FINAL AUDIT REPORT

Epic Health Services, Inc.
dba Epic Pediatric Therapy
Austin, TX

TPI Number: 214539301

AUDIT/CASE TRACKING NUMBER
2017-TXIG006-ST-09-07

DATE ISSUED
June 12, 2018

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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 Health Services, Inc., dba Epic Pediatric Therapy
TPI Number:	214539301
Address:	3721 Executive Center Drive, Suite 201 Austin, TX 78731-1645

Thirty recipient records were reviewed for dates of service January 1, 2015 through March 31, 2017. HMS's staff audited speech therapy (ST) records to verify services provided to recipients, paid by 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:

- *Government Auditing Standards* (GAS)
- *Code of Federal Regulations* (CFR)

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

- *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 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 218 recipients with a total Medicaid payment of $2,097,579.73. From this universe, a total of 30 randomly selected recipients totaling $362,951.06 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 2, 2017. No original records were removed from the Provider's premises.

Documents and medical records necessary to complete the audit, which were not received with the original record submission, were requested on November 3, 2017 during the on-site Pre-Exit Conference. The missing documents and medical records were received November 17, 2017.

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 218 recipients. The probability sample consisted of 30 randomly selected recipients totaling $362,951.06. 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 2,675 claim lines reviewed, there were 133 claim lines with recoupable monetary findings. See Appendix A for the Audit Finding Index.

Finding 1: **Insufficient Documentation (ID)**

There were sixty-two instances of the medical record not containing sufficient documentation to support the services that were billed and paid

Example: Sample SN-165-C-042-A – There was no CCP authorization form or other signed physician orders and no treatment plan for the authorization period under review included in the record submitted. It was also noted that the child had been out of the area for the summer and did not return for services until 08/31/2015. There was no documentation that indicated if services continued from a different provider or thru this Provider. The ST re-evaluation completed on 06/03/2015 was not valid if the child had not been receiving services for more than 60 days.

Rebuttal Medical Record Review: The rebuttal documentation submitted by the Provider included a coordination of care note signed by the therapy director on 06/09/2015 that the authorization would expire and the child would be discharged from ST services. It was also noted in the comments of the coordination of care document that a re-evaluation would need to be completed upon return. The documentation does not support that a valid ST evaluation was in place for the date of service (DOS) under review. The finding was changed from Missing Documentation to Insufficient Documentation.

Example: Sample SN-91-C-028-A – The note for the session on 04/07/2015 was not signed by the speech therapy assistant and the supervisor until 05/08/2015, more than 30 days after the DOS.

Rebuttal Medical Record Review: The Provider did not dispute the finding. Documentation was not completed for more than 30 days after the DOS. The sample remains discrepant.

Example: Sample SN-153-C-044-A – The documentation is conflicting on where the ST visit took place. The subjective part of the visit note reported it occurred at HeadStart, but the visit log was signed by the parent and not by a school staff member as in the other logs when the child was at school during the visit.

Rebuttal Medical Record Review: The rebuttal comment from the Provider stated, "Therapist is no longer with company to verify it treatment for services was received in HeadStart center, or at the clients home." The sample remains discrepant.

Example: Sample SN-206-C-160-A – The documentation does not support that a billable visit occurred on the DOS for 12/08/2016. The progress note shows no time in/out or billable minutes. The subjective entry stated "no visit progress note".

Rebuttal Medical Record Review: The Provider submitted an additional progress note by the speech therapy assistant for this DOS. However, the documentation did not support that the speech therapy assistant was supervised as required. There was no co-signature of the supervising SLP on the daily note. 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, 2.1.4.3 Physician Signature (effective August 2014) provides, "The dated signature of the physician (M.D. or D.O.) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physicians dated signature, proof of the verbal order must be submitted with the request.
Stamped signatures and dates are not accepted on the CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. …"

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 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, 2.12.3.3.1 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 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 no 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 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, 2.1.4.4 Physician Signature (effective March 2016, July 2015, and February 2017) provides, "The dated signature of the physician (M.D. or D.O.) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician's dated signature, proof of the verbal order must be submitted with the request.
Stamped signatures and dates are not accepted on the CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. …"

TMPPM Children's Services, 2.14.3.3 Prior Authorization and Documentation Requirements Services (effective 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 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 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 no 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 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: **Missing Documentation (MD)**

There were six instances of the medical record missing partial documentation to support the services billed and paid.

Example: Sample SN-125-C-011-A – There was no documentation of the CCP Outpatient Therapy authorization form signed by the physician or other signed prescription order and no treatment plan signed by the physician as being reviewed/authorized for the DOS under review provided in the record submitted. Additionally, there was no progress note for the DOS 01/06/2015.

Rebuttal Medical Record Review: Documentation in the rebuttal record was submitted for the signed orders and treatment plan but the progress note for 01/06/2015 was still missing. 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 *TMPPM Children's Services, 2.1.4.3 Physician Signature (effective August 2014)*; under Finding 1.

Refer to *TMPPM Children's Services, 2.1.4.4 Physician Signature (effective March 2016, July 2015, and February 2017)*; 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, 2.14.3.3.1 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: **Non-Covered Service (NCS)**

There were sixty-five instances of the Provider billing and receiving payment for services not covered by Medicaid.

Example: Sample SN-153-C-002-A – The documentation shows that services were provided while the child was at HeadStart during regular classroom times. ST services may only be provided before or after school on school premises unless delivered as part of the SHARS POS 9 or as part of ECI.

Rebuttal Medical Record Review: The rebuttal comment submitted by the Provider stated, "Treatment was provided during normal "school hours"; however unable to verify what time child actually started school (was it before their particular start time?)". There was no consistent time frame documented on the daily notes that would indicate the child was seen before or after school. The sample remains discrepant.

Basis for Findings:

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, Children's Services Handbook, 2.12 Therapy Services (CCP) (effective August 2014) provides, "… Therapy is provided in one of the following places of service:

- CORF and ORF
- Inpatient rehabilitation facility (freestanding)
- Home
- Licensed hospital
- Medicaid-enrolled private therapist office
- Physician office

… ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.
Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS in POS 9. …"

TMPPM, Children's Services Handbook, 2.14 Therapy Services (CCP) (effective July 2015 and March 2016) provides, "… Therapy is provided in one of the following places of service:

- CORF and ORF
- Inpatient rehabilitation facility (freestanding)
- Home
- Licensed hospital
- Medicaid-enrolled private therapist office
- Physician office

… ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.
Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS in POS 9. …"

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 $17,904.02. 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 $46,898.00. See Appendix D for the extrapolation summary.

The total amount due to the Texas Health and Human Services Commission is $46,898.00.

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.