MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

To the Executive Commissioner of the Texas Health and Human Services Commission Austin, Texas

Myers and Stauffer LC has completed the performance audit of Vida Clinic PLLC to determine whether 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. The specific state and federal Medicaid laws, regulations, rules, policies, and contractual requirements to be tested were agreed to by the Texas Health and Human Services Commission Office of the Inspector General (HHSC-OIG) in the approved audit test plan.

Our audit was performed under Myers and Stauffer's master contract #529-17-0117-00004, Work Order/Contract #HHS000325700001, Purchase Order #HHSTX-9-0000195405 with HHSC. Our audit covered the period of October 1, 2016, through April 30, 2020.

We conducted this audit in accordance with the performance audit provisions of Generally Accepted Government Auditing Standards 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.

Management responses from Vida Clinic PLLC are included in this report.

This report is intended solely for the information and use of the HHSC-OIG and Vida Clinic PLLC management and is not intended to be, and should not be, used by anyone other than these specified parties.

If we can be of any assistance to you, or if you have any questions concerning this report, please contact us.

Sincerely,

Myers and Stauffer LC

Myers and Stauffer LC
August 30, 2021

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Final Audit Report

Vida Clinic PLLC
NPI 1912389081

Report Date
August 30, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Background and Criteria

The Texas Health and Human Services Commission Office of the Inspector General (HHSC-OIG) contracted Myers and Stauffer LC (Myers and Stauffer) to conduct audits of Medicaid claims billed by providers and paid by the state Medicaid program. Vida Clinic PLLC (Provider) was selected by the HHSC-OIG for Myers and Stauffer to perform a claims audit. The audit focused on paid managed care organization (MCO) behavioral health claims having dates of service during the period of October 1, 2016, through April 30, 2020.

The Provider began operations in 2011 and is a behavioral health provider owned and operated by Dr. Elizabeth Minne as the sole proprietor. During the audit review period, the Provider had one central office location in Austin, Texas but also utilized offices on several school campuses as the Provider previously partnered with the Austin Independent School District (AISD) to offer behavioral health services on multiple AISD campuses.

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 (ECT).*

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 to be tested were agreed to by the HHSC-OIG in the approved audit test plan.

Sampling Overview

The HHSC-OIG identified $384,697 dollars at risk during the period of April 1, 2015, through April 30, 2020 focused on servicing providers being listed on claims for services exceeding 12 hours or more in one day. For the Provider, HHSC-OIG submitted all fee-for-service (FFS) and MCO claims for review. The claims data was analyzed and, due to immateriality, all FFS claims and certain MCO health plan claims were excluded when creating the final claims universes. This process resulted in the following claims universes being created: Superior Health Plan MCO, BlueCross BlueShield Health Plan (BCBS) MCO, and Dell Children's Health Plan MCO. Furthermore, to account for the risk area identified by the HHSC-OIG,

the Superior Health Plan MCO claims universe was separated into two distinct claims universes as follows:

- The first claims universe focused on two highly utilized dates of service (October 31, 2019 and February 18, 2020) for a single servicing provider.
- The second claims universe focused on all remaining Superior Health Plan MCO claims not included in the first Superior Health Plan MCO universe.

Statistically valid random samples (SVRS) were selected from the MCO claims universes for the BCBS Health Plan MCO, Dell Children's Health Plan MCO, and Superior Health Plan MCO claims provided by the HHSC-OIG. The claims universes consisted of services provided during the period of October 1, 2016, through April 30, 2020. Additional information for the respective claim universes is as follows:

- Superior Health Plan MCO (October 31, 2019 and February 18, 2020): Universe consisted of 90 claims for 89 unique recipients for which the Provider was reimbursed $4,888. The sample included 33 claims for 33 unique recipients for which the provider was reimbursed $1,710.
- Superior Health Plan MCO (all other claims): Universe consisted of the remaining 8,128 claims for 665 unique recipients for which the Provider was reimbursed $488,555. The sample included 30 claims for 28 unique recipients for which the Provider was reimbursed $2,042.
- BCBS Health Plan MCO: Universe consisted of 2,522 claims for 213 unique recipients for which the Provider was reimbursed $181,717. The sample included 36 claims for 32 unique recipients for which the Provider was reimbursed $2,605.
- Dell Children's Health Plan MCO: Universe consisted of 2,098 claims for 166 unique recipients for which the Provider was reimbursed $135,289. The sample included 30 claims for 26 unique recipients for which the Provider was reimbursed $1,934.

Audit Process

Scope

The scope of this audit includes the review of Medicaid MCO behavioral health claims with dates of service during the period of October 1, 2016, through April 30, 2020.

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 included:

- **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 Generally Accepted Government Auditing Standards (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:

- Verify billed services were provided to individuals by reviewing service delivery records.
- Verify 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.
- Verify the providers rendering the billed services were enrolled with Texas Medicaid.
- Verify all records required for the claims were submitted.
- Verify the correct modifier(s) and payment rate reductions were applied depending on the level of service provided/documented.
- Verify written informed consent was acquired prior to services being rendered.
- Verify documentation within the progress notes supports the Current Procedural Terminology (CPT) procedure codes billed.

Inquiries, observations, inspection of documents and records, review of other audit reports, and/or direct tests were performed to assess the design, implementation, and 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 findings on 126 of 129 behavioral health claims. One claim may have multiple finding types; however, not all findings resulted in an overpayment. The table below provides a summary of the findings that have been identified in the audit for all combined claims universes. The findings for each individual claims universe are listed in detail in Appendices A through D. The summary of findings and supporting policy follows in the table below.

List of Findings and Supporting Policy				
Finding No.	**Finding Type**	**Finding Definition**	**Number of FIndings**	**Supporting Policy**
1	Time Not Documented	The required time component was not documented to support the CPT procedure code billed.	114	22 TAC §465.22(a)(1) American Medical Association Current Procedural Terminology 2017 Professional 4th Edition
2	Incorrect Servicing Provider on Claim	The servicing provider name and national provider identifier (NPI) on the claim are not the same as the provider who performed the service.	121	1 TAC §355.8091 1 TAC §354.1001(a)(b)
3	Incorrect Modifier Billed on Claim	This claim was incorrectly billed with modifier AH indicating the service was provided by a clinical psychologist.	29	1 TAC §354.1001(a)(b)
4	Missing Informed Consent	The required informed consent form signed by the recipient or recipient's guardian was not submitted.	6	22 TAC §465.11(a)
5	Late Informed Consent	The required informed consent form was signed by the recipient or recipient's guardian after services were provided.	4	22 TAC §465.11(a)
6	Servicing Provider was Not Enrolled in Texas Medicaid	The servicing provider was not enrolled in Texas Medicaid.	9	1 TAC §354.1382(d) 42 U.S. Code §1396u-2 (d)(6)(A)

A lack of internal controls is considered a contributing cause of all findings included in the table above. The Provider has not placed sufficient emphasis on designing, implementing, and/or effectively operating internal controls as it does not appear that the Provider had controls in place to adequately review, document, and retain records to support that the billed services were provided in accordance with required regulations. A lack of policies and/or oversight of established policies creates an

environment in which management or personnel are unable to achieve the applicable control objectives and address related risks.

During the Provider's entrance conference, the Provider explained that during the period of review personnel relied on appointment times or CPT procedure code descriptions to determine what service to bill rather than documentation of time or other information within the progress notes for the service provided. The Provider did indicate that their practice was for the billing department to review every progress note and contact therapists to amend progress notes if it was determined corrections were needed. However, the findings above indicate this process of the billing department reviewing progress notes does not appear to have been effective. The Provider also expressed that having learned more about proper billing practices and since have implemented a new electronic health records system. The Provider stated internal policies have changed to better document the times of service, as well as ensuring that the individual who provided the service based on the documentation is listed as the servicing provider on the claim.

Management's Response

A draft copy of this report was sent to the Provider on August 2, 2021. The Provider submitted a letter in response to the preliminary findings on August 19, 2021 and an exit conference was held on August 20, 2021 to further discuss the preliminary findings. In the submitted letter and during the exit conference, the Provider requested additional information on the statistical sample design and extrapolation methodology. Although the sample design methodology and information needed to recreate the extrapolation was provided in the Preliminary Draft Audit Report, Myers and Stauffer provided an additional general summary of the process. On August 25, 2021, the provider submitted an additional letter and documentation for review. In the letter, the Provider again requested additional information in connection with the statistical sample design and extrapolation methodology. In response, HHSC-OIG informed the Provider that additional information, beyond what was already provided, would be submitted upon issuance of the final audit report.

In addition to requesting statistical sample design and extrapolation information, the Provider responded as follows to the individual findings:

- **Finding Type 1 Time Not Documented:** The Provider stated that time documentation is not required in any specific format in Section 4.2 of the Behavioral Health Handbook of the Texas Medicaid Provider Procedure Manual. The only requirement is that documentation exists for individual, family, or group psychotherapy. The Provider expressed that appointment audit logs were utilized which show the start time and duration. The Provider explained that their standard protocol is to complete the session and then enter in the appointment length so that the appointment entry information is adequate supporting documentation for this requirement.
- **Finding Types 2 Incorrect Servicing Provider on Claim, 3 Incorrect Modifier on Claim, and 6 Servicing Provider was Not Enrolled in Texas Medicaid:** The Provider expressed that a team approach was utilized as it lends to better clinical outcomes and availability for students. It was explained that under this approach, the individual therapists operate under the overall direction

and supervision of their managers as many times the owner was at the location, saw the recipient and consulted with the therapist on site. The provider conveyed that this was particularly applicable to clients who received services at a certain school where the owner, together with other providers, would interact with clients, collaborate on treatment planning, and work together to provide direct support for the recipients seen in that therapeutic setting. To support these statements, the Provider submitted two affidavits regarding the Provider's team approach and screen captures from personnel calendars as support for the Provider billing at a level of service higher than indicated by the servicing provider in the documentation. In addition, licensing information was provided to support that one therapist was provisionally licensed so the servicing provider indicated on the claim(s) in question was correct.

- **Finding Types 4 Missing Informed Consent and 5 Late Informed Consent:** The Provider expressed that it is their policy to never see a recipient without a valid consent in place and when written consents couldn't be obtained on day one due to school shutdowns or technical issues with the computer system or documents, the Provider made sure services were face-to-face (via telehealth or in person) with the parent on the first session and obtained verbal consent to treat from the parent or guardian. The Provider also expressed that obtaining verbal consent in the visit is also a valid way to obtain consent from a parent of a recipient who is underage, especially during the initial few visits before a formal signed consent can be put in the file. The Provider submitted additional signed informed consent forms and/or intake forms in connection with this finding.

In their response, the Provider objected to all questioned claim lines and submitted additional documentation for 128 of 128 claims with findings identified in the Preliminary Draft Audit Report.

Revised Findings Based on Management's Response

After reviewing the Provider's response and the additional documentation submitted, the findings were revised resulting in the number of questioned behavioral health claims decreasing from the 128 identified in the Preliminary Draft Audit Report to 126 questioned behavioral health claims. Findings were revised as follows:

- The Provider submitted signed informed consent forms that were dated prior to the date of service to support claims with findings for missing or late informed consent forms. Upon review of this additional documentation, the following findings were rescinded:
  - 16 findings for missing informed consent forms.
  - 11 findings for late informed consent forms.
- The Provider submitted license documentation showing one of their personnel was provisionally licensed at the time of services under review to support claims with findings for incorrect servicing provider and servicing provider was not enrolled in Texas Medicaid. Upon review of the submitted documentation, both findings were rescinded for the two claims where the provisionally licensed therapist performed the service.

- After reviewing the Provider's response, intake forms, and a spreadsheet titled "Informed Consent Report" created by the Provider listing notes and documentation submitted for the finding of missing or late consent forms, the findings identified were not revised from the Preliminary Draft Audit Report. In these instances, neither the intake forms nor the report were deemed sufficient to support state policies requiring consent be obtained and documented in writing prior to initiating the psychological service.
- After reviewing the Provider's response, affidavits, and personnel calendars submitted for findings of incorrect servicing provider, incorrect modifier billed, and servicing provider not enrolled in Texas Medicaid, the findings identified were not revised from the Preliminary Draft Audit Report. These findings were upheld due to state policies indicating the providers who performed the services, as supported in the documentation, are reimbursed at reduced rates based on the provider license and must be enrolled in Texas Medicaid. Of note, the Provider's "team approach" was not adequately documented at the time of services provided.
- After reviewing the Provider's response and the system audit logs submitted for the finding of time not being documented, the findings identified were not revised from the Preliminary Draft Audit Report. The submitted documentation did not support the duration of the services as no stop time or duration of service was indicated. In addition, the audit logs indicate an "Appointment Type" which appears to be connected only to the type of service input at a later time for the billing process rather than the documenting the actual length of the service provided.

Final Determination of Overpayment

The Medicaid paid claims with identified findings are listed in detail in Appendices A through D of this report. The corresponding overpayment amounts in Appendices A-1, B-1, C-1, and D-1 are only applicable to the sampled claims from the respective universes Myers and Stauffer reviewed during the audit. The total overpayment calculated from the respective samples is $3,561 (Total may not equal amounts shown below due to rounding.). The overpayments for each sample are as follows:

- Superior Health Plan MCO (October 31, 2019 and February 18, 2020): $508. See Appendix A-1.
- Superior Health Plan MCO (all other claims): $894. See Appendix B-1.
- BCBS Health Plan MCO: $1,414. See Appendix C-1.
- Dell Children's Health Plan MCO: $744. See Appendix D-1.

The total overpayment has been determined using extrapolation. Extrapolation was used according to the 1 TAC §371.35. The estimated total extrapolated overpayment from the respective universes is $303,097. The extrapolated overpayments for each universe are as follows:

- Superior Health Plan MCO (October 31, 2019 and February 18, 2020): $1,103. See Appendix A-2.
- Superior Health Plan MCO (all other claims): $174,916. See Appendix B-2.
- BCBS Health Plan MCO: $82,577. See Appendix C-2.
- Dell Children's Health Plan MCO: $44,501. See Appendix D-2.

The total amount due to the HHSC-OIG is $303,097 for the claims reviewed. Based on the findings cited in this Final Audit Report, the Provider is directed to:

- Remit the overpayment in the amount of $303,097, pursuant to 1 TAC §371.1719, Recoupment of Overpayments Identified by Audit. Payment is to be made to the Texas HHSC-OIG.
- Comply with all state and federal Medicaid laws, regulations, rules, policies, and contractual requirements.

Appendix A-1 – Superior Health Plan (Dates of Service October 31, 2019 and February 18, 2020) Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information												Audit Determination						
Sample Line Number	MCO	State Issued Medicaid ID	Member Full Name	Claim Number	Date of Service	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
19	Superior	[redacted]				90832			[redacted]		$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A	[redacted]	$37.33	$0.00
21	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
22	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
23	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
25	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
28	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
30	Superior					90837	59				$106.66	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$106.66	$0.00
31	Superior					90834					$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
34	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
35	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
41	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
42	Superior					90791					$83.87	INCORRECT SERVICING PROVIDER ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, D, F, G	1	N/A		$0.00	$83.87
48	Superior					90834					$49.71	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$49.71	$0.00
52	Superior					90837					$74.66	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$37.33
53	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
54	Superior					90834					$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
55	Superior					90834					$49.71	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$12.38
59	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
63	Superior					90834					$49.71	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$12.38
68	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
71	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
72	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
73	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
81	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
85	Superior					90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
86	Superior					90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
89	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
95	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
97	Superior					90834					$49.71	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$12.38
106	Superior					90832					$37.33	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$37.33	$0.00
111	Superior					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
121	Superior					90832					$37.33	INCORRECT SERVICING PROVIDER ON CLAIM, LATE SIGNED INFORMED CONSENT	A, C, D	1	N/A		$0.00	$37.33

Appendix A-1 – Superior Health Plan (Dates of Service October 31, 2019 and February 18, 2020) Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information												Audit Determination						
Sample Line Number	MCO	State Issued Medicaid ID	Member Full Name	Claim Number	Date of Service	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
129	Superior	[redacted]	[redacted]	[redacted]	[redacted]	90832			[redacted]	[redacted]	$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	N/A	[redacted]	$0.00	$37.33
02/18/2020 Subtotal											**$768.00**						**$535.00**	**$233.00**
10/31/2019 Subtotal											**$941.97**						**$666.61**	**$275.36**
Totals											**$1,709.97**						**$1,201.61**	**$508.36**

Appendix A-2: Superior Health Plan (Dates of Service October 31, 2019 and February 18, 2020) Claims Universe

Claims Universe and Sample Information

Vida Clinic PLLC Project Number 007 NPI 1912389081								
A	B	C	D	E	F	G	H	I
Strata	Universe Size (in Units)	Universe Reimbursements	Universe Weight	Sample Size	Sample Reimbursements[1]	Sample Units in Error[2]	Sample Error Rate (F/E)[2]	Total Sample Overpayment
2/18/2020	47	$2,059.44	52.22%	17	$768.00	17	100.00%	$233.00
10/31/2019	43	$2,828.37	47.78%	16	$941.97	16	100.00%	$275.36
Totals	**90**	**$4,887.81**	**100.00%**	**33**	**$1,709.97**	**33**	**100.00%**	**$508.36**

Extrapolated Overpayment Summary

Vida Clinic PLLC: Superior Health Plan DOS Claims Universe			
A	B	C	D
Point Estimate	Precision Amount	Precision Percentage (B/A)[3]	Extrapolated Overpayment - Lower Bound (A-B)[3,4]
$1,384	$281	20.31%	$1,103

[1] Sample Reimbursements (column F) represents the total paid amount for every claim line in the sample, and may not tie to the subtotals seen in Appendix A-1 as it only contains claims determined to be in error.

[2] Please note that an error does not always result in an overpayment. Please refer to Appendix A-1 and Appendix E for additional information.

[3] Amounts indicated represent direct results from the RAT-STATS statistical software utilized for extrapolation purposes and may not tie exactly to the formulas indicated due to rounding.

[4] Per Chapter 8.4.5.1 of the Medicare Program Integrity Manual, the lower limit of a one-sided 90 percent confidence interval was utilized to arrive at the extrapolated overpayment amount.

Appendix B-1 – Superior Health Plan (All Others) Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information											Audit Determination						
Sample Line Number	MCO	State Issued			Date of	Procedure	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
2	Superior	[redacted]							[redacted]		$100.78	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT	A, B, C, D, E	1	90832	[redacted]	$0.00	$100.78
3	Superior										$100.78	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$63.45
7	Superior										$68.49	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$31.16
8	Superior										$70.53	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$60.12	$10.41
14	Superior										$53.33	TIME NOT DOCUMENTED	B, E	2	N/A		$37.33	$16.00
17	Superior						AH				$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	90832		$0.00	$71.01
36	Superior										$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
49	Superior										$89.25	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$62.48	$26.77
50	Superior						AH				$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
51	Superior										$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
58	Superior										$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
62	Superior										$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
69	Superior										$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
70	Superior										$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
74	Superior										$49.71	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$12.38
75	Superior										$37.33	TIME NOT DOCUMENTED	B, E	3	N/A		$37.33	$0.00
78	Superior						AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
84	Superior						95				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
87	Superior										$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
88	Superior										$49.71	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$12.38
90	Superior						95	A[redacted]			$119.82	INCORRECT SERVICING PROVIDER ON CLAIM, LATE SIGNED INFORMED CONSENT, INCORRECT MODIFIER BILLED ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, C, D, F, G	1	N/A		$0.00	$119.82
96	Superior										$74.66	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$37.33
98	Superior										$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
100	Superior										$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
102	Superior										$100.78	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$63.45
112	Superior						95				$83.87	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$119.82	-$35.95
119	Superior						AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, LATE SIGNED INFORMED CONSENT, INCORRECT MODIFIER BILLED ON CLAIM	A, B, C, D, E	1	N/A		$0.00	$53.33
123	Superior										$49.39	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$12.06

Appendix B-1 – Superior Health Plan (All Others) Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information												Audit Determination						
Sample Line Number	MCO	State Issued Medicaid ID	Member Full Name	Claim Number	Date of Service	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
124	Superior	[redacted]	[redacted]	[redacted]	[redacted]	90837			[redacted]	[redacted]	$106.66	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832	[redacted]	$37.33	$69.33
90834 Subtotal											**$522.96**						**$261.31**	**$261.65**
90832 Subtotal											**$588.02**						**$410.63**	**$177.39**
90837 Subtotal											**$483.66**						**$149.32**	**$334.34**
All Other CPT Codes Subtotal											**$363.47**						**$242.42**	**$121.05**
Totals											**$1,958.11**						**$1,063.68**	**$894.43**

Appendix B-2: Superior Health Plan - All Other Services Claims Universe

Claims Universe and Sample Information

Vida Clinic PLLC Project Number 007 NPI 1912389081								
A	B	C	D	E	F	G	H	I
Strata	Universe Size (in Units)	Universe Reimbursements	Universe Weight	Sample Size	Sample Reimbursements[1]	Sample Units in Error[2]	Sample Error Rate (F/E)[2]	Total Sample Overpayment
90834	2,700	$168,163.76	33.22%	8	$522.96	8	100.00%	$261.65
90832	3,927	$179,795.17	48.31%	12	$588.02	12	100.00%	$177.39
90837	758	$73,280.01	9.33%	5	$483.66	5	100.00%	$334.34
All Other Codes	743	$67,316.11	9.14%	5	$447.34	4	80.00%	$121.05
Totals	**8,128**	**$488,555.05**	**100.00%**	**30**	**$2,041.98**	**29**	**96.67%**	**$894.43**

Extrapolated Overpayment Summary

Vida Clinic PLLC: Superior Health Plan All Others Claims Universe			
A	B	C	D
Point Estimate	Precision Amount	Precision Percentage (B/A)[3]	Extrapolated Overpayment - Lower Bound (A-B)[3,4]
$215,032	$40,116	18.66%	$174,916

[1] Sample Reimbursements (column F) represents the total paid amount for every claim line in the sample, and may not tie to the subtotals seen in Appendix B-1 as it only contains claims determined to be in error.

[2] Please note that an error does not always result in an overpayment. Please refer to Appendix B-1 and Appendix E for additional information.

[3] Amounts indicated represent direct results from the RAT-STATS statistical software utilized for extrapolation purposes and may not tie exactly to the formulas indicated due to rounding.

[4] Per Chapter 8.4.5.1 of the Medicare Program Integrity Manual, the lower limit of a one-sided 90 percent confidence interval was utilized to arrive at the extrapolated overpayment amount.

Appendix C-1 – BlueCross BlueShield Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information										Audit Determination						
Sample Line Number	MCO	State Issued			Date of	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
1	BCBS	[redacted]				90832			[redacted]		$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A	[redacted]	$36.40	$15.60
4	BCBS					90832					$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT	A, B, C, D, E	1	N/A		$0.00	$52.00
5	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT	A, B, C, D, E	1	90832		$0.00	$81.00
10	BCBS					90832					$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$15.60
11	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
15	BCBS					90832	AH				$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	N/A		$0.00	$52.00
18	BCBS					90832					$51.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	N/A		$0.00	$51.00
24	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
27	BCBS					90834	AH				$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
29	BCBS					90832					$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$15.60
38	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
39	BCBS					90832	95	AH			$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$52.00	$0.00
40	BCBS					90834	95				$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
43	BCBS					90791	95				$88.00	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$92.40	-$4.40
46	BCBS					90832					$51.00	TIME NOT DOCUMENTED	B, E	2	N/A		$36.40	$14.60
47	BCBS					90834	AH				$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	90832		$0.00	$81.00
64	BCBS					90832	AH				$52.00	INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, D	2	N/A		$36.40	$15.60
65	BCBS					90847	AH	95			$86.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$60.20	$25.80
66	BCBS					90832					$51.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$14.60
67	BCBS					90832					$51.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$14.60
82	BCBS					90834	95				$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
83	BCBS					90791	AH				$132.00	INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT, INCORRECT MODIFIER BILLED ON CLAIM	A, C, D	1	N/A		$0.00	$132.00
94	BCBS					90832					$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT	A, B, C, D, E	1	N/A		$0.00	$52.00
99	BCBS					90832	AH				$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$36.40	$15.60
101	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
103	BCBS					90837					$114.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	90832		$0.00	$114.00
114	BCBS					90837	AH				$114.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$36.40	$77.60
117	BCBS					90832					$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$15.60

Appendix C-1 – BlueCross BlueShield Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information												Audit Determination						
Sample Line Number	MCO	State Issued Medicaid ID	Member Full Name	Claim Number	Date of Service	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
118	BCBS	[redacted]				90832			[redacted]		$52.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A	[redacted]	$52.00	$0.00
120	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
122	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$36.40	$44.60
125	BCBS					90834					$81.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, LATE SIGNED INFORMED CONSENT	A, B, C, D, E	1	90832		$0.00	$81.00
126	BCBS					90834					$70.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, MISSING INFORMED CONSENT	A, B, C, D, E	1	90832		$0.00	$70.00
127	BCBS					90791					$88.00	INCORRECT SERVICING PROVIDER ON CLAIM	A, D	3	N/A		$92.40	-$4.40
128	BCBS					90832	59				$51.00	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$36.40	$14.60
90834 Subtotal											**$1,042.00**						**$327.60**	**$714.40**
90832 Subtotal											**$827.00**						**$468.00**	**$359.00**
All Other CPT Codes Subtotal											**$622.00**						**$281.40**	**$340.60**
Totals											**$2,491.00**						**$1,077.00**	**$1,414.00**

Appendix C-2: BlueCross BlueShield Claims Universe

Claims Universe and Sample Information

Vida Clinic PLLC Project Number 007 NPI 1912389081								
A	B	C	D	E	F	G	H	I
Strata	Universe Size (in Units)	Universe Reimbursements	Universe Weight	Sample Size	Sample Reimbursements[1]	Sample Units in Error[2]	Sample Error Rate (F/E)[2]	Total Sample Overpayment
90834	899	$70,456.60	35.65%	13	$1,042.00	13	100.00%	$714.40
90832	1,121	$58,129.76	44.45%	16	$827.00	16	100.00%	$359.00
All Other Codes	502	$53,130.82	19.90%	7	$736.00	6	85.71%	$340.60
Totals	**2,522**	**$181,717.18**	**100.00%**	**36**	**$2,605.00**	**35**	**97.22%**	**$1,414.00**

Extrapolated Overpayment Summary

Vida Clinic PLLC: BlueCross BlueShield Claims Universe			
A	B	C	D
Point Estimate	Precision Amount	Precision Percentage (B/A)[3]	Extrapolated Overpayment - Lower Bound (A-B)[3,4]
$98,982	$16,404	16.57%	$82,577

[1] Sample Reimbursements (column F) represents the total paid amount for every claim line in the sample, and may not tie to the subtotals seen in Appendix C-1 as it only contains claims determined to be in error.
[2] Please note that an error does not always result in an overpayment. Please refer to Appendix C-1 and Appendix E for additional information.
[3] Amounts indicated represent direct results from the RAT-STATS statistical software utilized for extrapolation purposes and may not tie exactly to the formulas indicated due to rounding.
[4] Per Chapter 8.4.5.1 of the Medicare Program Integrity Manual, the lower limit of a one-sided 90 percent confidence interval was utilized to arrive at the extrapolated overpayment amount.

Appendix D-1 – Dell Children's Health Plan Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information										Audit Determination						
Sample Line Number	MCO	State Issued	Date of	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
6	Dell Children's Health Plan	[redacted]		90834			[redacted]		$47.94	TIME NOT DOCUMENTED	B, E	2	90832	[redacted]	$37.33	$10.61
9	Dell Children's Health Plan			90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
12	Dell Children's Health Plan			90834					$47.94	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$10.61
13	Dell Children's Health Plan			90847	AH				$89.25	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$62.48	$26.77
16	Dell Children's Health Plan			90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
20	Dell Children's Health Plan			90791	AH				$119.82	INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, D	2	N/A		$83.87	$35.95
32	Dell Children's Health Plan			90834	AH				$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
33	Dell Children's Health Plan			90834					$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
37	Dell Children's Health Plan			90834					$68.49	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$31.16
44	Dell Children's Health Plan			90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
45	Dell Children's Health Plan			90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM, SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	A, B, D, E, F, G	1	N/A		$0.00	$53.33
56	Dell Children's Health Plan			90832	AH	95			$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
57	Dell Children's Health Plan			90832	AH	95			$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
60	Dell Children's Health Plan			90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
61	Dell Children's Health Plan			90834					$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
76	Dell Children's Health Plan			90832	AH				$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
79	Dell Children's Health Plan			90834					$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
80	Dell Children's Health Plan			90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
91	Dell Children's Health Plan			90832					$37.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	3	N/A		$37.33	$0.00
92	Dell Children's Health Plan			90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
93	Dell Children's Health Plan			90834	AH				$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
104	Dell Children's Health Plan			90832	AH	95			$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
105	Dell Children's Health Plan			90834	AH	95			$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
107	Dell Children's Health Plan			90837					$100.78	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	90832		$37.33	$63.45

Appendix D-1 – Dell Children's Health Plan Claims Universe Detailed Findings

Vida Clinic PLLC
Project Number 007
NPI 1912389081

Original Claims Information										Audit Determination						
Sample Line Number	MCO	State Issued			Date of	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Servicing Provider NPI	Servicing Provider Name	Paid Amount	Finding Type	Supporting Policy Reference	Recoupment Type	Adjusted CPT Code (if applicable)	Adjusted Servicing Provider Name (if applicable)	Corrected Claim Payment	Overpayment Amount
108	Dell Children's Health Plan	[redacted]				90837			[redacted]		$70.55	TIME NOT DOCUMENTED	B, E	2	90832	[redacted]	$37.33	$33.22
110	Dell Children's Health Plan					90837	AH				$106.66	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$69.33
113	Dell Children's Health Plan					90847					$76.06	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$62.48	$13.58
115	Dell Children's Health Plan					90834	AH				$71.01	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM, INCORRECT MODIFIER BILLED ON CLAIM	A, B, D, E	2	90832		$37.33	$33.68
116	Dell Children's Health Plan					90832					$53.33	TIME NOT DOCUMENTED, INCORRECT SERVICING PROVIDER ON CLAIM	A, B, D, E	2	N/A		$37.33	$16.00
90834 Subtotal											**$661.44**						**$373.30**	**$288.14**
90832 Subtotal											**$661.29**						**$447.96**	**$213.33**
All Other CPT Codes Subtotal											**$563.12**						**$320.82**	**$242.30**
Totals											**$1,885.85**						**$1,142.08**	**$743.77**

Appendix D-2 – Dell Children's Health Plan Claims Universe

Claims Universe and Sample Information

Vida Clinic PLLC Project Number 007 NPI 1912389081								
A	B	C	D	E	F	G	H	I
Strata	Universe Size (in Units)	Universe Reimbursements	Universe Weight	Sample Size	Sample Reimbursements[1]	Sample Units in Error[2]	Sample Error Rate (F/E)[2]	Total Sample Overpayment
90834	780	$50,667.98	37.18%	11	$709.38	10	90.91%	$288.14
90832	918	$45,823.30	43.76%	13	$661.29	13	100.00%	$213.33
All Other Codes	400	$38,797.58	19.07%	6	$563.12	6	100.00%	$242.30
Totals	**2,098**	**$135,288.86**	**100.00%**	**30**	**$1,933.79**	**29**	**96.67%**	**$743.77**

Extrapolated Overpayment Summary

Vida Clinic PLLC: Dell Children s Health Plan Claims Universe			
A	B	C	D
Point Estimate	Precision Amount	Precision Percentage (B/A)[3]	Extrapolated Overpayment - Lower Bound (A-B)[3,4]
$51,649	$7,149	13.84%	$44,501

[1] Sample Reimbursements (column F) represents the total paid amount for every claim line in the sample, and may not tie to the subtotals seen in Appendix D-1 as it only contains claims determined to be in error.

[2] Please note that an error does not always result in an overpayment. Please refer to Appendix D-1 and Appendix E for additional information.

[3] Amounts indicated represent direct results from the RAT-STATS statistical software utilized for extrapolation purposes and may not tie exactly to the formulas indicated due to rounding.

[4] Per Chapter 8.4.5.1 of the Medicare Program Integrity Manual, the lower limit of a one-sided 90 percent confidence interval was utilized to arrive at the extrapolated overpayment amount.

Appendix E – Detailed Findings Legends

Finding Type	Policy Reference	Definition
TIME NOT DOCUMENTED	B, E	The required time component was not documented to support the Current Procedural Terminology (CPT) procedure code billed.
INCORRECT SERVICING PROVIDER ON CLAIM	A, D	The servicing provider name and national provider identifier (NPI) on the claim are not the same as the provider who performed the service.
INCORRECT MODIFIER BILLED ON CLAIM	D	This claim was incorrectly billed with modifier AH indicating the service was provided by a clinical psychologist.
MISSING INFORMED CONSENT	C	The required informed consent form signed by the recipient or recipient's guardian was not submitted.
LATE INFORMED CONSENT	C	The required informed consent form was signed by the recipient or recipient's guardian after services were provided.
SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	F, G	The servicing provider was not enrolled in Texas Medicaid.

Recoupment Type	Recoupment Type Definition
1	Full
2	Partial (Partial recoupment due to downcoding to CPT code 90832 and/or reducing reimbursement to 70% due to service being provided by someone other than a licensed psychologist.)
3	The findings noted on this claim did not result in a provider overpayment and, as a result, no payment will be recouped.

Supporting Policy	Policy	Reference
1 TAC §355.8091	Counseling services provided by a licensed professional counselor, a licensed clinical social worker, or a licensed marriage and family therapist in compliance with applicable professional licensing laws and regulations are reimbursed at 70 percent of the existing fee for similar services provided by psychiatrists and psychologists as described in §355.8085 of this title (relating to Reimbursement Methodology for Physicians and Other Practitioners).	A
22 TAC §465.22(a)(1)	(a) General Requirements. (1) All licensees shall create and maintain accurate, current, and pertinent records of all psychological services rendered by or under the supervision of the licensee.	B
22 TAC §465.11(a)	(a) Except in an inpatient setting where a general consent has been signed, licensees must obtain and document in writing informed consent concerning all services they intend to provide to the patient, client or other recipient(s) of the psychological services prior to initiating the services, using language that is reasonably understandable to the recipients unless consent is precluded by applicable federal or state law.	C
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.	D

Appendix E – Detailed Findings Legends

Finding Type	Policy Reference	Definition
TIME NOT DOCUMENTED	B, E	The required time component was not documented to support the Current Procedural Terminology (CPT) procedure code billed.
INCORRECT SERVICING PROVIDER ON CLAIM	A, D	The servicing provider name and national provider identifier (NPI) on the claim are not the same as the provider who performed the service.
INCORRECT MODIFIER BILLED ON CLAIM	D	This claim was incorrectly billed with modifier AH indicating the service was provided by a clinical psychologist.
MISSING INFORMED CONSENT	C	The required informed consent form signed by the recipient or recipient's guardian was not submitted.
LATE INFORMED CONSENT	C	The required informed consent form was signed by the recipient or recipient's guardian after services were provided.
SERVICING PROVIDER WAS NOT ENROLLED IN TEXAS MEDICAID	F, G	The servicing provider was not enrolled in Texas Medicaid.

Recoupment Type	Recoupment Type Definition
1	Full
2	Partial (Partial recoupment due to downcoding to CPT code 90832 and/or reducing reimbursement to 70% due to service being provided by someone other than a licensed psychologist.)
3	The findings noted on this claim did not result in a provider overpayment and, as a result, no payment will be recouped.

Supporting Policy	Policy	Reference
American Medical Association Current Procedural Terminology 2017 Professional 4th Edition	90832 - Psychotherapy, 30 minutes with patient 90834 - Psychotherapy, 45 minutes with patient 90837 - Psychotherapy, 60 minutes with patient 90846 - Family Psychotherapy (without the patient present), 50 minutes 90847 - Family Psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	E
1 TAC §354.1382(d)	(d) These providers must: (1) meet the appropriate licensing requirements as required in subsections (a), (b) or (c) of this section; (2) comply with all applicable federal and state laws and regulations governing the services provided; (3) be enrolled and approved for participation in the Texas Medical Assistance Program; (4) sign a written provider agreement with the Commission or its designee; (5) comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the Commission or its designee; and (6) bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the Commission or its designee.	F
42 U S. Code §1396u-2 (d)(6)(A)	(6) ENROLLMENT OF PARTICIPATING PROVIDERS (A) In general Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this subchapter (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1396a(kk) of this title with the State agency administering the State plan under this subchapter. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.	G