STATE OF NEW MEXICO

COUNTY OF SANTA FE

FIRST JUDICIAL DISTRICT COURT

Case No. D-101-CV-2013-02436

The STATE OF NEW MEXICO, ex rel. THE NEW MEXICO FOUNDATION FOR OPEN GOVERNMENT,

Petitioner,

v.

RICHARD RUSSELL, and
JONNI LU POOL,

Respondents.

SUPPLEMENTAL MOTION FOR ORDER TO SHOW CAUSE WHY RESPONDENTS SHOULD NOT PRODUCE THE FULL BEHAVIORAL HEALTH AUDIT REPORT AND MEMORANDUM IN SUPPORT

Petitioner New Mexico Foundation for Open Government ("NMFOG") hereby moves for an order requiring Respondents to show cause why they should not produce the full report ("Report") of the audit of New Mexico behavioral health providers prepared for the New Mexico Human Services Department by Public Consulting Group, Inc. ("PCG").[1]

BACKGROUND

On September 17, 2013, the Court issued an alternative writ of mandamus ordering Respondents "to produce for NMFOG's inspection the full, unredacted report created by Public Consulting Group, Inc. of its audit of New Mexico behavioral health providers," or show cause why either the full, unredacted report or each redacted part of the report is excepted. Such

[1] Pursuant to Rule 1-007.1(B) NMRA, undersigned counsel has conferred with opposing counsel, and the Motion is opposed.

showing required that Respondents provide "information sufficient for the Court *and* NMFOG to determine whether the asserted exceptions apply." Alternative Writ of Mandamus (Sept. 13, 2013) at 2-3. The Respondents argued that the redacted portion of the report was excepted from inspection pursuant to Section 14-2-1(A)(4) NMSA 1978, which permits withholding from inspection "law enforcement records that reveal confidential sources, methods, information or individuals accused but not charged with a crime." *See* Resp. to Alternative Writ of Mandamus (Oct. 18, 2013) at 1-2. After a hearing, the Court ordered Respondents to provide the unredacted report with the redactions indicated for *in camera* review. *See* Order Concerning Alternative Writ of Mandamus (Nov. 21, 2013) ¶ 1. The Court further held that should it determine that it needed additional information, it would set the matter for evidentiary hearing. *See id.* ¶ 3. After conducting its review, the Court determined that the Section 14-2-1(A)(4) exception applied, and accordingly the Court did not compel Respondents to permit further inspection. *See* Order Regarding Disclosure of Document Following *In Camera* Review (Dec. 5, 2013) at 2 ("[T]he Court has determined that it would not be possible to make more limited redactions."). The Court left the matter open to permit NMFOG "to reapply for a writ if the circumstances change such that the law enforcement exception is no longer viable." *Id.* at 3.

Since the Court's Order, the Attorney General has cleared two of the 15 behavioral health providers and released portions of the report pertaining to those providers. In January, the Attorney General issued a news release stating that his office "found insufficient evidence to support allegations of fraud" by the Counseling Center. *See* NMAGO Media Advisory (Jan. 16, 2014) (Ex. A). At that time, the Attorney General released portions of the Report pertaining to the Counseling Center. *See* Report (Counseling Center) at 295-313 (Ex. B). In addition, the Attorney General disclosed that it had found approximately $19,000 in overbilling by the

Counseling Center. *See* Deborah Baker, *Attorney General clears Alamogordo behavioral health provider in fraud probe*, Albuquerque Journal, January 16, 2014, http://www.abqjournal.com/337821/news/ attorney-general-clears-alamogordo-behavioral-health-provider-in-fraud-probe.html (Ex. C). This compares with the $612,663 in overpayment estimated by PCG. *See* Report (Counseling Center) (Ex. B) at 303.

The Attorney General has since announced that it found insufficient evidence of fraud to proceed against Easter Seals el Mirador. *See* NMAGO News Release (May 6, 2014) (Ex. D). This time, the AGO not only released portions of the Report pertaining to Easter Seals el Mirador, *see* Report (Easter Seals) at 107-21 (Ex. E), but it also released its own investigative results. *See* Investigative Report (April 30, 2014) (Ex. F). In the released portion of the Report, PCG estimated total overpayments of $850,870 to Easter Seals el Mirador. *See* Report (Easter Seals) (Ex. E) at 107. The Attorney General's investigation, however, found only $34,126.19 in improper billing, only $10,842.46 of which was derived from information provided in the Report. *See* Investigative Report (Ex. F) at 7.

The newly released portions of the Report contain various information regarding alleged overpayments, *see, e.g.*, Report (Easter Seals) (Ex. E) at 114, including specific transactions. *See id.* at 111-13. In addition, they provide insight into PCG's methods. *See, e.g.*, *id.* at 118 (describing the "Provider Specific Methodology"). While the Report identifies some individuals, *see id.* at 118-19 (identifying key staff), it contains little to no discussion of individual conduct.

ARGUMENT

The Court should compel production of the remainder of the Report because it will not harm any investigation. The Attorney General has had ample time to secure the information needed for any potential prosecution arising from information learned from the Report. Release

of the rest of the Report will not disclose confidential methods, sources, or individuals accused, but not charged, with a crime. When the Court previously declined to compel disclosure, NMFOG did not have access to the portions of the Report that have since been released; it is now clear that the Report, or at the very least, much more of the Report than has been previously disclosed, is subject to inspection under IPRA.

I. The Attorney General Has Had Ample Time to Secure the Information Necessary for Any Prosecution Pursuant to the Report.

To the extent that the Court's previous ruling rested on the potential harm to the Attorney General's investigation of behavioral health providers, sufficient time has passed to render release of the Report harmless. The exception in Section 14-2-1(A)(4) exists to protect the integrity of ongoing criminal investigations. *See Estate of Romero v. City of Santa Fe*, 2006-NMSC-028, ¶ 17, 139 N.M. 671, 678; *see also* New Mexico Attorney General's Office, New Mexico Inspection of Public Records Act Guide at 10 (7th ed. 2012) ("Under this exception, records held by a law enforcement agency are protected if disclosure would *seriously* interfere with the effectiveness of a criminal investigation or prosecution.") (emphasis added).

In the initial briefing, the Respondents argued that the Section 14-2-1(A)(4) exception "exists to protect the integrity and effectiveness of . . . investigations." Resp. (Oct. 18, 2013) at 6-7; *see also id.* at 8 (expressing concern that publication of the Report would "unduly interfere with the AGO's ongoing criminal investigation."). The Court credited this concern. *See* Order Denying Disclosure of Document Following *In Camera* Review (Dec. 5, 2013) at 2 ("The information revealed by the Audit is not generally known, and revelation of it and how it was gathered could harm the AGO investigation."). But it has now been approximately a year since HSD suspended payment to the providers reviewed in the Report. *See* Mem. from Apodaca to MCO Program Integrity Directors (June 24, 2013) (Ex. C to Pet.). In that year, there have been

no indictments, but the AGO has had ample time to secure documentary evidence and testimony for any potential criminal prosecution.

II. Release of the Report Will Not Reveal Confidential Sources, Methods, Information, or Individuals Accused but Not Charged with a Crime.

The previously unreleased portions of the Report show that disclosure will not reveal confidential sources, methods, information, or individuals accused but not charged with a crime. Section 14-2-1(A)(4) applies to documents containing such information, and only to documents containing such information. New Mexico courts "have long recognized and acknowledged IPRA's core purpose of providing 'access to public information and thereby encourag[ing] accountability in public officials.'" *Cox v. N.M. Dep't of Pub. Safety*, 2010-NMCA-096, ¶ 6, 148 N.M. 934, 937 (quoting *Bd. of Comm'rs of Doña Ana Cnty. v. Las Cruces Sun-News*, 2003-NMCA-102, 134 N.M. 283). This means that exceptions to IPRA are construed narrowly. *See State ex rel. Toomey v. City of Truth or Consequences*, 2012-NMCA-104, ¶ 22 ("IPRA should be construed broadly to effectuate its purposes, and courts should avoid narrow definitions that would defeat the intent of the Legislature.") (citing *Cox*). As discussed below, the newly-released portions of the Report reveal that none of the types of information enumerated in Section 14-2-1(A)(4) will be disclosed.

First, release of the Report will not disclose confidential sources. While the Counseling Center and Easter Seals el Mirador sections of the Report mention "conference[s]," *see* Report (Easter Seals) (Ex. E) at 108, and "discuss[ions]," *see* Report (Counseling Center) (Ex. B) at 305, no individuals are identified in connection with these conferences or discussions. None of these conferences or discussions are referred to as confidential; nor is there any material that suggests that the discussions were confidential.

Second, release of the remainder of the Report will not disclose confidential methods. As an initial matter, to the extent that PCG—which is not a law enforcement agency—could be argued to employ confidential law enforcement methods, those methods have been disclosed by the release of the portions of the Report pertaining to the Counseling Center and Easter Seals el Mirador. *Compare* Report (Counseling Center) (Ex. B) *with* Report (Easter Seals) (Ex. E) (showing consistent methodology). Moreover, the released portions of the Report show that the discussion of methodology in the portions of the Report for each provider are fairly general and do not pose a risk to any investigation, and certainly not the "serious" interference required by the Attorney General's own IPRA Compliance Guide. *See* New Mexico Attorney General's Office, New Mexico Inspection of Public Records Act Guide at 10 (7th ed. 2012).

More importantly, releasing the Report will not reveal confidential methods jeopardizing the Attorney General's investigation because the Report's methods are not the Attorney General's methods, as shown by the radically different results of the Attorney General's investigations into the two cleared providers when compared to PCG's results. In each case, the Attorney General found less than 10% of the overbilling predicted by PCG's method. *Compare* Report (Easter Seals) (Ex. E) at 114 (finding $772,016 in tentative overpayment for Easter Seals el Mirador) *with* Investigative Report (Ex. F) at 7 (finding $34,126.19 in improper billing); Report (Counseling Center) (Ex. B) at 303 (finding $612,663 in tentative overpayment for the Counseling Center) *with* Baker, *supra* (Ex. C) (announcing a finding of approximately $19,000 in overbilling). Even the actual improper billings diverge substantially. *Compare* Report (Easter Seals) (Ex. E) at 115 (finding $78,854 in failed claims) *with* Investigative Report (Ex. F) at 7 (finding only $34,126.19). These vastly different figures cannot have resulted from the same

method; therefore, release of the remainder of the Report will not reveal confidential law enforcement methods.

Third, the Report will not release confidential information that would undermine the Attorney General's investigation into the remaining providers. As the Investigative Report shows, the Report was only a starting point for the Attorney General's investigation, and as discussed above, the Attorney General has had a year to develop documentary evidence and testimony based on the Report. Additionally, because the Investigative Report found that only four of the twenty claims identified by PCG lacked sufficient documentation to justify billing the claims, *see* Investigative Report (Ex. F) at 1, the inclusion of any specific transaction in the Report is far from a guarantee that there was anything criminal about that transaction, particularly since further review even of the four transactions identified by the Attorney General revealed no fraudulent activity. *See id.* at 1-2. And to the extent that there may be legitimately confidential information in the unreleased portions of the Report, review of the newly released portions shows that concerns regarding the release of such information may be addressed by more targeted redaction.

Finally, release of the Report will not reveal individuals accused, but not charged with a crime. The newly released portions of the Report contain no accusations whatsoever. At most, specific transactions identified by PCG as problematic are occasionally associated with particular staff. *See, e.g.*, Report (Easter Seals) (Ex. E) at 112 (identifying signatories for particular sessions). This is a far cry from accusing any of these individuals with a crime. Again, to the extent that the unreleased portions contain more damning information that actually accuses individuals of a crime, concerns about disclosure may be addressed by targeted redaction.

III. NMFOG is Entitled to a Hearing.

When the Court previously considered this issue, NMFOG was at a disadvantage because it did not have access to the withheld portions of the Report. That has been remedied in part by the Attorney General's disclosure of portions of the Report pertaining to the Counseling Center and Easter Seals el Mirador. While the Court's reluctance to interfere with an ongoing investigation is understandable, review of the newly released portions of the Report and the Attorney General's investigative report on Easter Seals el Mirador—in light of the Attorney General's finding that there was insufficient evidence of fraud against these two providers, and in light of the vast gulf between the extrapolated overpayment numbers in the Report when compared with the actual overbillings found by the Attorney General—warrant a hearing at which the Court can revisit NMFOG's request for disclosure of the full Report. NMFOG therefore requests that the Court retain jurisdiction of this matter until such time as the merits of NMFOG's request are finally decided after full briefing and hearing.

CONCLUSION

For the reasons above, Petitioner NMFOG respectfully requests that the Court grant this Motion.

Respectfully submitted,

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We hereby certify that on the 19th day of June, 2014 the foregoing was filed electronically and a copy served via email to counsel of record as follows:

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News List ›

AGO Release of Investigation Findings

1 post by 1 author

NO REPLY Jan 16

NMAGO MEDIA ADVISORY
Attorney General Gary K. King
Thursday, January 16, 2014
CONTACT: Phil Sisneros 505-222-9174 or Lynn Southard 505-231-4731

AG: Insufficient Evidence of Fraud by The Counseling Center

Investigation Findings Released to HSD Today

(ALBUQUERQUE)---New Mexico AG Gary King today announces that after an in depth investigation of The Counseling Center in Alamogordo, his office has found insufficient evidence to support allegations of fraud.

The AG's Office will continue to investigate other providers referred to the AGO as part of the overall behavioral health audit originating with the New Mexico Human Services Department.

...

EXHIBIT
A

The Counseling Center Inc.

Clinical Narrative
IT Narrative
Enterprise Narrative

PUBLIC CONSULTING GROUP

EXHIBIT
B

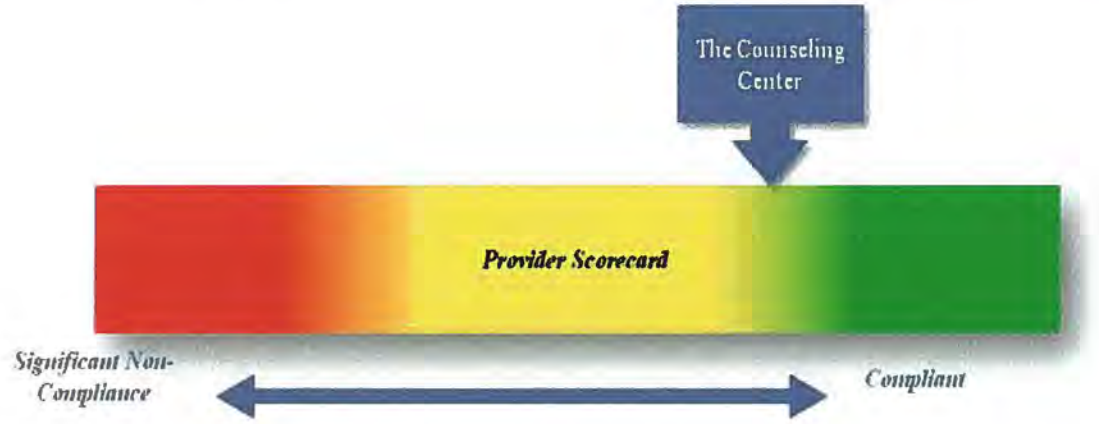
THE COUNSELING CENTER
BEHAVIORAL HEALTH PROVIDER AUDIT

Case File Audit

Dates of Onsite Review	March 6 – 11, 2013
Main Point of Contact at Facility	Jim Kerlin, Chief Executive Officer
Extrapolated Date of Service Overpayments	$612,663
Actual Longitudinal Overpayments	$43,137
Total Overpayments	$655,800

Scorecard results are as follows:

Random Sample Compliance Rate	Longitudinal Compliance Rate
83%	**80%**



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

Payer	$ Claims Paid FY12	$ Claims Paid Audit Period
BHSD	940,241	3,054,500
CYFD	47,531	127,226
Medicaid FFS	54,894	200,934
Medicaid MCO	846,114	2,934,261
NMCD	18,274	108,625
Other	3,365	115,508
Grand Total	**1,910,419**	**6,541,053**

Audit Team Observations

- Chief Executive Officer Jim Kerlin met the team at the site and an entrance conference was immediately held. Chief Operating Officer Sandra Wilder was also present at the entrance conference and was designated as the team's primary point of contact for data collection.
- Personnel files and supervision logs were produced in paper format within hours of the team's arrival onsite. The HR director explained the format of the personnel files and the PCG team manually pulled and scanned the necessary documentation.
- Clinical records were extracted from Anasazi, the organization's EHR system. Due to challenges with electronic transfer of the files, copies of the necessary documents were printed from the system and provided to the audit team in paper format for scanning and uploading. The audit team was not involved with the extraction of files from electronic systems.
- Counseling Center staff started extracting clinical files on the first day of the audit. They continued to extract files during the weekend, when the audit team was offsite, so that almost all of the files had been provided in paper format by the time of the team's return to the site on Monday.

- An exit conference was held with CEO Jim Kerlin on March 13. PCG reiterated that the onsite presence was for information gathering so no findings would be provided.
- Clinical Reviewers noted the following general findings:
  - Comprehensive Clinical Assessments were not always provided to determine/support medical necessity for the billed service.
  - 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
90804	Outpatient—20-30 minutes	7	307	0	0	0.0%
90806	Outpatient—45-50 minutes	22	1,450	0	0	0.0%
90847	Family Therapy	5	393	0	0	0.0%
90853	Group Therapy	14	424	0	0	0.0%
90862	Medication Management	7	508	0	0	0.0%
H0002	Behavioral Health Screening	5	248	1	40	20.0%
H0015	Intensive Outpatient Program	5	661	0	0	0.0%
H0031	Mental Health Assessment	6	1,627	0	0	0.0%
H2010	RN Medication Monitoring	14	1,033	0	0	0.0%
H2011	Crisis Intervention Services	5	403	0	0	0.0%
H2015	HO, HN, HM—CCSS	40	2,626	17	803	42.5%

H2017	Psychosocial Rehabilitation	13	1,813	6	803	46.2%
T1007	Behavioral Health Treatment Plan Update	7	792	2	228	28.6%
Grand Total		**150**	**12,284**	**26**	**1,873**	**17.3%**

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
90862	[redacted] 06/26/2012	Pass	Pass	Pass	Fail	Pass	Pass	Fail	NA	NA	No documentation of client's progress or lack of. No documentation of Informed consent for medication.
H0002	[redacted] 01/17/2012	Fail	NA	NA	NA	NA	Pass	NA	NA	NA	No documentation of family or collartoral involvement.
H2010	[redacted] 06/02/2010	Pass	Pass	Pass	Pass	Pass	Pass	Fail	NA	NA	No documentation of Informed Consent for Medication.
H2015	[redacted] 05/06/2011	Pass	Pass	Fail	Fail	NA	Pass	NA	NA	NA	Client called CSW about medication refills. No documentation of client's risk assessment.
H2015	[redacted] 09/27/2011	Pass	Pass	Pass	Fail	NA	Fail	NA	NA	NA	
H2015	[redacted] 09/07/2012	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Client called staff on re-scehduling appointments.
H2015	[redacted] 03/23/2011	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Contact made via phone.
H2015	[redacted] 12/08/2010	Fail	Fail	Fail	Fail	NA	Fail	NA	NA	NA	No documentation of Assessment or Treatment Plan in this file. Billed Code is for CCSS but service was Crisis Intervention. Billed Code is for CCSS but service was Crisis Intervention. Staff is not on provider's list.
H2015	[redacted] 08/18/2009	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Met with CSW at office.
H2015	[redacted] 03/31/2011	Pass	Pass	Pass	Pass	NA	Fail	NA	NA	NA	Staff is not listed and unknown as to her qualifications.
H2015	[redacted] 08/16/2012	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	CSW met with client at center.
H2015	[redacted] 02/10/2010	Pass	Pass	Fail	Pass	NA	Fail	NA	NA	NA	Client met with CSW at the center. Unknown history of CSW, not on list. Unknown history of CSW, not on list.
H2015	[redacted] 12/01/2009	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Treatment Plan Update meeting held at CSW office.

Proc Code	Recipient DOS	Assessment / Screening	Treatment Plan	Service Delivery	Psych / Progress Notes	Billing	Staffing	Consent Forms	Pharma	Other	Comments
H2015	[redacted] 03/11/2010	Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	6 units billed inappropriately as the progress note documents 3 units but same note entered two times and billed twice.
H2015	[redacted] 03/30/2010	Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	Two progress notes, same day, one at 2:30-3:00pm and another at 6:00-6:30pm but both notes typed at 4:37pm same day as the notes. Notes are almost duplicate in wording.
H2015	[redacted] 07/20/2011	Pass	Pass	Pass	Fail	NA	Pass	NA	NA	NA	Progress note documents case closure due to no contact/loss of contact with client.
H2015	[redacted] 02/24/2012	Pass	Pass	Fail	Fail	NA	Pass	NA	NA	NA	CSW called collateral contacts regarding client. No documentation of client's safety.
H2015	[redacted] 03/01/2012	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Telephone contact to remind client of appointment.
H2015	[redacted] 06/14/2010	Pass	Pass	Fail	Pass	NA	Pass	NA	NA	NA	Client met with CSW at the office as a scheduled appointment.
H2017	[redacted] 09/09/2009	Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Staff does not meet the required trainings.
H2017	[redacted] 10/29/2010	Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Staff is listed as not qualified.
H2017	[redacted] 09/10/2009	Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Staff is not qualified /has not met required trainings.
H2017	[redacted] 10/22/2010	Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Staff is listed as not qualified.
H2017	[redacted] 06/20/2012	Pass	Pass	Pass	Pass	Fail	Pass	NA	NA	NA	Staff not qualified or did not meet training requirements.
T1007	[redacted] 08/25/2010	NA	Fail	NA	NA	NA	Pass	NA	NA	NA	Inappropriate billing for case closure due to lost contact with client. Inappropriate billing for case closure due to lost contact with client. Inappropriate billing for case closure due to lost contact with client. Case was closed. Inappropriate billing for case closure due to lost contact with client.

T1007	[redacted] 03/28/2012	NA	Fail	NA	NA	NA	Pass	NA	NA	NA	

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.

— NAME REDACTED —	
Sample Size	150
Total Paid for Sample	$12,284
Sampling Frame Size	78,965
Number of Sample Claims with Overpayments	26
Tentative Overpayment Using Lower Bound of the 90% Confidence Interval	$612,663

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
H2015	HO, HN, HM—CCSS	5	520	30,693	71	4,315	13.7%
H2017	Psychosocial Rehabilitation	5	1,009	163,178	234	38,821	23.2%
Grand Total		**10**	**1,529**	**193,871**	**305**	**43,137**	**20.0%**

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
Community Support Worker	14
Therapist	17
Nurse	3
Psychiatrist	1
Psychosocial Rehabilitation	4
Unknown/Other	2
Total Staff Reviewed	**41**

IT/Billing Systems Audit

System Overview

The Counseling Center utilizes the Anasazi System for most of its medical records and billing. The system is used by all of the Rio Grande Network, and while each installation is administered by the individual agency, the differences are really superficial, such as:

- The way menus are customized to be displayed per the user roles,
- How user roles are defined,
- The customization and scheduling of reports and
- When certain system enhancements are implemented in each agency.

Individual agencies can decide what system upgrades are implemented and in what order. Most agencies in the Rio Grande system stay one to three updates behind the most recent. Each site generally deploys the updates to development installations to test and verify the updates before they are deployed into production.

The software is installed on the TCC Microsoft Window Network and is primarily accessed through the Citrix system, which allows all administrative and clinical staff to access the system from any computer.

Anasazi would not allow TCC (nor any provider) to disclose any training or systems documentation to our auditors, claiming it was proprietary.

Bill Processing

On a simple level, after services are provided to the client, the clinician updates the file with notes and the time and date of encounter. The Anasazi software processes this information and calculates the number of units that the service should be billed for, and what HCPCS/CPT code should be assigned to the service, using the service provided and start and stop times of the service.

The service is processed by the Anasazi system and transformed into an 837 billing format, which is uploaded to Optum health through the Optum Netwerkes system.

PCG auditors discussed IT with staff on March 5 & 6, 2013 and continued to receive information from TCC staff through March 13.

IT Contacts

- Sandra Wilder, COO, Clinical Director
- David Souder, IT Specialist
- Crystal Sampson, Billing Consultant
- Chris Moffat, IT Director, Rio Grande Behavioral Health Services, Inc.

Application Controls - System Walkthrough

Administration and Segregation of Duties

There are two systems that TCC users access: the Microsoft Windows Network and the Anasazi System. The Anasazi system is accessible both through the Windows network and through any computer that is connected to the internet. For that reason, PCG will only discuss Anasazi access in this report; the Windows network users are held in audit documentation collected by PCG for any required future reference.

User Roles

System Admin Group: Can add users and configure data sheets for health plans and services.

1. Chrystal Sampson, Rio Grande Behavioral Services
2. Cheryl Otero-Baker, Administrative Office Manager
3. Chris Moffat, Rio Grande Behavioral Services
4. Jaime Alvarez, Southwest Counseling

Administrative Group: Can configure data sheets for health plans and services.

1. David Souder
2. Bethany Akeroyd
3. Ashley Whitley

Medical Records and Intake Groups: Records Clerks and Intake Staff have appropriate administrative levels of access to records; primarily administrative and demographic records and read only for clinical information.

Clinical Group: All clinicians who bill are in the Clinical Group. They can enter clinical service provision to the system.

CQI Group: QI Manager is in this group.

Clinical Supervisors Group: Clinical Supervisors.

Rio Grande Supervisors Group:

Supervisory staff from Rio Grande Behavioral Health Services are provided with supervisory roles due to the management services agreement with TCC.

1. Cooper, Tammy
2. Lara, Maria
3. Sandoval, Dexter

Auditors Group: No staff at TCC currently have the Auditor Role, but TCC has established four Auditor accounts should auditors need access.

IT Strengths and Weaknesses

Strengths

- TCC's billing applications are available from any computer connected to the internet via Citrix, which make for ease of use from any computer and maintains a uniformly enforced security policy.
- Users do not share login accounts.
- The Anasazi software offers sequestration of clinical information so that users' roles determine the kind of information each user may have access to on a *per client* basis. For example, a front office clerk may have access to certain demographic information, but
- Each clinician enters his own billing information.
- Each clinician does not know what CPT/HCPCS codes are used for billing the service provided.
- Anasazi software calculates units billed based on start and end times recorded by the clinician.
- Anasazi software allows for members of a group therapy session to arrive and leave at different times, allowing for more accurate tracking group services, and therefore billing.

Weaknesses

- The point of entry to the claims payment system provides the ability to change any billing from what the clinician entered. The 837 can be changed when connected to Optum Netwerkes. The person uploading the 837 can make any changes to billing with no audit trail.
- Training is done mostly on an *ad hoc* basis.

Recommendations

- Create audit trail for any changes made to 837 files when they are uploaded to the clearinghouse.
- Develop formalized training system for all users who create charge entry and billing.

Enterprise Audit

Provider Specific Methodology

PCG utilized a consistent, systematic approach to conducting the enterprise audit of The Counseling Center. PCG began by locating The Counseling Center's legal entity, its officers, and organizers. PCG also reviewed initial founding and leadership information on The Counseling Center.

PCG located and reviewed The Counseling Center'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 Counseling Center provides mental health services to Otero and Lincoln Counties. The organization also provides clinical experience for students in New Mexico State University's Alamogordo nursing program.

Key Staff

First Name	Last Name	Position
Fred	Baker	President
Lulu	Valdez	VP
Noel	Brewer	Secretary
Donna	Dulmaine	Member
Ferial	Abood	Member
James R.	Kerlin, Jr	CEO
Sandra	Wilder	COO

Financial Relationships

The Counseling Center contracts with Rio Grande Behavioral Health Services, Inc. (RGBHS) for the provision of accounting, billing, and human resources functions. The organization paid RGBHS $168,000 for these services in 2010[1]. Rio Grande is a provider sponsored network and each organization's board members serve as rotating members of the RGBHS board. While RGBHS receives monthly fees from its members, it has also distributed various grants back to its members.

In addition, The Counseling Center contracts with Rio Grande Management, LLC (RGM) paying $139,000 for management services (2010). These include legal services and the provision of executive management. Providence Service Corporation fully owns RGM. Providence is a large, for-profit national corporation providing government sponsored social services directly or indirectly through managed local entities. Providence's network originated in Arizona and has developed a network of providers serving 70,000 clients in the US and Canada. The Executive Director of this organization is an employee of Providence Service Corporation.

In 2011, Executive Director, James Kerlin was paid $168,000 from this related organization.

Summary of Findings and Recommendations

Findings	Recommendations
In disclaimers, Rio Grande/Providence member organizations state that management staff may have other responsibilities to Providence. These arrangements make it unclear if the executives charged by Providence are part or full time for this organization. Moreover, without full disclosure, it is difficult to determine if the salaries or fees are reasonable. On the surface,	Full disclosure of executive effort, compensation and benefits should be revealed for this organization and for its services to Providence Service Corporation.

[1] Most recent year for which representative payments for both behavioral health and management services were reported.

the arrangements and amounts paid appear reasonable, but this weak and abnormal public disclosure may have the effect of masking excessive compensation or benefits. In addition, these arrangements circumvent federal disclosure requirements for charities filing Form 990 and make it difficult for the public to benchmark charitable organizations.	

List of Key Documentation Reviewed

Document/Source	Year (if applicable)
Audited Financial Statements	2012, 2011, 2010
Form 990 (Nonprofit filing)	2011, 2010, 2009
Contracts	
Organizational Charts	

Balance Sheet	2009	2010	2011
Assets			
Cash & cash equivalents	$ 687,129.00	$ 234,513.00	$ 221,188.00
Accounts receivable, less allowance for doubtful accts of $20k (2009); $10k (2010); $10k (20120	$ 292,399.00	$ 198,407.00	$ 195,602.00
Employee receivable	$ -	$ -	$ 900.00
Prepaid expenses	$ 12,467.00	$ 10,696.00	$ 12,310.00
Land	$ 100,000.00	$ 100,000.00	$ 100,000.00
Building & improvements	$ 1,041,730.00	$ 1,041,730.00	$ 1,041,730.00
Computer equipment	$ 72,795.00	$ 72,795.00	$ 72,795.00
Office equipment	$ 181,628.00	$ 181,628.00	$ 181,628.00
Vehicles	$ 75,699.00	$ 56,451.00	$ 56,451.00
Less accumulated depreciation	$ (617,624.00)	$ (636,174.00)	$ (668,890.00)
Total Assets	**$1,846,223.00**	**$1,260,046.00**	**$1,213,714.00**
Liabilities			
Accounts Payable	$ 516,531.00	$ 51,666.00	$ 55,228.00
Accrued expenses	$ 63,149.00	$ 31,866.00	$ 32,142.00

Deferred revenues	$ 2,043.00	$ -	$ -
Note payable-current portion	$ 46,201.00	$ 27,235.00	$ 22,173.00
Notes payable, net of current	$ 556,158.00	$ 534,923.00	$ 512,420.00
Total Liabilities	**$1,184,082.00**	**$ 645,690.00**	**$ 621,963.00**
Net Assets	**$ 662,141.00**	**$ 614,356.00**	**$ 591,751.00**
Total Liabilities and Net Assets	**$1,846,223.00**	**$1,260,046.00**	**$1,213,714.00**

Income Statement	2009	2010	2011
Revenue			
Grants/contracts	$ 1,670,949.00	$ 1,381,913.00	$ 2,280,139.00
Contributions & fees	$ 1,079,970.00	$ 1,063,861.00	$ 131,940.00
Interest income	$ 2,704.00	$ 7,511.00	$ 551.00
Miscellaneous income	$ 16,350.00	$ 30,008.00	$ 7,342.00
Total Revenues and Support	**$2,769,973.00**	**$2,483,293.00**	**$ 2,419,972.00**
Expenses			
Program expenses	$ 2,477,556.00	$ 2,278,595.00	$ 2,199,805.00
Admin expenses	$ 255,044.00	$ 235,344.00	$ 226,008.00
Fundraising	$ 18,393.00	$ 17,139.00	$ 16,765.00
Total Expenses	**$2,750,993.00**	**$2,531,078.00**	**$ 2,442,578.00**
Change in Net Assets	**$ 18,980.00**	**$ (47,785.00)**	**$ (22,605.00)**
Net Assets, beginning of year	**$ 643,161.00**	**$ 662,141.00**	**$ 614,356.00**
Net Assets, end of year	**$ 662,141.00**	**$ 614,356.00**	**$ 591,751.00**

abqjournal.com
http://www.abqjournal.com/337821/news/attorney-general-clears-alamogordo-behavioral-health-provider-in-fraud-probe.html

Attorney General clears Alamogordo behavioral health provider in fraud probe

Attorney General Gary King's office today cleared an Alamogordo behavioral health nonprofit it was investigating for possible Medicaid fraud.

King's office said it found $19,000 in overbilling of Medicaid by The Counseling Center, but "insufficient evidence to support allegations of fraud.".

It's the first word from the attorney general's office about its findings in an investigation of 15 behavioral health agencies. The state Human Services Department referred the agencies to the attorney general last year after an audit that the department said showed overbillings, widespread mismanagement and possible fraud.

Twelve of those nonprofits, including The Counseling Center, were taken over by Arizona companies brought in by the HSD.

The Counseling Center was affiliated with a network of nonprofits in southern New Mexico known as Rio Grande Behavioral Health Services.

"We felt we were wrongly accused from the beginning as part of this big dragnet that they threw out," said Jim Kerlin, who for 25 years was CEO of the agency.

EXHIBIT
C

AG Releases Results of Another HSD Audit Investigation

1 post by 1 author

AG News No Reply May 6

NMAGO NEWS RELEASE
Attorney General Gary K. King
Tuesday, May 6, 2014
CONTACT: Phil Sisneros 505-222-9174 or Lynn Southard 505-222-9048

AG's Probe Finds No Fraud in Health Provider's Audit
Easter Seals-El Mirador Cleared of Fraud but Overbilling Found

(ALBUQUERQUE)---New Mexico Attorney General Gary King says his investigation found insufficient evidence of fraud by Easter Seals El Mirador , one of the health organizations accused by the state Human Services Department of "credible allegations of fraud" last June.

"Although our investigation found no actionable evidence of fraud, we did discover that Easter Seals El Mirador overbilled Medicaid in the amount of $34,126.19," according to the Attorney General.

AG King says it is now up to HSD to take whatever action deemed appropriate to deal with the improper billing. A full report by the Attorney General's Medicaid Fraud & Elder Abuse Division will be provided to HSD.

More than a dozen other health and human services providers were accused of fraud and had their funding revoked as a result of allegations contained in audits and reports received by HSD. The Attorney General's Office has been investigating the claims, using the HSD information as a starting point for its own probe.

...

EXHIBIT
D

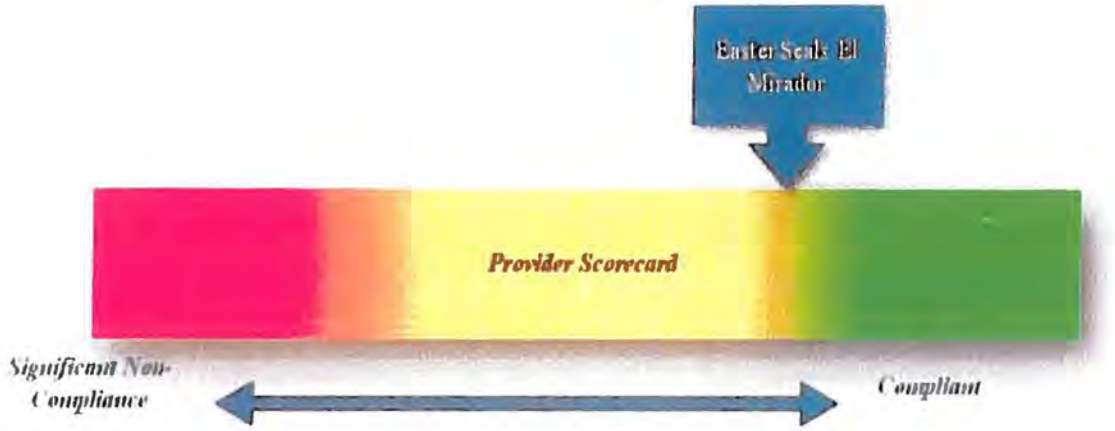
EASTER SEALS EL MIRADOR
BEHAVIORAL HEALTH PROVIDER AUDIT

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.

EXHIBIT
E

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**

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

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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