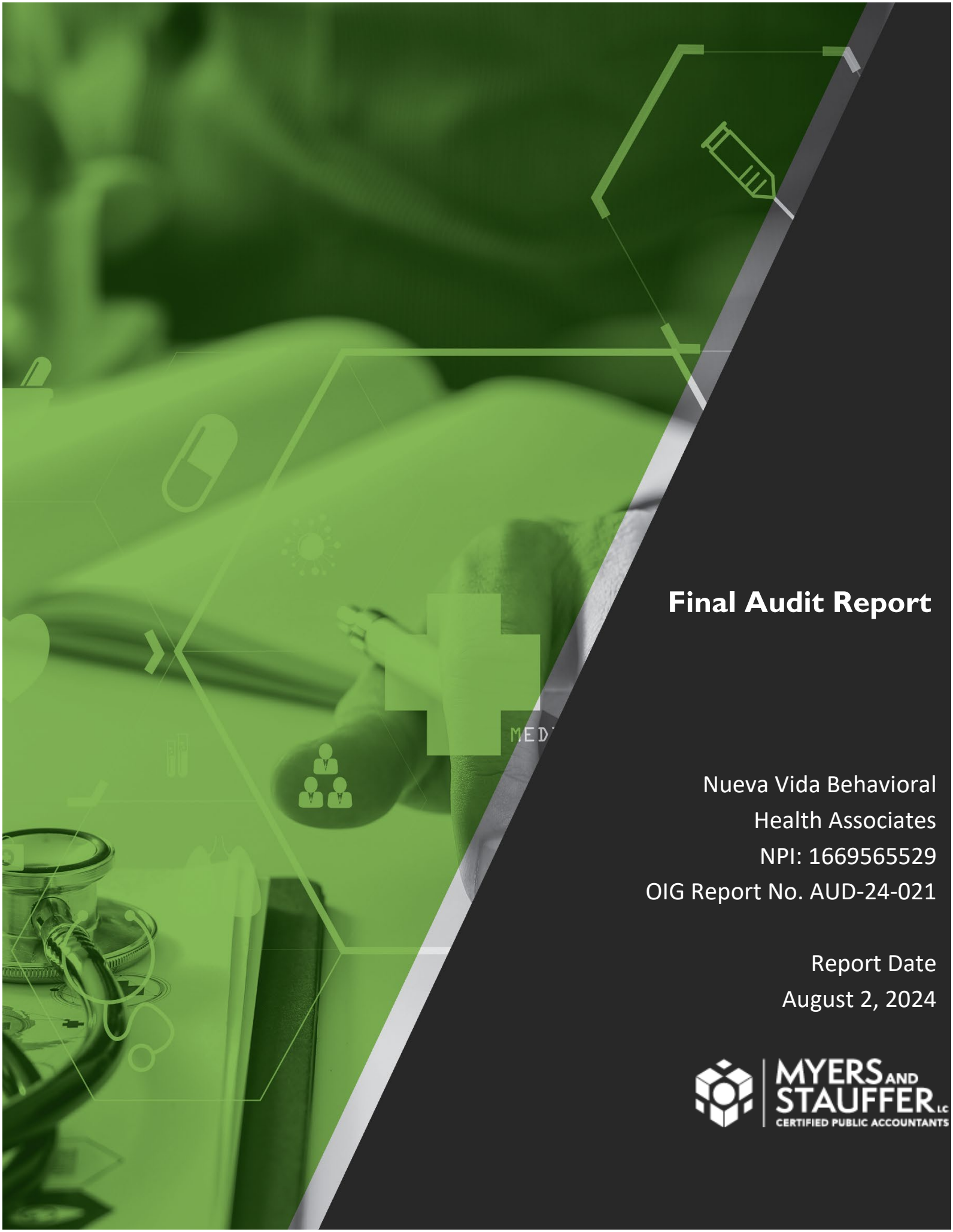

Final Audit Report

Nueva Vida Behavioral Health Associates
NPI: 1669565529
OIG Report No. AUD-24-021

Report Date
August 2, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Executive Summary

In coordination with the Texas Health and Human Services Commission Office of the Inspector General (HHSC-OIG), Myers and Stauffer LC (Myers and Stauffer) has completed the performance audit of Nueva Vida Behavioral Health Associates (Provider). The purpose of the performance audit was to determine whether paid managed care organization (MCO) behavioral health claims billed and paid under the state Medicaid program were in accordance with applicable state and federal Medicaid laws, regulations, rules, policies, and contractual requirements.

We conducted this audit in accordance with the performance audit provisions of Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to sufficiently obtain appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The purpose of this performance audit report is to clearly communicate the results of the audit to those charged with governance, Provider management, and the appropriate oversight officials.

The audit focused on certain paid MCO behavioral health claims with dates of service during September 1, 2020, through August 31, 2022. The audit identified that 1 of the 60 reviewed behavioral health claims did not comply with relevant policies as the claim was not billed with the correct procedure code.

Background and Criteria

HHSC-OIG contracted Myers and Stauffer to conduct audits of Medicaid claims billed by providers and paid by the state Medicaid program. Myers and Stauffer was engaged to perform a claims audit of Nueva Vida Behavioral Health Associates (Provider). The audit focused on paid MCO behavioral health claims having dates of service during the period September 1, 2020, through August 31, 2022.

The Provider is a behavioral health center with multiple locations across San Antonio, Texas, with the main location operating from 9500 Tioga Drive, San Antonio, TX 78230. The Provider offers therapy for individuals and families (anger management, domestic violence, veteran issues, etc.), workers' compensation services (diagnostic screenings, individual psychotherapy, biofeedback, etc.), and crisis counseling. The counselors consists of licensed professional counselors, marriage and family therapists, clinical social workers, and psychologists.

According to the Behavioral Health and Case Management Services Handbook:

> *Outpatient mental health services are used for the treatment of mental illness and emotional disturbances in which the clinician establishes a professional contract with the client and, utilizing therapeutic interventions, attempts to alleviate the symptoms of mental illness or emotional disturbance, and reverse, change, or ameliorate maladaptive patterns of behavior.*
>
> *Outpatient mental health services include psychiatric diagnostic evaluation, psychotherapy (including individual, group, or family psychotherapy), psychological, neurobehavioral, or neuropsychological testing, pharmacological management services and electroconvulsive therapy.*

Claims for the behavioral health centers should comply with the Texas Administrative Code (TAC), American Medical Association (AMA) Current Procedural Terminology (CPT) Professional Coding, Uniform Managed Care Manual, and MCO rules, if applicable.

Audit Objective

The objective of the claims audit was to determine whether behavioral health claims billed to, and paid under, the state Medicaid program were in accordance with applicable state and federal Medicaid laws, regulations, rules, policies and contractual requirements. The specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements tested were agreed to by HHSC-OIG in the approved audit test plan.

Sampling Overview

For the period December 1, 2020, through November 17, 2023, HHSC-OIG developed algorithms to identify risk areas for Texas Medicaid providers. The algorithms identified $343,798 at risk of $1,156,859 total behavioral health reimbursements for the Provider. HHSC-OIG provided all at risk fee-for-service and MCO encounter claims within the total payment population to Myers and Stauffer for review. HHSC-OIG subsequently provided only paid MCO claims data to Myers and Stauffer for audit purposes

covering the period September 1, 2020, through August 31, 2022, totaling $1,621,263 in provider reimbursement.

The claims data was analyzed and it was determined that the audit universe would include only CPT code 90837 (Psychotherapy, 60 minutes with patient) for paid Superior HealthPlan MCO claims.

A statistically valid random sample was selected from the claims universe created. The universe consisted of 13,789 claim lines for 811 unique recipients for which the Provider was reimbursed $1,051,041. The sample included 187 claim lines for 141 unique recipients for which the Provider was reimbursed $14,313. However, upon further discussions with HHSC-OIG, it was determined that only claims with dates of service during the period March 1, 2022, through August 31, 2022, would be reviewed. As a result, the final audited sample included 60 claims for 54 unique recipients for which the Provider was reimbursed $5,048.

Audit Process

Scope

The scope of this audit included the review of Medicaid paid MCO behavioral health claims with dates of service during the period September 1, 2020, through August 31, 2022.

In gaining an understanding of internal controls, Myers and Stauffer limited the review to the Provider's overall internal control structure significant to the audit objectives. Myers and Stauffer determined significant internal controls to the audit objective include:

- **Control Environment:** The foundation for an internal control system. It provides the discipline and structure to help an entity achieve its objectives.
- **Control Activities:** The actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system, which includes the entity's information system.
- **Monitoring:** Activities management establishes and operates to assess the quality of performance over time and promptly resolve the findings of audits and other reviews.

Methodology

Myers and Stauffer conducted this performance audit in accordance with GAGAS and applicable TAC rules, including 1 TAC §371.1719, as appropriate. Those standards require that the audit is planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. Audit testing was performed to verify compliance in the following areas:

- Verified billed services were provided to individuals by reviewing service delivery records.

- Verified providers were licensed through the Texas State Board of Examiners of Psychologists/Professional Counselors/Social Worker Examiners by obtaining and reviewing a copy of the licenses applicable to the period under review.
- Verified providers rendering the billed services were enrolled with Texas Medicaid.
- Verified the service delivery record includes all required information.
- Verified correct modifier(s) and payment rate reductions were applied depending on the level of service provided/documented.
- Verified supervision of services was properly documented, if applicable.
- Verified written informed consent was acquired prior to services being rendered.
- Verified documentation within the progress notes supports the procedure code(s) billed.
- Verified allowable diagnosis code(s) were billed for the service rendered.
- Verified service meets the telehealth requirements, if applicable.

In addition, inquiries; observations; inspection of documents and records; review of other audit reports; and/or direct tests were performed to assess the design, implementation and/or operating effectiveness of controls determined significant to the audit objectives stated in the scope.

Audit Results

Myers and Stauffer believes the evidence obtained during the course of the claims audit provides a reasonable basis for the findings and conclusions based on the audit objective. The audit was not intended to discover all possible errors and any errors not identified within this report should not lead to a conclusion the practice is acceptable. Due to the limited nature of the review, no inferences should be drawn from this report with respect to the Provider's overall level of performance.

Findings

Myers and Stauffer identified a finding on 1 of 60 behavioral health claims. The finding for the claims universe is listed in detail in Appendix A. The summary of the finding and supporting policies follows in the table below:

List of Findings and Supporting Policies

Finding No.	Finding Type	Finding Definition	Number of Claims with Finding	Supporting Policy
1	Incorrect Procedure Code	The incorrect procedure code was billed.	1	1 TAC §354.1001(a)(b) AMA CPT 2019 Professional Edition

As demonstrated by the results of this audit, the Provider's overall internal control system appears to be functioning well. However, to address the finding included in the table above, the Provider should continue to place additional emphasis on ensuring that the controls in place are designed to adequately review, document, and retain records to support that the billed services were provided in accordance with required regulations on a consistent basis.

Recommendations

The testing of patient consent forms during this audit did not result in findings with corresponding overpayment determinations. However, testing did identify that patient consent was not always obtained prior to the behavioral health service being provided. Although this item did not result in findings with corresponding overpayment determinations, Myers and Stauffer recommends the Provider update internal processes to ensure patient consent is obtained and documented prior to services being provided in accordance with 22 TAC §465.11(a).

Management's Response

A draft copy of this report was sent to the Provider on July 8, 2024. An exit conference was held on July 18, 2024, to discuss the preliminary findings. During the exit conference, the Provider did not contest the findings and stated they do not have any additional documentation to submit.

Final Determination of Overpayment

The Medicaid-paid claim with an identified finding is listed in detail in Appendix A of this report. The corresponding overpayment amount in Appendix A is only applicable to the sampled claims Myers and Stauffer reviewed during the audit. The overpayment calculated from our sample is $26.39. The sample was not confirmed to be representative of the universe; therefore, it would not be appropriate to project the test results to the universe.

The total amount due to HHSC-OIG is $26.39 for the claims reviewed. Based on the finding cited in this Final Audit Report, the Provider is directed to:

- Remit the overpayment in the amount of $26.39 pursuant to 1 TAC §371.1719, Recoupment of Overpayments Identified by Audit. Payment is to be made to HHSC-OIG.
- Comply with all state and federal Medicaid laws, regulations, rules, policies and contractual requirements.

Appendix A - Detailed Findings

Nueva Vida Behavioral Health Associates
Project Number 030
NPI 1669565529

Original Claims Information											Audit Determination				
Sample Line Number	MCO	State Issued Medicaid ID	Member Full Name	Claim Number	Date of Service	Procedure Code	Procedure Code Description	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Adjusted Procedure Code (if applicable)	Corrected Claim Payment	Overpayment Amount
40	Superior HealthPlan	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$81.77	INCORRECT PROCEDURE CODE	A, B	[redacted]	$55.38	$26.39
Totals										**$81.77**				**$55.38**	**$26.39**

Legends

Finding Type	Policy Reference	Definition
INCORRECT PROCEDURE CODE	A, B	The incorrect procedure code was billed.

Reference	Supporting Policy	Policy
A	1 TAC §354.1001(a)(b)	(a) Eligible providers are required to provide separate claim information for each eligible recipient. Claims must be complete, accurate, and as specified by the Texas Health and Human Services Commission (HHSC) or its designee. (b) Required information includes the following: (1) name, address, and appropriate Texas provider identification number of the provider of services or supplies or both; (2) the date of the claim; (3) the name, address, identification number, and date of birth of the individual who received services or supplies or both; (4) the type of such services or supplies or both provided; (5) the date(s) each service or supplies or both were provided; (6) the amounts of each charge for the various types of services or supplies or both; (7) the total charge for services or supplies or both; (8) credits for any payments made at the time of submission of the claim, including payments made by private health insurance and under Medicare; (9) indication that the eligible recipient has health, accident, or other insurance policies, or is covered by private or governmental benefit systems, or other third party liability, when reported, known, or suspected; (10) the date of the eligible recipient's death, if applicable; and (11) the name and associated national provider identifier of: (A) the eligible billing provider; (B) the ordering or referring provider or other professional, if services or supplies, or both, are ordered or referred; and (C) the supervising and supervised provider, except for pharmacy claims, if: (i) the services or supplies, or both, were provided due to a referral or ordered by a provider; (ii) the referring or ordering provider is acting at the direction or under the supervision of another provider; and (iii) the referral or order is based on the supervised provider's evaluation of the recipient or enrollee.
B	AMA CPT 2019 Professional Edition	Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 90837 - psychotherapy, 60 minutes with patient. 90834 - psychotherapy, 45 minutes with patient.