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

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

Case Name: Easter Seals El Mirador
Mark Johnson, CEO
10A Van Nu Po, Santa Fe, New Mexico 87507

Case Number: 13-088

Synopsis

On June 24 2013 MFEAD received a referral from Human Services Department (HSD), Program Policy and Integrity Bureau. The following allegations were listed in the report issued by Public Consulting Group (PCG) on June 21, 2013: missing documents, insufficient documentation of services, no medical necessity for the services, billing discrepancies, services provided by unqualified staff. Also included in the referral was a report generated from OptumHealth which identified numerous irregularities.

On June 24, 2013 the New Mexico Humans Services Department issued a letter to Easter Seals El Mirador stating that payments from Medicaid program have been suspended due to credible allegations of fraud.

An investigation was conducted by the Medicaid Fraud Control Unit at the Attorney General Office into potentially fraudulent activities of Easter Seals El Mirador (Provider). The investigation looked at the Public Consulting Group audit, the OptumHealth New Mexico (OptumHealth) audit, and three separate complaints that came from private individuals regarding the Provider.

Background

Public Consulting Group Report: see Supplemental Report, case 13-088, pages 2-13.

Public Consulting Group utilized two different methodologies for the Provider:

1) Random sampling of provider claims. The sampling methodology allows for a statistically valid extrapolation of the findings.
2) Longitudinal review of claims. This review included consumers' complete file review: a review of a full year's worth of case file documentation for selected consumers; these findings are not extrapolated.

Random Sampling Review

The Audit Report generated by PCG stated that 150 random dates of service claims were reviewed for a period from July 1, 2009 through January 31, 2013. PCG found that 20 claims were not in compliance with behavioral program standards. Upon review by the MFEAD investigative staff it was determined that 4 of 20 failed claims did not have sufficient documentation to justify billing the claims. Total amount associated to this finding was $368.28; see Table 1, Line 2.

Follow up investigation was conducted on these 4 claims to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate

attempt to bill Medicaid for services that were not provided.

Longitudinal Review

PCG performed a complete review of 5 consumers who received services billed for skills training and development and treatment foster care during calendar year 2012. PCG stated that 640 of 2,301 claims were not in compliance with behavioral program standards. It was noted that number of claims that were referred to MFEAD for noncompliance was 646 claims. Upon review by the MFEAD investigative staff it was determined that 39 of these 646 claims did not have sufficient documentation to justify billing the claims. Total amount associated to this finding was $4,752.03; see Table 1, Line 1.

Follow up investigation was conducted on these 39 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Independent of the longitudinal and random review conducted by PCG the MFEAD investigative staff reviewed additional claims related to 6 consumers who received behavioral services from the Provider. A review of these claims resulted in a finding of additional 58 claims for which documentation was lacking. Total amount associated to this finding was $5,722.15; see Table 1, Line 3.

Follow up investigation was conducted on these 58 claims to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and interviews with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

MFEAD investigative staff determined that amount of findings associated with allegations from PCG totals to $10,842.46; see Table 1, Line 4.

OptumHealth Report: see Supplemental Report, case 13-088, pages 13-17.
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 the OptumHealth's desk review was to condense various issues into corresponding summary for pre-audit. OptumHealth did not review patient files.

OptumHealth identified the following irregular billing patterns: unbundling bundled services, cross-billing and excessive billing of specific codes.

MFEAD investigative staff conducted an investigation to determine if the irregular billing patterns identified in the OptumHealth report were the result of fraudulent activity.

Unbundling bundled services

Claims for Medicaid payments for the treatment of patients in the areas of Treatment Foster Care, In-patient, Intensive Outpatient, and RTC (Residential Treatment Centers) were referred to the MFEAD for investigation.

8,531 claims were analyzed for the possible unbundling bundled services. It was noted that 62 of these 8,531 claims were billed with an additional procedure code which could present an opportunity for unbundling of a bundled service. Of these 62 claims 5 were categorized as improperly billed.

Follow up investigation was conducted by MFEAD investigative staff to determine if the unbundling of these 5 claims was the result of fraudulent activity. After a review of documents and claims it was determined that MFEAD staff could discern no pattern of a deliberate attempt to bill Medicaid as result of unbundling bundled services.

Total overbilling for unbundling bundled services was $330.00. Associated with the above finding the MFEAD investigative staff identified additional $1,774.71 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $2,104.71; see Table 2, Line 4.

Cross Billing

110,453 claims were reviewed to determine if the Provider was improperly billing for multiple services in one day. The claims analysis was performed to verify whether Provider was reimbursed for services that are not allowed to be billed on the same day (cross billing).

143 claims for services billed for individual psychotherapy were examined for cross billing. MFEAD investigative staff determined that individual psychotherapy and skills training and development services were billed inappropriately 2 times. Total overbilling for individual psychotherapy services was $137.64. Associated with this finding the MFEAD staff identified additional $7,936.56 in claims which did not have sufficient documentation to support the claims; see Table 2, Line 1.

40 claims for services billed for family psychotherapy and multiple family group psychotherapy were analyzed and found to be billed inappropriately 21 times. Total overbilling of family psychotherapy and multiple family group psychotherapy services was $1,033.77. Associated with this finding the MFEAD staff identified additional $1,727.07 in claims which did not have sufficient documentation to support the claims; see Table 2, Line 2.

MFEAD staff could discern no pattern of a deliberate attempt to bill Medicaid as result of cross billing for services.

MFEAD investigative staff determined that total overbilling for claims associated with cross billing was $10,835.04 (8,074.20+2,760.84); see Table 2, Line 1 and Line 2.

Excessive billing for skills training and development

Procedure code for skills training and development was examined to determine if this code was utilized to treat adolescents whose behavior assessments did not warrant this level of therapy. Upon examination of the claims the MFEAD staff determined that utilization of this code fell within the guidelines established by the Behavioral Collaborative for the use of this code.

Excessive billing for psychosocial rehabilitation services

Procedure code for psychosocial rehabilitation services was examined to determine if this code was utilized to treat clients whose behavior assessments did not warrant this level of therapy. Upon review of these claims the MFEAD staff could not determine an overuse of this code.

Excessive billing for foster care therapeutic services

Procedure code for foster care therapeutic services was examined to determine if the length of stay in out of home placement services billed by Provider was excessive. MFEAD staff examined the claims of 55 foster placement children to determine if their out of home placement was excessive. MFEAD staff could find no evidence to suggest that this code was used in an excessive manor.

Duplicate Billing

Through the course of investigating length of stay in out of home placement, MFEAD staff expanded the investigation to include the possibility of duplicate billing for treatment foster care and treatment foster care with step-down level of care.

8,469 claims were analyzed for fraudulent billing. It was noted that 34 of the 8,469 claims were billed as duplicate billing. This resulted in duplicate billing of $6,905.00. Associated with the above finding the MFEAD investigative staff identified additional $1,801.00 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $8,706.00; see Table 2, Line 3.

Follow up investigation was conducted on these 34 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and communications with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Double Billing

Independent of the OptumHealth report the MFEAD investigative staff expanded the inquiry to include an analysis of group psychotherapy and skills training and development for double billing occurring at the same time on the same day.

86,831 claims for group psychotherapy and skills training and development were analyzed. It was determined that 29 claims were result of double billing and should not have occurred. These 29 instances of double billing totaled to $325.12. Associated with the above finding the MFEAD investigative staff identified additional $1,312.86 in claims which did not have sufficient documentation to support the claims. Total amount associated to this finding was $1,637.98; see Table 2, Line 5.

Follow up investigation was conducted on these 29 to determine if the lack of documentation was the result of fraudulent activity. After a review of documents and communications with agency personnel the MFEAD investigative staff could discern no pattern of a deliberate attempt to bill Medicaid for services that were not provided.

Referral from a private citizen (Complainant) dated August 6, 2013: see Supplemental Report, case 13-088, pages 18-25.

The referral contained following allegations:

1. Billing for ICFMR residential services while consumers were attending summer camp.
2. Billing for medication management services not provided by psychiatrist.
3. Billing for adult rehabilitation day care (dayhab) services not provided.
4. Billing for occupational therapy services not provided by therapist.
5. Behavioral therapy was provided by unlicensed personnel.
6. Interest income was improperly accounted in the cost reports.
7. Expenses were improperly accounted in the cost reports.
8. Provider forced employees to commit fraud by inducing them into wrongful actions, or preventing them from correct actions.

Each of these allegations was investigated by MFEAD.

1. An analysis of claims for the individual client who was attending summer camp revealed that Medicaid was billed for 6 days in August 2011 for ICFMR (Intermediate Care Facilities for individuals with Mental Retardation) services. This billing correctly reflected the time when consumer was not receiving services from Provider.

2. A review of the medical file of the individual client did not support the allegation that medication management services were not provided by the psychiatrist. Complainant was interviewed regarding this allegation. MFEAD staff found that the services described by Complainant were appropriate for the medication management services. Upon review of the claims the MFEAD staff determined that medication management was billed correctly as part of ICFMR services.

3. Complainant was interviewed regarding allegations that dayhab were billed without services provided. The services which Complainant described were found to be appropriate for the category of dayhab services. Upon review of the claims the MFEAD staff determined that dayhab was billed correctly as part of ICFMR services.

4. Complainant was interviewed regarding allegations that occupational therapy was billed without services provided. The services which Complainant described were found to be appropriate for the category of occupational therapy. Upon review of the claims the MFEAD staff determined that occupational therapy was billed correctly as part of ICFMR services.

5. Behavioral therapy was provided by unlicensed personnel. Proof of licensure of therapists who provided behavioral therapy was obtained by MFEAD investigative staff.

6. Cost reports prepared by accounting firm Myers and Stauffer LC CPA were reviewed by MFEAD staff to identify whether the interest income from trust accounts were reflected properly in cost reports for fiscal years 2008 and 2009, and 2010. MFEAD staff was not able to confirm that interest income was improperly accounted in the cost report.

7. Provider's former finance officer was interviewed regarding financial records used in preparation for the cost reports performed by Myers and Stauffer. MFEAD staff noted that this interview did not provide any corroboration as to any improper expenses which may have been included in the cost reports submitted to New Mexico Human Services Department. MFEAD investigative staff was not able to corroborate the allegation of improper items included in the Provider's cost reports.

8. Complainant provided the MFEAD investigative staff with the names of former employees who believed had been forced employees to commit fraud. Interviews conducted by MFEAD investigative staff with each of the available individuals failed to substantiate a directive to induce them to commit fraud or instructions preventing them from billing correctly.

MFEAD could not substantiate the allegations as contained in the referral dated August 6, 2013.

Referral from Anonymous dated August 21, 2012: see Supplemental Report, case 13-088, pages 25-30.

The referral suggested allegations:
1. Behavioral therapy staffing ratio was not in compliance with regulations;
2. Behavioral therapy services were not available or provided by unlicensed personnel;
3. Clients' behavioral therapy was not effective, or not implemented;
4. Incidents related to clients behavioral outbursts were not reported, not investigated, no recommendations followed.

1. MFEAD investigative staff reviewed the medical files and billing records of 7 clients receiving ICFMR services from Provider to determine if any of the clients were receiving services in violation of a therapist to client ratio.

Investigative staff could not locate any regulation or statute which mandates a staffing ratio of therapist to client as suggested by the information provided in this referral.

2. MFEAD obtained a proof of licensure for each of the three therapists working for Provider. Each of the three therapists corresponded to the billing associated with the services provided.

3. The anonymous source identified 7 clients who received behavioral health services from Provider, and whose behavioral health therapy was not effective or not implemented at all.

MFEAD reviewed the files of each of the 7 clients. The review of the documents for each of the clients indicated that all were receiving behavioral health therapy. Investigative staff could not determine which client had not benefited from behavioral health therapy they were receiving.

4. MFEAD could not substantiate the allegation as contained in the referral.

MFEAD could not substantiate the allegations as contained in the referral dated August 21, 2012.

Referral from a private citizen (Complainant) dated April 4, 2014: see Supplemental Report, case 13-088, pages 31-32.

The referral contained following allegations:
1. Abuse/neglect: deliberate discharge of difficult consumer.
2. Exploitation: interest earned on investment trust account was used to pay management fee instead of flat fee.
3. Not reporting incidents. Provider prevented its staff from reporting incidents to Department of Health (DOH).

Each of these allegations was investigated by MFEAD:
1. The investigation of abuse and/or neglect of a particular consumer was conducted by MFEAD in 2013. It was noted that the case was closed on January 1, 2014 due to insufficient evidence to substantiate any abuse, neglect and/or exploitation.

2. Complainant was interviewed regarding allegations of exploitation. Follow up investigation revealed that the interest earned on consumers trust investment account in 2012-2013 was less than suggested monthly flat fee. Review of individual sub ledgers revealed that no management fees were charged to consumers.

3. Complainant was interviewed regarding allegations that Provider concealed incidents by preventing its staff from reporting incidents to DOH. Further investigation determined that the incidents were inconclusive as to necessity to report the incidents.

Summary of MFEAD findings
As a result of interviews with individuals conducted during the investigation, documentation reviewed by the MFEAD investigative team, a thorough analysis of claims review and application of the New Mexico Administrative Code for the payment of Medicaid claims, review of documents issued by New Mexico Behavioral Health Collaborative, the MFEAD investigative team determined that insufficient evidence exists to support a finding of fraudulent activity.

Conclusion

Provider's improper billing practices associated with findings that derived from information provided in PCG report resulted in an amount of $10,842.46 as presented in Table 1, Line 4. Additional improper billing resulted in an amount of $23,453.73 as presented in Table 2, Line 6. The total amount is $34,126.19 (10,842.46 + 23,283.73)

Table 1

	Type of Review or Investigation - Reviewed claims	Number of Claims = denominator	Total Numbers of claims / percentage to recoup	Amount of recoupment ($)
1	Auditors longitudinal review	2,301	39 / 1.7%	4,752.03
2	Auditors random clinical	150	4 / 2.6%	368.28
3	Additional 58 claims related to Auditors report	2,509	58 / 2.3%	5,722.15
4	Total claims 2,509 = (2,301+150 +58)	2,509	101 / 4.0%	10,842.46

Table 2

	Allegations by OHNM	Amount corresponding to the allegation	Amount corresponding to insufficient documentation other than the allegation	Amount of Recoupment ($)
1	Cross-billing outpatient services	137.64	7,936.56	8,074.20
2	Cross-billing family therapy	1,033.77	1,727.07	2,760.84
3	Duplicate billing	6,905.00	1,801.00	8,706.00
4	Unbundling bundled services	330.00	1,774.71	2,104.71
5	Double billing	325.12	1,312.86	1,637.98
6	Total	8,731.53	14,552.20	23,283.73

[x] Completed **[ ] Closed**

Investigator: _Veronica Levshin _____ **Date:** 4/30/2014

Supervisor: _Adrian Flores _____ **Date:** 4/30/14

Director: _Jody Curran _____ **Date:** 4/30/14

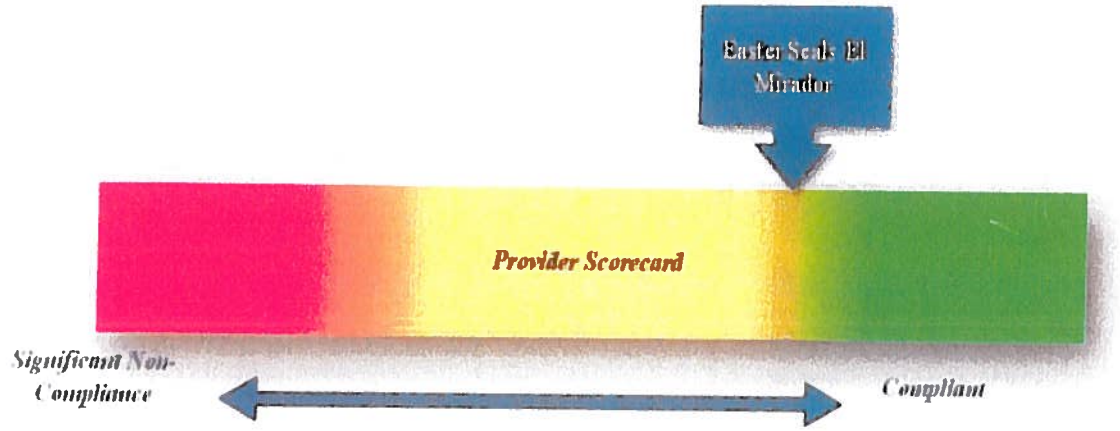
EASTER SEALS EL MIRADOR
BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 13 – 20, 2013
Main Point of Contact at Facility	Patsy Romero, Chief Operating Officer
Extrapolated Date of Service Overpayments	$772,016
Actual Longitudinal Overpayments	$78,854
Total Overpayments	$850,870

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
87%	**72%**



This scorecard result translates to the following Risk Tier:

2	Significant volume of findings that include missing documents	• Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.

Provider Overview

Santa Maria El Mirador provides behavioral health services in Alcalde and Santa Fe, New Mexico. Within these locations, Santa Maria El Mirador delivers behavioral health services including community living services, supported employment, meaningful day activities services, training institutes, greenhouse and camp and recreation services. PCG was tasked with reviewing several of these programs for compliance with New Mexico regulations.

Payer	$ Claims Paid FY12	$ Claims Paid Audit Period
BHSD	0	0
CYFD	33,765	137,675
Medicaid FFS	311,665	1,802,419
Medicaid MCO	3,304,250	12,345,189
NMCD	0	0
Other	0	0
Grand Total	**3,649,680**	**14,285,283**

Audit Team Observations

- An entrance conference was held within the first hour of the team's arrival onsite. Chief Executive Officer Mark Johnson and Program Director Patsy Romero were offsite at the time of the entrance conference but would later introduce themselves to the team and inquire as to whether all requested documentation was being provided.
- Paper copies of progress notes were provided within hours of the conclusion of the entrance conference. Staff indicated that files would need to be gathered from multiple locations and that some would be delivered via shipment while others could be driven to Santa Fe from other locations.
- The team moved to Easter Seals' office location in Taos to conduct the bulk of the data collection processes since the majority of clinical and personnel files are stored at that location.

- Files were provided primarily in hard copy and PCG pulled the relevant documentation from the files. A number of files were provided electronically, having been scanned by Easter Seals staff.
- Clinical Reviewers noted the following general findings:
  - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service or the provided assessments were not up to date for the date of service under review.
  - Treatment plans were missing, not up to date, and/or not individualized per consumer.
  - Progress Notes/Recipient Documents were missing, incomplete, and insufficient of necessary information.

Random Date of Service Claim Review

PCG reviewed one hundred and fifty (150) random date of service claims for July 1, 2009 through January 31, 2013. Below is a table showing the relevant programs that were included in PCG's random audit sample and the resulting findings:

Procedure Code	Program Description	# of Claims Reviewed	$ Value Claims Reviewed	# Claims Failed	$ Value Claims Failed	% Claims Failed
90801	Psychiatric Diagnostic Evaluation	1	87			0.0%
90806	Outpatient—45-50 minutes	4	268			0.0%
90812	Interactive Psychotherapy—45-50 minutes	7	490	1	71	14.3%
90814	Interactive Therapy—75-80 minutes	1	80			0.0%
90834	Outpatient –45 minutes	1	68	1	68	100.0%
90847	Family Therapy	7	543	1	78	14.3%
90849	Outpatient Psychotherapy Services	1	24			0.0%
90853	Group Therapy	4	124	4	124	100.0%
90862	Medication Management	4	272	2	136	50.0%

H2014	Behavior Management Services	99	14,953	10	1,327	10.1%
H2015	HO, HN, HM—CCSS	3	327	1	188	33.3%
S5145	Treatment Foster Care	18	2,853			0.0%
Grand Total		**150**	**20,088**	**20**	**1,990**	**13.3%**

Specific Random Sample Review Findings

For each program reviewed, PCG identified the level of compliance and any specific areas of concern. Below is a table showing each of the non-compliant claims PCG validated, the reason(s) why the claim was found to be out of compliance, and the area(s) of concern PCG identified:

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2014	—, 06/30/2010	Fail	Fail	NA	Pass	NA	Pass	NA	NA	NA	Psychosocial assessment invalid. No signature. Missing documentation: There is no treatment plan found for this client.
H2014	—, 08/07/2010	Fail	Pass	NA	Pass	NA	Pass	NA	NA	NA	Psychosocial Assessment dated 9/10/09 does not show risk of inpatient hospitalization, residential treatment or separation from family. No documented history of hospitalization or out-of-home placement.
H2014	—, 07/09/2012	Fail	Fail	NA	Pass	NA	Pass	NA	NA	NA	Documentation does not support risk of inpatient hospitalization, residential treatment, separation from family or hx of out of home placement. Initial treatment plan does not mention working with the family, treatment plan review in file is dated 7/17/12 and is not applicable to date of service. Generic, broad goals/interventions.
H2014	—, 08/13/2012	Fail	Fail	NA	Pass	NA	Pass	NA	NA	NA	Client is not at risk of out of home placement, document states she has always lived with her father and has a close relationship with her step mother, she is not at risk of being placed in a more restrictive environment. Missing documentation: Leann Martinez and Sally Warnick not on staff roster.
H2014	—, 01/04/2011	Fail	Fail	NA	Fail	NA	Fail	NA	NA	NA	Missing Document: Psychosocial assessment/ updates; treatment plan and updates. Billie Apodaca signed this note for 1/4/11--time from 8am to 3:15pm --This progress note for 1/4/11 BMS does not check off the Target Behaviors, interventions or Positive behaviors observed. H2014—Behavior Management Services(NMAC 8.322.3: LOC 745.2)--.
H2014	—, 01/25/2013	Pass	Fail	NA	Pass	NA	Pass	NA	NA	NA	Treatment plan designed primarily around the client in the school environment.
H2014	—, 07/21/2009	Fail	Fail	NA	Fail	NA	Fail	NA	NA	NA	Missing Documentation- Psychosocial assessment and Treatment plan not found. Only documentation found for this client is a BMS Daily log BUT is dated 9/25/09 so nothing on file

											for this DOS.
H2014	[redacted] 11/21/2011	Pass	Pass	NA	Fail	NA	Fail	NA	NA	NA	Progress note indicates the time in is 12:00, time out is 12:30=2 units. The billing on this claim is for 24 units. Missing documentation- The BMS Provider April Unaccarato (Sp?) not on the staff list.
H2014	[redacted] 01/23/2012	Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	Unable to locate a signature on this note. There is no signature at bottom of the document..
H2014	CS 02/29/2012	Pass	Pass	NA	Pass	NA	Fail	NA	NA	NA	BMS daily log not signed for this day--H2014—Behavior Management Services (NMAC 8.322.3; LOC 745.2).
H2015	[redacted] 05/10/2010	Fail	Fail	Fail	Fail	NA	Pass	NA	NA	NA	Missing documentation- There is not a Psychosocial assessment prior to DOS. Review is dated 10-6-2010. Missing documentation- There is not a Psychosocial assessment prior to DOS. Review is dated 10-6-2010. No documentation about safety issues. Can not verify this, note was used as a transportation.
90812	[redacted] 12/01/2011	NA	NA	NA	NA	NA	NA	NA	NA	Fail	Q19: H2014—Behavior Management Services(NMAC 8.322.3; LOC 745.2) and 90806—Outpatient—45-50 minutes--(NMAC 8.310.8) (90812) two services rendered on the same day at the same time.
Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
90834	[redacted] 01/10/2013	NA	NA	NA	NA	NA	NA	NA	NA	Fail	Billing BMS and outpatient at the same time for the same day. Duplicate Billing. There are two services for this date 1/10/13 a BMS (per note from 8am to 12pm) and this outpatient from 11;15 to 12pm. Therefore the times do not match as it is indicated he was receiving BMS and at the same time receiving outpatient therapy.
90847	[redacted] 07/13/2010	NA	NA	NA	NA	NA	NA	NA	NA	Fail	This family therapy session from 1;30pm to 2;30pm signed by Sally Warnick, LISW and CCSS Progress note from 2:15 to 2;45pm on 7/13/10 singed by Pat Martinez (?)

90853	[redacted] 01/16/2013	NA	NA	NA	NA	NA	NA	NA	NA	Fail	Goals unmeasurable, interventions not specific to the consumer. Treatment plan not individualized, interventions not specific to the consumer, no information about group therapy. 90853—Group Therapy–(NMAC 8.310.8) Q15: there is no documentation of group therapy as a part of the treatment plan-90853—Group Therapy–(NMAC 8.310.8)–Treatment plan indicates outpatient with Terri Richards, but no indication of group.
90853	[redacted] 07/17/2009	NA	NA	NA	NA	NA	NA	NA	NA	Fail	Treatment plan did not relate to the individualized needs of the consumer. Provider is listed as rendering the service instead of required practitioner.
90853	[redacted] 07/13/2009	NA	NA	NA	NA	NA	NA	NA	NA	Fail	Illegible signature to determine rendering staff. Provider is listed as rendering the service instead of practitioner.
90853	[redacted] 01/27/2010	NA	NA	NA	NA	NA	NA	NA	NA	Fail	No qualifications submitted for rendering provider Francine Lindburg.
90862	[redacted] 11/21/2012	NA	NA	NA	NA	NA	NA	NA	NA	Fail	No medication consent submitted for review.
90862	[redacted] 08/30/2011	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Pass	Pass	No medication consent submitted for review.

Sampling Definition: Sampling is a statistical technique designed to produce a subset of elements drawn from a population, which represents the characteristics of that population. The goal of sampling is to determine the qualities of the population without examining all the elements in that population. Random selection of claims is necessary in order to produce a valid sample. In a random sample, claims are selected from a population in such a way that the sample is unbiased and closely reflects the characteristics of the population.

Sampling Frame Size: Total number of claims from universe of claims from which the sample was selected.

Sampling Unit: The entire claim amount.

Time Period: 7/1/2009 – 1/31/2013

Sample Size: Sample size is 150 claims.

Extrapolation: The overpayment was identified using the lower bound of the 90% confidence interval.

Santa Maria El Mirador	
Sample Size	150
Total Paid for Sample	$20,088
Sampling Frame Size	103,733
Number of Sample Claims with Overpayments	20
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	$772,016

Longitudinal File Review

PCG selected between one and five of high risk procedure codes at each reviewed provider and then selected the five recipients who accounted for the highest dollar billing associated with each selected procedure code. PCG then performed an administrative and clinical review of 100 percent of the claims associated with each selected procedure code and recipient which were paid during calendar year 2012. Below is a table showing the relevant programs that were included in PCG's longitudinal file review and the resulting findings:

Proc Code	Program Description	# of Cases Reviewed	# Claims Reviewed	$ Claims Reviewed	# Claims Failed	$ Value Claims Failed	% Claims Failed
H2014	Behavior Management Services	5	980	118,604	292	36,441	29.8%
S5145	Treatment Foster Care	5	1,321	187,806	348	42,413	26.3%
Grand Total		**10**	**2,301**	**306,409**	**640**	**78,854**	**27.8%**

Provider Credential Review

For all random date of service claims and longitudinal files reviewed, PCG requested provider credential information for each of the clinicians or other staff that had rendered the service. The table below shows the number of staff reviewed by provider type:

Provider Type	# Reviewed
Therapist	**5**
Therapeutic Foster Care	**3**
IOP	**1**
Psychologist	**1**
BMS	**66**
Total Staff Reviewed	**76**

IT/Billing System Audit

System Overview

Easter Seals El Mirador uses Medisoft for case tracking and billing system. Medisoft is a 3rd party, cloud based billing system based on Microsoft technology.

Bill process

Medisoft uses Optum Netwerkes ACH to submit their bills for processing and payment. Data intake forms are entered into the Medisoft system and electronically scanned and stored on a secure file server. All PCs are encrypted.

IT Contacts

- Walter Sadlowski – IT Admin
- Carmela Dominguez, Senior Accountant
- Mike Easley, Controller

Application Controls - System Walkthrough

All data intake information collected on paper and encounter data is entered into the Medisoft 3rd party system. The paper forms are keyed in by a small number of staff. The claims are billed on a monthly basis.

The El Mirador office is the central accounting office for Raton and Taos also. After claims are submitted by Taos and Raton a spreadsheet of their billings are sent to Carmela Dominguez and Mike Easley for review. Both of them analyze the billings and review the data for increases or decreases.

IT Strengths and Weaknesses

Strengths:

- The Medisoft software application is provided by a division of Mckesson, a $123 billion dollar health company.
- The Medisoft software is a cloud based, practice management software application that is secure and backed up on a regular basis.
- Medisoft user names and passwords are not shared and are distributed to individual users.

- Claims and remittances are sent and received electronically through Networks ACG clearing house.
- The system has reports to reconcile billings and remittances.
- None of the staff have access to the billing system source code.
- Formal training to use the system is provided to the users.

Weaknesses:

The weaknesses identified below are common among all the providers we audited, especially the three groups that are organized under El Mirador (El Mirador, Taos and Raton), because they all use the same system and owned and managed by the same central corporation.

Application controls may be compromised by the following application risks:

- All data forms are keyed into the application by a few individuals. Despite the application's data entry edits there is opportunity for data entry error. There should be a periodic audit of the stored electronic form and the corresponding data that is stored online (e.g. compare # of units and procedures) to see if differences exist.
- There is opportunity for clerical staff to create and manage fictitious clients and providers. Independent audits on a periodic basis are needed to verify both the provider and patient and the patient's condition exists.

Recommendations

- Verify that billing data in 837s and remittance data in 835s balance out using the Medisoft accounting reports or other available reports. Confirm that billings and remittances match to progress notes and billing data in the Medisoft system.
- On a monthly or quarterly basis create a process to verify that patient treatment documentation stored as an image on the image server matches what is in the Medisoft database to prevent data entry mistakes.

Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of Easter Seals El Mirador (ESEM). PCG began by locating ESEM's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on CAI. This organization was formerly Santa Maria El Mirador. As such PCG reviewed both Santa Maria El Mirador and Easter Seals El Mirador (ESEM). We also reviewed the financials of a related foundation (The Knights of Templar).

PCG located and reviewed ESEM's audited financial statements and tax data. PCG recorded and reviewed recent officers, key employees, and independent contractors. PCG also searched for other entities owned by key employees and contractors. PCG located related parties and analyzed both the parties and the relationships, reviewing for potential conflicts of interest.

PCG assembled the financial data and analyzed it, looking at key ratios, trends, and tracking variances. PCG tracked the organization's addresses and reviewed ownership of property online or through the county assessor's office. Finally, PCG performed media and court record searches on the organization or related individuals.

Audit Observations

The organization provides active rehabilitative services, including residential and day treatment services. The organization has a related foundation, The Knights of Templar, which exists for the sole benefit of ESEM. However, each organization is governed by a different board of directors thus prohibiting the consolidation of both entities.

Key Staff

First Name	Last Name	Position
Larry	Lujan	Director
Beth	Sultemeier	Director
Kirt	Flanagan	Director
Jane	Amos	Director
Mark	Johnson	President/CEO
John	DePaula	Deputy Director
Eloy	Duran	Deputy Director
Loretta	Garduno	Program Director

Margaret	Trivino	Health Service Coordinator
John	Petty	President
Carmen	Rodriguez	VP
Alice	Witcher	Secretary
Allen	Hamilton	Treasurer
Manley	Allen	Liason (2010)

Financial Relationships

The Knights of Templar Foundation raises and advances funds for ESEM.

Summary of Findings and Recommendations

Findings	Recommendations
CEO, Mark Johnson, is cousin to board member Larry Lujan. The organization established a deferred compensation trust agreement for the benefit of the executive director. The trust provides payment of $60K per year for seven years and upon reaching January 1, 2014, ten years upon termination of the director's employment for any reason.	This transaction should be evaluated for a determination of excess benefit. Mr. Johnson and Lujan should be evaluated to determine if they are disqualified persons.

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2011, 2010, 2009
Provider Organizational Chart	Current
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	

Balance Sheet	FY2010	FY2011
Assets		
Cash & cash equivalents	$ 446,566.00	$ 214,327.00
Receivables, net of allowance for doubtful accounts of approx. $122k (FY2012) & $178k (FY2011)	$ 908,616.00	$ 980,910.00
Prepaid expenses	$ 59,596.00	$ 71,042.00
Due from affiliated organization	$ 730,605.00	$ 376,912.00
Property & equipment, net	$ 604,660.00	$ 523,966.00
Capitalized leased assets, net	$ 96,942.00	$ 69,723.00
Beneficial interest in the assets of affiliated organization	$ 2,545,671.00	$ 2,353,894.00
Investments held for Deferred Compensation Plan	$ 181,086.00	$ 287,579.00
Cash held for Deferred Compensation Plan	$ 101,328.00	$ 1,470.00
Client deposits	$ 3,670.00	$ 3,212.00
Deposits – rental	$ 7,200.00	$ -
Total Assets	**$ 5,685,940.00**	**$ 4,883,035.00**
Liabilities		
Book overdraft	$ -	$ 357,074.00
Accounts payable	$ 338,192.00	$ 552,199.00
Short-term borrowings	$ 290,978.00	$ 1,026,667.00
Salaries, wages & payroll taxes	$ 584,516.00	$ 642,999.00
Compensated absences	$ 536,207.00	$ -
Deferred revenue	$ 32,856.00	$ 21,515.00
Current maturities of long-term debt	$ 76,311.00	$ 80,790.00
Current portion of deferred compensation	$ 60,000.00	$ 60,000.00
Current portion of capital lease obligations	$ 30,318.00	$ 33,981.00
Trust deposits held for clients	$ 3,670.00	$ 3,212.00
Long-term debt	$ 138,300.00	$ 57,977.00
Deferred compensation	$ 200,000.00	$ 221,844.00
Capital lease obligations	$ 68,635.00	$ 34,656.00
Total Liabilities	**$ 2,359,983.00**	**$ 3,092,914.00**
Net Assets	**$ 3,325,957.00**	**$ 1,790,121.00**
Total Liabilities and Net Assets	**$ 5,685,940.00**	**$ 4,883,035.00**

Income Statement	FY2010	FY2011
Revenue		
Medicaid revenue	$ 8,772,743.00	$ 8,911,788.00
Medicaid waiver	$ 1,135,310.00	$ 864,024.00
Federal revenue	$ 370,086.00	$ -
Patient revenue	$ 4,965,689.00	$ 4,040,597.00
Sales of products & services	$ 162,216.00	$ 112,992.00
Other government grants & contracts	$ 6,061.00	$ 560.00
Other	$ 30,817.00	$ 39,318.00
Loss from affiliated organization: beneficial interest in the assets of affiliated organization	$ (56,182.00)	$ (191,777.00)
Contributions	$ 86,000.00	$ 6,217.00
Investment return	$ 10,016.00	$ 6,449.00
Other interest & dividend income	$ 11,704.00	$ 13,186.00
Gain on disposal of equipment	$ -	$ 11,634.00
Net assets released from restrictions	**$ -**	**$ 34,724.00**
Total Revenues and Support	**$ 15,494,460.00**	**$ 13,849,712.00**
Expenses		
Intermediate care	$ 9,116,835.00	$ 8,630,006.00
Outpatient behavioral health to children & youths	$ 3,464,096.00	$ 2,963,582.00
Community integration	$ 1,363,806.00	$ 963,670.00
Treatment foster care placement & support	$ 378,440.00	$ 349,290.00
General & administration	$ 1,881,663.00	$ 2,444,276.00
Total Expenses	**$ 16,204,840.00**	**$ 15,350,824.00**
Change in temporarily restricted net assets	**$ 34,724.00**	**$ (34,724.00)**
Change in Net Assets	**$ (675,656.00)**	**$ (1,535,836.00)**
Net Assets, beginning of year	**$ 4,001,613.00**	**$ 3,325,957.00**
Net Assets, end of year	**$ 3,325,957.00**	**$ 1,790,121.00**