiscal years 2008 and 2009, and 2010. MFEAD staff was not able to confirm that interest income was improperly accounted in the cost report.

7. Provider's former finance officer was interviewed regarding financial records used in preparation for the cost reports performed by Myers and Stauffer. MFEAD staff noted that this interview did not provide any corroboration as to any improper expenses which may have been included in the cost reports submitted to New Mexico Human Services Department. MFEAD investigative staff was not able to corroborate the allegation of improper items included in the Provider's cost reports.

8. Complainant provided the MFEAD investigative staff with the names of former employees who believed had been forced employees to commit fraud. Interviews conducted by MFEAD investigative staff with each of the available individuals failed to substantiate a directive to induce them to commit fraud or instructions preventing them from billing correctly.

MFEAD could not substantiate the allegations as contained in the referral dated August 6, 2013.

Referral from Anonymous dated August 21, 2012: see Supplemental Report, case 13-088, pages 25-30.

The referral suggested allegations:
1. Behavioral therapy staffing ratio was not in compliance with regulations;
2. Behavioral therapy services were not available or provided by unlicensed personnel;
3. Clients' behavioral therapy was not effective, or not implemented;
4. Incidents related to clients behavioral outbursts were not reported, not investigated, no recommendations followed.

1. MFEAD investigative staff reviewed the medical files and billing records of 7 clients receiving ICFMR services from Provider to determine if any of the clients were receiving services in violation of a therapist to client ratio.

Investigative staff could not locate any regulation or statute which mandates a staffing ratio of therapist to client as suggested by the information provided in this referral.

2. MFEAD obtained a proof of licensure for each of the three therapists working for Provider. Each of the three therapists corresponded to the billing associated with the services provided.

3. The anonymous source identified 7 clients who received behavioral health services from Provider, and whose behavioral health therapy was not effective or not implemented at all.

MFEAD reviewed the files of each of the 7 clients. The review of the documents for each of the clients indicated that all were receiving behavioral health therapy. Investigative staff could not determine which client had not benefited from behavioral health therapy they were receiving.

4. MFEAD could not substantiate the allegation as contained in the referral.

MFEAD could not substantiate the allegations as contained in the referral dated August 21, 2012.

Referral from a private citizen (Complainant) dated April 4, 2014: see Supplemental Report, case 13-088, pages 31-32.

The referral contained following allegations:
1. Abuse/neglect: deliberate discharge of difficult consumer.
2. Exploitation: interest earned on investment trust account was used to pay management fee instead of flat fee.
3. Not reporting incidents. Provider prevented its staff from reporting incidents to Department of Health (DOH).

Each of these allegations was investigated by MFEAD:
1. The investigation of abuse and/or neglect of a particular consumer was conducted by MFEAD in 2013. It was noted that the case was closed on January 1, 2014 due to insufficient evidence to substantiate any abuse, neglect and/or exploitation.

2. Complainant was interviewed regarding allegations of exploitation. Follow up investigation revealed that the interest earned on consumers trust investment account in 2012-2013 was less than suggested monthly flat fee. Review of individual sub ledgers revealed that no management fees were charged to consumers.

3. Complainant was interviewed regarding allegations that Provider concealed incidents by preventing its staff from reporting incidents to DOH. Further investigation determined that the incidents were inconclusive as to necessity to report the incidents.

Summary of MFEAD findings
As a result of interviews with individuals conducted during the investigation, documentation reviewed by the MFEAD investigative team, a thorough analysis of claims review and application of the New Mexico Administrative Code for the payment of Medicaid claims, review of documents issued by New Mexico Behavioral Health Collaborative, the MFEAD investigative team determined that insufficient evidence exists to support a finding of fraudulent activity.

Conclusion

Provider's improper billing practices associated with findings that derived from information provided in PCG report resulted in an amount of $10,842.46 as presented in Table 1, Line 4. Additional improper billing resulted in an amount of $23,453.73 as presented in Table 2, Line 6. The total amount is $34,126.19 (10,842.46 + 23,283.73)

Table 1

	Type of Review or Investigation - Reviewed claims	Number of Claims = denominator	Total Numbers of claims / percentage to recoup	Amount of recoupment ($)
1	Auditors longitudinal review	2,301	39 / 1.7%	4,752.03
2	Auditors random clinical	150	4 / 2.6%	368.28
3	Additional 58 claims related to Auditors report	2,509	58 / 2.3%	5,722.15
4	Total claims 2,509 = (2,301+150 +58)	2,509	101 / 4.0%	10,842.46

Table 2

	Allegations by OHNM	Amount corresponding to the allegation	Amount corresponding to insufficient documentation other than the allegation	Amount of Recoupment ($)
1	Cross-billing outpatient services	137.64	7,936.56	8,074.20
2	Cross-billing family therapy	1,033.77	1,727.07	2,760.84
3	Duplicate billing	6,905.00	1,801.00	8,706.00
4	Unbundling bundled services	330.00	1,774.71	2,104.71
5	Double billing	325.12	1,312.86	1,637.98
6	Total	8,731.53	14,552.20	23,283.73

[x] Completed **[ ] Closed**

Investigator: _Veronica Levshin _____ **Date:** 4/30/2014

Supervisor: _Adrian Flores _____ **Date:** 4/30/14

Director: _Jody Curran _____ **Date:** 4/30/14