OFFICE OF THE ATTORNEY GENERAL OF NEW MEXICO
MEDICAID FRAUD & ELDER ABUSE DIVISION
CONFIDENTIAL INVESTIGATIVE REPORT

[X] Case Report **[ ] Supplemental Report**

Case Name: **Referral 0613069 - Hogares**
Hogares, Inc
Nancy Jo Archer, CEO of Hogares, Inc.
1218 Griegos Rd, NW
Albuquerque, NM 87107

Synopsis

An investigation was conducted by the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General (OAG) into the activities of Hogares, Inc (Provider). The investigation looked at the Public Consulting Group (PCG) audit and other separate sources of information regarding the Provider. The investigation was conducted by Veronica Levshin, and other MFCU investigative staff.

This Completed Case Report (CCR) was created to provide the details of the investigation relevant to the referrals and complaints that provide the basis of this investigation. The list of sources and corresponding allegations is as follows:

- Part I - Referral # 0613069 dated June 24, 2013 from HSD Program Policy and Integrity Bureau; allegations: possible double billing, billing for services not rendered, up-coding; Exhibit A.

- Part II - OptumHealth Report dated June 2013; suggested allegations: unbundling, cross billing, double billing, up-coding and excessive billing of specific codes; Exhibit B.

- Part III - Letter from Nancy Archer dated August 21, 2013 with explanation of "anomalies"; suggested allegations: unbundling, double billing; Exhibit D.

- Part IV - Referral from Judy Wilmore dated September 12, 2013; suggested allegations: up-coding; Exhibit C.

- Part V - Incomplete investigation of Hogares by SIU dated January 12, 2012; suggested allegations: excessive billing of specific codes; Exhibit E.

After a review of documents and communication with agency personnel, MFCU concluded that Hogares improperly billed the Medicaid Program during a period from July 1, 2009 through January 31, 2013. Upon completion of the investigation, MFCU staff could discern no pattern of a deliberate attempt to fraudulently bill Medicaid.

General Information:

- Procedure Code H2014 - Skills training and development, per 15 minutes (Behavior Management Skills Development); Exhibit F (page 25).
- Procedure Code H2015 – Comprehensive Community Support Services, per 15 minutes; Exhibit F (page 26).

Investigation:

Part I - Referral # 0613069

The referral was received on June 24, 2013 from the Human Services Department (HSD), Program Policy and Integrity Bureau; Exhibit A (pages 1-3).

The following allegations were listed in the report issued by PCG on June 21, 2013: missing documents, insufficient documentation of services, no medical necessity for the services, billing discrepancies, and services provided by unqualified staff. See selected pages from the PCG Audit Report relevant to Hogares; Exhibit A (pages 4-23).

The PCG audit stated that claims for one hundred and forty seven (147) random dates of service were reviewed for a period from July 1, 2009 through January 31, 2013 using a random sampling review technique. PCG found that thirty two (32) claims were not in compliance with behavioral program standards.

Also, PCG performed a longitudinal review of ten (10) consumers who received services billed with procedure codes H2014 and H2015 during calendar year 2012, meaning all dates of service for those procedure codes were reviewed. PCG stated that 831 of 1,176 claims were not in compliance with behavioral program standards; Exhibit A (pages 15-16).

The list of behavioral program standards that was compiled by PCG is presented in Exhibit G.

On June 24, 2013 the New Mexico Human Services Department issued a letter to Hogares, stating that payments from the Medicaid program were suspended due to credible allegations of fraud; Exhibit A (pages 24-27).

Investigation of Part I.

This Investigator reviewed documents that were included into Referral # 0613069 by PCG; Exhibit A, CD # 1:

- Hogares Credentials. Employees' documents were presented in 286 files; files contained records copied from personnel files which included job applications, eligibility letters from CYFD, training logs, supervision forms, certificates, diplomas, transcripts, and other documents/forms appropriate for employment records.
- Failed Claims Provider Docs. Consumer files were separated into two types of review, Longitudinal and Random; documentation about relevant services was presented in 229 files; files contained consumers' information relevant to the period of PCG review:
    - Longitudinal. This Investigator reviewed Hogares' documents for 10 consumers.
    - Random. This Investigator reviewed Hogares' documents for 32 consumers

PCG's findings related to the Random Sampling indicated there were issues associated with 2 out of 12 procedure codes; those 2 procedure codes were H2014 and H2015. Exhibit A (pages 8-9).

PCG reviewed 33 randomly selected claims billed for H2015 and 19 claims billed for H2014; they found different issues of noncompliance in 9 of H2014 claims. Exhibit A (pages 8-9).

PCG selected 2 procedure codes (H2014 and H2015) for longitudinal review.

PCG reported findings in 588 claims related to H2014 (9 random plus 579 longitudinal) and 275 claims related to H2015 (23 random plus 252 longitudinal). The total number of failed claims was 863.

Following preliminary review, this Investigator requested and subsequently received additional documents from PCG on November 6, 2014. Exhibit H and Exhibit H on CD # 2.

Upon review of the documents, this Investigator requested and subsequently received additional documents from Hogares on November 14, 2014. The Notice of Official Request for Immediate Production of Documents included a list of employees who were identified by PCG as unqualified providers; Exhibit I.

Hogares hand-delivered the original documentation which was scanned into 47 files by MFCU staff at the OAG. The originals were returned to Hogares on December 3, 2014. Also, along with the documents, owner of Hogares, Nancy Archer, submitted a letter stating that four employee files were not found. Exhibit J and Exhibit J on CD # 3.

On January 26, 2015 this Investigator requested and subsequently received from Hogares, 11 additional consumer files for analysis; Exhibit K and Exhibit K on CD # 4.

Upon review of Hogares' supporting documents, MFCU grouped its findings by the subject of noncompliance into six (6) groups corresponding to the notes 1 through 6 listed below. This Investigator compiled the list of PCG's files into spreadsheets to reflect a reference between the findings in the PCG audit and the provider's documentation. See Exhibit/Note and Group for procedures H2014 and H2015 presented accordingly in Exhibit L and Exhibit N.

Table 1

Group	
1	Technical writing issues in progress notes or supporting documents
2	Services provided by unqualified staff; direct care employees were not qualified to provide services
3	Utilization of billing field
4	Missing supporting documentation
5	Duplicate billing and billing for services not rendered
6	Double billing and overbilling

Each group identified in Table 1 was investigated as detailed below.

Investigation of Part I, Group # 1.
Technical writing issues in progress notes or supporting documents

MFCU staff noted that PCG identified a justification for each finding. Research was conducted to determine if support could be found in the regulations for each justification.

The following regulations and guidance were researched:

- HCPCS H2015 Comprehensive Community Support Services; Exhibit Q.
- 8.315.6 NMAC Comprehensive Community Support Services; Exhibit R.
- 8.321.2 NMAC Specialized Behavioral Health Provider Enrollment and Reimbursement; Exhibit U.
- 8.322.3 NMAC Behavioral Management Skills Development Services; Exhibit T.
- Provider Alert, Value Options, issued on March 25, 2009; Exhibit U.

- Check List issued by Behavioral Health Purchasing Collaborative in July 2009; Exhibit V.

This Investigator reviewed each of Hogares' supporting records to determine whether the documentation of services was made in compliance with the regulations. There were no findings. It was concluded that there was insufficient evidence of fraud with respect to Group # 1.

Investigation of Part I, Group # 2.

Services provided by unqualified staff; direct care staff was not qualified to provide services

PCG's comments indicated that PCG was not able to locate the personnel files of the direct care providers; therefore, MFCU staff requested the personnel files for relevant CCSS providers, BMS workers and supervisors; Exhibit I.

This Investigator reviewed these personnel records to verify whether the Provider complied with the qualification requirements set forth in the regulation NMAC 7.20.11 Certification Requirements for Child and Adolescent Mental Health Services; Exhibit W (pages 24-28 for CCSS, and pages 29-30 for BMS)

This Investigator noted that Hogares did not comply with the aforementioned regulation, as noted below:

- April Campbell, BMS staff. Campbell's complete personnel file is missing. This Investigator was unable to verify whether Hogares complied with any of the qualification requirements; Exhibit J.
- Sarah Stuckey, CCSS staff. Stuckey's complete personnel file is missing. This Investigator was unable to verify whether Hogares complied with any of the qualification requirements; Exhibit J.
- Nakita Walker, CCSS staff. This Investigator noted that the Ms. Walker's training requirements were not met with regard to the initial 20 hours of training within the first 90 days of employment as indicated by Walker's personnel file, which does not include records for about 1.5 hours of training. Also, Walker's records did not reflect ongoing training of 20 hours per year for each subsequent year after the beginning of employment as demonstrated by missing records for 12 hours and 2 hours of training in her second and third year of employment, respectively. See Exhibit J (CD#3).
- John Charles, CCSS staff. Charles's complete personnel file is missing. This Investigator was unable to verify whether the Provider complied with any of the qualification requirements; Exhibit J.
- Jerald Byers, CCSS staff. Byers's complete personnel file is missing. This Investigator was unable to verify whether the Provider complied with any of the qualification requirements; Exhibit J.
- Leann Leaser, CCSS staff. This Investigator noted that the staff's training requirements were not met with regard to the ongoing training of 20 hours per year for each subsequent year after the beginning of employment; her records are missing 2 hours of training in her second year of employment. See Exhibit J (CD#3).

The majority of the personnel files reviewed contained supporting documentation showing adequate training and qualifications. Additionally, information was gathered from interviews and attempts to obtain records. This Investigator obtained information that because the agency shut down in 2013, its records keeping may have been affected. This Investigator did not identify a deliberate pattern of fraud. Therefore, no further investigation will be conducted.

Investigation of Part I, Group # 3.
Utilization of billing field

MFCU reviewed the Provider's progress notes corresponding to PCG's comments regarding their finding that Hogares identified the facility but not the provider in the claim.

This Investigator reviewed all relevant progress notes. It was noted that these progress notes displayed the signature of the rendering provider. No pattern of fraud could be discerned. No further investigation will be conducted.

Investigation of Part I, Group # 4.
Missing Supporting Documentation

MFCU reviewed the documents that were presented by PCG and by Hogares to determine whether a pattern of fraud could be detected. This investigation found 36 claims for H2014 and 1 claim for H2015 of PCG's selection that were missing supporting documentation.

A detailed recoupment for claims associated with Group # 4 for procedures H2014 and H2015 is presented accordingly in Exhibit M and Exhibit O.

Independently from PCG's findings MFCU staff noted that an additional 8 progress notes were not submitted for this Investigator's review. Detailed recoupment for claims associated with these claims are marked as "Extra" in the exhibits; Exhibit M and Exhibit P.

While there was missing documentation, there did not appear to be a pattern of fraud.

Investigation of Part I, Group # 5.
Duplicate billing and billing for services not rendered.

MFCU reviewed the documents that were presented by PCG and by Hogares to determine whether a pattern of fraud could be detected.

MFCU staff made an unsuccessful attempt to contact Nakita Walker, CCSS staff, with an inquiry regarding her duplicate progress notes that occurred on 9 occasions. All claims associated with the duplicate progress notes are recommended for recoupment. However, no pattern of fraud was detected.

Detailed recoupment for claims associated with Group # 5 for procedures H2014 and H2015 presented accordingly in Exhibit M and Exhibit O.

Investigation of Part I, Group # 6.
Overbilling.

MFCU reviewed the documents that were presented by PCG and by Hogares to determine whether a pattern of fraud could be detected.

MFCU calculated the number of units based on the start and end time as indicated in the corresponding progress notes. Units were calculated incorrectly for various consumers for procedure code H2014. However, this Investigator could discern no pattern of a deliberate attempt to bill Medicaid for services not provided.

Detailed recoupment for claims associated with Group # 6 for procedures H2014 and H2015 is presented accordingly in Exhibit M and Exhibit O.

Summary of investigation of Referral # 0613069 – Part I

MFCU staff completed the investigation by reviewing PCG's Audit, locating and reviewing Hogares' documentation, and determining whether the Provider's billing was in compliance with the relevant regulations. This Investigator could discern no pattern of a deliberate attempt to bill Medicaid for services not provided.

Part II - OptumHealth Report

OptumHealth issued the Program Integrity Referral Detail Report in June 2013. The report listed potential program integrity issues; these issues were identified by OptumHealth through analysis of claims and records (desk review). The purpose of OptumHealth's desk review was to condense various issues into a corresponding summary for pre-audit. OptumHealth did not review patient files. Exhibit B.

OptumHealth identified the following irregular billing patterns:

- Cross-billing,
- Double billing,
- Up-coding of individual therapy codes,
- Excessive billing of BMS code,
- Excessive billing of PSR code,
- Excessive billing of CCSS code,
- Excessive billing of TFC code.

MFCU investigative staff conducted an investigation to determine whether the irregular billing patterns, identified in the OptumHealth report, were the result of the Provider's fraudulent activity. The list of claims that was used for the investigation of Part II was presented to MFCU by OptumHealth; Exhibit PP on CD # 9.

Cross-billing. CMS has implemented cross-billing edits called the NCCI edits that indicate the codes that should not be paid together on the same day. OptumHealth performed research to identify providers with violations of NCCI edits, research identified providers billing code combinations for a consumer on a single date of service in violation of CMS NCCI settings. Exhibit B.

Investigation of Part II
(Cross-billing)

MFCU noted that OptumHealth did not list the procedure codes specified by CMS NCCI for this allegation. The Provider was not identified as an "outlier" for this issue. Therefore, MFCU team tested all claims for cross-billing.

MFCU noted that the check-list related to the allegation was compiled from the New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines, HCPCS instructions - H0019 (Transitional Living Services); Exhibit X.

This Investigator noted that regulations do not exclude PHARMACOLOGIC MANAGEMENT (CPT code 90862), or PHARMACOLOGIC MANAGEMENT VIA INTERACTIVE AUDIO AND VIDEO TELECOMMUNICATION SYSTEM (CPT code 90862GT) from billing in conjunction with H0019. Exhibit X.

The results of the claims analysis are presented in Table 2 below:

Table 2

Codes that cannot be billed on the same day	Family Stabilization S9482	Inpatient or Residential H0019	ARTC and RTC 1001/0191
90804-90808 Outpatient Individual Psychotherapy		1 claim for 90804 18 claims for 90806 2 claims for 90808 Total 21 claims in 4 years	
90810-90814, 90809, 90815, 90846, 90849, 90857		No cross-billing in claims	
90847 Outpatient Family Therapy		3 claims for 90847	
90853 Outpatient Group Therapy		58 claims for 90853	
Total	No cross-billing in claims	82 claims in 4 years	No cross-billing in claims

Detailed recoupment for claims associated with cross-billing is presented in Exhibit Y. No pattern could be discerned for claims tested over a 4 year period.

Double billing. Optum SIU research identified providers who regularly billed individual or family and group therapy sessions on the same day. Tips came in that some providers billed for both services, did not deliver both services, but used the same time period for both services. Exhibit B.

Investigation of Part II
(Double billing)

MFCU noted that Individual Therapy or Family Therapy and Group Therapy services are permitted if documentation indicates the sessions were provided at separate times.

MFCU analyzed claims billed by the same rendering provider to verify whether the Group Therapy was possibly billed for the same time period as the Individual Therapy or Family Therapy.

The analysis of claims indicated that multiple rendering providers billed Individual Therapy (90804-90814) or Family Therapy (90846-90847) and Group Therapy (90853) on the same day. It was noted, that the possible double billing for 90853 with either Individual Therapy or Family Therapy comprised less than 0.5% of the total amount paid for all claims within a period of 4 years.

Also, this Investigator selected 19 consumers that were billed for all three types of services on the same day to verify whether the rendering providers billed for services not provided. This Investigator requested supporting documents to verify whether the Provider double billed; Exhibit Z.

On January 8, 2016 these documents were received from Hogares. Exhibit QQ on CD# 10

(folder "AG-12-18-15").

Review of the supporting documentation revealed that Hogares did not bill for overlapping time while providing Individual Therapy or Family Therapy and Group Therapy services. However, this Investigator noted that supporting documentation for 18 claims was not submitted for review, billing for 2 claims was based on deficient documents, and 1 claim was billed regardless of the notation that service was not provided.

Detailed recoupment for these claims is presented in Exhibit AA.

Up-coding of individual therapy codes. Optum SIU research identified possible up-coding of individual therapy codes. Research showed specific providers using excessive billing of Individual Therapy (specifically 90806 and 90808) significantly more frequently than the network standard. Exhibit B.

Investigation of Part II
(Up-coding)

MFCU noted that OptumHealth compared Provider's billing to the "network" billing using its own standards; these network standards were not available to this Investigator. Therefore, the claims analysis was made to compare the use of the highest codes to the overall claims billed by the Provider for the individual psychotherapy services provided within a 4 year period.

MFCU staff noted that the use of the Individual Psychotherapy codes was as follows: 90804 (20-30 min) – 6%. 90806 (45-50 minutes) – 84%, and 90808 (75-80 minutes) – 9%. This proportion does not indicate the over-utilization of the 90808 which is the highest code. The compilation of the claims is presented in Exhibit BB.

The claims were analyzed to verify whether rendering providers were performing Individual Psychotherapy (90804-90814) for excessive hours per day. It was noted that none of the rendering providers were billing Individual Psychotherapy for more than 8 hours a day.

It was also noted, that PCG's audit did not reveal any findings in randomly selected claims for 90806 services; Exhibit A.

Therefore, no further investigation was conducted.

Excessive Billing of BMS code. Optum SIU analysis identified potential overuse of BMS H2014. Optum SIU research identified outliers in both the amount of units per consumer and the length of treatment for BMS consumers. Exhibit B.

Investigation of Part II
(Excessive Billing for H2014-BMS)

This Investigator only reviewed consumers files related to the H2014 services from Hogares; therefore, no determination was made whether the Provider's billing for H2014 was comparatively greater than other providers. However, investigation was conducted to verify whether Provider billed for services that were not allowed by regulations.

This Investigator was not able to locate regulations that mandate the limitation of H2014 units other than as recommended by consumers' individual service plans. The investigation of the possibility that Provider billed for unnecessary BMS services is included into this CCR in its

section "Part IV - Referral from Judy Wilmore." This Investigator could discern no proof that BMS services were provided without appropriate recommendations given in consumer assessments.

Investigators reviewed a Provider Alert issued on September 14, 2011. The Alert stated that starting April 2011, OptumHealth enforced 350 units for usage of H2014. Exhibit CC.

Analysis was performed to verify whether the Provider followed OptumHealth's requirement.

This Investigator analyzed the spreadsheet with claims from OptumHealth. It was noted that two fields corresponding to the number of paid units and to the total paid amount were not reflecting the correct correlation of the price per unit. Thus, OptumHealth's price per unit was varying in a range from $0.97 to $8. Investigator compiled an analysis to verify the price that was the most frequently used to pay for one unit of BMS. It was determined that $7.76 was paid in 96% of the claims. Exhibit DD.

Therefore, this Investigator used price per unit $7.76 to recalculate the effective number of units that were paid in each claim. It was noted that none of the consumers was paid for more than 350 units a month. No further investigation was performed.

Excessive Billing for PSR code. Optum SIU analysis identified potential overuse of PSR H2017. Optum SIU research identified outliers in both the amount of units per consumer and the length of treatment for PSR consumers. Exhibit B.

Investigation of Part II
(Excessive Billing for H2017)

It was noted that the claims data received from OptumHealth contained no records relevant to the procedure code H2017. No investigation was conducted.

Excessive Billing for CCSS code. Optum SIU analysis identified potential overuse of CCSS H2015. Optum SIU research identified outliers in both the amount of units per consumer and the length of treatment for CCSS consumers.

Investigation of Part II
(Excessive Billing for H2015)

This Investigator only reviewed consumers' files related to individuals receiving H2015 services from Hogares; therefore, no determination was comparatively greater than other providers. However, investigation was conducted to verify whether Hogares billed for a volume of CCSS services that was not allowed by regulations, or billed for unnecessary CCSS services.

This Investigator was not able to locate regulations that mandate limitation of H2015 units other than recommended by consumers' individual service plans.

While conducting the investigation, Investigator could discern no evidence that CCSS services were provided without appropriate recommendations given in consumer assessments. The details of this conclusion are included into this CCR in its section "Part IV - Referral from Judy Wilmore."

Excessive billing for TFC. Optum SIU claims research identified outliers in length-of-stay for out of home placement services, including for Treatment Foster Care. Exhibit B.

Investigation of Part II.
(Excessive Billing for S5145/S5145U1 -Treatment Foster Care, TFC)

This Investigator only reviewed consumers' files related to individuals receiving TFC services from Hogares; therefore, no determination was made whether the Provider's billing for TFC was comparatively greater than other providers. However, analysis of OptumHealth claims indicated that although consumers received TFC for 7 months in average, consumers were not billed for the same length of stay.

While reviewing the claims, this Investigator found a double billing where both codes (S5145 and S5145U1) were charged to 2 consumers on 8 dates. Exhibit EE.

It was also noted, that duplicate billing was charged to 5 consumers on 13 dates. Exhibit FF.

This Investigator noted that the total overbilling for duplicate and double billing for TFC occurred in less than 0.01% of claims within a 4 year period. Therefore, no further investigation was conducted.

Summary of investigation of OptumHealth referral – Part II.

MFCU staff completed the investigation by reviewing allegations listed in the OptumHealth report, by locating and reviewing Provider's documentation, analyzing claims, and determining whether the Provider's billing was in compliance with relevant regulations. Investigator could discern no pattern of a deliberate attempt to fraudulently bill Medicaid.

Part III - Letter from Nancy Archer

On August 20, 2013, the MFCU received a letter from Hogares which was signed by Nancy Jo Archer, CEO, and William Herman, President, Hogares Board of Directors. Besides general information, the letter provided an overview of the following billing issues:

- Unbundled services,
- Billing for services without prior authorization,
- Double billing.

Allegation: Unbundling of CCSS.

Provider's letter stated "Services to the client were billed for two different locations on the same day. If a client is discharging from a high level of care (Residential Treatment, Hospital or Treatment Foster Care) to whatever the location, the CCSS worker from the home provides services on the same day." Exhibit D.

Investigation of Part III
(Unbundling)

MFCU staff analyzed Provider's claims to verify whether billing for CCSS complied with the regulation that allows billing for 16 units per discharge; Exhibit S.

It was determined that Provider billed for more than 16 units per discharge for six (6) consumers. Detailed calculation of recoupment for 19 claims associated with unbundling is presented in Exhibit HH.

Allegation: Billing for Services Without Prior Authorization

Provider's letter stated "Some services were delivered to clients that are normally not billable. For example clients receiving TFC are ineligible to receive Behavioral Management Service while in TFC." Exhibit D.

Investigation of Part III
(Billing Without Prior Authorization)

Investigator analyzed claims to determine whether BMS services were provided to the consumer while they were receiving TFC services.

It was determined that 3 individuals were billed for BMS while they received TFC. The proof of the Prior Authorization/Approval from MCO was requested from the Provider; Exhibit Z.

On January 8, 2016 Hogares submitted a letter stating that prior authorizations for two consumers were not found. Provider also suggested that alternative communication related to the third consumer may be used as evidence that the prior authorization for BMS was granted; see Exhibit RR.

This Investigator reviewed the documents and came to a conclusion that they are not sufficient as evidence of prior authorization. Therefore, it was determined that Provider billed for BMS services without prior authorization in 103 claims.

Detailed recoupment for claims associated with billing for services without prior authorization is presented in Exhibit GG.

Investigative staff noted that the number of affected claims identified through this investigation that are relevant to billing without prior authorization is less than 0.04%. Therefore, there is no indication of a pattern of fraudulent activity; no further investigation was conducted.

Allegation: Double billing
Provider's letter stated "Two services were billed by a provider at the same time for a single client." It referenced the Telehealth services as an example of the double billing that was billed by the Provider. Exhibit D.

Investigation of Part III
(Double Billing for Telehealth)

There does not appear to be mandating guidance that Telehealth services not be provided to the same client by rendering providers at two different locations. No further investigation was conducted.

Summary of Investigation of Part III

Investigator reviewed Provider's documentation related to the comments listed in the Letter from Nancy Jo Archer, and analyzed claims in order to determine whether the Provider's billing was in compliance with relevant regulations. Investigator could discern no pattern of a deliberate attempt to fraudulently bill Medicaid.

Part IV - Referral from Judy Wilmore

On September 12-13, 2013 Judy Wilmore contacted MFCU to provide information that Shannon Burke was instructed to bill for "in-depth assessments when she actually conducted a lesser assessment." Exhibit C.

Investigation of Part IV
(Up-coding; Prescribing services that were not warranted by medical necessity)

Investigation was conducted to verify whether the Provider billed for Enhanced Assessments (H0031U8) while only conducting the Comprehensive Assessment (90801) in order to receive reimbursement at a higher rate.

Also, MFCU staff investigated the possibility that up-coding of the assessment codes was associated with consumers' misdiagnoses, such as more severe diagnoses were stated than it was warranted by the consumers' illness. Thus, it could lead to prescribing unnecessary BMS and CCSS services.

It was noted that in a period 2011-2013 Burke billed H0031 to 73 consumers. On February 5, 2015 MFCU requested documentation from Hogares to support the billing. The documents were subsequently received for 71 consumers. Exhibit II and Exhibit II on CD # 5.

The Provider's documents were printed and organized by the date of assessment, and presented to Burke at the time of the interview on 3/26/2015.

The documentation that supported billing was not received for 2 consumers.

On March 26, 2015 the MFCU staff conducted an interview with Burke to verify the list of assessments that she was instructed to up-code by her supervisor.

Burke stated that she utilized a specialized computer software to save and organize the records relevant to the clients' assessments. After she completed her assessment, the records were available for the supervisor's review and comments. The supervisor's comments included some notes of minor corrections and prompts to fill up the missed fields, and to provide more narrative details to the certain data.

Burke stated that one day her supervisor was coaching her how to use the specialized software to qualify clients for more expensive services than necessary. During that face-to-face conversation, Burke's supervisor demanded that Burke use the more detailed assessments instead of the less detailed assessments, including 4 qualification "checks" at the end of the form.

This Investigator noted that Burke was somewhat doubtful whether it actually was her supervisor at the time of the incident, or someone else. It was also noted that Burke was not able to recall the approximate period when the conversation occurred.

Burke suspected that Hogares was "bleeding money," that is why the less expensive psychiatric evaluations were replaced with more expensive Enhanced Assessments. She also stated that with Enhanced Assessments the clients would qualify for more treatment services with more severe diagnoses, which would suggest "more money."

Burke said that she complied with Romero's demand to use the more detailed evaluation because she "needed a job." In order to perform the higher level of assessment, she used more time to interview and observe clients and parents, and collect the necessary collateral information, but Burke never gave her clients more severe diagnoses than necessary.

This Investigator presented Burke with the Enhanced Assessments of those 71 clients. She was asked to identify the clients who received a higher level of assessment than necessary.

This Investigator noted that Burke made comments about almost every client that she reviewed, which indicated that she remembered their illnesses and needs for mental services.

However, Burke was not able to identify any client who was assigned a more severe diagnosis than appropriate; she was not able to identify any client who was fraudulently qualified for more services than was necessary. Also, she was not able to identify any of the assessments where a Comprehensive Assessment would be enough for proper diagnosis of the consumer.

Burke was not able to recall whether any of her colleagues shared with her a similar concern related to demand of up-coding from their supervisors.

This Investigator analyzed claims for Procedure Codes 90801 and H0031U8 to verify whether the code 90801 was replaced with more expensive procedure code H0031U8. It was noted that 90801 was consistently billed in 2009, 2010, 2011 and 2012 in a range of $9,600-$13,800 per month in average. Therefore, the billing pattern within a 4 year period does not support an allegation of the exclusive H0031U8 billing in the recent years.

No further investigation related to the allegation of up-coding of assessment codes will be conducted.

Summary of Investigation of Part IV

This Investigator interviewed the therapist who initially reported allegations against the Provider: up-coding and providing services regardless of medical necessity. However, during the interview, the therapist was not able to identify a single instance of improper assessment out of 71 assessments that were given to her for review. Also, she was not able to identify a single consumer who received an undeserved diagnosis, or received unnecessary services.

This Investigator could discern no pattern of a deliberate attempt to bill Medicaid for up-coding or unnecessary services.

Part V - Incomplete investigation of Hogares by SIU

MFCU made an inquiry to OptumHealth regarding the case that was investigated by OptumHealth in connection with unbundling, excessive CCSS, PSR and BMS, and overpayments. Exhibit C.

The case notes were consequently received by MFCU for review. Review of the case notes revealed that OptumHealth stopped its investigation with the intention of referring the case to MFCU. The allegations of unbundling and excessive billing were investigated by MFCU and included into this CCR in section "Part II – OptumHealth Report."

MFCU also noted that the Provider submitted a self-reporting notification of overpayment for crisis payment plan. OptumHealth did not complete the investigation of the overpayments. Exhibit JJ and Exhibit JJ on CD # 6.

Investigation of Part V
(Double Billing)

MFCU staff requested from the Provider a list of audited consumers as identified in Provider's self-reporting. The list was received on March 24, 2015; Exhibit KK.

On September 24, 2015, this Investigator requested the supporting documents for the consumers identified by the Provider on March 24, 2015; the list of consumers was included in Attachment 1; Exhibit LL.

The requested documents were received on October 7, 2015 and January 8, 2016. Exhibit PP, Exhibit MM on CD # 7, Exhibit QQ on CD # 10 (folder "AG-Page 27").

Review of the Provider's documentation revealed that Provider double billed while performing Comprehensive Assessments and Enhanced Assessments. Interviews with Provider's therapists were conducted to verify whether the double billing was intentionally billed to the Medicaid program.

On November 5, 2015 MFCU's Investigator interviewed Kathleen Moore (Moore), Therapist. Moore stated that she was contracted by Bryce Pittenger, Provider's Clinical Director, to conduct assessments to new and established clients. Moore recalled that, while she interviewed the clients, the Community Support Worker (CSW) was also present in the room. According to Moore, she valued the CSW's collateral inputs that they provided for established consumers. Moore did not bill for the CCSS services; she could not recall whether she knew that the CCSS services were double billed in 2012. The interview was recorded; Exhibit OO on CD # 8.

On November 10, 2015 MFCU's Investigator interviewed Sarah Herbert (Herbert), Therapist. Herbert stated that she was a salary employee; her responsibility was to provide assessments to the clients. According to Herbert, at some point in time all assessments were conducted with the CSW present during an appointment. She recalled that the CCSS providers would not intervene with the client but rather collect the information for the CCSS Crisis Safety Plan. Herbert stated that the Crisis Safety Plan then was given to the clients' parents at the end of the appointment to assist them in times of consumer's crises.

Herbert recalled that the situation was addressed at the Provider's meetings as an improper organizational decision that lead to double billing. The interview was recorded; Exhibit OO on CD # 8.

On December 9, 2015 MFCU's Investigator interviewed Bryce Pittenger (Pittenger), Clinical Director. Pittenger stated she does not remember any details of the decision meetings. However, she remembers that she agreed with the Provider's decision to collect the information for the CCSS Crisis Safety Plan at the time of Assessment appointment. According to her, it helped the Provider to make the collection of the information as efficient as possible. She also stated, that as soon as the Provider realized its inconsistency with the proper billing, the internal audit was ordered by Nancy Jo Archer, CEO, to identify the instances of double billing. Pittenger did not participate in that internal audit; she does not recall the outcome of the audit. The interview was recorded; Exhibit RR on CD # 8.

The detailed recoupment related to the allegation of the double billing is presented in Exhibit NN.

Summary of Investigation of Part V

The MFCU's staff conducted a review of documentation related to the double billing identified by the Provider in its self-reporting addressed to OptumHealth. The interview with the clinical director was consistent with interviews of the therapists. Therefore, it was determined that the double billing was not intentionally fraudulent conduct.

Summary of MFCU findings and Conclusion

As a result of interviews with individuals conducted during the investigation, documentation reviewed by MFCU's investigative team, thorough analysis of claims and application of the New Mexico Administrative Code for the payments of Medicaid claims, and review of documents issued by the Mexico Behavioral Health Collaborative, the MFCU determined that insufficient evidence exists to support an allegation of Provider's fraudulent activity.

The Medicaid Fraud and Elder Abuse Division has evaluated investigative findings in accordance with the statutory standards of proof incorporated in the Medicaid Fraud Act Sect 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 finding are not inclusive of and may differ from overpayment calculations or other claims conducted by HSD.

[x] Completed **[ ] Closed**

Investigator: _Veronica Levshin _____ **Date:** 2/5/2016

Director: _Patricia Tucker _____ **Date:** 2/5/2016