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MEDICAID FRAUD & ELDER ABUSE DIVISION
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CASE REPORT
PATHWAYS INC

Case Name: Pathways, Inc.

DRAFT

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Pathways, Inc. (PI). 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:

- Missing provider qualifications, provider not listed on staff list or unqualified staff;
- Missing progress notes or other supporting documentation such as signatures or service times;
- Overbilling;
- Missing assessment or insufficient risk assessment or no goals or objectives in treatment plan;
- Treatment provided over telephone;
- Note does not pertain to correct client;
- Unable to verify where service took place;
- Service provided by another staff member.

OptumHealth also provided a report of their audit of PI with various allegations.

Issues raised in the OptumHealth audit are as follows:

- Violations of billing code combinations; and
- Potential overuse of H2017, and H2015.

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 PI. 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 data analysis applied to the individual PI patient claims and processed a number of queries for the PI 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 in both the PCG and OptumHealth reports.

2. Client File Analysis and Investigation Procedures

   As noted above, the 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 patient 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;

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

   e. 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 overbilling;

      ii. Utilizing procedure codes that are mutually exclusive; or

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

3. Forensic Data Analysis Results

   Of the 7,057 positive query results there were 974 with and 6,083 with no findings. 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 241 additional claims with findings.

   Table 1 summarizes those claims with a finding (query result claims – 974 and additional claims 241) by provider and the claim finding.

Table 1 – Summary of Forensic Data Analysis Findings

	Number of claims associated with each finding					
Provider Index #	**Code Overlap**	**Duplicate/ Unit Billing Issues**	**Missing Documentation**	**Session Time Overlap**	**Provider/Signature Related**	**Grand Total**
1	-	6	22	89	1	118
9	-	4	13	74	-	91
12	-	6	14	42	-	62
8	-	5	23	77	11	116
2	-	2	16	18	-	36
35	-	-	2	12	-	14
4	182	-	2	25	-	209
24	96	-	4	27	-	127
10	-	2	5	25	-	32
41	-	-	-	11	-	11
16	35	-	2	22	-	59
14	-	-	1	9	-	10
36	-	2	1	8	-	11
29	-	2	1	8	-	11
22	-	1	4	12	-	17
3	27	-	-	16	-	43
5	34	1	-	8	-	43
13	-	1	1	6	-	8
18	-	-	1	8	-	9
6	-	-	-	11	1	12
33	-	-	7	7	-	14
21	-	-	-	8	-	8
32	-	-	1	6	-	7
19	-	-	4	5	-	9
31	-	-	6	10	-	16
38	13	-	-	3	-	16
17	-	-	12	7	-	19
7	18	-	-	3	-	21
39	8	-	-	3	-	11
47	9	-	1	1	-	11
Providers with 6 or less findings	-	3	11	27	3	44
Total	**422**	**35**	**154**	**588**	**16**	**1,215**

The code overlap findings in Table 1 (422) 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).

It was noted that many of the records reviewed did not have a stop time documented, which caused a short overlap with the next service based on the units calculated. Several interviews were conducted with providers to obtain a greater understanding regarding the documentation for progress notes and the lack of a stop time indicated on the progress notes. All providers interviewed confirmed that both start and stop times were required by the computer system before a progress note could be submitted. All providers interviewed confirmed that the computer system calculated the units billed.

The code overlap, missing documentation, duplicate or unit billing discrepancies, provider/signature related, session time overlap, and no stop time findings do not appear to indicate a pattern of fraud.

B. Application of Analytical Procedures

The specific analytical procedures applied to the PI 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 providers that had more than 100 sessions; and

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

Findings:

Table 2 – Summary of Session Time Overlaps Identified

Provider Index #	Number of Sessions
1	107
9	86
8	84
12	55
24	38
2	35
3	31
4	31
10	30
16	29
31	17
41	15
6	14
33	14
22	14
32	14
35	13
13	13
17	12
18	12
14	11
21	10
29	9
5	9
19	8
38	8
26	8
36	8
25 providers with 7 or less session time overlaps	57
Grand Total	**792**

Our investigation and analysis indicates that when no stop time was recorded in the progress notes, there was a greater likelihood of overlapping session times. These session time overlaps were generally for one billing unit (15 minutes).

Several interviews were conducted with providers to understand the potential cause of the session time overlaps. Several of those interviewed indicated that because the psychosocial rehabilitation services were generally offered in group sessions and contained break times there were problems of session time overlap as clients sought other services during the breaks such as comprehensive medication services. Several of those interviewed indicated that special guidelines had to be developed to prevent this from happening.

Our findings resulting from session time overlap review of services provided by PI 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 the claims detail (subsequent to December 31, 2010; individual as provider rather than entity; Medicaid as funding source; and 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. We summarized the population of claims identified in b. by provider; and

c. For the claims identified in b. associated with PI, 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 PI 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 credentialing review was aimed at addressing the question that 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 PI.

Table 3 - Summary of PCG Credential Findings

H2015	H2017	Reason for Fail
27	–	Missing provider or staff credentials
17	–	Provider or staff not credentialed
1	–	Provider qualifications unknown
6	2	Other
51	**2**	**Total**

1. Provider Selection

The PCG findings indicate that 96.2% of the 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 staff qualifications for that procedure code.

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 whether 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 was 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 indicates that more than one of the HO, HN or HM modifiers were utilized; and

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

Findings: The credentialing analysis was completed for PI and there were no findings.

III. CONCLUSION

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