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CASE REPORT
TEAMBUILDERS COUNSELING SERVICES INC

Case Name: Teambuilders Counseling Services, Inc.

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Teambuilders Counseling Services Inc. (TCS). 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 progress notes and other support documentation or missing signatures;
- Potential overbilling and double billing:
- Missing assessment or insufficient risk assessment or no goals or objectives in treatment plan;
- Staff not qualified;
- Service provided by telephone;
- Unable to verify where service took place; and
- Safety issues unaddressed.

OptumHealth also provided a report of their audit of TCS 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;
- Violations of billing code combinations;
- Potential billing of individual, family and/or group therapy during the same day without providing all services billed;
- Potential overuse of H2033, H2014, and H2015; and
- Outliers in length-of-stay for out of home placement services.

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 TCS. 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 TCS patient claims and processed a number of queries for the TCS 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 as for potential fraud. The selection of queries was based on both the findings articulated in 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 unit billing 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 1,693 claims with positive query results there were 1,208 with and 485 with no findings. While our focus was on analyzing claims in connection with our forensic analysis we may have looked at other claims filed on the same day to gain a greater understanding of the client record and in that process identified 3 additional claims with findings.

   Table 1 summarizes those claims with a finding (query result claims – 1,208 and additional claims – 3) 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**	**Missing Documentation**	**Duplicate or Unit Billing Discrepancies**	**Provider/Signature Related**	**Session Time Overlap**	**Total**
3	7	-	-	-	-	7
4	7	-	-	-	-	7
5	9	2	-	-	-	11
12	18	11	-	-	-	29
13	2	2	4	-	-	8
14	27	3	-	-	-	30
16	4	2	-	-	-	6
17	27	5	1	-	-	33
19	42	6	-	-	-	48
22	25	7	-	-	-	32
27	1	6	-	-	-	7
29	-	-	10	-	-	10
33	-	14	-	-	-	14
39	10	1	-	-	-	11
41	15	2	-	-	-	17
44	13	3	-	1	-	17
47	25	3	-	-	-	28
49	-	7	-	-	-	7
50	389	101	26	185	-	701
54	3	3	-	-	-	6
68	8	1	-	-	-	9
73	26	-	1	-	-	27
95	18	-	-	-	-	18
Providers with less than 5 findings	71	39	9	7	2	128
Total	**747**	**218**	**51**	**193**	**2**	**1,211**

A portion of the code overlap findings in Table 1 (662) 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 been established for HCPCS S5145. HSD rules Title 8, Chapter 10, Part 8 Covered Services (8.310.8.13 (C) NMAC) 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), family psychotherapy (HCPCS 90846-90847), pharmacologic management (HCPCS 90862), comprehensive community support services (HCPCS H2015), telehealth (HCPCS Q3014), and alcohol and substance abuse services treatment plan update (HCPCS T1007). These services are not indicated as excluded services but files did not generally have preauthorization information.

With respect to HCPCS S5145, we analyzed individual claims where there were 8 or more instances of a code overlap for a given client. There were additional HCPCS S5145 code overlaps. We identified 2,320 instances when the HCPCS S5145 code was billed and one or more additional claims were billed on the same day. For the 2,320 instances when the HCPCS S5145 code was billed, there were 3,648 instances of another code billed on the same day. The 2,320 HCPCS S5145 claims approximates 5.8% of the total HCPCS S5145 claims (only Medicaid claims). Major claim codes billed were:

- HCPCS 90804-90815 – 849
- HCPCS 90846-90847 – 636

- HCPCS 90862 – 957
- HCPCS Q3014 – 415

A request was made for additional information (documentation, forms and process) on how the preauthorization worked when additional services were billed. Through this request and interviews of some individuals involved in the process, it was represented that additional services rendered along with HCPCS S5145 were "rare," "not frequent" and "only approximated 1% of clients." The data does not support these statements.

Another explanation was that the approvals were obtained via telephone and a preauthorization number was obtained and documented in the client file. As noted above, we did not identify any preauthorization information documented in the client files that we analyzed.

A representative of OptumHealth, the managed care organization accepting and paying claims, indicated that the provider is not responsible for keeping a record of the prior authorization, nor would the provider need to input the prior authorization number with the claim. The claims system links to the authorization system to determine whether prior authorization was issued. OptumHealth also indicated that HCPCS 90862 was allowed to be billed separately without preauthorization. A third of the overlapping claims involved HCPCS 90862.

A portion of the code overlap findings in Table 1 (77) 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 code overlap, missing documentation, duplicate or unit billing discrepancies, 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 TCS 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 potential 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), 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 TCS, we analyzed the client file documentation to determine if there was an extended presence of session time overlap.

Findings:

Table 2 – Summary of Session Time Overlaps Identified

Provider Index #	Number of Sessions
2	9
115	8
38	5
97	5
110	3
112	3
30	2
45	2
105	2
111	2
21 Providers with 1 session	21
Total	**62**

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 TCS, we analyzed the client file documentation to determine if there was evidence of an unbundling of group services.

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

3. Missing Documentation

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 files;

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 7 – Summary of Missing Documentation Findings

Provider Index #	Number of Sessions
50	388
101	39
122	23
33	22
99	20
98	11
12	11
13	10
97	10
16	9
38	9
121	8
114	8
49	7
22	7
Providers with less than 7 claims	94
Total	**676**

The findings noted in Table 7 do not appear to indicate a pattern of fraud.

C. Credentialing Analysis

PCG indicated 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)
- 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 TCS.

Summary of PCG Credential Findings (20)

H2014	H2015	Reason for Fail
3	2	Missing documentation
-	9	Unqualified provider/staff
-	3	Reason not listed
-	3	Other
3	**17**	**Total**

1. Provider Selection

   The PCG findings indicate that 85% of the credentialing issues related 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 Utilizations 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 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
   - 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 that 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 TCS verify that educational achievement, background and certification of the provider supports the highest level of modifier used in the billing process.

Findings:

Provider Index #	Code	# Claims	Comments
57	H2015HN	6	Employee file lacked support for required qualifications
58	H2015HN	280	Employee file lacked support for required qualifications
58	H2015HO	230	Employee file lacked support for required qualifications
59	H2015HN	1	Employee file lacked support for required qualifications
9	H2015HO	5	Employee file lacked support for required qualifications
60	H2015HO	7	Employee file lacked support for required qualifications

Provider 58's employee file indicated that they have a Bachelor degree in a human services field but documentation was not present in the file. There was no documentation related to Master degree or higher.

The instances reflected in the findings do not appear to indicate 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 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.