FINAL AUDIT REPORT

Tropical Texas Behavioral Health
Edinburg, Texas

TPI Number: 138708610

AUDIT/CASE TRACKING NUMBER
2017-TXIG002-BH-09-07

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Proprietary and Confidential

TABLE OF CONTENTS

Page

I. AUDIT SUMMARY……………………………………………………….……..3

II. AUDIT AUTHORITY & REFERENCES……….……………………….…....3

III. AUDIT PROCESS….………………………………………………….……....4

IV. FINDINGS…………………………………………………………..…....5

Finding 1: Improper Procedure Code……………………………………….…..5
Finding 2: Insufficient Documentation….…………………………………….…..7
Finding 3: Missing Documentation……………………………………………10
Finding 4: Non-covered Service….……………………………………………11
Finding 5: Over Billed Quantity…………………………………………….....12

V. SUMMARY OF OVERPAYMENTS…………………………………………12

APPENDIX A: AUDIT FINDINGS INDEX

APPENDIX B: REFERENCES

APPENDIX C: SAMPLING PLAN

APPENDIX D: EXTRAPOLATION SUMMARY

APPENDIX E: RESPONSE TO PROVIDER

I. AUDIT SUMMARY

On October 25, 2017, an on-site audit was initiated by Health Management Systems, Inc. (HMS), contracted by the Texas Health and Human Services Commission – Office of Inspector General (OIG). The audit was for services provided to medical assistance recipients by:

Name:	Tropical Texas Behavioral Health
TPI Number:	138708610
Address:	1901 S. 24th Avenue Edinburg, TX 78540
Correspondence:	P.O. Box 1108 Edinburg, TX 78540-1108

Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited behavioral health records to verify services provided to recipients and paid by Texas Medical Assistance (Medicaid) Program. Detailed audit findings for individual claim lines are contained in the Appendices.

This report reflects only the findings of this audit and is not intended to discover all possible errors in billing or recordkeeping. Any omission of other errors from this report does not mean such practice is acceptable. Because of the limited nature of this audit, no inferences as to the overall level of provider performance should be drawn solely from this report.

II. AUDIT AUTHORITY & REFERENCES

The OIG is responsible for maintaining an ongoing program to audit providers participating in the Medicaid program.

This audit was carried out consistent with the *Texas Administrative Code* (TAC), *Title 1, Part 15, Chapter 371*, *et seq.*; and *Generally Accepted Governmental Auditing Standards*, as issued by the United States Government Accountability Office.[1]

Refer to Appendix B for the State Regulations and Policy Provider Manual provisions which were used to support the audit. The regulations and guidelines used were in effect at the time the service was provided. These include:

[1] 1 Tex. Admin. Code § 371.1719(b)(1)(A) (effective May 1, 2016).

- *Government Auditing Standards* (GAS)
- *Code of Federal Regulations* (CFR)
- *Texas Administrative Code* (TAC)
- *Texas Medicaid Provider Procedures Manual* (TMPPM)
- Applicable coding references (CPT, HCPCS, ICD-9-CM, ICD-10-CM)

III. AUDIT PROCESS

This provider audit was conducted in the following manner:

Case Selection

For the audit of Medicaid claims, a universe of paid claims with service dates ranging from January 1, 2015 through March 31, 2017 was developed. Only claims with a paid amount greater than zero were included in this universe. The universe included 1,419 recipients with a total Medicaid payment of $4,532,691.83. From this universe, a total of 30 randomly selected recipients totaling $204,623.24 were selected for review.

Claims previously identified as overpayments in prior audits or through post payment reviews performed by the Payment Review Program are removed from the audit universe. This prevents the same claim from being recovered twice.

Documentation Reviewed

Documentation to support services reimbursed by Medicaid was obtained on-site at the Provider's facility on November 6, 2017. No original records were removed from the Provider's premises.

An Exit Conference was held with the Provider on February 14, 2018 to review the Revised Draft Audit Report. In response to the Revised Draft Audit Report, the Provider submitted additional documentation to support the claims under review on February 16, 2018.

The documents were analyzed to identify any billing irregularities or deviations from program rules, regulations, and the Medicaid Provider Agreement. The results are contained in Sections IV and V of this report.

Statistical Sampling

A sample was drawn from the universe of claims paid by the Medicaid program. The sample was produced using the RAT-STATS 2010-v4 random number generator. Overpayments, if any, are determined for the claims within the probability sample. These overpayments are then extrapolated to the audit universe

to determine an overpayment amount. The extrapolation detail file contains the (a) population of claims, (b) sample frame, including sample size determination, (c) seed value for random number generation, (d) extrapolation validation, and (e) results printout from the RAT – STATS software. See Appendix D Extrapolation Summary for more information.

The audit population consisted of 1,419 recipients. The probability sample consisted of 30 randomly selected recipients totaling $204,623.24. All claims were itemized on the Medical Assistance Remittance Advices to the Provider. Overpayments identified in the probability sample are extrapolated to the audit universe in accordance with *TAC, Title 1, Part 15, Chapter 371, Subchapter B, Rule 371.35 Use of Statistical Sampling and Extrapolation (effective 05/01/2016).* See Appendix C Sampling Plan and Appendix D Extrapolation Summary for more information.

IV. FINDINGS

Out of 1,492 claim lines reviewed, there were six claim lines with recoupable monetary findings. See Appendix A for the Audit Finding Index.

Finding 1: Improper Procedure Code (IPC)

There was one instance where the documentation in the medical record did not support the procedure code and units that were billed and paid.

Example: Sample SN-1096-C-023-A – The documentation in the record indicated that 1 unit of medication education and support was provided on date of service (DOS) 06/28/2015. The Provider billed and was paid for 1 unit of psychosocial rehabilitation (PSR), which was not supported in the documentation. Claim has been repriced from PSR ($26.93/unit) to medication education and support ($13.53/hr); therefore, 1 unit PSR ($26.93) minus correct amount of 1 unit medication education and support ($13.53) equals a recoupment of $13.40.

> *Rebuttal medical record review:* The multi-service progress noted dated 06/28/2015 identified medication training and support as the service provided. The sample remains discrepant.

Basis for Finding:

TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015) provides, “(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; …"

TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1004 Retention of Records (effective 05/24/2002) provides, "The provider must maintain all records necessary to fully disclose the services provided. These records must be retained for a period of five years from the date of the service, or until all audit questions are resolved, whichever is longer. Records and supporting information must be made available upon request, regarding any payment of claims for services or supplies by the provider, to the Texas Department of Health or its designated agent."

TAC, Title 1, Part 15, Chapter 371, Subchapter G, Division 2, Rule 371.1653 Claims and Billing (effective 05/01/2016) provides, "A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, a claim for payment by the Medicaid or other HHS program:
(1) for an item or service for which the person knew or should have known the claim or cost report was false or fraudulent;
(2) for an item or service that was not provided as claimed; …
(5) based on a code that would result in greater payment than the code applicable to the item or service that was actually provided;
(6) for an item or service that was not coded, bundled, or billed in accordance with standards required by statute, regulation, contract, Medicaid or other HHS program policy or provider manual, and that, if used, has the potential of increasing any individual or state provider payment rate or fee; …"

TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective February 2017) provides, "All services require documentation to support the medical necessity of the service rendered, including MH and IDD services.
MH and IDD services are subject to retrospective review and recoupment if documentation does not support the service billed."

TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective August 2014, July 2015, and March 2016) provides, "All services require documentation to support the medical necessity of the service rendered, including MH and MR services.
MH and MR services are subject to retrospective review and recoupment if documentation does not support the service billed."

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 2: Insufficient Documentation (ID)

There was one instance of the medical record contacting insufficient documentation to support the service that was rendered, billed, and paid.

Example: Sample SN-1362-C-024-A – No documentation was found in the record to support that services were provided. In addition, a Person Centered Plan (PCP) was not provided for the date of service as required (no active PCP for dates 09/28/2015-12/30/2015).

> *Rebuttal medical record review:* A note was provided for the DOS under review that indicated the patient was seen for an update to the PCP. However, page 2 of the note stated "no skills training was utilized; Routine Case Management". The note or PCP developed does not contain skills training as an identified need. The finding was changed from Missing Documentation to Insufficient Documentation.

Basis for Finding:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 1.

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1004 Retention of Records (effective 05/24/2002)*; under Finding 1.

TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.6 Service Authorization and Recovery Plan (effective 01/22/2014) provides, "… (b) Recovery planning.
(1) In collaboration with the individual or LAR, develop a recovery plan in accordance with §412.322(e) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) that also includes a list of the type(s) of MH rehabilitative services authorized in accordance with subsection (a)(1) of this section.
(2) A provider must develop the recovery plan required by paragraph (1) of this subsection within 10 days after the authorization date. …
(e) Recovery plan review.
(1) In collaboration with the individual or LAR or primary caregiver, the provider must, review the recovery plan to determine if the plan adequately assists the individual in achieving recovery through the identified goals, objectives, and needs:
(A) at intervals set forth in the utilization management guidelines;

(B) as clinically indicated; and
(C) at the request of the individual, LAR, or primary caregiver.
(2) At the time the recovery plan is reviewed, the provider must:
(A) solicit active participation of the individual and LAR or primary caregiver of a child or adolescent regarding the services received to date and whether the services received have led to improvement and/or if there are other services to address unmet needs; and
(B) document such input.
(f) Revisions to the recovery plan. If, after review of the recovery plan, the provider in collaboration with the individual or LAR determines that the recovery plan does not adequately address the needs of the individual, the provider must, as appropriate:
(1) revise the content of the recovery plan; or
(2) must document medical necessity if there is a change in an LOC; and
(3) request authorization for a change in the type or amount of the MH rehabilitative services authorized consistent with subsection (d)(2) of this section."

TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.7 Crisis Intervention Services (effective 01/22/2014) provides, "(a) Description. Crisis intervention services are interventions provided in response to a crisis in order to reduce or manage symptoms of serious mental illness or SED and to prevent admission of an individual to a more restrictive environment. Crisis intervention services consist of the following interventions:
(1) an assessment of dangerousness of the individual to self or others;
(2) the coordination of emergency care services in accordance with §412.314 of this title (relating to Access to Mental Health Community Services);
(3) behavior skills training to assist the individual in reducing distress and managing symptoms;
(4) problem-solving;
(5) reality orientation to help the individual identify and manage his or symptoms of serious mental illness or SED; and
(6) providing instruction, structure, and emotional support to the individual in adapting to and coping with immediate stressors. …"

TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.12 Documentation Requirements (effective 01/22/2014) provides, "(a) MH rehabilitative services documentation. A rehabilitative services provider must document the following for all MH rehabilitative services:
(1) the name of the individual to whom the service was provided;
(2) the type of service provided;
(3) the specific goal or objective addressed, modality, and method used to provide the service;
(4) the date the service was provided;
(5) the begin and end time of the service;
(6) the location where the service was provided;

(7) the signature of the staff member providing the service and a notation of their credential (e.g., a QMHPCS, a pharmacist, a CSSP, a CFP, or a peer provider);
(8) any pertinent event or behavior relating to the individual's treatment which occurs during the provision of the service;
(9) any pertinent information required to be documented by the curricula, protocol, or practice approved by the department; and
(10) the outcome or response, as applicable:
(A) for crisis intervention service, the outcome of the crisis;
(B) for psychosocial coordination services, the outcome of the services;
(C) for day programs for acute needs, the progress or lack of progress in stabilizing the individual's acute psychiatric symptoms; or
(D) for all other services, the individual's response, including the progress or lack of progress in achieving recovery plan goals and objectives.
(b) Crisis services documentation. In addition to the requirements described in subsection (a) of this section, when providing crisis services, a provider must document the information required by §412.321(e) of this title (relating to Crisis Services).
(c) Medical necessity documentation. An LPHA must document that MH rehabilitative services are medically necessary when the services are authorized and reauthorized.
(d) Frequency of documentation.
(1) Day programs for acute needs. For day programs for acute needs, the documentation required by subsection (a)(1) - (9) and (10)(C) of this section must be made daily.
(2) Programs other than day programs for acute needs. For MH rehabilitative services other than day programs for acute needs, the documentation required by subsection (a)(1) - (9) and (10)(A), (B), and (D) of this section must be made after each face-to-face contact that occurs to provide the MH rehabilitative service.
(3) Medical necessity. An LPHA must document medical necessity in accordance with §416.6 of this title (relating to Service Authorization and Recovery Plan).
(4) Retention. A provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations."

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective February 2017)*; under Finding 1.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective August 2014, July 2015, and March 2016)*; under Finding 1.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 3: Missing Documentation (MD)

There was one instance of the medical record missing documentation to support the service that was rendered, billed, and paid.

Example: Sample SN-1322-C-011-A – No documentation was provided to support that another 8 units of PSR were provided during date span of 01/22/2015 through 01/23/2015. One progress note dated 01/22/2015 was provided to support 8 units of PSR services; however, these units were billed and paid appropriately under Sample SN-1322-C-010-F.

> *Rebuttal medical record review:* The progress notes for 01/22/2015 and 01/23/2015 submitted with the rebuttal documentation were for 2 different patients with the initials of G.A. and M.A. There was no additional progress note submitted for the DOS under review for this patient. The sample remains discrepant.

Basis for Finding:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 1.

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1004 Retention of Records (effective 05/24/2002)*; under Finding 1.

Refer to *TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.6 Service Authorization and Recovery Plan (effective 01/22/2014)*; under Finding 2.

Refer to *TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.12 Documentation Requirements (effective 01/22/2014);* under Finding 2.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective February 2017)*; under Finding 1.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective August 2014, July 2015, and March 2016)*; under Finding 1.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 4: Non-Covered Service (NCS)

There was one instance of a service being billed and paid that are recreational and therefore not covered service reimbursed by Medicaid.

Example: Sample SN-370-C-028-D – Medicaid does not cover recreational activities. The progress note for this DOS showed that a peer facilitator took a group of patients on an outing to a nature resort. They were taken on a guided tour; progress toward objectives was described as seeing different animals in their environment. The activities and interventions provided in this outing were not documented in the patient's PCP as goals/objectives/interventions applicable to the patient's treatment.

> *Rebuttal medical record review:* This finding was not disputed by the Provider. The sample remains discrepant.

Basis for Finding:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 1.

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1004 Retention of Records (effective 05/24/2002)*; under Finding 1.

Refer to *TAC, Title 25, Part 1, Chapter 416, Subchapter A, Rule 416.12 Documentation Requirements (effective 01/22/2014)*; under Finding 2.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective February 2017)*; under Finding 1.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective August 2014, July 2015, and March 2016)*; under Finding 1.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

Finding 5: Over Billed Quantity (OBQ)

There were two instances of the Provider billing for more units of service than were documented in the medical record.

Example: Sample SN-1149-C-021-A – The Provider billed and was paid for more units than what the documentation supported. Documentation showed services were provided from 10:30 to 12:41, which equals 2 hours and 11 minutes (9 units). The Provider billed and was paid for 10 units; therefore, 1 unit is recoupable.

> *Rebuttal medical record review:* The Provider did not dispute the finding. The sample remains discrepant.

Example: Sample SN-1365-C-046-A – The Provider billed and was paid for more units than what the documentation supported. The progress note showed that crisis intervention services were provided from 3:20 to 5:07 pm (1 hour 47 minutes = 7 units). A total of 9 units were billed and paid; therefore, 2 units are recoupable.

> *Rebuttal medical record review:* The Provider did not dispute the finding. The sample remains discrepant.

Basis for Findings:

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1001 Claim Information Requirements (effective 01/01/2015)*; under Finding 1.

Refer to *TAC, Title 1, Part 15, Chapter 354, Subchapter A, Division 1, Rule 354.1004 Retention of Records (effective 05/24/2002)*; under Finding 1.

Refer to *TAC, Title 1, Part 15, Chapter 371, Subchapter G, Division 2, Rule 371.1653 Claims and Billing (effective 05/01/2016)*; under Finding 1.

TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.2.3.7 Billing Units (effective August 2014, July 2015, March 2016, and February 2017) provides, “All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary care giver or legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are individual, group (15 continuous minutes), and day programs (45 to 60 continuous minutes). No reimbursement is available for partial units of service.”

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective February 2017)*; under Finding 1.

Refer to *TMPPM, Volume 2, Behavioral Health, Rehabilitation, and Case Management Services, 5.3 Documentation Requirements (effective August 2014, July 2015, and March 2016)*; under Finding 1.

Summary: Valid documentation is required to support claims submitted for reimbursement. As a result, the paid amounts of the associated claims are recoupable.

V. SUMMARY OF OVERPAYMENTS

The identified overpayments for the discrepant sampled claims totaled $242.21. See Appendix A for detailed information. The overpayment amount is below the threshold and was not extrapolated to the population. See Appendix D Extrapolation Summary.

The total amount due to the Texas Health and Human Services Commission is $242.21.

NOTE: Actions resulting from this report and its directives do not take into consideration any subsequent program recoveries, Provider repayments, or Medicaid and Medical Assistance reimbursements, which relate to the period covered by this report.