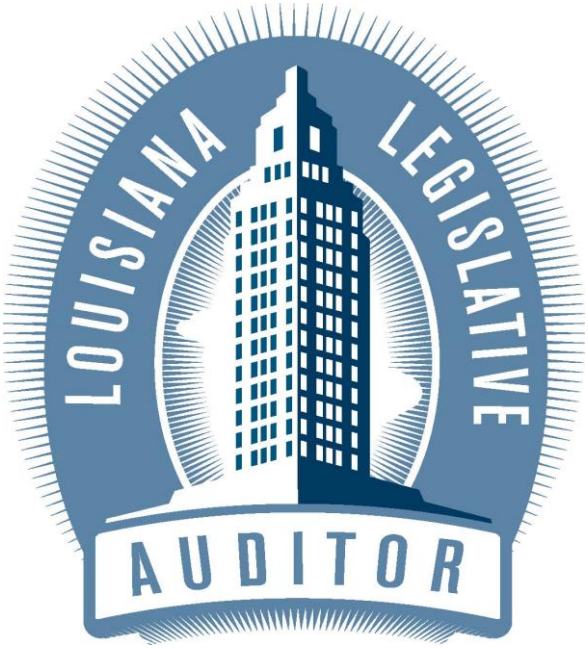
OVERSIGHT OF BEHAVIORAL HEALTH PROVIDER REQUIREMENTS

LOUISIANA DEPARTMENT OF HEALTH



PERFORMANCE AUDIT SERVICES
DATA ANALYTICS UNIT
ISSUED MARCH 10, 2021

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LOUISIANA LEGISLATIVE AUDITOR

March 10, 2021

The Honorable Patrick Page Cortez,
President of the Senate
The Honorable Clay Schexnayder,
Speaker of the House of Representatives

Dear Senator Cortez and Representative Schexnayder:

This report provides the results of our data analytics performance audit of the Louisiana Department of Health's (LDH) processes for monitoring mental health rehabilitation service providers. The purpose of this audit was to determine whether individual providers are complying with requirements detailed in LDH's Behavioral Health Provider Manual (Provider Manual) and Informational Bulletins.

We found LDH could strengthen the integrity of the behavioral health program by using routine data analysis and/or edit checks to see whether providers are following the requirements of the Provider Manual and Informational Bulletins.

Our evaluation reviewed Medicaid encounter data for the period of December 1, 2015, through September 12, 2020. We found approximately $1.48 million in payments that may have violated behavioral health program requirements.

Specifically, between December 2015 and August 2020, we identified $455,846 in payments for 4,249 encounters in which an individual received mental health rehabilitation (MHR) services while in an inpatient hospital setting. According to the provider manual, Medicaid recipients who reside in an inpatient hospital setting are not permitted to receive MHR, as all MHR services these individuals receive are provided by the institution and are not separately reimbursable by Medicaid.

In addition, for the period between December 2015 and March 2020, we identified at least $806,898 in payments for 10,383 instances where two different providers were paid for providing the same services to the same Medicaid recipient on the same day. Under program rules, a Medicaid recipient may only receive services from one provider at a time.

We also identified at least $219,965 in payments for 2,546 encounters for the period between March 2020 and September 2020, in which providers did not properly code MHR services delivered via telehealth.

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This report contains our findings, conclusions, and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the Louisiana Department of Health for its assistance during this audit.

Respectfully submitted,

Thomas H. Cole, CPA, CGMA
Temporary Legislative Auditor

THC/aa

Louisiana Legislative Auditor

Oversight of Behavioral Health Provider Requirements
Louisiana Department of Health

March 2021

Audit Control #82190013

Introduction

We evaluated whether the Louisiana Department of Health (LDH) had adequate processes in place to prevent providers from providing mental health rehabilitation[1] (MHR) services in violation of specific requirements in the Behavioral Health Provider Manual (Provider Manual)[2] and Informational Bulletins. These requirements include the following:

MHR services are behavioral health services that promote the restoration of community functioning and well-being of an individual diagnosed with a mental health or mental or emotional disorder. The intent of MHR services is to minimize the disabling effects on one's capacity for independent living and to prevent or limit the periods of inpatient treatment.
Source: LDH Provider Manual

- Medicaid recipients who reside in an inpatient hospital setting are not permitted to receive MHR, as all MHR services these individuals receive are provided by the inpatient hospital setting and are not separately reimbursable by Medicaid.
- Medicaid recipients may only receive Psychosocial Rehabilitation Services (PSR) or Community Psychiatric Support and Treatment (CPST) from one MHR provider at a time;[3] and
- To be reimbursed for telehealth MHR services delivered during the COVID-19 pandemic, providers must use a specific modifier and place of service when billing those services.

Enforcing program requirements through routine data analyses and/or edit checks is important because noncompliance may indicate improper payments or potential fraud. Monitoring the program is also important because of ongoing concerns with the integrity of MHR services and providers. For example, LDH and other stakeholders, such as the Medicaid Fraud Control Unit within the Attorney General's Office, have identified MHR providers as an area of potential risk and noncompliance. In response to issues with the integrity of the MHR

[1] MHR services can include psychosocial rehabilitation (PSR), community psychiatric support and treatment (CPST), crisis intervention (CI), assertive community treatment (ACT), homebuilders, functional family therapy (FFT), and multi-systemic therapy (MST). See Appendix C for definitions for these services.
[2] The Provider Manual outlines rules for the behavioral health program, including service limitations, utilization, allowed provider types and specialties, and eligibility criteria. MHR providers are responsible for ensuring services are delivered in accordance with the Provider Manual.
[3] The three exceptions are (1) if a recipient is receiving tenancy support through the permanent supportive housing program, (2) if the behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one provider, or (3) if the recipient is transferring to a new provider.

program, the legislature passed laws during the 2018[4] and 2019[5] Regular Sessions to place additional controls on the MHR program.

Previous LLA audits evaluated LDH oversight and provider compliance with these laws and found issues. The first report, *Identification of Behavioral Health Service Providers*,[6] found that some behavioral health providers were not complying with the state law passed in the 2018 Regular Session that required each claim for PSR and CPST services to identify the National Provider Identifier of the rendering service provider. The second report, *Individual Behavioral Health Service Providers Billing More than 12 Hours of Services in a Day*,[7] found that some behavioral health providers were not complying with the state law passed in the 2019 Regular Session that limits the number of hours of service an individual provider can bill on a single day to 12 hours.

In this report, we analyzed Medicaid encounter data from December 1, 2015, through September 12, 2020, to determine whether individual providers were complying with the Provider Manual and provider requirements. Our results are summarized below. Appendix A includes LDH's response, and Appendix B includes our scope and methodology. Appendix C contains definitions of the MHR services included in this report.

[4] R.S. 40:2162
[5] R.S. 46:460.77.1 and R.S. 46:460.77.2
[6] http://app.lla.state.la.us/PublicReports.nsf/0/466E17299AAC9851862583FC0053761D/$FILE/0001CAF6.pdf
[7] http://app.lla.state.la.us/PublicReports.nsf/0/6038E4B99C8CEB17862585BB006BF73B/$FILE/RR_OBH.pdf?OpenElement&.7773098

Results

We found that LDH could strengthen the integrity of the Behavioral Health program by enforcing requirements outlined in its Provider Manual and Informational Bulletins through the implementation of routine data analyses and/or edit checks. Overall, we found approximately $1.48 million in payments that potentially violated program requirements from December 1, 2015, through September 12, 2020.

From December 2, 2015, through August 26, 2020, we identified $455,846 in payments for 4,249 encounters where an individual received PSR, CPST, or Crisis Intervention (CI) services while in an inpatient setting, which is prohibited according to the Provider Manual. According to the Provider Manual, Medicaid recipients residing in an inpatient hospital setting are not permitted to receive PSR, CPST, or CI services from any provider other than the inpatient hospital.[8] However, we identified $455,846 in payments for 4,249 encounters for PSR, CPST, and CI services that occurred while an individual was in an inpatient setting that appear to have violated the Provider Manual. For example, one provider was paid $21,900 for 53 services allegedly provided to a Medicaid recipient in the recipient's home, even though the recipient was actually in an inpatient setting, which may indicate that the services were not actually provided. Exhibit 1 shows the number of encounters and amounts paid to MHR providers who billed for services they allegedly provided to Medicaid recipients who were in an inpatient setting from December 2, 2015, through August 26, 2020.

Exhibit 1
Number of Encounters and Amount Paid for Inpatient Overlaps
December 2, 2015 through August 26, 2020

Fiscal Year	Encounters	Amount Paid
2016*	357	$37,483
2017	908	97,032
2018	957	96,917
2019	1,005	123,219
2020**	900	90,202
2021***	122	10,991
Total	**4,249**	**$455,846****

* Only seven months of data are included in this fiscal year.
** Since providers have 365 days to bill for services rendered, this does not represent the final total for this year.
*** Only three months of data are included in this fiscal year.
**** Total does not equal the sum for the years due to rounding.
Source: Prepared by legislative auditor's staff using Medicaid data.

According to LDH, it does not have a process to routinely analyze Medicaid data to identify potential noncompliance with this program requirement. Establishing routine analyses is important to identify noncompliance with program requirements but also to identify instances of potential improper payments and potential fraud.

[8] If the Medicaid recipient is a resident of an institute for mental disease, such as a free-standing psychiatric hospital or psychiatric residential treatment facility, then these services are delivered as part of the institutional service and are not separately reimbursable by Medicaid.

From December 1, 2015, through March 2, 2020, we identified at least $806,898 in payments for 10,383 instances where two different MHR providers were paid for providing the same PSR or CPST service to the same Medicaid recipient on the same day, which is prohibited according to the Provider Manual. According to the Provider Manual, recipients may only receive PSR or CPST services from one provider at a time, with exceptions.[9] A Medicaid recipient receiving the same service on the same day from two different providers may indicate that one of the services was not actually provided. Exhibit 2 shows the number of instances and total amounts paid to all providers on days when more than one provider billed for providing PSR or CPST to the same person on the same day from December 1, 2015, through March 2, 2020.

On July 25, 2017, LDH established an edit check to deny encounters where two different MHR providers each billed for PSR or CPST for the same person on the same day. Based on the information presented in Exhibit 2, this edit appears to have reduced noncompliance with this program requirement and shows the importance of establishing edit checks for enforcing program rules. However, LDH did not recoup payments that violated this program requirement after establishing this edit check. According to LDH, it will review these results and begin the process to recoup these payments if warranted. In addition, LDH stated that errors still exist after the edit check was implemented because there are some situations in which receiving MHR services from multiple providers on the same day is allowable and that these instances cannot be identified using encounter data alone.

Exhibit 2
Number of Instances and Amount Paid for Two Providers Billing for the Same Service for Same Person on Same Day
December 1, 2015 through March 2, 2020

Fiscal Year	Encounters	Amount Paid
2016*	4,704	$344,640
2017	4,666	386,287
2018	985	74,128
2019	24	1,605
2020**	4	238
Total	**10,383**	**$806,898**

* There are seven months of data analyzed in this fiscal year.
** Since providers have 365 days to bill for services rendered, this does not represent the final total for this year.
Source: Prepared by legislative auditor's staff using Medicaid data.

From March 20, 2020, through September 12, 2020, we identified at least $219,965 in payments for 2,546 encounters where MHR providers did not properly code MHR services delivered via telehealth. Through Informational Bulletin 20-4 LDH issued approval for MHR services, beginning on or after March 20, 2020, to be rendered by MHR providers via telehealth. According to this bulletin, providers must use a secure, HIPPA-compliant platform if available, or they may use everyday communication technologies that have reasonable security and privacy measures such as the telephone, Skype, or FaceTime, with each recipient's permission. When providing MHR services via telehealth, providers must use the modifier "95" and the place of service "02" when submitting these claims for reimbursement. However, these

[9] As mentioned previously, there are three exceptions that allow this to occur, including (1) if a recipient is receiving tenancy support through the permanent supportive housing program, (2) if the behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one provider, or (3) if the recipient is transferring to a new provider.

2,546 encounters did not use both of these codes. Requiring that providers use these codes but not enforcing the requirement undermines the integrity of the program.

Allowing MHR services to be delivered via telehealth was in response to the COVID-19 pandemic and was new to many providers. According to LDH, the MCOs worked with providers to educate them on the newly established requirements for proper telehealth claims submission and the number of improper submissions has decreased from approximately 5% of telehealth encounters in March 2020 to 1% of telehealth encounters in September 2020. LDH stated that it does not have edit checks to flag or deny encounters that do not comply with this requirement. Establishing edit checks to identify these instances would help to ensure that providers correctly bill for telehealth services.

Recommendation 1: LDH should implement routine analyses and/or edit checks to identify instances of noncompliance with program requirements which may indicate billing errors, improper payments, or potential fraud.

Summary of Management's Response: LDH agrees with this recommendation and stated that selective deny and educational edits, along with routine analyses of encounter data, are appropriate to monitor compliance for healthcare services that require flexibility, and are not conducive to hard deny edits. See Appendix A for management's full response.

Recommendation 2: LDH should recoup any improper payments identified through the analyses in this report, such as two different providers who billed for the same service for the same recipient on the same day and providers who billed for services provided in the home while the recipient was in an inpatient setting.

Summary of Management's Response: LDH agrees with this recommendation for instances where LDH Legal is of the opinion that recoupment is allowable and indicated. LDH further stated that it will validate the numbers provided by LLA to ensure an accurate recoupment of any improper payment is made. See Appendix A for management's full response.

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

March 3, 2021

VIA E-MAIL ONLY

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

Re: Oversight of Behavioral Health Provider Requirements

Mr. Purpera:

On behalf of the Louisiana Department of Health (LDH), I acknowledge receipt of your correspondence dated February 4, 2021, in regards to your office's findings and recommendations related to Oversight of Behavioral Health Provider Requirements. The LDH also appreciates the opportunity to address the finding and the two recommendations presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

The Louisiana Legislative Auditor found that LDH could strengthen the integrity of the Behavioral Health program by enforcing requirements outlined in its Provider Manual and Informational Bulletins through the implementation of routine data analyses and/or edit checks.

LDH Response to Audit Content on Provider Requirements

LDH generally agrees with the intent of the findings and focus on the integrity of the program. The LLA points to three examples of program requirements they believe may represent areas of noncompliance. However, the methodology utilized in the LLA data as examples of the requirements in the Behavioral Health program may have largely overestimated the scale of the issue identified. We noted the following components of the finding presented to the department and provide the feedback to each below.

Mental Health Rehabilitation (MHR) services during an inpatient hospital stay

- LDH agrees that Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST) and (Crisis Intervention) CI services provided by MHR providers during an inpatient psychiatric hospital stay should not

occur during the stay, but may occur on the patient's admission or discharge day.

- However, MHR services provided in a general hospital may be allowed. Professional services provided above and beyond general services in an acute care hospital are allowable, including Licensed Mental Health Practitioner (LMHP) services and MHR services. MHR services are not a standard hospital service. A notable volume of the encounters represented in the LLA data pull represent inpatient stays in general acute care hospitals.

MHR: different providers, same recipient, same day, same service

- LDH agrees with the statement that two MHR services on the same day by different providers is not allowable, with a few exceptions like provider transition and medical necessity. A medical record review would need to be completed in order to verify the validity of such occurrences.

- After LDH implemented the requirements for rendering provider National Provider Identifier (NPI) numbers in claims submissions in 2019, the issue captured here all but disappeared. Based on the above, LDH represents that this is no longer a programmatic issue.

- LDH contends the LLA methodology in this data pull may be duplicated for the two services alleged to occur on the same day. The audit assumes both are wrong and suggests both should be voided as fraud, not just one of them. The actual overpayment may be closer to half of the encounters duplicated.

- Some of the data reported may not be reliable because there was no requirement for providers to input a rendering provider NPI prior to 2019. There is no way, using a retrospective encounter data review, to determine who rendered the services prior to 2019 for the purpose of determining whether the encounter was incorrect. In addition, billing provider organizations can, and do, have multiple NPIs, so varying NPIs do not ensure that a different provider organization provided the service.

Telehealth

LLA reviewed telehealth claims immediately after the COVID-19 pandemic started for accuracy of submission. MCOs may not have originally implemented hard edits because of the immediacy of the pandemic response and priorities around simply establishing these services during an unprecedented time as allowable by a provider type who has never provided services in this way nor ever billed for them as telehealth. Currently, providers are 99% compliant with the billing requirement. LDH

will work with MCOs to require that providers submit claims with both the telehealth modifier and POS if required.

Recommendation 1 - LDH should implement routine analyses and/or edit checks to identify instances of noncompliance with program requirements which may indicate billing errors, improper payments, or potential fraud.

LDH Response to Recommendation 1 -
LDH concurs with this recommendation.

In general, LDH does agree that selective deny and educational edits, along with routine analyses of encounter data, are appropriate to monitor compliance for healthcare services that require flexibility, and are not conducive to hard deny edits.

In addition, LDH holds the Managed Care Organizations (MCOs) accountable for implementing necessary claim system edits, as identified in Section 17.2.7. of the current contracts between Bureau of Health Services Financing (BHSF) and each individual MCO, and between Office of Behavioral Health (OBH) and Magellan Complete Care of Louisiana. The MCOs are also required to perform internal audit reviews to confirm claim edits are functioning properly.

Recommendation 2 - LDH should recoup any improper payments identified through the analyses in this report, such as two different providers who billed for the same service for the same recipient on the same day and providers who billed for services provided in the home while the recipient was in an inpatient setting.

LDH Response to Recommendation 2 -
LDH concurs with this recommendation if LDH Legal is of the opinion that recoupment is allowable and indicated. LDH will validate the numbers provided by LLA to ensure an accurate recoupment of any improper payment is made.

Corrective Action Plan

LDH will develop a process to routinely analyze Medicaid data to identify potential noncompliance with the program requirement that Medicaid recipients residing in a psychiatric inpatient hospital setting are not permitted to receive PSR, CPST, or CI services in order to identify noncompliance with program requirements but also to identify instances of potential improper payments and potential fraud.

In addition, LDH will conduct an analysis of the claims identified in this report and work with LDH Program Integrity and LDH Legal to quantify any improper payments and begin the recoupment process, if warranted. We expect to complete this corrective action by June 30, 2021.

You may contact Karen Stubbs, OBH Assistant Secretary by telephone at 225-342-1435 or by e-mail at karen.stubbs@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

APPENDIX B: SCOPE AND METHODOLOGY

We conducted this analysis under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. The purpose of this report was to analyze LDH's oversight of select provisions of the Provider Manual and identify opportunities to strengthen the integrity of the Behavioral Health Program regarding MHR services.

The scope of our audit was less than that required by *Government Auditing Standards*. We believe the evidence obtained provides a reasonable basis for our findings and conclusions. To conduct this analysis we performed the following steps:

- Researched relevant LDH regulations, policy, and guidance regarding providing multiple MHR services to one Medicaid recipient by multiple providers in the same day, MHR services provided while a Medicaid recipient is in an inpatient setting, and requirements for coding MHR services delivered to Medicaid recipients via telehealth.

- Interviewed LDH staff regarding these areas to determine monitoring activities LDH perform and exceptions to the program requirements.

- Analyzed Medicaid claims and encounter data to determine compliance with LDH's Provider Manual and Informational Bulletins.

APPENDIX C: DEFINITIONS OF MENTAL HEALTH REHABILITATION SERVICES

Service	Definition
Assertive Community Treatment (ACT)	Therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness.
Community Psychiatric Support and Treatment (CPST)	A comprehensive service, which 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 the individualized treatment plan.
Crisis Intervention (CI)	Provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.
Functional Family Therapy (FFT)	A strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.
Homebuilders	An intensive, in-home evidence based program (EBP) utilizing research based strategies (e.g. motivational interviewing, cognitive and behavioral interventions, relapse prevention, skills training), for families with children (birth to 18 years of age) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders®), or being reunified from placement.
Multi-Systemic Therapy (MST)	An intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings.
Psychosocial Rehabilitation (PSR)	Assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan.

Source: Prepared by legislative auditor's staff using information from the Provider Manual and Services Definition Manual.