FINAL AUDIT REPORT

Epic Pediatric Therapy, LP
Dallas, TX

TPI Number: 149984001

AUDIT/CASE TRACKING NUMBER
2017-TXIG005-ST-09-07

DATE ISSUED
June 12, 2018

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: Duplicate Payment……………………………..…………..5
Finding 2: Insufficient Documentation…………….……………………9
Finding 3: Missing Documentation……………..……..……………....11
Finding 4: Over Billed Quantity………………..………………………13

V. SUMMARY OF OVERPAYMENTS………………………………………..14

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 20, 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:	Epic Pediatric Therapy, LP
TPI Number:	149984001
Address:	915 W. Exchange Parkway, Suite 100 Allen, TX 75013-7018
Correspondence:	5220 Spring Valley Road, Suite 400 Dallas, TX 75254-3099

Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited speech therapy 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 State medical assistance programs.

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 524 recipients with a total Medicaid payment of $6,034,020.05. From this universe, a total of 30 randomly selected recipients totaling $424,447.04 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 October 30, 2017. No original records were removed from the Provider's premises.

Additional documents necessary to complete the audit, which were not received with the original record submission, were requested on October 31, 2017 during the on-site Pre-Exit Conference.

An Exit Conference was held with the Provider on March 1, 2018 to review the Draft Audit Report. In response to the Draft Audit Report, the Provider submitted additional documentation to support the claims under review on March 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 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.

The audit population consisted of 524 recipients. The probability sample consisted of 30 randomly selected recipients totaling $424,447.04. All claims were itemized on Medicaid remittance advices to the Provider. Overpayments identified in the probability sample will be 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 for more information.

In some instances, more than one audit finding relates to an individual service provided. This is referred to as “overlap” of findings. When more than one finding requires repayment on an individual service, the amount asserted for recoupment is limited to the amount paid by the Medicaid.

IV. FINDINGS

Of the 3,040 claim lines reviewed, there were sixty-seven claim lines with recoupable monetary findings. Of the sixty-seven claim lines with recoupable findings, one claim line had more than one error resulting in a total of sixty-eight errors. See Appendix A for the Audit Finding Index.

Finding 1: Duplicate Payment (DP)

There were two instances of the Provider billing twice for the same service.

Example: Sample SN-273-C-051-A – A progress note was found in the record for this date of service (DOS); however, all 3 units provided were billed and paid under sample SN-273-C-050-A. There was no documentation to support that more time was provided on this date of service; therefore, this entire claim is denied.

> *Rebuttal medical record review:* The rebuttal comment from the Provider confirmed that this was claim was billed in error. The sample remains discrepant.

Basis for Findings:

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 included 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 various types of services or supplies or both;
(7) the total charge for service 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 …"

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, 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; …
(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 Children's Services 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014) provides, "… All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline that is

provided, the documentation maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy …"

TMPPM Children's Services 2.12.3.3.1 Initial Prior Authorization Requests (August 2014) provides, "Therapy services may be initiated upon receipt of the physician's order. Therapy services initiated before the date of the physician's order will not be approved.
The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.
The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
    - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

  Note: A verbal order is considered current when the date received is on or not more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.
    - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.
  Note: A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.
- A client-specific comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
    - Date and signature of the licensed therapist
    - Diagnosis(es)
    - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
    - A description of the specific therapy disciplines being prescribed
    - Duration and frequency of therapy

- Date of onset of the illness, injury, or exacerbation that requires the therapy services
- Requested dates of service …"

TMPPM Children's Services 2.14.3.3 Prior Authorization and Documentation Requirements Services (March 2016 and July 2015) provides, "… All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. For each therapy discipline provided, the documentation that is maintained in the client's medical record must identify the therapy provider's name and must include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy …"

TMPPM Children's Services 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015) provides, "Therapy services may be initiated upon receipt of the physician's order. Therapy services initiated before the date of the physician's order will not be approved.

The initial request for prior authorization must be received no later than five business days from the date therapy treatments are initiated. Requests that are received after the five business-day will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Request for CCP Outpatient Therapy prior authorization form. The request form must be signed and dated by the ordering physician.
    - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date that the verbal order was received.

  Note: A verbal order is considered current when the date received is on or not more than 60 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no more than 60 days before the start of therapy.
    - A request received without a physician's signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.
- A current therapy evaluation for each therapy discipline that documents the client's age at the time of the evaluation.

  Note: A therapy evaluation is current when it is performed within 60 days before the initiation of therapy services.

- A client-specific comprehensive treatment plan is established by the ordering physician or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Treatment goals that are related to the client's individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Requested dates of service …"

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 were twenty-two instances of the medical record containing insufficient documentation to support the services that were billed and paid.

Example: Sample SN-18-C-002-A – The documentation does not support that a valid order or current evaluation was in place on or before 60 days prior to the start of therapy. The evaluation was completed on 06/07/2016 and the order for the prescribed service was on 07/07/2016. Therapy was not initiated until 09/08/2016.

> *Rebuttal medical record review:* The Provider confirmed that therapy services were not initiated on or before 60 days from the date the evaluation was completed and the order was signed by the physician. The sample remains discrepant.

Example: Sample SN-18-C-013-A – The documentation does not support that an individual session for ST services were provided on the DOS billed. The note in the record was for an update on the overall progress of the treatment goals. There was no subjective information on which specific goals/outcomes were addressed during the session. Additionally, the documentation does not support that a valid order or current evaluation was in place no more than 60 days prior to the start of therapy. The evaluation was completed on 06/07/2016 and the order for the prescribed service was on 07/07/2016. Therapy was not initiated until 09/08/2016.

> *Rebuttal medical record review:* The Provider confirmed that the note was missing the required elements to support the services billed and that therapy services were not initiated on or before 60 days from the date the evaluation

was done and the order was signed by the physician. The sample remains discrepant.

Example: Sample SN-329-C-025-D – The documentation did not support services billed and paid. The progress note did not contain a description of the therapy provided. The SLP wrote that the patient participated in tasks with moderate cues; however, she did not document what the tasks were. The reviewer was unable to determine if tasks were covered services, necessary and/or appropriate without a description of the specific therapy performed as required.

Rebuttal medical record review: The rebuttal documentation submitted by the Provider was the daily note for 03/30/2015. The DOS under review was the session on 04/08/2015. The progress note for the DOS under review did not include the required documentation of the specific therapy performed. The sample remains discrepant.

Example: Sample SN-422-C-003-B – The documentation did not support services billed and paid. The progress note did not contain a description of the therapy provided. The note was missing goals and tasks performed, and the rest of the content was a duplicate of the previous visit. The reviewer was unable to determine if tasks were covered services, necessary and/or appropriate without a description of the specific therapy performed as required.

Rebuttal medical record review: The rebuttal comment from the Provider indicated that they were unable to provide a progress note that was unduplicated or contained all of the required documentation elements. The sample remains discrepant.

Example: Sample SN-492-C-144-L – The documentation does not support that an individual session for ST services were provided on the DOS billed. The note in the record was for an update on the overall progress of the treatment goals. There was no subjective information or which specific goals/outcomes were addressed during the session.

Rebuttal medical record review: The rebuttal comment from the Provider indicated that they were unable to provide a progress note that was unduplicated or contained all of the required documentation elements. The sample remains discrepant.

Example: Sample SN-495-C-023-B – The progress note does not contain specific information about which therapy was done and the patient response/outcome during the session for the DOS under review of 04/02/2015.

Rebuttal medical record review: The rebuttal comment from the Provider confirmed the note was missing the required documentation elements. The sample remains discrepant.

Basis for Findings:

TMPPM Children's Services 2.12 Therapy Services (CCP) (August 2014) provides, "… Providers must maintain a comprehensive treatment plan that includes documentation that supports medical necessity for therapy services and confirms that the client meets the criteria for acute services. The treatment plan must include all of the following:

- The specific procedures and disciplines to be used
- The amount, duration, and frequency of therapy
- The therapist who participated in developing the comprehensive treatment plan
- Rehabilitation potential of the client
- Functional limitations of the client
- Date client was last seen by the physician …"

Refer to *TMPPM Children's Services 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014);* under Finding 1.

Refer to *TMPPM Children's Services 2.12.3.3.1 Initial Prior Authorization Requests (August 2014);* under Finding 1.

Refer to *TMPPM Children's 2.14.3.3 Prior Authorization and Documentation Requirements Services (March 2016 and July 2015)*; under Finding 1.

Refer to *TMPPM Children's Services 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015)*; 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 were thirty-nine instances of the medical record missing partial documentation to support the services billed and paid.

Example: Sample SN-235-C-079-B – No documentation was found in the record to support that this service was provided. An evaluation of speech and sound production was not found in the record for this DOS. In addition, it had not been 180 days since the child's last evaluation was completed (01/13/2016), and the Provider did not bill HCPCS code S9152 with documentation to support the rationale for an additional evaluation as required.

<u>*Rebuttal medical record review*</u>*:* The Provider noted that they could not verify what was billed and this DOS was for a ST therapy session CPT code 92507. A print out of the claim detail from THMP was included in the documentation originally submitted showed that a claim for CPT code 92507 and CPT code 92523 were submitted and paid for the DOS 02/10/2016. The claim for CPT code 92507 (SN-235-C-078-A) was reviewed and found to be Non-Discrepant during the initial review. The sample for CPT code 92523 (SN-235-C-079-B) remains discrepant.

Example: Sample SN-401-C-001-A – All required documentation related to therapy services billed and paid were not provided in the record. A current evaluation or re-evaluation during the authorization period prior to 05/20/2015 was missing. A speech therapy re-evaluation dated 05/20/2015 was found in the record; however, a valid evaluation for claims prior to this date was not provided.

<u>*Rebuttal medical record review*</u>*:* The rebuttal documentation submitted by the Provider did not include the missing ST evaluation for DOS prior to 05/20/2015 as identified in the initial record review. The Provider submitted a signed Plan of Care. The sample remains discrepant.

Example: Sample SN-273-C-005-A – No progress note was found in the record to support that a service was provided on this DOS.

<u>*Rebuttal medical record review*</u>*:* The rebuttal comment from the Provider indicated that they could not locate the progress note for this DOS. The sample remains discrepant.

Basis for Findings:

TMPPM Children's Services 2.12.3.2 Services, Benefits, and Limitations (effective August 2014) provides, "… ST procedures codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. ... All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. …
The documentation retained in the client's file must include the billable start time, billable stop time, total billable minutes, and activity that was performed. …"

Refer to *TMPPM Children's Services 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014)*: under Finding 1.

Refer to *TMPPM Children's Services 2.12.3.3.1 Initial Prior Authorization Requests (August 2014)*: under Finding 1.

Refer to *TMPPM Children's Services 2.12.3.3.2 Subsequent Prior Authorization Requests (August 2014)* provides, "A prior authorization request for subsequent services must be received no more than 30 days before the current authorization

expires. Prior authorization requests for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received. …”.

TMPPM Children’s Services 2.14.3.2 Services, Benefits, and Limitations (March 2016 and July 2015) provides, “… ST procedures codes that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. ...
All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. …
The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes and activity that was performed. …”.

Refer to *TMPPM Children’s 2.14.3.3 Prior Authorization and Documentation Requirements Services (March 2016 and July 2015)*; under Finding 1.

Refer to *TMPPM Children’s Services 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015)*; under Finding 1.

TMPPM Children’s Services 2.14.3.3.2 Subsequent Prior Authorization Requests (March 2016 and July 2015) provides, “A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization request for subsequent services that are received after the current authorization expires will be denied for dates of service that occurred before the date that the submitted request was received. …”.

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: Over Billed Quantity (OBQ)

There were five instances of the Provider billing and being paid for more units of speech therapy than were documented in the medical record.

Example: Sample SN-18-C-014-A – The documentation indicated that the session on the DOS was for 15 minutes (1 unit) however, the Provider billed and was paid for 2 units. Additionally, the documentation does not support that a valid order or current evaluation was in place on or before 60 days prior to the start of therapy. The evaluation was completed on 06/07/2016 and the order for the prescribed service was on 07/07/2016. Therapy was not initiated until 09/08/2016.

Rebuttal medical record review: The Provider noted that they could not verify the number of units billed and confirmed that therapy services were not initiated

on or before 60 days from the date the evaluation was done and the order was signed by the physician. The sample remains discrepant.

Example: Sample SN-235-C-025-A – The progress note showed service was provided from 10:00-10:30, which was 30 minutes (2 units). No documentation to support that another 30 minutes (2 units) were provided. A total of 2 units were allowed and 2 were denied.

Rebuttal medical record review: The rebuttal response from the Provider noted, "Unable to verify what was submitted to insurance by billing dept". The claims billing information submitted with the original documentation showed that 4 units were billed to and paid by Medicaid. The internal ledger document shows that only 2 units were credited as being paid. The sample remains discrepant.

Basis for Findings:

Refer to *TMPPM Children's Services 2.12.3.2 Services, Benefits, and Limitations (August 2014)*; under Finding 3.

Refer to *TMPPM Children's Services 2.12.3.3 Prior Authorization and Documentation Requirements (August 2014)*; under Finding 1.

Refer to *TMPPM Children's Services 2.12.3.3.1 Initial Prior Authorization Requests (August 2014)*; under Finding 1.

Refer to *TMPPM Children's 2.14.3.3 Prior Authorization and Documentation Requirements Services (March 2016 and July 2015)*; under Finding 1.

Refer to *TMPPM Children's Services 2.14.3.2 Services, Benefits, and Limitations (March 2016 and July 2015)*; under Finding 3.

Refer to *TMPPM Children's Services 2.14.3.3.1 Initial Prior Authorization Requests (March 2016 and July 2015)*; 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 $8,540.33. See Appendix A for detailed information. When extrapolated to the universe of claims from which the sample was selected, the calculated overpayment at the

lower limit of 80% confidence interval is $34,697.00. See Appendix D for the extrapolation summary.

The total amount due to the Texas Health and Human Services Commission is $34,697.00.

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.