DISTRICT / COUNTY COURT

COUNTY OF EL PASO

STATE OF COLORADO

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AFFIDAVIT OF PROBABLE CAUSE FOR ARREST WARRANT

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1. The affiant, Luke Terry, Criminal Investigator with the Medicaid Fraud Control Unit of the Colorado Attorney General's Office, a peace officer, being duly sworn upon oath, says that the facts stated herein are true.

2. I am a criminal investigator and commissioned peace officer employed by the Colorado Attorney General, assigned to the Medicaid Fraud Control Unit, Criminal Justice Section. I have been employed as a peace officer for over 18 years, most recently as an Attorney General Investigator, investigating complex crimes, and other violations of the Colorado Revised Statutes.

3. I have probable cause to believe that:

Martha Lilly Sutherland
DOB: [redacted]
SSN: [redacted]

described as a white female, 5'3" tall weighing 136 pounds with brown hair and brown eyes

has committed the offenses outlined in the attached Felony Complaint and Information. These offenses are:

COUNT ONE: Theft, C.R.S. 18-4-401, a Class 3 Felony

COUNT TWO: Cybercrime, C.R.S. 18-5.5-102(1)(d), a Class 3 Felony

REASONS FOR MY BELIEF

MEDICAID

Medicaid is a combined state and federal program that pays for essential medical care and services for the categorically needy (C.R.S. 25.5-1-101, et. seq.). It is funded by the state and federal governments and is administered by the Colorado Department of Health Care Policy and Financing (HCPF). The medical care and services are provided by private individuals, organizations, and companies, which are then reimbursed by the State of Colorado. HCPF has an internal division called Program Integrity (PI) that reviews potentially fraudulent activity in the Medicaid system

CRS § 24-31-801 et seq. created within the Colorado Department of Law and under the control of the Office of the Attorney General the Colorado Medicaid Fraud Control Unit (COMFCU). Those statutes also tasked the COMFCU with the investigation and prosecution of fraud, misuse, waste, and abuse committed by Medicaid providers and with the investigation and prosecution of cases of patient abuse, neglect, and exploitation.

Current Procedural Terminology (CPT) codes provide a listing of descriptive terms and identifying codes for reporting medical services and procedures. CPT is a registered trademark of The American Medical Association (AMA) and is updated annually. The first edition was in 1966. CPT is available both online and in printed format. In 2000, the CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under HIPAA. This means that for all financial and administrative health care transactions sent electronically, the CPT code set will need to be used.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule covers all identifiable information or personal health information (PHI) about a patient that is transferred to or maintained by a healthcare provider. In order to protect the privacy of medical information regarding individual Medicaid Clients referred to in this affidavit; I have identified the adult Medicaid Clients who received services with the moniker "AMC", along with an individual number (i.e. AMC 1, AMC 2, etc.) to distinguish them. A separate key with the Medicaid client's specific identifying information will be maintained and made available to the Court upon request and as appropriate during future legal proceedings.

SUMMARY OF CASE

Front Range Mental Health and Summit Assessments (aka Sutherland Counseling / Summit Assessments) provides pre-bariatric surgery mental health assessments with its primary administrative office located at 422 East Vermijo Avenue, Colorado Springs, El Paso County, Colorado. The company is owned and operated by [redacted] Martha Sutherland. [redacted] voluntarily surrendered his license in October 2017 after an investigation by the Department of Regulatory Agencies (DORA). After [redacted] surrendered his license, Martha Sutherland became the primary operator and biller for the company.

A review of the company's client records showed that between August 25, 2017 and February 26, 2021 the Martha Sutherland billed for multiple units of psychological testing services that were not provided. In addition, Martha Sutherland frequently billed for the same series of services two to three times without the services being provided. The duplicate / triplicate claims were submitted with different dates of service. During an interview with Martha Sutherland, she stated she believed the CPT codes were billed in 15-minute increments rather than 60-minute increments as listed in the CPT manuals. Martha Sutherland could not explain the duplicate and sometimes triplicate billing for services that were not provided or why the dates of service would change from claim to claim although the documentation from the company clearly depicted when the services were provided. A review of the date the claims were submitted showed the duplicate / triplicate claims were billed weeks and often months apart.

The calculated value of theft after May 1, 2019 is $240,238.03.

PROBABLE CAUSE

On August 10, 2018, I was assigned this case for investigative follow-up. I reviewed the intake report completed by Investigative Supervisor Bruce Norton and learned that HCPF PI submitted a referral advising that Sutherland Counseling LLC was billing for counseling services using CPT procedure code 96101 (psychological testing) with an associated diagnosis code of Morbid Obesity. HCPF PI also found that [redacted], the owner of Sutherland Counseling, had relinquished his license through the Department of Regulatory Agencies (DORA) after he "admitted that he had diagnosed patients to obtain certification for an emotional support pet based solely on online questionnaires and two telephone sessions conducted with other staff who may not have met the qualifications required". After [redacted] relinquished his license, HCPF PI analyst Alex Weichselbaum noted that Sutherland Counselling LLC began to be listed as the rendering

provider in Medicaid billing data substantially more than in previous years. Weichselbaum noted the increase in claims listing Sutherland Counseling LLC as the rendering provider came at the same time [redacted]s claims decreased, making it appear that [redacted] listed the business as the rendering provider instead of himself since his license was no longer valid.

Weichselbaum's data analysis also showed that Sutherland Counseling LLC was an outlier regarding the volume of clients listing a diagnosis code for morbid obesity and was the 2nd highest utilizer of code 96101. He also remarked, "This diagnosis appears to be utilized because it is a highly reimbursable code but is not necessarily related to a psychological diagnosis and is not specific to a psychiatric disorder in the DSM 5 manual. Morbid obesity is more often found under a medical diagnosis or condition versus a psychological one. Additionally, by billing the diagnosis codes for morbid obesity, which is not a Behavioral Health Organization (BHO) covered diagnosis, with procedure codes that normally would be required to be submitted through the BHO, Sutherland Counseling is able to bill fee-for-service for these codes". It should be noted that BHO claims are typically paid at a capitated, contracted rate through the BHOs and not on a claim by claim / fee for service basis.

I searched the DORA licensing web site and confirmed that [redacted] voluntarily surrendered his license in October 2017. I also searched for Sutherland Counseling LLC on the Colorado Secretary of State web site and confirmed that [redacted] is listed as the registered agent with the company's most recent filing.

I obtained updated billing data for Sutherland Counseling LLC and noted the business has continued to bill Medicaid for services with similar diagnosis codes and procedural codes since Weichselbaum's initial analysis. In reviewing the data, I confirmed Weichselbaum's initial observations regarding the shift in rendering provider from [redacted]s personal ID to that of the business between 2016 and 2017.

I also noted a marked increase in billing for services between 2017 and 2020 with billing increase from $88,916.56 in 2017 to over $1.162 million in 2020. Of note, I found that in 2020 only one rendering provider was listed in all claims, Dr. [redacted]. Based on the billing data, it would be impossible for Dr. [redacted] to have provided all the services that listed her as the rendering provider.

Through additional research I learned that Sutherland Counselling LLC has a public facing tradename of Front Range Mental Health and Summit

Assessments. I also learned the business is operated by [redacted] Martha Sutherland. A review of the CPT coding guidelines showed that codes 96101 through 96103 were discontinued at the end of 2018. The updated codes for psychological testing include 96130 for the first hour of psychological testing and 96131 for each additional hour.

On October 15, 2020, I contacted AMC 1, who was listed as a client of Sutherland Counseling LLC per billing data and was one of the highest billed clients for the company in 2020. Prior to contacting AMC 1, I noted that Sutherland Counseling LLC was paid for $11,275.59 of services by HCPF / Medicaid for services on 15 dates of service between June 19, 2020 and July 27, 2020. I noted a pattern in the billing which consists of one date with multiple procedure codes (96137, 96136, 96131 96130 and 90791) followed by four consecutive days of procedure code 96131. On the first day of each series, Sutherland Counseling LLC billed for 3 units of 96137, 7 units of 96131, and 1 unit each of 93136, 96130 and 90791. On the day when only code 96131 is billed, 7 units are billed on each date of service. Below is a listing of the associated descriptions for each code:

Procedure Code	Procedure Code Description
90791	Psychiatric diagnostic evaluation
96130	First hour of psychological evaluation
96131	Each additional hour of psychological evaluation
96136	The first 30 minutes of test administration and scoring is billed using 96136
96137	Each additional 30-minute increment needed to complete the service is billed with code 96137

AMC 1 stated she saw a therapist named [redacted] from Front Range Mental Health. AMC 1 never went to Front Range Mental Health in person and did all her sessions by phone or Zoom. AMC 1 explained that she "took a test" online but made an error the first two times she took the test and had to retake it. She had a total of 5 or 6 visits with [redacted] by phone / Zoom. She estimated that each visit was 2 hours long.

AMC 1 stated her first meeting with [redacted] was a discussion regarding her background. The second sessions consisted of her taking the assessments. The third session was her retaking the assessment online. The fourth session was her taking the assessment with [redacted] over the phone since she still had issues submitting it. The remaining one or two sessions were them discussing the assessment and talking about how her mental health affected her eating.

Based on the information provided by AMC 1, she would have received no more than 12 hours of services from [redacted]. According to the billing data, she would

have received approximately 38 hours of services, not including the untimed Psychiatric Diagnostic Evaluation code, 90791.

I asked AMC 1 if the timeframe of the sessions matched up with the timeframe of June 19, 2020 through July 27, 2020. AMC 1 stated this timeframe sounded correct but she did not meet with [redacted] 15 times on consecutive days. AMC 1 did not have her appointments with [redacted] documented anywhere, such as her calendar.

On October 16, 2020, I contacted AMC 2 by phone. AMC 2 was listed as a client of Sutherland Counseling LLC per billing data and was one of the highest billed clients for the company in 2020. Prior to contacting AMC 2, I noted that Sutherland Counseling LLC was paid for $10,607.89 of services by HCPF / Medicaid for services on 14 dates of service between January 10, 2020 and February 11, 2020. I noted the same pattern in billing as AMC 1. While reviewing the billing I found that 7 units of 96131 were not reimbursed by HCPF.

While speaking with AMC 2, she told me the following:

AMC 2 was referred to Front Range Mental Health by the Denver Center for Bariatric Surgery (DCBS). AMC 2 explained that as part of the preparation for the bariatric surgery, she was required to see a counselor. She received a folder of information from DCBS which contained a business card for [redacted] with Front Range Mental Health. [redacted] was listed as the Executive Director of Front Range Mental Health on the business card. AMC 2 called the business and was put in contact with the counselor, [redacted]. AMC 2 met with [redacted] at his office located in Parker on two occasions. The first appointment consisted of her having a discussion with [redacted] for about an hour and a half at the end of which she took a computerized assessment. The second appointment was approximately 45 minutes long where she and [redacted] discussed the results of the computerized assessment.

AMC 2 referred to her calendar and noted that her first appointment was on February 14th at 10 am. The second appointment was on February 27th at 1 pm. I advised AMC 2 that the billing data showed she received services on several dates between January 10th and February 11th but did not list any services on February 14th or February 27th. AMC 2 did not recall receiving any services from [redacted] or Front Range Mental Health on any other dates and did not show any appointments on her calendar.

Based on the information provided by AMC 2, she would have received approximately 2 hours and 15 minutes of services from [redacted] not including

the assessment she took after her initial appointment. AMC 2 did not provide an estimate as to how long it took her to complete the assessments. However, based on subsequent conversations with Martha "Lily" Sutherland I learned the assessments can take up to 4 hours to complete. Based on the combination of AMC 2's estimate and Martha Sutherland's later statements, AMC 2 would have received no more than 7 hours of services from Sutherland Counselling / Summit Assessments. According to the billing data, she would have received approximately 38 hours of services, not including the untimed Psychiatric Diagnostic Evaluation code, 90791.

On January 7, 2021, I responded to the residence of Martha Sutherland [redacted]. While speaking with Martha Sutherland, I advised her of the referral received from HCPF due to the abnormal combination of diagnosis and CPT codes used in the company's billing. She confirmed that her company does assessments for clients seeking bariatric surgery. She also confirmed that most therapists who provide services to clients are contracted employees who also have their own practices. She stated that [redacted] is the Executive Director of the business and Dr. [redacted] is the Senior Clinician.

I told Martha Sutherland that part of the concern that I uncovered while reviewing the billing data was that the only rendering provider listed in 2020 was Dr. [redacted]. She replied that the business currently has approximately 16 contracted therapists. This number did not include Dr. [redacted] or [redacted]. She added that Dr. [redacted] signs off on all the Medicaid billing. From experience with the Medicaid billing system, I know that providers not enrolled with Medicaid cannot be listed as a Rendering Provider in the billing system. Martha Sutherland explained that all the providers submit their notes through Kareo, the company's Electronic Healthcare Records (EHR) system. The therapists provide a billing sheet, and she uses the information on the billing sheet to submit the billing to Medicaid. She added that she commonly uses 5 different billing codes.

I asked Martha Sutherland to describe the process a typical client goes through when receiving therapy for bariatric surgery. She stated that during the first visit, the client completes an initial written assessment which is observed by the therapist. During the second visit with the client, the therapist will discuss the initial assessment with them to obtain additional, more specific answers to determine if the client is prepared for bariatric surgery. She explained that each client is different depending on their individual issues and the requests of the referring physician. Some clients require additional follow-up sessions. Martha Sutherland estimated approximately 50% of clients are determined to be eligible for surgery based on their initial assessment.

On March 8, 2021, I submitted a Request for Records to Martha Sutherland via email. The Request for Records was based on an updated analysis of Medicaid billing data to identify the highest billed clients of Sutherland in 2019, 2020 and 2021 to date. I also requested records for AMC 1, although she had fallen out of the top 5 in 2020, since I had already spoken with her. Martha Sutherland delivered the records to me on March 18, 2021.

While reviewing the documents, I found that each of the client packets contained the same general documents. I found most documents contained the dates the assessments were performed but noted that some did not. Sutherland also provided a large stack of Billing Sheets for the various providers / therapists. The billing sheets were specific to the providers and listed the various clients they saw and listed the services provided and related dates. I subsequently reviewed the documents provided by Martha Sutherland and compared it to the Medicaid billing data and found several discrepancies between the two sets regarding the dates of service as well as between the CPT codes listed by the provider submitting billing sheets and the CPT codes ultimately billed by FRMH.

16 client files were reviewed and discrepancies were observed for each client. Based on my review of the billing data, Martha Sutherland billed almost exclusively for the same set of billing codes for each client regardless of the actual services documented. This "common set" of billing codes is the same as those observed with AMC 1 and AMC 2. I also noted that Martha Sutherland billed for multiple claims of the "common set" of codes with different ranges of dates of service without documentation to support the additional claims. Of the 16 client files reviewed, 9 had duplicate billing, 6 had triplicate billing and 1 had a varied array of units billed but used the same billing codes. It should be noted that two of the clients who had duplicate billing had a lesser number of code 96131 billed in one of the claims. As noted with AMC 1 and AMC 2, the documentation provided by Martha Sutherland was insufficient to substantiate all the services billed for the single "common set" of billing codes. A subsequent calculation of theft determined that Martha Sutherland billed HCPF / Medicaid $120,669.47 for services not provided for the 16 clients reviewed.

On May 5, 2021, I contacted Martha Sutherland by phone to arrange an interview with her regarding my review of the documentation. While speaking with Sutherland, she stated she had not provided any documentation from the initial contact with the clients. She advised that [redacted] is the therapist who makes the initial contact with clients to prep them for their visits although they may be assigned a different therapist later. She did not obtain any documentation from [redacted] for these visits. These "sessions" were not billed separately but integrated into the billing that was submitted.

Sutherland estimated [redacted]s initial contact with the clients would last 30 to 45 minutes. Sutherland added that [redacted] reviews the assessments completed by the therapists.

I advised Sutherland there were several issues concerning the billing including billing submitted prior to the services that were documented. Sutherland stated it may be that the client spoke with [redacted] by phone prior to their initial contact with their individual therapist, alluding to her prior statement that she did not have all of [redacted]'s documentation.

I provided Sutherland with a list of the issues pertaining to client AMC 3. Based on my review of the billing data, it appeared AMC3 received 3 rounds of services including diagnostic assessments and meetings with her therapist all within a 6-week period. Sutherland did not have an explanation as to why multiple claims were billed. I pointed out the multiple billings of code 90791, advising Sutherland the code was supposed to be an initial visit between the client and therapist. Sutherland admitted that billing for multiple instances of the code would be incorrect. Sutherland confirmed that she was submitting the billing during the timeframe of AMC 3's billing and that she submitted the billings directly through the Medicaid provider portal, not a 3rd party system such as an EHR.

I arranged to meet with Sutherland in person on May 11th, 2021 at her office.

On May 11, 2021, I met with Sutherland at her office at 422 East Vermijo Avenue in Colorado Springs. I showed Sutherland the process I went through when evaluating the Medicaid billing data and comparing it to the documentation she provided to illustrate the disparities I observed. While speaking with Sutherland, I learned the following:

Sutherland has done the majority of the billing for the company for the past several years. She had brief assistance from an employee, [redacted] [redacted]has her own account credentials for the HCPF / Medicaid portal. [redacted] started prior to 2019 but Sutherland was not certain the date range of her employment. Sutherland also hired another person to help with billing in 2020, [redacted] (unknown last name), but she never submitted billing on her own.

Sutherland usually bills once per week but occasionally gets backlogged due to illness. Sutherland stated she will have a list of clients who she is billing for and highlight the names as she works on the list. She added, however, she often is uncertain whether she submitted the billing, questioning if she highlighted the client's name before or after the billing was submitted.

Sutherland stated she has issues with her memory sometimes because of prior chemotherapy treatments. Sutherland taught herself to bill Medicaid and denied ever receiving training on how to submit billing. She started learning how to bill Medicaid approximately 14 years ago. She learned which codes to bill through "trial and error". Some companies have short video tutorials and she used those as a resource when determining what to bill. Sutherland would also call the EHR companies they have used and tried calling Medicaid to receive guidance. Sutherland believed one unit of CPT code 96131 was equivalent to 15 minutes of time but recently learned that each unit accounts for one hour of service. Sutherland claimed she was told this by HCPF but admonished that she never received solid guidance from HCPF on how to submit billing and what the proper coding was.

Sutherland commonly billed for 35 units of code 96131 and 1 unit of 96130, which equals 36 hours or psychological testing and evaluation services. Based on Sutherland's stated understanding that the units were intended to be 15-minute spans, the business would have provided 9 hours of services. Based on my prior conversations with clients, the assessments took approximately 3-4 hours, not including the grading and interpretation of the assessments by the counselor. I advised Sutherland that nearly 10 hours of assessments and evaluation still appeared to be excessive based on my knowledge of the process. Sutherland stated the assessments are lengthy, pointing out that the PAI assessment has 332 questions and takes several hours to complete. She added that the first 4 lines of the billing are for the initial evaluation and include the review of those assessments by the counselor. She added that Medicaid requires they provide two sessions to the client, including the initial interview and the subsequent review of the counselor's findings with the client.

I showed Sutherland the analysis I conducted for AMC 1, which showed two claims containing the "common set" of codes noted above. I pointed out that based on the billing, it appeared AMC 1 received an initial interview, completed her diagnostic exams and had a follow up appointment during one week and then came back the two weeks later and completed the same series of interviews and assessments again. Sutherland replied "Yeah, that's wrong", meaning that a second series of services should not have been billed.

Sutherland said she was confused, stating that if she billed a duplicate claim the system should have denied the second claim. I told Sutherland that the system would reject the claim if the dates of service had been the same, but since the dates of service were different, the system would not identify the error. Sutherland did not initially explain why there would be duplicate claims submitted but stated that she always uses the same codes and number of units since the services are identical for each client unless they require additional sessions. Sutherland explained that she pulls up a claim for a previous client

and then changes the name to the current client. Sutherland stated that even if she starts the billing process without using a prior client's data, the system still pre-populates the same billing information when creating a new claim. I advised Sutherland that even if the system has built in templates, it is ultimately the biller's responsibility to ensure that the billing is based on the documentation and actual services provided. Sutherland stated she understood.

I asked Sutherland why Dr. Chavez was always listed as the rendering provider in the 2020 / 2021 claims data. She explained that it was because Dr. Chavez was reviewing the work of the contracted therapists.

Sutherland stated the only way she knows of to check if a claim was already submitted is to run a report in the system. I advised Sutherland that although it was feasible to submit a duplicate claim, it would not explain the variances in the dates of service listed in the claims data, especially those where the dates of service were often weeks or months apart. I added that claims data I reviewed showed the date each claim was paid and several of the duplicate claims had the same paid date, indicating the claims were submitted on the same date.

I advised Sutherland that if duplicate claims with different dates of service were submitted on the same date, it indicated to me that the duplicate claim was submitted intentionally and that the dates of service were intentionally changed to make it appear two sets of services were provided. Sutherland denied intentionally submitting duplicate claims but stated the website used to submit claims sometimes crashes or continually buffers after she submits the claims, causing her to believe the claims was not successfully submitted. Sutherland theorized this was the reason for the duplicate or triplicate claims. I advised Sutherland that this reasoning did not explain why the dates of service would change. Sutherland did not provide a further explanation for the discrepancy. Sutherland was subsequently provided with an updated Request for Records requesting additional client files for analysis as well as employment files related to the therapists who provided services to Medicaid clients.

On June 3, 2021, I met with Martha Sutherland at Safeway located at 624 East Highway 105 in Monument, CO. Sutherland provided me with a thumb drive which she stated contained the requested documents pursuant to the Request for Records. While reviewing the files, I noted they fell into two categories; provider files such as applications and copies of the therapist's licensure documents and client files. The client files consisted of various documents similar to those obtained from the initial Request for Records.

Based on prior review of documentation, my earlier conversation with Martha Sutherland, and the information derived above, the "common set" of billing codes contains errors specifically for code 96131. Except for code 96131, the remaining codes and number of units appears to be correct. FRMH was credited 9 hours (1 unit of 96130 and 8 units of 96131). It should be noted, however, that based on the timesheets submitted by providers it appears the average time spent on 96130 and 96131 services is actually closer to 3 to 5 hours, but maximum credit will be given to ensure the calculated values are a benefit to FRMH. This calculation will be termed below as the "adjusted common set" to distinguish between the services documented and the services billed.

Based on my review of the documentation provided by FRMH and comparing to the Medicaid billing data, FRMH was paid $191,374.29 for services not provided. This amount does not include the figures calculated previously based on the initial Request for Records, $120,669.47. The total value of theft between the two analyses is $312,043.76. The total value of theft after May 1, 2019 is $240,238.03. Below is a breakdown of the value of theft for each year. The values for 2019 are separated into two portions to denote the values before and after May 1, 2019.

2017	2018	2019<April	2019>May	2020	2021
$9,366.91	$45,397.30	$16,167.49	$56,045.03	149,806.72	$34,386.28

On September 3, 2021, I contacted Martha Sutherland by phone. The intent of the call was to arrange service on an additional Request for Records regarding counselors with Front Range Mental Health (FRMH). The conversation developed to additional questions regarding the prior information I had obtained from FRMH and the issues concerning duplicate billing. During the conversation, Sutherland told me the following:

Sutherland had begun reviewing the claims she previously submitted and noted duplicate claims in the system, stating, "You're right about the duplication, I don't know how that happened". Sutherland stated the HCPF provider portal would often "kick her out" while submitting a claim and believes the duplicate claims may be a result of resubmitting the claim after believing it had been submitted unsuccessfully.

Sutherland had decided not to alter any of the claims she identified until speaking with me further to determine the extent of the issues with the FRMH billing. Sutherland asked if she should issue refunds for the duplicate claims she finds. I advised Sutherland that it was up to her, as I would take any refunds into consideration when calculating the amount of overpayment to

FRMH.

I advised Sutherland that it did not make sense to me that the duplicate or triplicate claims would be caused by the system "kicking her out" since the dates of service changed between claims, indicating that the dates changed simply to allow for the duplicate claims to process. I told Sutherland that I would assume that her claims submission was based on the documentation she had on hand and that the dates of service on that documentation would not change just because the Medicaid Provider Portal did not run properly. Based on the slight changes in dates of service, I told Sutherland that it appeared intentional; that she had changed the dates of service so the system would not recognize the claim as a duplicate.

Sutherland agreed that it was concerning that the dates of service would change between each claim but did not directly deny she intentionally changed the dates of service. I asked her why the dates of service changed when she would resubmit the claims. Sutherland stated, "I have no idea". Sutherland stated that due to the issues I uncovered, she is no longer submitting billing and has hired a 3rd party biller to submit FRMH's claims. Sutherland stated she did make claims adjustments recently but has not "deleted" or voided any claims.

I asked Sutherland what her process was to submit claims. Sutherland stated that she looks at a conglomeration of information when submitting billing including the "billing sheets" submitted by the providers and the included "demographics" and "notes" sections. Sutherland stated that if there isn't documentation, she's will not bill for the services. Sutherland admonished that some of the providers are "lazy" and don't always submit notes right away. If there aren't notes included in the information she reviews, she will not submit billing for the services. She'll go back every week to see if the provider updated the notes so she can submit billing.

I asked Sutherland why, if she used the information from the conglomeration of documentation, the dates of service would change. Sutherland suggested that part of the discrepancy could be that some clients would come back for additional therapy after their bariatric review. I advised Sutherland that I took those cases into account when clients had follow-up visits or were initially denied for surgery.

Sutherland stated that she tends to transpose numbers, suggesting that the date discrepancies could be due to accidental mistyping of the dates. I advised her that the discrepancies in the dates of service were not likely caused by a transposition of numbers, such as changing January 3rd to March 1st (01/03/XX to 03/01/XX) since many of the dates of service for duplicate claims

were the week after the original claim, not a different month.

Sutherland then theorized that it may be a result of the system loading new client demographics for a new claim without changing the dates of service from the previous client she was working on but did not elaborate on if she had actually observed this issue.

I advised Sutherland that based on my experience, businesses tend to track and analyze their income and expenses to have an idea of the income that would be expected from month to month. I added that the duplicate claims would have created a substantial increase in the income of the business, considering that each duplicate claim was valued at more than $3000, and asked her if she had noticed the dramatic increase in income caused by the duplicate claims. Sutherland stated that she did not notice the excess funds due to the volume of clients her practice sees each month. She estimated FRMH currently sees around 60 clients per week with most clients coming from Medicaid. Sutherland added that FRMH has "grown exponentially" over the past few years and expressed that they may have grown "too fast".

FRMH does have clients with private insurance. I asked Sutherland if the claims submitted to private insurers have the same CPT codes and number of units as the claims submitted to Medicaid. She claimed they do, but added the claims were often rejected and she had to "go back and forth" with the private insurance companies to receive reimbursement. Sutherland claimed the insurance companies did not provide reasons for rejecting the claims. I asked Sutherland what adjustments or changes she would make to have the claims approved. Sutherland claimed she had "just fought hard enough" to have the claims paid and stated it was part of the reason they changed to a 3rd party biller.

Sutherland stated their new 3rd party biller, [redacted], started submitting claims for FRMH in August 2021. I asked Sutherland what changes [redacted] made to the CPT coding and number of units that are billed. Sutherland stated [redacted] created a fee schedule, which showed that the standard sessions were valued at about $1600, not including the final review session. Sutherland did not know the difference between the codes or number of units [redacted] was using compared to those she previously used, stating she had not yet sat down with [redacted] to conduct a thorough review.

As I spoke with Sutherland, we discussed FRMH's use of Kareo, the company's Electronic Health Records (EHR) management software. Sutherland stated she had multiple issues with Kareo. One of the primary issues was that Kareo would submit claims for reimbursement but the claims would not be paid. Sutherland felt that Kareo did not help them obtain payment for the claims

and often had to resubmit the claims herself through the provider portal. Sutherland explained that each week, on Friday, she would identify the claims that had not been reimbursed by Kareo and submit those claims herself through the HCPF provider portal.

FRMH has been using Kareo for approximately 5 years and they have continually had issues with receiving payment for claims submitted through the system. They stopped using Kareo when they hired [redacted]. I asked Sutherland if, when resubmitted a claim through the HCPF provider portal, she would use the information from Kareo or if she would rely on the source documentation from the counselors. Sutherland stated she would use both sets of information.

On September 26, 2021, I submitted an email to HCPF PI Supervisor Sarah Geduldig and requested the banking information for Sutherland Counseling LLC for the previous 6 years. On September 27, 2021, I received the requested information, showing the business had one banking account registered with HCPF through Vectra Bank. On November 24, 2021, I submitted a Court Orders for Production of Records for the Vectra Bank account information to the Denver County Courts. Judge Beth Faragher reviewed and signed the affidavits and returned them to me via email later the same day. The Court Order for Production of Records was served to Vectra Bank by mail on December 2, 2021.

On February 1, 2022, I spoke with [redacted]. While speaking with [redacted], she told me the following:

[redacted] began working for Sutherland in August 2021. At the time, Sutherland was still using Kareo to submit billing from prior months. [redacted] did not take over all billing responsibilities for Sutherland until October 2021 as the company was still working with Kareo on some claims. [redacted]'s initial task was to submit billing that was backlogged for June, July and August of 2021. [redacted] submitted billing for Front Range Mental Health initially, using their tax ID, but then submitted billing for Summit Assessments under a different tax ID. [redacted] submitted "very few" claims for Front Range Mental Health and said the majority of the billing she has submitted for Martha Sutherland was under the Summit Assessments tax ID.

[redacted] receives billing sheets from Sutherland and submits the billing based on those sheets. She does not receive or review any other documentation when submitting the billing. [redacted] occasionally requires additional information to submit the billing, such as the code modifiers of the rendering provider's name and ID. She added that occasionally she observes typos, such as a transposition of numbers or missing digits, and will contact Sutherland for

clarification to correct the error but does not otherwise modify the billing information she receives from Sutherland. [redacted] submits the billing by each date of service, rather than span billing as Sutherland had previously.

I asked [redacted] which billing codes are commonly used. [redacted] listed codes 96131, 96130, 90791, 96136 and 96137. I asked [redacted] if she ever received any duplicate claims from Sutherland. [redacted] stated she could not recall receiving any duplicate claims, adding that if a duplicate claim were submitted the system would reject it. I asked [redacted] if she recalled any instances where the same client related to multiple similar claims. [redacted] did not recall, stating that she also submits billing for other practices and goes through a high volume of information. [redacted] agreed to review the documentation she received from Sutherland to determine if she received multiple claims related to the same client for similar / duplicate services. As of this report, [redacted] has not provided an update regarding her review.

On February 2, 2022 I obtained updated COGNOS billing data for Sutherland Counselling / Front Range Mental Health. The purpose of the data was to compare FRMH's billing practices prior to and after billing responsibilities were transferred to [redacted] and my May 11, 2021 interview with Martha Sutherland. A review of the data showed FRMH had a distinct decrease in billing in April 2021. In the 1st quarter of 2021, the average monthly gross billing for FRMH was $112,792.24. The second quarter average billing was $36,152.17, with a $4774.26 average in the 3rd quarter.

Based on my conversation with [redacted], she submitted most claims under Summit Assessments rather than Sutherland Counseling / FRMH. I added the Summit Assessments billing data to the analysis and found that as the billing for FRMH began to decrease in April 2021, the billing for Summit Assessments increased. Prior to April 2021 Summit Assessments did not submit any billing. I updated the analysis of the average monthly gross billing, including 2020 and 2021, and found the following:

2020 1st Quarter Average: $126,308.27
2020 2nd Quarter Average: $116,060.82
2020 3rd Quarter Average: $147,755.43
2020 4th Quarter Average: $141,815.68
2021 1st Quarter Average: $112,792.24
2021 2nd Quarter Average: $50692.12
2021 3rd Quarter Average: $58,098.85
2021 4th Quarter Average: $43,859.67

[redacted] submitted billing on a per date of service basis, rather than span billing as Martha Sutherland had previously. A gross analysis of the specific

units billed per client on a per claim basis could not be performed due to the change in how the billing was submitted. I instead conducted a gross analysis based on the number of units billed and total clients served to obtain an average number of units and average amount paid per client for each quarter in 2020 and 2021. Below is the result:

2020

Criteria	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Medicaid ID Count	109	107	116	103
Gross Quarterly Paid	$378,924.82	$348,182.45	$443,266.20	$425,447.05
Average Per Medicaid ID Paid	$3,476.37	$3,254.04	$3,821.26	$4,130.55
Gross Quarterly Units Allowed	4140	3837	4916	4659
Average Units Per Medicaid ID Allowed	37.98	35.86	42.38	45.23

2021

Criteria	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Medicaid ID Count	102	197	213	153
Gross Quarterly Paid	$338,376.73	$152,076.37	$174,296.54	$131,579.00
Average Paid Per Medicaid ID	$3,317.42	$771.96	$818.29	$859.99
Gross Quarterly Units Allowed	3757	1905	1850	1394
Average Units Per Medicaid ID Allowed	36.83	9.67	8.69	9.11

Based on the above information analysis, the decrease in gross payments to FRMH / Summit Assessments was not due to a decrease in the number of clients seen, but rather a decrease in the number of units billed per client. This analysis is supportive of the prior assessments that FRMH billed for 3-4 times the number of units actually provided.

On February 8, 2022, I conducted an analysis of the date of submission for the claims submitted by Front Range Mental Health. While reviewing the data, I was unable to locate any claims where the duplicate claim was submitted on the same date as the original. I also noted multiple instances where duplicate claims with earlier dates of service were billed after claims with later dates of service listed. In some instances, the duplicate claims were submitted within a week of the original claim while in others the duplicate claims were billed months later even though the dates of service listed were shortly after the original claim. I did not note any specific pattern regarding the duplicate claims and when they were billed.

On February 8, 2022, I received an email from [redacted], an Operations Legal Support Specialist with Zion Bank Corp (Vectra's parent company) with a link to the requested files. The purpose of this review was to confirm payment from HCPF / Medicaid to Sutherland Counseling LLC for services

billed and found the total of deposits from Colorado / Medicaid to the account is $4,482,954.94 between April 15, 2016 and November 18, 2021.

On February 23, 2022, I called [redacted] by phone. While speaking with [redacted], he told me the following:

[redacted] began working for [redacted] in late 2016 when the company was still operating as Sutherland Counseling. [redacted] provided counseling services through Sutherland / Front Range Mental Health for the first several years but currently primarily works as the company's Referral Coordinator. [redacted] described his current responsibilities as reaching out to and communicating with the referring provider to obtain the clients information and demographics. He takes the information provided and enters the data into the company's intake system, Office Ally. [redacted] does not have any involvement in billing. Based on [redacted]s description, he does not provide any billable counseling or therapy services during these contacts as they are primarily an administrative function.

The company currently has a biller named [redacted] (aka [redacted]), who started in late 2021. Prior to [redacted], Martha Sutherland was the "ultimate decision maker" regarding billing. [redacted] would submit a billing spreadsheet to [redacted] via email containing the client names and CPT codes. [redacted] stated he and the other counselors who work for the company were provided with a list of codes and associated services. He could not recall how the CPT coding was structured for each year he worked for the company but had the list for the current year. [redacted] stated the most recent CPT coding direction from the company was as follows:

> Clinical Interview – 90791 – 1 unit
> Test admin – 96136 - 1 unit
> Evaluation report writing – 96130 for 1st hour, 96131 for each additional hour. Multiple units allowed.
> Follow-up interview – 96131

[redacted] stated the billing codes and number of units has not changed drastically over the last few years. He added that since [redacted] began billing, he and the other counselors received additional clarification on the quantity of allowable units.

I asked [redacted] what the prototypical client process would be, assuming the client did not require additional sessions prior to surgery being authorized. [redacted] stated the standard process was very structured. The counselor will meet with the clients for a Clinical Interview which typically lasts for 2 hours. Afterward, the client takes a battery of assessments, which the counselor

subsequently reviews. At least a week after the assessments, the counselor meets with the client again to review the results of the assessments. After the second client interview, the counselor will write a report regarding the client's suitability for surgery.

[redacted] admonished that although most clients take the same battery of assessments, some may take different assessments if they were previously denied for surgery. He added that "outliers", individual who required additional sessions prior to surgery being authorized, typically included clients whose primary language was not English or those who are neurodivergent. [redacted] explained sessions with these types of clients simply took longer and thus required additional sessions to complete.

I asked [redacted] what percentage of clients required additional sessions. [redacted] could not quantify a percentage but estimated 5 clients per year required additional sessions. I asked [redacted] what percentage of clients were ultimately denied for surgery. [redacted] stated that roughly two to three of every ten clients were denied for surgery.

On March 4, 2022, I contacted [redacted] by phone. While speaking with [redacted], I learned the following:

[redacted] began working for Sutherland Counseling in 2014 as a part time therapist. She was promoted to Clinical Supervisor in 2017 and currently works as Executive Director since May 2019. No one occupied the position prior to her as [redacted] was "running the business".

Prior to August 2021, the company used Kareo for their EHR system. The therapists would submit their notes and documentation into the system but did not enter any CPT or diagnosis coding. They would submit a separate timesheet to [redacted]. The company did not initially use the billing module from Kareo and Martha Sutherland was submitting the billing directly to Medicaid. Evans did not know if Martha Sutherland used the timesheets when submitting billing to Medicaid. In April 2021 the company began using HPI to assist with billing. HPI primarily submitted billing via the Kaero software's billing module but did submit some claims directly to Medicaid via the provider portal.

HPI "didn't really work out" and so the company selected a new biller, [redacted] around August 2021. [redacted] added that Martha Sutherland did not submit any billing after the company switched names to Summit Assessments.

I asked [redacted] about the general process each client goes through, giving her a summary of the information provided by [redacted] and Martha Sutherland.

[redacted] confirmed the general process but admonished that it has matured over time. When [redacted] first started with the company, the assessing clinician would have additional interviews with the client prior to making their final determination. [redacted] stated the additional sessions may occur if there was concern regarding the client's suitability for surgery. The process changed to allow for one or two extra sessions so the assessing clinician could further evaluate the client, not provide talk therapy. [redacted] was not sure of the exact date the change in procedure occurred, but believed it to be prior to March 2020, when the pandemic began.

[redacted] was not sure what percentage of clients required additional sessions, but said it was likely less than half. She added that some clients requested additional sessions with the assessing clinicians for talk therapy. [redacted] confirmed that the billing for a client who received talk therapy session would be entirely different than a client who went through the standard regiment of assessments. When [redacted] initially worked for the company, [redacted] primarily managed the business. [redacted] felt that [redacted] wanted to make sure they were doing a good job, were ethical, and provided a quality product to keep the patients safe. [redacted] did not believe that Martha Sutherland had the same standards.

I asked [redacted] if she spoke with Martha Sutherland regarding the number of units to be submitted by the clinicians. [redacted] stated Martha Sutherland did send her examples of what she suggested. [redacted] told Martha Sutherland the codes had hour long units. Martha Sutherland disagreed, saying the codes were for 15-minute intervals. [redacted] stated she was not a biller and so felt unqualified to have the discussions with Martha Sutherland. However, [redacted] confirmed the codes were an hour in duration because she asked [redacted] to purchase a CPT coding book to review and referenced the book when creating the training manual for the clinicians. [redacted] stated she did not want to provide direction to the clinicians that she disagreed with.

I asked [redacted] if she recalled when she had the discussion with Martha Sutherland regarding the time duration of the units. [redacted] could not recall specifically, but stated it was "around the time we were switching over to Summit". Based on the prior statements from [redacted], this would have been around May or June of 2021, since the transition to the Summit Assessments name somewhat coincided with the transition to HPI. She added that she and Martha Sutherland had argued about this particular topic several times but could not recall exactly when the discussions occurred other than she was positive one of the discussions occurred around the time they transition to Summit Assessments. I asked [redacted] how many times she had this particular discussion with Martha Sutherland prior to May of 2021. [redacted] stated that she likely did not have the discussion prior to May 2021 since she had just

started learning about the aspects of coding around that time.

I asked [redacted] if she and Martha Sutherland had any other discussions surrounding billing. [redacted] replied that they had some recent discussions regarding code 96131 being used by [redacted] when he conducts the initial client intake. [redacted] disagreed, saying that 96131 was an add on code for 96130 and could not be used until the initial evaluation was conducted. Martha Sutherland "doesn't believe anything (she) says" and so conferred with [redacted]. [redacted] concurred with [redacted].

I asked [redacted] if she had an example of the timesheets she submitted prior to March 2020. [redacted] located a timesheet from December 2018 and later emailed it to me. When she reviewed the timesheet, [redacted] corrected information she provided earlier regarding the use of CPT codes on the timesheets submitted by the clinicians. [redacted] stated the timesheet did include CPT codes, but the ones on the timesheets were out of date since the CPT codes they were using changed. From prior research into the codes, I know that codes 96101 -96103 were updated from 2018 into 2019 to 96130 and 96131 along with other changes to some mental health billing codes. I reviewed the timesheet [redacted] provided and noted it was the same format as the timesheets provided by Martha Sutherland on March 18, 2021.

On March 8, 2022, I contacted [redacted] by phone. While speaking with [redacted], I learned the following:

[redacted] began working for Front Range Mental Health in either 2018 or 2019. When he was hired, [redacted] was the primary person in charge of the business. [redacted] was hired as an Assessing Clinician and is currently in the same position with the company. [redacted] described his job duties as meeting with patients to conduct clinical assessments prior to bariatric surgery. Over time, he has taken on additional administration responsibilities such as faxing documents to referring physicians / surgeons.

I asked [redacted] if he participated in billing or was given any direction on what the coding for the assessments was. [redacted] stated the clinicians complete timesheets and are asked to put CPT codes for the work and the number of units depending on the timeframe.

I asked [redacted] if the time allotted to each unit had changed over time. [redacted] stated that, to his knowledge, the timeframe for the codes has not changed. He stated CPT code 96130 is for the 1st hour, and 96131 is for each additional hour if it surpasses 31 minutes. [redacted] provided an example of report writing taking 1 hour and 45 minutes to complete being 2 units of 96131.

I asked [redacted] how a "prototypical client" would be billed. [redacted] provided the following:

Initial Assessment – Code 90791 – 1 unit
1st half of assessment battery - 96136 – 1 unit
2nd half of assessment battery 96137 – 1-2 units
Administrative Work - 96130 – 1 unit
Completion of Report – 96131 – 2 units

Prior to the COVID 19 pandemic the clinicians did not note any CPT coding and only turned in timesheets. The timesheets included the client information, the tasks completed and amount of time each task took. [redacted] did not know how the information he submitted for his timesheet was used in the billing process. During the pandemic, prior to changing from Front Range Mental Health to Summit Assessments in August 2021, the clinicians would enter "superbills" into Kareo, the EHR system used by the company at the time. They were provided with a list of CPT codes to use with the superbills and would follow those guidelines when entering their notes to create the superbill. Based on my prior conversations with Martha Sutherland and [redacted] this timeframe would have been around April, May or June of 2021.

[redacted] stated he had a meeting with Martha Sutherland in 2021 that was particularly "odd". He could not recall the specific date, stating he would have to look through his calendar to find it. [redacted] explained he received an email from Sutherland requesting a meeting with him. [redacted] arranged to meet with Sutherland at her residence. Prior to the meeting, Sutherland asked [redacted] to sign a nondisclosure agreement, which he signed. At the meeting, Martha Sutherland told [redacted] her vision for the future of the business and how she thought the company could move forward. Martha Sutherland showed [redacted] a listing of CPT codes and told [redacted] she wanted to bring him in so "he could see what (he) could be making" adding "If we did all these things, this is what you could be making per year". [redacted] reviewed the coding on the sheet and explained to Sutherland that they don't provide some of the services that were listed. One of the codes pertained to the use of therapy codes and [redacted] stated they don't typically provide therapy, just assessments. [redacted] explained that if clients do need therapy, they usually refer them to other providers. [redacted] stated he has retained some assessment clients for therapy, but very few. The most therapy clients he has retained at one time was 3 because he doesn't have the time to see more.

The other CPT code they discussed was 96132, a code for neuropsychic testing. [redacted] explained that neuropsychic evaluations relate to the physical structure or chemical interactions in the brain and evaluating the effect of defects in that structure on the client's symptoms, such as depression and anxiety. The

assessments they do relate more to the client's life circumstances and specific events and the effect those incidents have on the client's symptoms. [redacted] explained to Martha Sutherland "that's not something we do" and that the neuropsychic testing was outside the scope of their practice. [redacted] sat with Sutherland at her computer and showed her the requirements of the code to convince her that the use of the 96132 code was improper. [redacted] stated that at the end of the conversation Sutherland concurred that the use of 96132 was not valid. [redacted] has not had any subsequent one on one conversations with Sutherland since the meeting.

[redacted] was frustrated with the need to use the CPT codes, stating, "We're not billers, we're therapists". He felt pressured by Sutherland to use the 96132 billing code and felt the need to learn more about the codes they were being asked to use. [redacted] called [redacted] after leaving Sutherland's residence and discussed the conversation he'd had with Martha Sutherland. [redacted] agreed the code was inappropriate based on the services they provide. He stated [redacted] provided the clinicians with good guidance on the coding and encouraged them to keep track of their documentation to make sure it supported the items that were billed.

I asked [redacted] if he had any discussions with either [redacted] or Martha Sutherland regarding the amount of time allotted to each specific code, such as 15 minutes or an hour for codes 96130 and 96131. [redacted] stated he did not.

[redacted] also told me of a company-wide Zoom meeting he attended that was "rather strange". Martha Sutherland's primary point during the meeting was that the clinicians could be "doing more". I asked [redacted] how the clinicians could "do more" since the majority of the work they did was dictated to them. [redacted] wasn't sure and found the entire discussion odd. I asked [redacted] if they were directed or encouraged to increase the number of units documented for tasks such as report writing or to encourage the clients to schedule additional appointments that weren't necessary. [redacted] said there was no such direction and was not sure how Sutherland expected them to "do more".

On March 9, 2022, I contacted [redacted] by phone. I asked him if he recalled when Marth Sutherland began doing the billing for the company. [redacted] was uncertain of the exact date Martha Sutherland began submitting billing. He added that the company had used a couple of billing companies prior to Martha Sutherland taking over. They used "Ponderosa" initially as well as a "lone wolf" / independent biller who they knew locally. There were issues with both billers.

The company used Kareo for practice management and EHR for 4-6 years. [redacted] found Kareo frustrating because the software and the

company are more geared toward medical practices, not mental health providers. While moving from Front Range Mental Health to Summit Assessments they worked to get [redacted] credentialed with Kareo but during the process Kareo was bought out by HPI. HPI was initially doing a better job with credentialing and he felt they may be able to assist them with their billing as well. They worked with HPI to do their billing after the company switched to the Summit Assessments name during the summer of 2021. Part of the reason they started using HPI was to seek guidance with their billing. To this end, HPI gave them articles to read but were not directly helpful in answering questions or providing guidance. [redacted] felt that part of the issue was their practice is very "niche" and HPI didn't seem to know much about behavioral health billing. Because of the continuing issues, they hired [redacted] around August 2021.

I advised [redacted] of how the case was referred to the Attorney General's Office and noted one of the initial issues of concern being the high volume of CPT codes 96130 and 96131. I explained that Martha Sutherland claimed to believe 1 unit of each code was 15 minutes rather than an hour but had also spoken with others in the office who stated there had been internal discussion regarding the time interval of the units. I asked [redacted] if he recalled any of these discussions and when they may have occurred. [redacted] stated he recalled seeing a document or online article that the units were 15-minute codes but stated this was several years ago. He made no mention of prior discussions on the topic.

I asked [redacted] if he knew how Martha Sutherland came to that realization. [redacted] initially postulated it was through [redacted]. I advised [redacted] was hired in August 2021 and my conversation with Martha Sutherland was in March 2021. [redacted] then suggested it may have been when HPI began to assist with billing.

I asked [redacted] why, when he stepped down from being the primary operator of the business, did Martha Sutherland take on the billing. [redacted] didn't take on billing because he was "spread too thin" and didn't have the time. Martha Sutherland was in the medical field for "years and years and years" and had been an office manager for a mental health facility around 30 years ago but had never been a biller before. Martha Sutherland "had a steep learning curve" when she began billing, but "spent a lot of time on the phone with Medicaid and Medicare" to identify which codes to bill. [redacted] admonished that Martha Sutherland is not good with organization or numbers but felt that they "didn't have a choice" to use her as the biller.

I asked [redacted] if he recalled any discussions surrounding the use of code 96132, adding that other people I had spoken with suggested that Martha Sutherland was insistent the company could bill the code. [redacted] stated he recalled discussing the use of the code but did not believe they had ever billed it. I explained to [redacted] I was attempting to determine the process Martha Sutherland used for selecting the codes the company used. [redacted] confirmed he spoke with Martha Sutherland about the use of the code and told her he did not think they could use it. I asked [redacted] why he thought Martha Sutherland was resistant to the idea that the code should not be billed. [redacted] replied that Martha Sutherland is stubborn, but did not elaborate further.

I advised [redacted] that one of the other concerns in the investigation related to multiple submissions of the same claim but with varying dates of service and asked if he knew how Martha Sutherland would have submitted the erroneous dates of service. [redacted] replied that Martha Sutherland's "health isn't very good". He explained that Martha Sutherland spends about 60% of her time in bed, is on a lot of medications and her short-term memory is not great and is getting worse. [redacted] suspects Martha Sutherland forgot that she had entered the claims already and may have tried a different date just to get the claim to go through.

[redacted] explained that Martha Sutherland was diagnosed with breast cancer 16 years ago which resulted in a mastectomy and aggressive chemotherapy. Martha Sutherland subsequently underwent reconstructive surgery, which was difficult for her. [redacted] felt that Martha Sutherland never "bounced back cognitively" and added that she also has fibromyalgia and is on several medications including some for pain and anxiety.

[redacted] does the accounting and payroll for the business. I asked [redacted] if the increase revenue from the duplicate billings ever stirred any discussion between him and Martha Sutherland since the increased revenue appeared to outpace the growth of the business. [redacted] replied that "hindsight is 20-20" but they had gone through recredentialing with Medicaid and experienced an approximate 6-month gap without payments from Medicaid. He assumed the additional revenue was a result of the previously unpaid claims finally being paid as well as the growth of the business. He added that he believed therapy services were also being billed. [redacted] stated he never reviewed the explanation of benefits because he was "always swamped". [redacted] feels now that he should have "drilled down further" and that it was "bad management on (his) part".

I asked [redacted] how clinicians submitted their documentation and completed their timesheets prior to the current system of using CPT codes to document their work and time. [redacted] stated the process had developed over time and was "never really nailed down as it should have" been.

I asked [redacted] what information Martha Sutherland used when submitting the billing to Medicaid and if that information changed over time. [redacted] stated the business tried several EHR systems prior to Kareo and moved to Kareo because it was a "fully integrated system". He was not certain of the date the company began using Kareo but confirmed they were on Kareo from 2019 going forward.

I asked [redacted] if there was any additional information he felt was pertinent for me to know. [redacted] stated that he never should have left Martha Sutherland in her position as long as he had due to her cognitive issues, health problems and poor organization. [redacted] believed Martha Sutherland thought she was "doing it correctly" and stated he felt it was his fault for failing to oversee the business better.

Based upon the above information, the affiant requests the court issue an arrest warrant for **Martha L. Sutherland**.

Affiant

SUBSCRIBED AND SWORN to before me this 28th day of April

20 22.

Erica Mancha
Notary Public

ERICA MANCHA
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20144035639
MY COMMISSION EXPIRES SEPTEMBER 25, 2022

My Commission expires 9/25/2022.

Judge