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CASE REPORT
YOUTH DEVELOPMENT INC

Case Name: Youth Development Inc.

I. SYNOPSIS

An investigation was conducted into potentially fraudulent conduct of Youth Development Inc. (YDI). 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:

- Practitioners' qualifications not submitted, staff not qualified or assessment of safety/monitoring of at risk situations not performed;
- Agency used as rendering services instead of CSW;
- Missing treatment plan, assessments do not document the length of treatment or contain a discharge plan;
- Documentation does not support the number of units billed; and
- Missing progress notes or other supporting documentation.

OptumHealth also provided a report of their audit of Youth Development Inc. with various allegations.

Issues raised in the OptumHealth audit are as follows:

- Unbundling of bundled services;
- Possible up-coding of individual therapy codes;
- Violations of billing code combinations; and
- Potential overuse 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 YDI. 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 YDI patient claims and processed a number of queries for the YDI 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. Claim file Analysis and Investigation Procedures

   As noted above, 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 30 positive query results there were 19 with and 5 with no findings.

   Table 1 summarizes those claims with a finding (query result claims - 19) 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**	**Session Time Overlap**	**Total**
1	1	-	-	1	2
2	1	-	-	-	1
3	1	4	-	-	5
4	1	-	3	-	4
5	-	2	-	-	2
6	-	-	-	-	-
7	-	-	-	2	2
8	-	-	1	-	1
9	-	-	1	-	1
10	-	-	-	1	1
Total	**4**	**6**	**5**	**4**	**19**

The duplicate or billed unit discrepancies, missing documentation 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 YDI 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 data to identify potential claims for further analysis and evaluation. These analytical procedures consisted of the following:

a. From a subset of all 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 the claims of providers that had more than 100 sessions; and

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

Findings: Three instances of overlapping treatment sessions were identified among the claims reviewed for YDI. The findings resulting from session time overlap review of services provided by YDI 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; 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 customers 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 by provider; and

c. For the claims identified in b. associated with YDI, we analyzed the client file documentation to determine if there was evidence of unbundling group services.

Findings: The unbundling of group sessions analysis was completed for YDI 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 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;

e. We then determined the client makeup and compared those clients to the client files that we had already obtained; and

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

Findings: Three individual providers were missing documentation for several sessions. These findings do not appear to indicate a pattern of fraud.

C. Credentialing Analysis

PCG indicates in its report that they 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's 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 YDI.

Table 2 – Summary of PCG Credential Findings

H2015	Reason for Fail
5	Name of provider not on the staff list
10	Staff not qualified (per staff roster)
1	No documentation (progress note) to support claim
7	Provider qualifications not submitted (NMAC 8.315.6)
2	Services outside of provider scope (medication monitoring by CSW)
1	Agency rendered service
26	**Total**

1. Provider Selection

The PCG findings indicate all 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. 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 YDI 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 YDI 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.