IMPROPER BILLING OF SERVICES WITHIN THE MEDICAID BEHAVIORAL HEALTH PROGRAM

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT REPORT
ISSUED SEPTEMBER 4, 2019

LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

ASSISTANT LEGISLATIVE AUDITOR
FOR STATE AUDIT SERVICES
NICOLE B. EDMONSON, CIA, CGAP, MPA

DIRECTOR OF PERFORMANCE AUDIT SERVICES
KAREN LEBLANC, CIA, CGAP, MSW

FOR QUESTIONS RELATED TO THIS MEDICAID AUDIT UNIT REPORT, CONTACT CHRIS MAGEE, DATA ANALYTICS MANAGER, AT 225-339-3800.

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

September 4, 2019

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report details the results of our audit of billing within Louisiana's Medicaid Behavioral Health program.

We found that the Louisiana Department of Health (LDH), the managed care organizations (MCOs), and Magellan Health Services (Magellan) do not have adequate procedures in place to ensure that behavioral health services are properly billed and that improper encounters and claims are denied.

We identified approximately $47.5 million in encounters and claims for services between December 2015 and June 2019 that were paid by the MCOs and Magellan even though they did not comply with LDH's fee schedule.

The total included about $38.5 million paid for 646,746 encounters and claims that were billed using incorrect modifier codes; more than $9 million paid for 647,910 encounters and claims that exceeded the rates allowed by the fee schedule; and $7,800 paid for 322 encounters and claims for add-on behavioral health services that lacked a primary service.

The report contains our findings, conclusions, and recommendations. Appendix A contains LDH's response to this report, and Appendix B lists previously-issued Medicaid Audit Unit reports. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of LDH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa
IMPROPERBILLINGBHS

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Improper Billing of Services Within the Medicaid Behavioral Health Program Louisiana Department of Health

September 2019

Audit Control #82180007

Introduction

We evaluated whether the Louisiana Department of Health (LDH) has established sufficient edit checks to ensure behavioral health providers are properly coding the claims of the services for which they were paid. In 2012, LDH began moving from a fee-for-service (FFS) model, where LDH paid all claims submitted by Medicaid providers for each service performed, to Healthy Louisiana, a full-risk prepaid managed care model.[1] Under LDH's current full-risk prepaid managed care model, it pays a fixed per-member per-month (PMPM) fee, essentially an insurance premium, to the Managed Care Organization (MCO) for the administration of health benefits. LDH contracted with five[2] MCOs to operate the *Healthy Louisiana* Medicaid program through December 31, 2019. In addition, LDH contracts with Managed Care of North America to operate as an MCO for dental benefits and Magellan Health Services (Magellan) to administer behavioral health services for the Coordinated System of Care. However, LDH is responsible for determining participant eligibility, enrolling participants into Medicaid programs, and monitoring the MCOs and Magellan.

Behavioral health providers submit claims for reimbursement to the five MCOs and Magellan who pay providers based on the specialized behavioral health services fee schedule developed by LDH. The MCOs then submit those paid claims to LDH as encounters.[3] The MCOs, Magellan, and LDH have each developed their own edit checks that should deny claims and encounters if they do not contain all required information, if the information submitted is invalid, or if the rate billed does not correspond to the service billed. For example, a claim or an encounter should be denied if it does not include the recipient's name, includes an invalid procedure code, or if a procedure code does not include the required modifier code.[4]

[1] Healthy Louisiana was previously called Bayou Health. A managed care model is an arrangement for health care in which an organization, such as an MCO, acts as a gatekeeper or intermediary between the person seeking care and the physician. MCOs function similar to a private insurance company. FFS still covers some Medicaid recipients who are not eligible for managed care.

[2] LDH contracted with AmeriHealth Caritas Louisiana, Inc.; Aetna Better Health, Inc.; Healthy Blue; Louisiana Healthcare Connections, Inc.; and UnitedHealthcare Community Plan of Louisiana, Inc. on February 1, 2015. AmeriHealth Caritas, Healthy Blue, and Louisiana Healthcare Connections originally contracted with LDH on February 1, 2012.

[3] 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] Many behavioral health services include both a procedure code and a modifier. The modifier identifies the age of the recipient, location where the service was provided, educational background of the person providing the service, and the license(s) they may have obtained.

The importance of accurate data. It is important that encounter data be accurate because LDH and other stakeholders, such as the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office, use this data to identify improper payments and potential fraud. LDH also uses this encounter data to establish PMPM rates for the MCOs. This report is the second report in a series of reports on behavioral health services. Our first report,[5] issued on May 15, 2019, found that behavioral health providers did not include the National Provider Identification (NPI) number of the individual who provided the service in the claim, as required by Louisiana Revised Statute 40:2162. Specifically, we found that 114,963 (40.2%) of the 286,312 Medicaid claims paid by the MCOs and submitted as encounters to LDH for certain behavioral health services provided from January 1, 2019, through March 31, 2019, did not include the required individual NPI. LDH required the MCOs to correct the encounters and to void the payments made to providers for the improperly submitted claims. According to LDH, 99% of encounters now contain the required individual NPI. This situation exemplifies the need for LDH to implement its own data analytics procedures so it can identify the actual service providers on an ongoing basis. Information such as this is critical as it allows LDH, the MCOs, and MFCU, who are charged with ensuring the integrity of the Medicaid program, to analyze claims and encounter data and to identify outliers such as providers who are working an abnormally high number of hours in a day.

Results

Overall, we found that the MCOs, Magellan, and LDH have not established sufficient edit checks to ensure behavioral health services are properly billed. We identified approximately $47.5 million in encounters and claims for services between December 2015 through June 2019 that were paid by LDH, the MCOs, and Magellan even though the encounters and claims did not comply with LDH's fee schedule.

Providers[6] were paid $38,533,711[7] for 646,746 encounters and claims for behavioral health services that were billed using incorrect procedure and modifier codes. LDH's fee schedule outlines procedure codes for services and the applicable billing rates. Some services require that procedure codes also contain modifier codes which indicate information such as the age of the recipient, location where the service was provided, the educational background of the person providing the service, and the license(s) they have obtained.[8] For example, to bill 30 minutes of psychotherapy, providers must use procedure code 90840 to identify the service provided and also include one of the modifier codes from LDH's fee schedule to identify the license held by the provider. If the psychotherapy was provided by a psychiatrist, the claim

[5] https://www.lla.la.gov/PublicReports.nsf/466E17299AAC9851862583FC0053761D/$FILE/0001CAF6.pdf.
[6] To ensure that our analysis only included behavioral health services, we removed all claims submitted by providers who do not specialize in providing behavioral health services from our population. For example, a claim submitted by a physician for an established patient office visit uses the same procedure code (99214) as a claim for an established patient office visit submitted by a Psychiatrist.
[7] These totals include 101,441 fee-for-service claims totaling $2,140,345.
[8] For this analysis, we did not evaluate whether the age modifier was included, since this can be determined by reviewing the recipient's date of birth.

would list 90840 as the procedure code and the modifier code "AF." If the service was provided by a licensed professional counselor, the claim would list the modifier code "HO." It is important to include accurate information on each claim since there are different billing rates depending on the procedure and modifier codes. If the procedure code does not have the required modifier codes or has an invalid modifier code, the MCO, Magellan, and LDH cannot ensure reimbursements are accurate. MCO guidance to providers and LDH bulletin 16-1[9] both require that behavioral health services be billed in accordance with the fee schedule or the claim will be denied.

We analyzed encounter and claim data from December 2015 through June 2019 and found 646,746 encounters and claims totaling $38,533,711 where procedure codes that were billed did not have the required modifier codes, procedure codes had invalid modifiers codes, or procedure codes had multiple modifier codes. Exhibit 1 summarizes this information.

Exhibit 1
Summary of Issues with Procedure Codes and Modifier Codes
December 2015 through June 2019

Issue	Number of Encounters	Amount
Procedure code requires a modifier code but does not have one	556,260	$30,863,191
Procedure code includes a modifier code, but the modifier code is invalid or does not include all required modifier codes (not on the fee schedule or invalid for that procedure code)	84,452	6,801,766
Procedure code includes multiple modifier codes so it is impossible to tell which one is accurate	6,034	868,754
Total	**646,746**	**$38,533,711***

***** The total may not equal the sum due to rounding.
Source: Prepared by legislative auditor's staff using encounter data.

Providers were paid $9,044,773[10] more than indicated on the fee schedule[11] for 647,910 encounters and claims for behavioral health services. As mentioned above, the fee schedule outlines different rates depending on the procedure code and modifier codes. As such, the MCOs, Magellan, and LDH should have edit checks that ensure that these procedure codes and modifier codes comply with the fee schedule. However, we identified 647,910 encounters and claims where the providers were paid a total of $9,044,773 more than the amounts indicated on the fee schedule based on the procedure code and modifier codes for the service. For example, a provider submitted a claim for psychotherapy that – based on the procedure code and modifier code – should have been billed at $87.87 per hour, but was instead billed and paid at $125.53 per hour.

[9] LDH Informational Bulletin 16-1 focuses on the use of modifiers when billing for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services, but this bulletin also requires providers to follow LDH's fee schedule when submitting claims for all other procedure codes.
[10] These totals include 1,435 fee-for-service claims totaling $26,068.
[11] Providers were paid a total of $60,171,659 for these 647,910 encounters and claims. However, they would have been paid $51,126,886 if the encounters and claims were paid using the rates listed on the fee schedule.

Providers were paid $7,800[12] for 322 encounters and claims for improperly billed add-on behavioral health services. According to MCO guidance to providers, add-on services are reimbursable when provided in addition to the appropriate primary service performed by the same provider and cannot be billed as standalone services. For example, for providers to use the psychotherapy add-on code, they must also provide a primary service such as a psychiatric diagnostic evaluation or prescription management within the same day. However, we identified 322 add-on claims totaling $7,800 that were billed by providers and paid for by the MCOs, Magellan, or LDH even though they lacked a primary service.

Conclusion

All of the issues identified in this report exist because the MCOs, Magellan, and LDH have not established sufficient edit checks to ensure claims and encounters that do not comply with the fee schedule are denied. According to LDH, the MCOs and Magellan may use other data fields to determine information, such as the type of license held by a provider, which could help to identify the proper fee schedule rate to use when providers do not include the required modifiers. In addition, LDH stated it "would not be appropriate for them to edit the encounters using the fee schedule" because the MCOs and Magellan are allowed to contract with individual providers and pay them at rates that exceed LDH's fee schedule.[13] However, LDH does not currently maintain a list of these providers and therefore cannot determine if a claim paid at an excessive rate was improperly billed. LDH further stated that additional reviews of the encounter data are not necessary because the MCOs are contractually obligated to ensure that claims are paid correctly. LDH requires the MCOs to submit a monthly claims payment accuracy report to LDH to ensure their compliance with this contractual requirement.

Recommendation 1: LDH should ensure that the MCOs establish edit checks to ensure that behavioral health claims are not paid unless they comply with the fee schedule.

Summary of Management's Response: LDH disagreed with this recommendation and stated that the recommendation is inconsistent with a risk-based managed care model. In addition, LDH stated that the MCOs have edit checks in place, and LDH has procedures in place to review claims and encounters on a post-pay basis.

LLA Additional Comments: According to four of the five MCOs and Magellan, their contracted providers are required to follow LDH's fee schedule. In addition, both of the MCOs who were sent examples of the issues identified in this report agreed that the examples were errors. If MCO edit checks were working appropriately then these claims should have been denied.

[12] These totals include $9 for 13 fee-for-service claims. In addition, $55 was overbilled and is included in the $9,044,773 of services paid at a rate that exceeded the fee schedule.
[13] All claims and encounters from providers identified by the MCOs and Magellan as having contracts which paid rates that exceeded the fee schedule were removed from our results and are not included in the $9,044,773 of services paid at rates which exceeded the fee schedule.

Recommendation 2: LDH should establish edit checks to ensure that behavioral health encounters are accepted only when they comply with the fee schedule.

Summary of Management's Response: LDH disagreed with this recommendation and stated that the recommendation is inconsistent with a risk-based managed care model. In addition, LDH stated that it has procedures in place to review claims and encounters on a post-pay basis.

LLA Additional Comments: Although LDH has procedures to monitor on a post-pay basis, edit checks are important for ensuring encounter data is accurate and for ensuring only valid claims are paid. In addition, LDH has established edit checks which deny claims with invalid or missing modifier codes for other types of services such as physician claims and emergency medical transportation. Therefore, establishing edit checks to deny specialized behavioral health claims with invalid or missing modifiers should be consistent with a risk-based managed care model.

APPENDIX A: MANAGEMENT'S RESPONSE

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

August 30, 2019

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

Re: Improper Billing of Behavioral Health Services

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid Audit Unit report on the Improper Billing of Behavioral Health Services. The Louisiana Department of Health (LDH) is committed to ensuring the integrity of the Medicaid program, and it appreciates the efforts of the legislative audit team toward that end.

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

Recommendation 1: LDH should ensure that the MCOs establish edit checks to ensure that behavioral health claims are not paid unless they comply with the fee schedule.

LDH Response: LDH does not agree with this recommendation.

This recommendation is inconsistent with a risk-based managed care model. While federal law mandates that Medicaid MCOs be paid an actuarially sound rate, there is no federal requirement that plans pay their providers in a particular way or at a particular level. Most states elect to take a hands-off approach to provider reimbursement by MCOs. Some states set **minimum** requirements, often benchmarking from fee-for-service, like Louisiana.

Beyond minimum requirements, states allow MCOs to pay their providers higher than fee for service. With provider reimbursement being among the most critical factors contributing to provider participation in MCOs, this flexibility enables MCOs to maintain an adequate network, particularly in rural areas and for provider types in short supply. Consistent with federal law and the current contracts between the Bureau of Health Services Financing (BHSF) and the individual MCOs, such payments are not considered overpayments. Edit checks that eliminate this ability will result in decreased access to care for the most vulnerable and hard to treat Louisiana residents.

LDH holds the MCOs accountable for implementing necessary claims payment system edits, as identified in Section 17.2 of the current contracts. In order to meet these requirements, the MCOs employ a variety of edits that are not dependent on modifiers, including the use of information readily available through interfaces with their provider enrollment and service authorization data. The use of this additional

information allows the MCOs to properly adjudicate claims while reducing administrative burden on providers.

Further, post-payment reviews are a core component of a risk-based managed care model. Numerous reviews of behavioral health claims and encounters have been and continue to be conducted by the Surveillance and Utilization Review Subsystem Unit (SURS), the Unified Program Integrity Contractor (UPIC) and the MCOs to ensure that claims are paid appropriately. These reviews preserve flexibility for payment variances while ensuring program integrity with more depth than edit checks can provide.

Recommendation 2: LDH should establish edit checks to ensure that behavioral health encounters are accepted only when they comply with the fee schedule.

LDH Response: LDH does not agree with this recommendation.

This recommendation is also inconsistent with a risk-based managed care model. It would be inappropriate for LDH to limit encounter acceptance to only those encounters that are in alignment with the Medicaid fee schedule. While the MCOs are required to provide all of the services listed on the Medicaid fee schedule, the fee schedule defines only the **minimum** services that must be provided and the **minimum** amount that should be paid for those services. Section 9.2 of the current contract requires MCOs to provide reimbursement for defined core benefits and services provided by an in-network provider at a rate of reimbursement that is **no less than the published Medicaid fee-for-service rate** in effect on the date of service or its equivalent, unless mutually agreed to by both the plan and the provider in the provider contract.

As noted above, Medicaid programs that are operated under a managed care model uniquely afford MCOs the ability, and responsibility, to negotiate rates with providers in order to ensure that contractual requirements related to access and quality are met. For example, MCOs are specifically instructed, per their current contracts, to develop capacity for enhanced rates or incentives to behavioral health clinics to employ primary care providers in a psychiatric specialty setting in an effort to monitor the physical health of patients and improve the integration of behavioral and physical healthcare.

In addition to the use of specific edits that are consistent with a risk-based managed care model, LDH has elected to contract with a third party to perform CMS's voluntary External Quality Review (EQR) Protocol 4 - Validation of Encounter Data Reported by the MCO or PIHP. Though not required, we have tasked our contractor with assessing MCO Information Systems Capabilities in furtherance of ongoing encounter data validation efforts.

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342-0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,

Cindy Rives

Cindy Rives
Undersecretary

CR/vb/ap

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 analysis was to determine compliance by LDH, MCOs, Magellan, and providers regarding the coding, billing, and payment requirements for certain specialized behavior health procedures. These requirements are outlined in LDH's Behavioral Health Services Provider Manual, fee schedule, and Informational Bulletins and specify that providers must include information such as the age of the recipient, location where the service was provided, the educational background of the person providing the service, and the license(s) they have obtained when billing for certain behavioral health 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, policies, and guidance regarding the coding, billing, and payment of behavioral health services.
- Obtained information from LDH related to the controls it has in place to ensure that encounters submitted by the MCOs and Magellan comply with LDH's fee schedule.
- Obtained information from the MCOs and Magellan related to the controls they have in place to ensure that claims submitted by providers comply with LDH's fee schedule
- Analyzed Medicaid claims and encounter data to determine compliance with LDH's Behavioral Health Services Provider Manuals, LDH's fee schedules, and Informational Bulletins.

APPENDIX C: LIST OF PREVIOUS MAU REPORTS

Issue Date	Title
May 15, 2019	*Identification of Behavioral Health Service Providers*
May 1, 2019	*Update on Wage Verification Process of the Medicaid Expansion Population*
December 12, 2018	*Medicaid Eligibility: Modified Adjusted Gross Income Determination Process*
November 8, 2018	*Medicaid Eligibility: Wage Verification Process of the Expansion Population*
October 31, 2018	*Identification of Incarcerated Medicaid Recipients*
June 20, 2018	*Reliability of Medicaid Provider Data*
May 2, 2018	*Strengthening of the Medicaid Eligibility Determination Process*
November 29, 2017	*Improper Payments for Deceased Medicaid Recipients*
October 4, 2017	*Monitoring of Medicaid Claims Using All-Inclusive Code (T1015)*
September 6, 2017	*Improper Payments in the Medicaid Laboratory Program*
July 12, 2017	*Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services*
March 29, 2017	*Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers*
March 22, 2017	*Program Rule Violations in the Medicaid Dental Program*
October 26, 2016	*Medicaid Recipient Eligibility – Managed Care and Louisiana Residency*

Source: MAU reports can be found on the LLA's website under "Reports and Data" using the "Audit Reports by Type" button. By selecting the "Medicaid" button, all MAU reports issues by LLA will be displayed. https://www.lla.la.gov/reports-data/audit/audit-type/index.shtml?key=Medicaid