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**CASE REPORT
SOUTHWEST COUNSELING CENTER INC**

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Southwest Counseling Center Inc. (SWC). 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; and
- Missing progress notes or other supporting documentation.

OptumHealth also provided a report of their audit of Southwest Counseling Center 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;
- Excessive billing of individual therapy codes, 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 SWC. 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 SWC patient claims and processed a number of queries for the SWC 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. Claims 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 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 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 492 positive query results there were 389 with, 103 with no findings. Our focus was on analyzing claims in connection with our forensic analysis. In some cases it was necessary to review other claims filed on the same day to gain a greater understanding of the client record. That review process identified 84 additional claims with a finding.

Table 1 summarizes those claims with a finding (query result claims – 389 and additional claims – 84) by provider and the claims finding.

Table 1 - Summary of Forensic Data Analysis Findings

Provider Index #	Number of claims associated with each finding type					Total
	Code Overlap	Missing Documentation	Duplicate or Unit Billing Discrepancies	Provider/Signature Related	Session Time Overlap	
1	13	-	6	-	-	19
2	3	-	1	4	-	8
3	-	-	-	1	1	2
4	1	-	-	-	1	2
5	1	-	-	-	-	1
6	-	-	-	1	-	1
7	-	1	1	1	1	4
8	23	-	-	-	-	23
9	1	-	-	-	-	1
10	18	-	-	-	-	18
11	1	-	2	-	-	3
12	1	-	-	-	-	1
13	1	-	-	1	-	2
14	-	-	1	-	-	1
15	-	-	-	1	-	1
16	1	-	-	-	-	1
17	-	-	-	1	-	1
18	1	-	-	-	1	2
19	1	-	-	-	1	2
20	4	-	-	-	-	4
21	61	-	-	-	-	61
22	1	-	-	-	-	1
23	-	1	-	-	-	1
24	16	-	-	-	-	16
25	78	-	-	-	-	78
26	-	-	2	4	-	6
27	-	-	-	1	-	1
28	144	1	1	5	1	152
29	-	-	1	-	-	1
30	2	-	-	-	-	2
31	-	-	1	-	-	1
32	-	-	-	2	1	3
33	11	-	-	-	-	11
34	9	-	10	17	1	37
35	1	-	2	2	-	5
Total	393	3	28	41	8	473

A portion of the code overlap findings in Table 1 (287) are related to Long-Term Residential Treatment (LTRT) (HCPCS H0019) and represent when other services are billed on the same day as HCPCS H0019. The New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines (BHS Guidelines) for HCPCS H0019 provides a list of services that may not be billed in conjunction with the HCPCS H0019. An analysis of the code overlap in Table 1 indicates that the additional services provided were medication management (HCPCS 90862) alcohol or other drug testing (HCPCS H0031), assertive community treatment (HCPCS H0039), crisis intervention services

(HCPCS H2011), and alcohol and substance abuse services treatment plan update (HCPCS T1007). These services are not indicated as excluded services. The analysis also indicates that outpatient Therapies (HCPCS 90801, 90804), family and group psychotherapy (HCPCS 90853), comprehensive community support services (HCPCS H2015) were provided which are indicated as excluded services. Generally, the HCPCS H0019 services were funded by BHSD and Medicaid (SESE rules BA3 and BB1 and M1A) while other services were primarily billed to Medicaid (SESE rules M1A and M2A).

A portion of the code overlap findings in Table 1 (104) 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 CPCS H2010 requires that the services be delivered by a practitioner with specific qualifications, including a licensed clinical nurse specialist or a 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 certification. 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).

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 SWC 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 SWC, we analyzed the client file documentation to determine if there was evidence of session time overlap.

Findings: Four instances of overlapping treatment sessions were identified among the claims reviewed for SWC. Our findings resulting from session time overlap review of services provided by SWC 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. We summarized the population of claims identified in b. by provider; and
- c. For the claims identified in b. associated with SWC, 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 SWC 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 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 SWC.

Table 2 - Summary of PCG Credential Findings

H0031	H2015	H2017	T1007	T1024	T1502	Reason for Fail
-	4	-	1	1	2	Staff not on staff roster
-	1	-	-	-	-	Missing provider qualifications
-	1	-	-	-	-	Unable to verify provider qualifications
-	-	1	-	-	-	Qualifications for provider are missing according to the staff roster list
-	-	-	2	-	-	Missing signature
1	5	4	2	1	1	Missing documentation (progress note, assessment, treatment plan, etc.) to support claim
-	1	-	-	-	-	Telephone Call
1	12	5	5	2	3	Total

1. Provider Selection

The PCG report findings note that 42.9% 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 staff qualifications for 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 was to read and analyze the provider file, which included the provider's educational achievement and background. This involved the following procedures:

- a. Reviewing the NM service requirements and guidelines for CCSS H2015 procedure code;
- b. From a subset of H2015 claims data, filtering 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. Reviewing the provider file information received from SWC to verify that educational achievement, background and certification of the provider supported the highest level modifier used in the billing process.

Findings: The credentialing analysis was completed for SWC 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 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.