# LOUISIANA DEPARTMENT OF HEALTH
# BEHAVIORAL HEALTH PROVIDER
# DESTINED FOR A CHANGE, INC.

INVESTIGATIVE AUDIT
ISSUED JANUARY 20, 2021

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January 20, 2021

Dr. Courtney N. Phillips, Secretary
Louisiana Department of Health
Baton Rouge, Louisiana

We are providing this report for your information and use. This investigative audit was performed in accordance with Louisiana Revised Statutes 24:513, *et seq*. to determine the validity of complaints we received.

The purpose of this audit was to evaluate whether Destined for a Change, Inc. (DFAC) was complying with the Louisiana Medicaid Program's laws, rules, policies and contracts.

We found DFAC billed and was paid $71,112 for behavioral health services it did not appear to have provided, in whole or in part, between January 2016 and August 2019.

The $71,112 included $20,169 for services provided to children whose parents/guardians indicated the children did not receive the services; $13,705 for services allegedly provided at one household after services had ended; $35,225 for services allegedly performed on weekends for clients who said they did not receive services on weekends; and $2,013 for alleged services when the client was in an inpatient setting (e.g., a hospital).

In addition, we found DFAC appeared to have improperly billed Medicaid for $26,163 in services between January 2016 and August 2019. According to the clients we spoke with, DFAC provided services to all children in the household at the same time. However, Medicaid records showed that DFAC billed for each child separately, which costs five times more than group services.

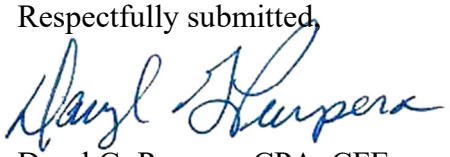
We also found in a review of 13 client files that there was no documentation to support a majority (52%) of the services billed to the Medicaid program. Medicaid requires providers to complete service/progress notes documenting the services performed to be eligible for reimbursement for behavioral health services. As a result, DFAC may have been paid for ineligible services and may have violated its Medicaid provider agreements.

The procedures we performed primarily consisted of making inquiries and examining selected financial records and other documents and do not constitute an examination or review in accordance with generally accepted auditing or attestation standards. Consequently, we provide

no opinion, attestation, or other form of assurance with respect to the information upon which our work was based.

The accompanying report presents our findings and recommendations as well as management's response. This is a public report. Copies of this report have been delivered to the Louisiana Attorney General, the Orleans Parish District Attorney, the District Attorney for the 19th Judicial District of Louisiana, and others as required by law.

Respectfully submitted,



Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

LDH-DFAC

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

### Medicaid Services Apparently Not Provided

Based on our review, Destined for a Change, Inc. (DFAC) billed the Louisiana Medicaid Program (Medicaid) and was paid $71,112 for services that DFAC does not appear to have provided, in whole or in part, from January 2016 through August 2019. By billing Medicaid for services that were not provided, DFAC may have violated federal and state law, and its provider agreements with the Louisiana Department of Health (LDH), as well as the Managed Care Organizations (MCO) that operate the Medicaid program on LDH's behalf.

### Provider Improperly Billed for Medicaid Services

Based on our review of DFAC records and client interviews, DFAC appears to have improperly billed Medicaid for $26,163 in services from January 2016 through August 2019. According to the clients we spoke with, DFAC provided services to all children in the household at the same time. However, Medicaid records show that DFAC billed for each child separately, which costs five times more than group services. As such, it appears that DFAC either improperly billed group services as individual services, or billed for multiple individual services at the same time. By improperly billing Medicaid, DFAC may have violated federal and state law, and its provider agreements with LDH and the MCOs that operate the Medicaid program on behalf of LDH.

### No Documentation of Services Provided

We reviewed DFAC client files for 13 clients from January 2016 to August 2019 and found that there was no documentation to support a majority (52%) of the services billed to the Medicaid program. To be eligible for reimbursement for behavioral health services, Medicaid requires providers to complete service/progress notes documenting the services performed. By billing Medicaid for services that were not documented, DFAC may have been paid for ineligible services and may have violated its Medicaid provider agreements.

# BACKGROUND AND METHODOLOGY

The Louisiana Department of Health (LDH) is an executive branch department that reports to the governor. LDH's mission is to protect and promote health and to ensure access to medical, preventative, and rehabilitative services for all citizens of the state of Louisiana. LDH is responsible for developing and providing health and medical services for the prevention of disease for the citizens of Louisiana. LDH provides health and medical services for uninsured and medically indigent persons and also coordinates the delivery of services provided by the Louisiana State University Health Sciences Center with services provided by LDH, local health departments, and federally-qualified health centers, including but not limited to, the following:

- Services for:
    - Persons with mental illness;
    - Persons with intellectual disabilities;
    - Persons with developmental disabilities; and
    - Persons with addictive disorders.
- Public health services.
- Services provided under the medical assistance program (Medicaid).

In 2012, LDH began transitioning from a fee-for-service (FFS) model, where LDH paid all claims submitted by Medicaid providers for each service performed, to *Healthy Louisiana,*[A] a full-risk prepaid managed care model. Under LDH's current full-risk prepaid managed care model, LDH pays a fixed monthly premium to a Managed Care Organization (MCO) for the administration of health benefits and payment of claims for each member. LDH contracted with five MCOs to operate the *Healthy Louisiana* Medicaid program through December 31, 2019.[B] However, LDH is responsible for determining Medicaid recipient eligibility and enrolling applicants into Medicaid programs.

Past LLA reports on behavioral health services identified various issues with the Medicaid Behavioral Health Program. For example, LLA's report on the *Oversight of Surveillance and Utilization Review Subsystem – Medicaid Program Integrity Activities* identified instances of high-risk billing patterns by behavioral health providers, and the report, *Identification of Behavioral Health Service Providers,* identified issues with compliance by behavioral health providers with state law that requires certain claims to identify the National

[A] *Healthy Louisiana* was previously called Bayou Health. A managed care model is an arrangement for health care in which an organization (e.g., an MCO), acts as a gatekeeper or intermediary between the person seeking care and the physician. FFS still covers some Medicaid recipients who are not eligible for managed care.

[B] All five MCO contracts were bid out to begin covering Medicaid recipients on January 1, 2020, but protests were filed by the losing bidders. The MCOs are currently operating under emergency contracts to administer the Medicaid program through December 31, 2020.

Provider Identification Number (NPI) of the rendering service provider. Another report, *Improper Billing of Services Within the Behavioral Health Program,* identified behavioral health providers who did not comply with guidance from LDH and the MCOs about how to properly bill for services rendered. During the course of these audits we developed analyses of behavioral health provider Medicaid claims and encounters.[C] These analyses identified "red flags" associated with the billing practices of behavioral health providers which were then used to create a risk-matrix. This risk-matrix identified Destined For A Change, Inc. (DFAC) as having "red flags". As a result, we initiated this investigative audit to evaluate DFAC's compliance with certain provisions of the Medicaid program.

DFAC is a Louisiana non-profit corporation domiciled in Orleans Parish, Louisiana that registered with the Louisiana Secretary of State on April 9, 2009. DFAC is licensed by LDH to provide specialized behavioral health services to children, adolescents, adults, and families. According to Medicaid data, DFAC was paid $3,834,787 for claims submitted to MCOs for Medicaid services provided between January 2016 and September 2019. These services primarily consisted of psychosocial rehabilitation services (PSR) and community psychiatric supports treatment (CPST), both of which are face-to-face services which require the individual to be present. PSR is designed to help an individual compensate for, or eliminate, functional deficits and interpersonal and/or environmental barriers associated with his or her mental illness. CPST is a comprehensive service that focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and solution-oriented interventions intended to achieve identified goals or objectives as set forth in an individualized treatment plan.

In order to provide eligible behavioral health services, a licensed mental health professional (LMHP) or a physician must determine medical necessity, perform an assessment of needs, and develop a treatment plan. Once the assessment, treatment plan, and other data are received by the appropriate MCO, the MCO will determine the eligibility, frequency, and duration of CPST and PSR that a member may receive. LDH policy requires that DFAC complete progress notes to document the services provided and to bill the MCO. Progress notes include the date of service, start and end time of the service session, the type of session/therapy conducted, and the location of the session. The progress notes also provide the goal of the session, the recipients' behavior during the session, the intervention/activities performed during the session, the recipient's response to the intervention, and the plan for the recipient going forward.

We analyzed DFAC's Medicaid claims and progress notes to determine whether DFAC was in compliance with the Medicaid program's laws, rules, policies and contracts. The procedures performed during this included:

(1) interviewing DFAC employees;

(2) interviewing other persons, as appropriate;

(3) examining selected LDH and DFAC documents and records;

[C] An encounter is a distinct set of healthcare services provided to a Medicaid member enrolled with an MCO on the date that the services were delivered. It is a claim paid for by the MCO but submitted to LDH.

(4) gathering and examining external parties' documents and records; and

(5) reviewing applicable state laws and regulations.

During our audit, we received assistance from the Louisiana Attorney General's office. Their participation was instrumental to the completion of this audit.

# FINDINGS AND RECOMMENDATIONS

## Medicaid Services Apparently Not Provided

**Based on our review, Destined for a Change, Inc. (DFAC) billed the Louisiana Medicaid Program (Medicaid) and was paid $71,112 for services that DFAC does not appear to have provided, in whole or in part, from January 2016 through August 2019. By billing Medicaid for services that were not provided, DFAC may have violated Federal[1] and state law,[2,3,4] and its provider agreements with the Louisiana Department of Health (LDH), as well as the Managed Care Organizations (MCO) that operate the Medicaid program on LDH's behalf. These services are comprised of the following:**

- DFAC was paid $20,169 for services provided to children whose parents/guardians stated that the children did not receive services from the counselors for which DFAC billed Medicaid.
- DFAC was paid $13,705 for services allegedly provided at one household after services had ended.
- DFAC was paid $35,225 for services allegedly performed on weekends for clients who said they did not receive services on weekends.
- DFAC was paid $2,013 for alleged services when the client was in an inpatient setting (e.g., a hospital).

Clients Did Not Receive Services from the Counselors For Which DFAC Billed Medicaid

During our audit, we spoke with the heads of several households whose children received services from DFAC, including two heads of household who told us their children did not receive services from the LMHP and/or direct care staff workers (counselors) for which DFAC billed Medicaid. DFAC was paid $20,169 for these services from February 2016 to January 2019. These services were either not provided or improperly billed using the wrong provider.

*Household No. 1*

Household No. 1 consisted of a mother (head of household) and her three children who were DFAC clients. According to LDH records, DFAC billed Medicaid for 1,987 units[D] of service totaling $31,914 for the three children in this household from January 2016 to April 2017. These services primarily consisted of PSR and CPST units, but also included psychotherapy sessions, assessments, and physician visits; all were face-to-face services requiring the provider and the client to be present. The breakdown of DFAC's billings by attending provider (counselor) and the total number of units for this household are listed in the table below:

[D] Individual PSR and CPST units are 15 minutes in duration, meaning, 1,987 units equals 496.75 hours.

| Attending Provider | Units of Service Billed | Amounts Billed |
|---|---|---|
| Daryl Wells | 916 | $11,963 |
| DFAC[E] | 1040 | 18,891 |
| Physician | 9 | 385 |
| Other Counselor | 22 | 675 |
| **Total** | **1,987** | **$31,914** |

We spoke with the mother of Household No. 1 to confirm DFAC provided the services that were billed to Medicaid. The mother told us that her three children were DFAC clients and that LaQuesha Richardson was their only counselor. She stated that after Ms. Richardson resigned from DFAC, her children were assigned new counselors on two different occasions; however, neither counselor ever showed up to provide services. When asked if Daryl Wells provided services to her children, the mother informed us that she had never heard of Daryl Wells, and that Daryl Wells did not provide services to her children. From February 2016 to January 2017, DFAC billed Medicaid for 916 service units totaling $11,963 for services allegedly provided to Household No. 1 by Daryl Wells.

We obtained DFAC's available progress notes for the three siblings included in Household No. 1 and found DFAC had progress notes supporting 725 (36%) of the 1,987 units. This included progress notes for 689 units apparently completed by Ms. Richardson; progress notes for 24 units[F] completed by another worker (not included in the table above); and progress notes for two units completed by Daryl Wells. We compared DFAC's billing data to the progress notes completed by Ms. Richardson (689 units) and found that 145 units were billed under Ms. Wells' National Provider Identifier Number (NPI) and the remaining 544 units were billed using DFAC's NPI.

We spoke with Daryl Wells. She told us she was not the counselor for the children in this household. In addition, we told Ms. Wells that she was DFAC's highest-billed employee overall from January 2016 through August 2019 (15,869 units: equivalent to 2,509 hours). Ms. Wells stated that these figures did not seem correct, as she worked for DFAC on a part-time basis. Ms. Wells stated that she typically provided services to DFAC clients during the week from 4:00 p.m. to 8:00 p.m. Based on Ms. Wells' statements, we used her pay rate and gross earnings for calendar year 2016 to determine the number of hours she worked each week. This analysis showed that Ms. Wells worked an average of 18 hours per week; however, LDH records show that DFAC billed Ms. Wells' NPI as though she provided services totaling 48 hours per week. For example, DFAC billed Ms. Wells' NPI for a total of 81 service units (21 hours) on October 21, 2016, which included 15 service units (3.75 hours) for children in Household No. 1. Ms. Wells stated that she was not the counselor for the children in Household No. 1, and that she never worked 21 hours in a day for DFAC.

[E] These units were billed using DFAC's National Provider Identification Number (NPI). As such, there was no billing information to determine who performed the services billed under DFAC's NPI. Beginning January 1, 2019, LDH required behavioral health service providers to include the NPI of the individual who provided the services when billing for services.

[F] These units were billed using DFAC's NPI and the NPI of another worker.

Based on this information and the statements provided by the mother of Household No. 1 and Ms. Wells, it appears that DFAC billed Medicaid for 916 units totaling $11,963 that were either not provided or provided by someone else and improperly billed using Ms. Wells' NPI.

*Household No. 2*

Household No. 2 consisted of a mother (head of household) and her two children, all of whom were DFAC clients. According to LDH records, DFAC was paid $27,640 for services provided to this household from January 2016 to May 2019. These services primarily consisted of PSR and CPST units, but included some psychotherapy sessions, assessments, and physician visits. The breakdown of DFAC billings by attending provider and the number of units for all members of Household No. 2 are listed in the chart below:

| Attending Provider | Units of Service Billed | Amounts Billed |
|---|---|---|
| Shelia Bax | 587 | $8,206 |
| Karlana Kaywood | 352 | 5,662 |
| Daryl Wells | 250 | 6,220 |
| DFAC | 226 | 3,572 |
| Other Counselors | 89 | 1,570 |
| Physicians | 51 | 2,410 |
| **Total** | **1,555** | **$27,640** |

We spoke with the mother of Household No. 2 to verify whether DFAC provided the services billed to Medicaid. The mother confirmed that she and her two children were DFAC clients and stated that the services provided to her children always took place away from their home. She stated that her children would be picked up by either Karlana Kaywood or Daryl Wells and taken into the community for their sessions. We provided the mother with a schedule of DFAC's billings for her household, which stated the names of the attending providers (counselors) whom DFAC billed Medicaid for providing services to her and her children. The mother reviewed the schedule and told us that she did not know Sheila Bax, and that Ms. Bax has never provided services to her children. In addition, her oldest child, who was also present, stated that he knew Ms. Bax from DFAC's office; however, Ms. Bax was never his counselor, and Ms. Bax did not provide services to him or his sister. From October 2016 to January 2019, DFAC billed Medicaid for 587 service units totaling $8,206 for services provided to Household No. 2 by Sheila Bax.

We obtained DFAC's available progress notes for Household No. 2 and found that DFAC had progress notes supporting only 318 (20%) of the 1,555 units, including three that appear to have been completed by Ms. Bax for a total of 19 service units. According to these three progress notes, Ms. Bax provided PSR services to one child on October 25, 2018, and PSR services to both of the children on January 18, 2019. Although the progress note for services billed on October 25, 2018 appears to have been signed by Ms. Bax, LDH records show that the services were billed using DFAC's company NPI. Ms. Bax stated that she provided the services for which DFAC billed, but could not explain why there were no progress notes to support the majority of the units billed.

Based on the statements provided by the members of this household and the lack of progress notes to support the services, it appears that DFAC billed Medicaid for 587 units of service totaling $8,206 by Ms. Bax that were not provided.

DFAC Billed Medicaid after Services to the Household Ended

DFAC was paid $56,389 for 2,571 units of behavioral health services provided to five different children in the same household (Household No. 3) from January 2016 to November 2018. We spoke with the mother of the children in Household No. 3, who told us that the last time DFAC provided services to four of the five children was August 2017. According to the mother of Household No. 3, her sister-in-law passed away in August 2017. She stated that her children received grief counseling from DFAC in August 2017, and that was the last time her children received services from DFAC.

LDH records show that DFAC billed Medicaid for 622 units of service totaling $13,705 for four of the children in Household No. 3 from September 2017 to November 2018. Of the 622 units billed after August 2017, 568 of them were billed under Ms. Wells' NPI. The mother of Household No. 3 acknowledged that Ms. Wells was her children's counselor but stated that DFAC provided no services to her household after the grief counseling in August 2017.

Services Not Provided on Weekends

LDH records show that DFAC was paid $1,011,280 for 64,210 units of behavioral health services provided on weekends (Saturdays and Sundays). During the course of our audit, five out of seven clients we spoke with informed us that DFAC did not provide behavioral health services to them on weekends. These clients included the three households mentioned above, a fourth household (Household No. 4), and one adult client. We showed these clients billing schedules indicating weekend counseling services were provided to them and they all confirmed to us that they (and/or their children) did not receive services on the weekend. However, the adult client confirmed that a DFAC counselor did provide some services to her on Saturdays (those services are not included in this report). In essence, DFAC billed Medicaid 1,914 units of services totaling $35,225 for weekend services to clients who stated they never received services on the weekend from January 2016 to August 2019.

For example, Household No. 4 consisted of four children who were DFAC clients. We spoke with the mother of Household No. 4 to confirm that DFAC provided the services billed to Medicaid. The mother told us that DFAC provided some services to her children but did not provide services to her children on weekends. From February 2016 to November 2017, DFAC billed Medicaid $10,163 for 573 service units for children in this household on Saturdays and Sundays. According to LDH records, 569 of the 573 units of service units were billed under DFAC's NPI. We provided the mother of this household with the following list of service dates and services that DFAC billed Medicaid for two of her children:

| Child | Service Date | Day of Week | Procedure Code | Units Billed | Amount Paid |
|---|---|---|---|---|---|
| 1 | 5/21/2016 | Saturday | H0036 | 5 | $101.40 |
| 1 | 5/21/2016 | Saturday | H2017 | 10 | 126.70 |
| 2 | 5/21/2016 | Saturday | H0036 | 5 | 101.40 |
| 2 | 5/21/2016 | Saturday | H2017 | 10 | 126.70 |
| 1 | 6/4/2016 | Saturday | H2017 | 10 | 126.70 |
| 1 | 6/4/2016 | Saturday | H0036 | 5 | 101.40 |
| 2 | 6/4/2016 | Saturday | H0036 | 5 | 101.40 |
| 2 | 6/4/2016 | Saturday | H2017 | 10 | 126.70 |
| 1 | 10/30/2016 | Sunday | H0036 | 5 | 101.40 |
| 1 | 10/30/2016 | Sunday | H2017 | 10 | 126.70 |
| 2 | 10/30/2016 | Sunday | H0036 | 5 | 101.40 |
| 2 | 10/30/2016 | Sunday | H2017 | 10 | 126.70 |
| **Total** | | | | **90** | **$1,368.60** |

After reviewing the schedule the mother stated, "These services did not happen. Her children did not receive services on the weekend."

For the service dates shown in the table above, we reviewed the progress notes and found that DFAC had progress notes for eight out of the 12 services billed to Medicaid including three of the four services billed for the two children on Saturday, June 4, 2016. According to the available progress notes, and the number of units billed to Medicaid for both children, DFAC's counselor would have been in the home for more than 7.5 hours, from 8 a.m. to at least 4:25 p.m.[G] In addition, LDH records and DFAC progress notes show that DFAC billed for one of the children the previous day (June 3, 2016) for 10 units (150 minutes) from 3:00 p.m. to 5:30 p.m. The mother of Household No. 4 told us that the counseling sessions provided by DFAC did not last that long, and that she would have remembered an instance in which her children were with the counselor for more than 7.5 hours.

Services Billed While Clients Were Hospitalized

During our audit, we compared the dates that DFAC billed Medicaid for its clients to the dates that other providers billed Medicaid for the same clients. We found that DFAC billed Medicaid for 119 units of behavioral health services to 13 clients totaling $2,013 while the clients were hospitalized. These services primarily consisted of PSR and CPST, both of which are face-to-face services that require the individual to be present and should not be performed in a hospital setting. For example, from July 1, 2017 to April 1, 2019, DFAC billed Medicaid $454

[G] Available progress notes for this day shows that services ran 8:00 am to 9:15 am (5 units); 9:30 am to 12:00 pm (10 units); and 12:10 pm to 1:25 pm (10 units). Based on these times, the earliest time that the remaining 10 units (150 minutes) could have been completed was 4:25 pm. Progress notes were not available for remaining 10 units of service.

for 21 units of service for an adult client who was hospitalized on the days DFAC claims it provided services. These services included the following:

- DFAC billed four units of CPST services (one hour) on July 1, 2017. The progress note for this session indicates that the client and therapist went to a local park from 1:00 p.m. – 2:00 p.m. to help the client increase her overall exercise regimen. Medicaid records show that the client was hospitalized from June 29, 2017 to July 3, 2017.

- DFAC billed one unit of Psychotherapy (45 minutes) on October 21, 2017. According to Medicaid records, the client was hospitalized in Morgan City, Louisiana from October 17, 2017 to October 23, 2017. Progress notes for this session did not indicate the place where the session took place.

- DFAC billed eight units of CPST services (16 total units) on March 29, 2019 and April 1, 2019. Progress notes for both sessions indicate that the services were provided at the client's home. Medicaid records show that the client was hospitalized from March 28, 2019 to April 4, 2019.

The client informed us that no one from DFAC came to visit her while she was hospitalized; however, she recalled one counselor phoned and checked on her while she was in the hospital.

## Provider Improperly Billed for Medicaid Services

**Based on our review of DFAC records and client interviews, DFAC appears to have improperly billed Medicaid for $26,163 in services from January 2016 through August 2019. According to the clients we spoke with, DFAC provided services to all children in the household at the same time. However, Medicaid records show that DFAC billed for each child separately, which costs five times more than group services. As such, it appears that DFAC either improperly billed group services as individual services, or billed for multiple individual services at the same time. By improperly billing Medicaid, DFAC may have violated federal[1] and state law,[2,3,4] and its provider agreements with LDH and the MCOs that operate the Medicaid program on behalf of LDH.**

Behavior health services such as PSR and CPST are face-to-face services that require the individual to be present. CPST services are performed on an individual basis; however, PSR services may be performed individually or in a group setting. Medicaid requires service providers to use the Healthcare Common Procedure Coding System (HCPCS) code H2017 to bill for individual PSR services. Further, service providers must use HCPCS code H2017 with a modifier, HQ, to bill for group PSR services. The modifier is used to distinguish between the individual and group rates as the unit rate for individual PSR services is five times greater than the group PSR unit rate. For example, PSR services provided to a group of five clients in a community setting for one hour would allow the provider to bill Medicaid a total of $50.60 for the entire session. However, if the provider failed to use the HQ modifier and billed the same services on an individual basis, the provider would be paid $253.40. The table below provides the Medicaid rates for individual and group PSR Services.

| HCPCS Code | Modifier | Type of Service | Unit | Price/Unit | Price/Hour |
|---|---|---|---|---|---|
| H2017 | N/A | Individual – Office | 15 Min | $10.99 | $43.96 |
| H2017 | N/A | Individual - Community | 15 Min | $12.67 | $50.68 |
| H2017 | HQ | Group – Office (per client) | 15 Min | $2.20 | $8.80 |
| H2017 | HQ | Group – Community (per client) | 15 Min | $2.53 | $10.12 |

During our audit, we interviewed the heads of four households who had multiple children that received services from DFAC. The mothers of each of these households told us that the DFAC counselors met with all of their children at the same time and that the counseling sessions lasted no more than one hour at a time. However, Medicaid records show that DFAC billed services for each of the children in these households on an individual basis or at separate times. Based on our review of DFAC records and client interviews, DFAC appears to have improperly billed Medicaid $26,163 for these services from January 2016 through August 2019.

For example, DFAC separately billed five units of individual PSR services (One hour and 15 minutes) for each of the three children in Household No. 1 on October 31, 2016. Progress notes were only available for one of the individual PSR sessions, which consisted of five units. The progress notes for this session indicated that the session took place from 8:20 a.m. to 9:35 a.m. and stated that, "…Member[H] and family were informed on how to look for signs and how to receive treatment…," suggesting that all members of the family participated in the session at the same time. However, because progress notes were only available for one of the children's sessions, it could not be determined if DFAC billed for each of the children during the same timeframe. The mother of Household No. 1 told us that the DFAC counselor would pick up her kids and take them outside of the household for services, and that they would be gone for no longer than one hour. Based on DFAC's progress notes and the statements provided by the mother of this household, it appears that DFAC improperly billed individual PSR services when group PSR services were provided.

We also found that DFAC may have billed for multiple individual services that appear to have been performed at the same time. Medicaid records and available progress notes show that DFAC billed the following services in Household No. 1 on June 28, 2016:

- Child No. 1 – CPST services from 9:00 a.m. to 10:15 a.m. (Five units)
- Child No. 2 – CPST services from 10:20 a.m. to 11:35 a.m. (Five units)
- Child No. 1 – CPST services from 10:20 a.m. to 11:35 a.m. (Five units)
- Child No. 3 – CPST services from 11:40 a.m. to 12:55 p.m. (Five units)

Although the progress notes suggest that the counselor provided services in the household for approximately four hours, the mother of this household told us that services were not

[H] Based on the progress notes provided for the members of this family, it appears that the counselor generally referred to the client for whom services were being billed as the "Member".

provided in her home and that the counselor took all of the children into the community at the same time for no longer than hour. In addition, the progress notes show that DFAC billed Child No. 1 and Child No. 2 for the same time period (10:20 a.m. to 11:35 a.m.). The progress notes for these sessions were identical (except for the client's personal information) and contained language suggesting that all members of the family participated in each session at the same time. Based on DFAC's progress notes and the statements provided by the mother of this household, it appears that DFAC improperly billed multiple CPST services performed at the same time.

Finally, Medicaid records show that DFAC billed Household No. 1 for individual PSR services when group PSR services were provided and multiple CPST services performed at the same time on the same day. Medicaid records and available progress notes show that DFAC billed the following services in Household No. 1 on July 9, 2016:

- Child No. 2 – PSR services from 8:00 a.m. to 9:15 a.m. (Five units)
- Child No. 1 – CPST services from 9:00 a.m. to 10:15 a.m. (Five units)
- Child No. 2 – CPST services from 10:20 a.m. to 11:35 a.m. (Five units)
- Child No. 3 – CPST services from 11:40 a.m. to 12:55 p.m. (Five units)
- Child No. 1 – PSR services (progress notes were not available (Five units)
- Child No. 3 – PSR services (progress notes were not available) (Five units)

The Medicaid records and available progress notes for these services indicate that a total of 30 units (7.5 hours) were provided beginning at 8:00 a.m. on Saturday, July 9, 2016. Although these records show that DFAC billed the PSR services using Daryl Wells' NPI, the progress notes for the PSR services performed for Child No. 2 from 8:00 a.m. to 9:15 a.m. appear to have been completed by another counselor and overlap with the CPST services billed for Child No. 1 from 9:00 a.m. to 9:15 a.m. The mother of this household told us that her children did not receive services on the weekend; that Daryl Wells was not her children's counselor; and that services were provided to all of her children at the same time. Based on DFAC's progress notes and the statements provided by the mother of this household, it appears that DFAC improperly billed individual PSR services and CPST services (allegedly performed at the same time), on the same day.

## No Documentation of Services Provided

**We reviewed DFAC client files for 13 clients from January 2016 to August 2019, and found that there was no documentation to support a majority (52%) of the services billed to the Medicaid program. To be eligible for reimbursement for behavioral health services, Medicaid requires providers to complete service/progress notes documenting the services performed. By billing Medicaid for services that were not documented, DFAC may have been paid for ineligible services and may have violated it Medicaid provider agreements.**

To be eligible for reimbursement for behavioral health services, Medicaid requires that providers complete service/progress notes documenting the services performed. Service/ progress notes must reflect the service delivered and are the "paper trail" for services delivered. According to LDH's Behavioral Health Services Provider Manual, the following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of the recipient;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;
- Date of service contact;
- Start and stop time of service contact; and
- Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), and progress made toward functional and clinical improvement.

Further, service/progress notes must be reviewed by a supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient. During our audit, we reviewed files for 13 clients which DFAC billed Medicaid for 2,257 claims for reimbursement totaling $179,043 from January 2016 to August 2019. We found that DFAC did not maintain service/progress notes for 1,164 (52%) of the 2,257 claims totaling $88,317.

We also found several instances in which DFAC's available progress notes appeared to be inaccurate. For example, available progress notes for Household No. 1 were completed by someone other than the individual whom DFAC billed Medicaid for the services. In this instance, one counselor completed progress notes for 689 units of service; however, Medicaid records show that DFAC billed 145 units using another counselor's NPI and the remaining 544 units were billed using DFAC's NPI.

**Recommendations**

We recommend that LDH management consult with its legal counsel to determine the appropriate action to be taken, including the recovery of payments for services not provided.

In addition, LDH management should:

(1) Require providers to implement detailed written policies and procedures to ensure they appropriately bill for services provided. These policies and procedures should require supervisory review and approval of service/progress notes completed by staff members;

(2) Require providers to implement detailed written policies and procedures to ensure that all staff members have received the appropriate training required to perform the services billed to the Medicaid program;

(3) Conduct periodic monitoring visits to ensure that staff members are providing the services that are billed. Monitoring visits should determine if the services are being performed, are properly documented, and authorized in an approved plan of care;

(4) Investigate service providers who billed for services that are not properly documented to determine if fraud occurred;

(5) Require providers to sign an annual certification stating that the provider has reviewed and will comply with the provisions of the provider manuals; and,

(6) Issue guidance to the MCOs regarding strategies for monitoring providers to ensure that providers comply with federal and state law and their provider agreements with LDH.

# LEGAL PROVISIONS

[1] **18 United States Code (U.S.C) §666,** provides, in part, "That theft concerning programs receiving federal funds occurs when an agent of an organization, state, local, or Indian tribal government or any agency thereof embezzles, steals, obtains by fraud, or otherwise intentionally misapplies property that is valued at $5,000 or more and is owned by or under control of such organization, state, or agency when the organization, state, or agency receives in any one year period, benefits in excess of $10,000 under a federal program involving a grant contract, or other form of federal assistance."

**18 U.S.C. §1343,** "Wire Fraud" provides, in part, "That whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communications in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined not more than $1,000 or imprisoned not more than five years, or both."

[2] **Louisiana Revised Statute (La. R.S.) 14:67(A)** provides that, "Theft is the misappropriation or taking of anything of value which belongs to another, either without the consent of the other to the misappropriation or taking, or by means of fraudulent conduct, practices, or representations. An intent to deprive the other permanently of whatever may be the subject of the misappropriation or taking is essential."

[3] **La. R.S. 14:70.1(A)** provides, in part, that, "The crime of Medicaid fraud is the act of any person who, with intent to defraud the state or any person or entity through any medical assistance program created under the federal Social Security Act and administered by the Louisiana Department of Health or any other state agency, does any of the following: … (1) Presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise. (2) Knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise. (3) Knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise."

[4] **R.S. 14:125(A)** provides that, "False swearing is the intentional making of a written or oral statement, known to be false, under sanction of an oath or an equivalent affirmation, where such oath or affirmation is required by law; provided that this article shall not apply where such false statement is made in, or for use in, a judicial proceeding or any proceeding before a board or official, wherein such board or official is authorized to take testimony."

# APPENDIX A

## Management's Response

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

# State of Louisiana

Louisiana Department of Health
Office of the Secretary

**VIA E-MAIL ONLY**

January 7, 2021

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Behavioral Health Service Provider - Destined For a Change, Inc.

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit report on Destined For A Change, Inc. The Bureau of Health Services Financing, which is responsible for the administration of the Medicaid program in Louisiana, and the Office of Behavioral Health are committed to ensuring the integrity of the Medicaid program. Louisiana Department of Health (LDH) appreciates the efforts of the LLA to identify potentially fraudulent or abusive behavior by providers in the Medicaid program.

We have reviewed the audit and provide the following response to the findings and recommendations documented in the report.

**Response to LLA Audit Findings:** LDH agrees with the three findings based on the evidence presented in the audit. Program Integrity will work with LDH Legal to coordinate next steps on finalizing the alleged overpayment with LLA and MFCU.

**Recommendation 1:** LDH should require providers to implement detailed written policies and procedures to ensure they appropriately bill for services provided. These policies and procedures should require supervisory review and approval of service/progress notes completed by staff members.

> **LDH Response:** LDH agrees with this recommendation in part and considers it implemented. This recommendation was implemented prior to this audit. LDH agrees supervisors should be required to approve service/progress notes. The Medicaid Behavioral Health Services (BHS) Provider Manual contains recordkeeping requirements, including

requirements for service/progress notes. The BHS Provider Manual states: "A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred. The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate. Additionally, evidence of supervisory oversight of the treatment record is an element that is reviewed by the Medicaid Managed Care Organizations (MCOs) as part of their quality monitoring visits.

Based on the above, LDH disagrees that it should mandate additional policies and procedures of the providers regarding supervision.

**Recommendation 2:** LDH should require providers to implement detailed written policies and procedures to ensure that all staff members have received the appropriate training required to perform the services billed to the Medicaid program.

**LDH Response:** LDH agrees with this recommendation in part and considers it implemented. This recommendation was implemented prior to this audit. LDH agrees staff members shall have appropriate training. The BHS Provider Manual contains staff training requirements that must be met prior to the provision of services for which they are reimbursed. The BHS Provider Manual also establishes that provider agencies are required to maintain documentation of training completed. Furthermore, providers must adhere to the licensing requirements found in the Louisiana Administrative Code Chapter 56, Subchapter C, Section 5633(C)(5) and 5645.

Based on the above mandates, LDH disagrees that it should mandate additional policies and procedures of the providers regarding training.

**Recommendation 3:** LDH should conduct periodic monitoring visits to ensure that staff members are providing the services that are billed. Monitoring visits should determine if the services are being performed, are properly documented, and authorized in an approved plan of care.

**LDH Response:** LDH agrees with this recommendation and considers it implemented. This recommendation was implemented prior to this audit. LDH agrees that monitoring visits shall occur. Medicaid MCOs, on behalf of LDH, conduct periodic monitoring visits to ensure patient records substantiate services billed. One component of the MCO monitoring visits is a member interview, which compares services billed to services documented. These MCO monitoring visits are conducted on a statistically significant sample of providers. The MCOs submit detailed monitoring reports to LDH quarterly, which includes, among other details, the number of providers monitored that reporting period compared against the number of providers in their network.

**Recommendation 4:** LDH should investigate service providers who billed for services that are not properly documented to determine if fraud occurred.

**LDH Response:** LDH agrees with this recommendation and considers it implemented. This recommendation was implemented prior to this audit. Medicaid's Surveillance and Utilization Review Subsystem (SURS) unit routinely investigates providers, where suspicious billing patterns have been identified. During these investigations, if fraud is suspected, the case is referred to the State's Medicaid Fraud Control Unit for further review.

**Recommendation 5:** LDH should require providers to sign an annual certification stating that the provider has reviewed and will comply with the provisions of the provider manuals.

**LDH Response:** LDH agrees in part with this recommendation and considers it implemented. This recommendation was implemented prior to this audit. LDH agrees providers should comply with the provider manuals. Providers are required to comply with the provisions of the Medicaid BHS Provider Manual through their written provider agreements with the Medicaid MCOs. LDH already requires the MCOs to credential providers and to include compliance with the Medicaid provider manual as a contractual requirement in their provider

agreements. Please note, providers contract directly with the Medicaid MCOs through written provider agreements, and not with LDH.

LDH disagrees with requiring the additional annual certification. LDH feels the contract is a more stringent and binding document than an additional self-attested certification.

**Recommendation 6:** LDH should issue guidance to the MCOs regarding strategies for monitoring providers to ensure that providers comply with federal and state law and their provider agreements with LDH.

**LDH Response:** LDH agrees with this recommendation and considers it implemented. This recommendation was implemented prior to this audit. Through their contracts with the State, LDH requires the MCOs to implement a plan for monitoring providers and facilities across all levels of care, which shall incorporate strategies such as onsite reviews, administrative desk audits, and member interviews. In addition, the contracts with LDH and the MCOs require provider monitoring plans to include review criteria for behavioral health provider types and services, random audit selection criteria, monitoring tools to be used, frequency of review, and corrective actions to be imposed. Providers do not hold agreements with LDH.

You may contact Ms. Karen Stubbs, Assistant Secretary, the Office of Behavioral Health by telephone at (225) 342-1435 or by email at Karen.Stubbs@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips

Attachment

APPENDIX B

# Destined For A Change, Inc.’s Response

# MALEY LAW FIRM

Attorneys & Counselors

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January 8, 2021

**Via Email and First-Class Mail:**
RHarris@lla.la.gov

Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Purpera:

This letter is in response to the investigative audit report that was addressed to my client, Mr. Drew Armstead (Destined For A Change, Inc.), and performed on, Destined For A Change, Inc., on December 11, 2020. Let me begin by thanking you for the gracious extension of time to confer with my client and submit this response, on his behalf.

Mr. Armstead respectfully maintains his innocence with regard to this report, its methodology, analysis, investigation, interviews, and conclusions. Mr. Armstead, at no time during the ownership of his business, and the activities associated with same, has ever had the "specific intent" to commit any criminal activity whatsoever, including but not limited to, the limited billing practices and examples outlined in this report.

Mr. Armstead and his staff have in fact, over the life of his company, served many thousands of satisfied patients/clients in the Metropolitan New Orleans community without complaints or concerns being expressed. His company has provided much needed, and valuable medical/counseling services for years and looks forward to the opportunity to continue to serve his patients/clients in the future.

Again, I wish to thank you for the opportunity to respond to your report. It is my hope that you include his response in any publication of said report.

Should you have any questions, please contact me.

With kind regards, I remain,

Sincerely,

Martin K. Maley, Sr.

cc: Mr. Drew Armstead