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MEDICAID FRAUD & ELDER ABUSE DIVISION
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CASE REPORT
PRESBYTERIAN MEDICAL SERVICES

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Presbyterian Medical Services (PMS). 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;
- Overbilling;
- Missing treatment plans;
- Treatment over telephone; and
- Signature mismatch.

OptumHealth also provided a report of their audit of Presbyterian Medical Services with various allegations.

Issues raised in the OptumHealth audit are as follows:

- 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 billing of individual, family, and/or group therapy in the same day without providing services billed; and
- Potential overuse of H2033, 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 PMS. 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 PMS patient claims and processed a number of queries for the PMS 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 overbillings;

   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 3,561 positive query results there were 2,002 with and 1,559 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 301 additional claims with findings.

Table 1 summarizes those claims with a finding (query result claims – 2,002 and additional claims 301) by provider and the claim finding.

Table 1 – Summary of Forensic Data Analysis Findings

	Number of claims associated with a finding					
Provider Index #	**Code Overlap**	**Missing Documentation**	**Duplicate Or Unit Billing Discrepancies**	**Provider/Signature Related**	**Session Time Overlap**	**Total**
1	-	-	7	-	-	7
2	1	-	-	-	-	1
3	1	1	-	-	-	2
4	-	19	-	-	-	19
5	-	1	-	-	-	1
6	-	2	3	1	-	6
7	1	-	-	-	-	1
8	2	-	-	-	-	2
9	-	1	-	-	-	1
10	-	-	1	-	-	1
11	-	2	15	3	-	20
12	-	21	15	103	6	145
13	3	2	-	-	-	5
14	-	2	-	-	-	2
15	-	8	-	-	-	8
16	1	19	7	3	17	47
17	1	-	-	-	-	1
18	2	4	-	-	1	7
19	-	-	2	-	-	2
20	1	-	-	-	-	1
21	-	1	-	-	-	1
22	1	-	-	-	-	1
23	1	1	-	-	-	2
24	-	69	-	-	-	69
25	25	9	-	1	2	37
26	6	1	-	-	-	7
27	1	-	-	-	2	3
28	-	-	1	-	-	1
29	-	1	-	-	-	1
30	12	-	-	-	-	12
31	3	5	-	-	1	9
32	8	-	-	-	-	8
33	4	-	-	-	-	4
34	1	1	-	-	-	2
35	-	1	2	-	-	3
36	4	-	1	-	-	5
37	1	-	-	-	-	1
38	2	3	-	-	-	5
39	2	-	-	-	-	2
40	-	-	1	-	-	1
41	-	3	-	1	-	4
42	-	1	-	-	-	1
43	2	129	-	-	-	131
44	-	1	-	-	-	1

Case Name: Presbyterian Medical Services

	Number of claims associated with a finding					
Provider Index #	**Code Overlap**	**Missing Documentation**	**Duplicate Or Unit Billing Discrepancies**	**Provider/Signature Related**	**Session Time Overlap**	**Total**
45	-	1	-	-	-	1
46	1	4	3	-	-	8
47	-	1	1	-	-	2
48	6	-	-	-	-	6
49	1	-	-	-	-	1
50	2	-	-	-	-	2
51	44	4	-	1	3	52
52	-	-	-	-	1	1
53	-	3	3	-	-	6
54	2	1	1	-	-	4
55	-	3	-	-	-	3
56	1	-	-	-	-	1
57	3	-	-	-	-	3
58	-	2	-	-	-	2
59	2	123	3	23	3	154
60	-	39	20	1	8	68
61	-	4	-	-	-	4
62	2	-	-	-	-	2
63	2	2	-	-	-	4
64	3	-	1	-	-	4
65	-	4	5	-	-	9
66	-	27	5	-	-	32
67	3	-	-	-	-	3
68	-	1	-	-	-	1
69	2	-	1	-	-	3
70	-	1	-	1	-	2
71	1	15	9	9	10	44
72	1	3	-	-	-	4
73	-	14	-	-	-	14
74	-	-	2	-	4	6
75	3	-	-	-	-	3
76	297	87	37	2	6	429
77	2	95	33	7	6	143
78	2	-	-	-	-	2
79	9	1	-	-	-	10
80	1	-	-	-	-	1
81	2	-	-	-	-	2
82	-	-	-	1	-	1
83	-	3	-	-	-	3
84	-	1	3	-	-	4
85	5	-	-	-	-	5
86	1	7	1	-	-	9
87	1	-	-	-	-	1
88	3	1	-	-	-	4
89	1	1	-	-	-	2

	Number of claims associated with a finding					
Provider Index #	**Code Overlap**	**Missing Documentation**	**Duplicate Or Unit Billing Discrepancies**	**Provider/Signature Related**	**Session Time Overlap**	**Total**
90	3	-	-	-	-	3
91	-	1	-	-	-	1
92	-	2	-	-	-	2
93	-	-	13	1	-	14
94	-	8	-	1	-	9
95	-	3	3	-	5	11
96	-	1	-	-	-	1
97	-	-	-	1	-	1
98	-	4	-	-	-	4
99	1	4	-	-	-	5
100	-	7	4	-	1	12
101	-	4	-	-	-	4
102	-	2	1	-	-	3
103	4	17	13	6	11	51
104	-	-	2	-	-	2
105	-	1	-	-	1	2
106	1	-	-	-	-	1
108	-	1	1	-	1	3
109	1	13	-	-	-	14
110	1	1	-	-	-	2
111	15	4	1	-	2	22
112	-	3	-	3	-	6
113	-	2	-	-	-	2
114	72	3	4	-	-	79
115	1	334	7	3	3	348
116	7	3	-	-	-	10
117	1	9	3	4	12	29
118	1	5	-	-	-	6
119	1	-	-	-	-	1
Total	**598**	**1,188**	**235**	**176**	**106**	**2,303**

A portion of the code overlap findings in Table 1 (486) are related to Alcohol and/or Drug Services Intensive Outpatient Program (IOP- HCPCS H0015) and represent when other services are billed on the same day as HCPCS H0015. The 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 were medication management (HCPCS – 90862), alcohol or other drug testing (HCPCS – H0031), comprehensive community support services (HCPCS – H2015) and alcohol and substance abuse services treatment plan update (HCPCS – T1007). These services are not indicated as excluded services. The analysis also indicates that psychiatric diagnostic interview examination (HCPCS – 90801), group psychotherapy (HCPCS – 90853), assertive community treatment (HCPCS – H0039), alcohol and/or other drug testing (HCPCS – H0048) and individual psychotherapy (HCPCS – 90804-90815) services were provided, which are indicated as excluded services.

A portion of the code overlap findings in Table 1 (52) 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) and assertive community treatment (HCPCS – H0039) which are indicated as excluded services.

A portion of the code overlap findings in Table 1 (8) are related to Treatment Foster Care (HCPCS S5145) and represent when other services are billed on the same day as HCPCS S5145. HCPCS S5145 services are provided to children and adolescents who are placed with licensed and professionally trained families who provide 24 hour skilled therapeutic care. The New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines (BHS Guidelines) has not established a service definition for HCPCS S5145. HSD rule Title 8, Chapter 10, Part 8 Covered Services (8.310.13 C.) states that additional services not covered by the fixed rates may be provided only after obtaining prior authorization from the utilization review agent. The additional services must be consistent with the service plan and include medication management, psychological testing and individual group and family therapy. An analysis of the code overlap in Table 1 indicates that the additional services provided were psychiatric diagnostic interview examination (HCPCS 90801), individual psychotherapy (HCPCS 90804-90815), and family psychotherapy (HCPCS 90846-90847). These services are not indicated as excluded services but files did not generally have written preauthorization information.

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, session time overlap, and provider/signature related findings do not appear to indicate a pattern of fraud.

B. Application of Analytical Procedures

The specific analytical procedures applied to the PMS 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 PMS, 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
12	6
16	17
18	1
25	2
27	2
31	1
51	3
52	1
59	3
60	8
71	10
74	4
76	6
77	6
95	5
100	1
103	11
105	1
108	1
111	2
115	3
117	12
Total	**106**

The instances of overlapping treatment sessions identified in Table 2 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 PMS, 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 PMS and there were no findings.

3. Missing Documents

Analysis: During our review of the client files to support the claims identified as part of our forensic data analysis, we noted with some frequency situations where the documentation supporting the claim was not present in the client file. The missing documentation generally occurred in a limited number of clients for a limited number of providers. This issue can only be identified by the analysis and evaluation of individual client medical records. We applied analytical procedures to identify

potential providers, clients and claims for further analysis and evaluation. These analytical procedures consisted of the following:

a. We sorted the client claims data by the largest dollar amount over the investigative period and identified those clients with the highest total claims;

b. For the clients identified in step a., we selected the top three to five clients where we had already obtained the client medical records;

c. We sorted the provider claims data by the largest dollar amount over the investigative period and identified those providers with highest total client claim reimbursements;

d. For the providers with the highest total claims reimbursements we determined if there was evidence of missing documentation in our previous analysis and selected the top three to five providers; and

e. We analyzed the client file documentation to determine if there was missing documentation over a period of time.

Findings:

Table 3 – Summary of Missing Documentation Findings

Provider Index #	Number of Sessions
115	1,087
59	431
77	309
43	129
76	88
60	71
24	69
12	50
16	43
66	42
103	38
4	36
65	30
105	28
71	21
116	19
100	17
74	16
25	14
73	14
109	13
117	11
94	10
120	10
15	8
106	8
86	7
99	7
31	5

Provider Index #	Number of Sessions
95	5
118	5
128	5
63 Providers with less than 5 sessions	119
Total	**2,765**

Interviews were conducted with providers 115 and 59. The providers were no longer employed at PMS and provided no additional information as to why the supporting documentation was missing on certain clients. An interview was conducted with the Administrator of the location where both provider 115 and 59 worked. As outlined by the Administrator, both a progress note and a billing sheet were required for each encounter with a client. These records were sent on to a Customer Access Representative (CAR) who would separate the progress note and send it to medical records and the billing sheet and send it to the billing department. The Administrator indicated that the CAR was having difficulty completing the tasks for her position. According to the Administrator the medical records department experienced high turnover. Both of these could account for the high number of missing records. While we did note instances of missing documentation, we did not identify a pattern of fraud based on our 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 PMS.

Table 4 – Summary of PCG Credential Findings

H0002	H0048	H2015	H2017	Reason for Fail
	-	3	4	Missing provider qualifications.
-	-		2	Provider not listed on staff list.
-	-	12	1	Unqualified staff.
-	-	2	3	Missing progress notes.
-	-		2	Incomplete progress notes.
-	-	1	-	Overbilling.
-	-	1	-	Missing treatment plans.
-	2	-	1	Missing support documentation.
-	-	3	-	Treatment over telephone.
1	-	-	1	Signature Related
1	**2**	**22**	**14**	**Total**

1. Provider Selection

The PCG findings indicate that 56.4% 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 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 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 indicated that more than one of the HO, HN or HM modifiers were utilized; and
d. From the provider file information received from BAMH verify that educational achievement, background and certification of the provider supports the highest level of modifier used in the billing process.

Findings:

Table 5 – Summary of Credential Findings

	Number of claims with provider lacking proper credentials	
Provider Index #	**H2015HN**	**H2015HO**
4	5	-
7	8	5
16	2	7
22	1,551	2
29	82	-
37	4	-
38	-	4
39	-	11
41	-	1
42	5	-
48	14	1
50	19	5
55	-	1
56	7	2
63	15	1
65	3	32
83	11	-
95	2	12
102	-	1
103	-	4
105	-	1
111	2	5
114	4	-
125	6	-
126	3	-
129	15	-
130	-	1
131	1	-
132	-	54
133	-	-
134	9	1
135	2	-
136	3	1
137	3	-
138	250	-
139	4	-
140	-	5
141	-	1
142	4	-
143	24	6
144	-	1
145	26	2
146	8	2
147	829	4
148	1	-
149	117	-

Interviews were conducted with providers 22, 138 and 147. For each of these providers, claims were submitted with the HN modifier. According to the BHS Guidelines, the HN modifier requires that the provider rendering the service have a Bachelor degree in a human services field along with necessary experience. None of these providers have a Bachelor degree in a human service field. One provider has an Associate degree in a human services field and another provider has an Associate degree in a business field. The third provider has no formal education beyond high school. While these claims do not appear to be billed correctly, there does not appear to be a pattern of fraud.

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.