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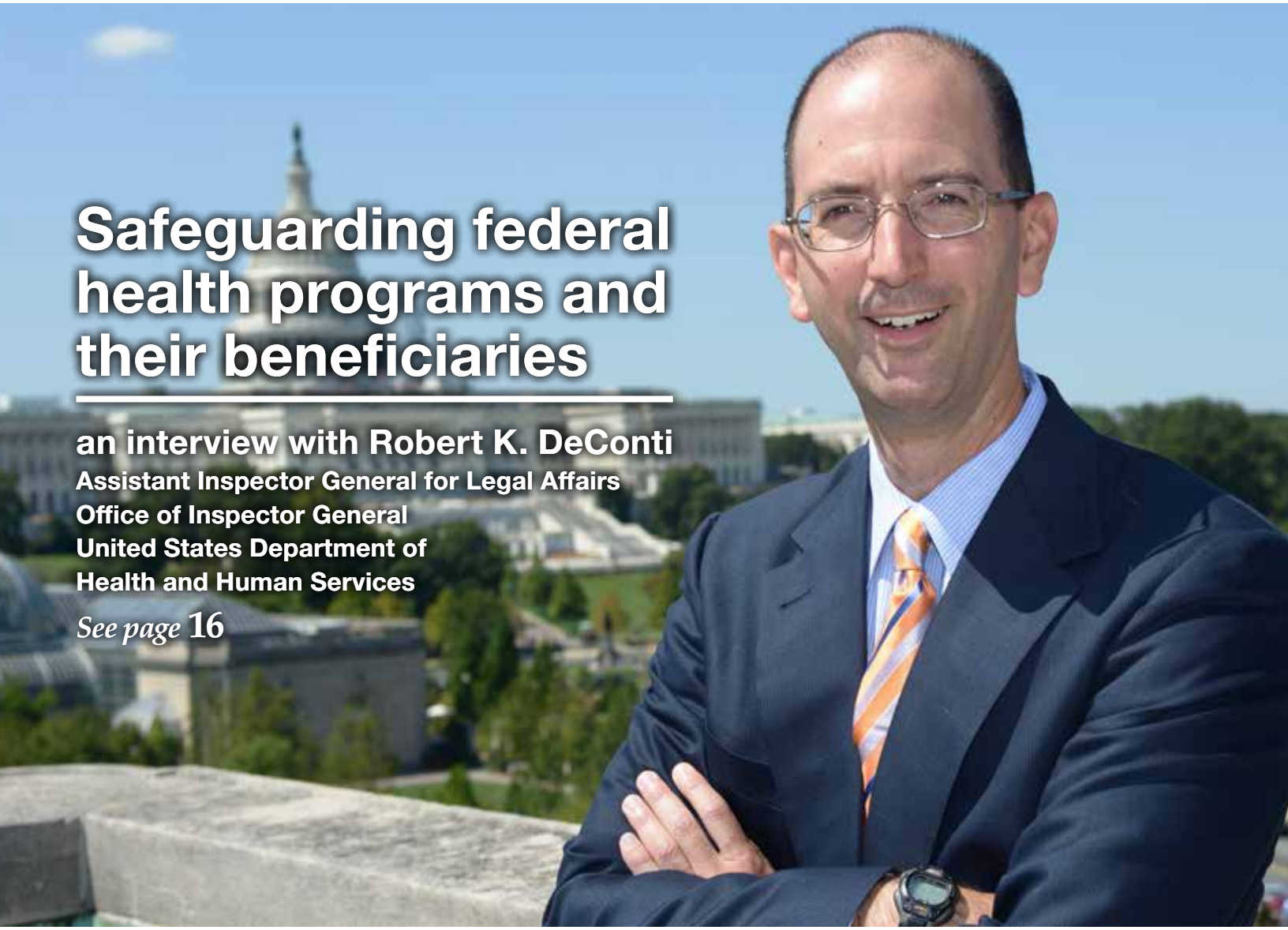

Safeguarding federal health programs and their beneficiaries

an interview with Robert K. DeConti
Assistant Inspector General for Legal Affairs
Office of Inspector General
United States Department of Health and Human Services

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by Andria Jacobs, RN, MS, CEN, CPHQ

Compliance 101

Mental health fraud hits the most vulnerable citizens

» Fraud across the mental health landscape is running rampant.
» Proper documentation is essential for complying with federal/state laws.
» Compliance officers can help protect practitioners from litigation and investigation.
» Documentation should include the services rendered and accurate billing codes.
» Claims should be checked to ensure charges match services received.

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Despite advancements in understanding over the past few decades, the stigma of suffering from an acute mental illness continues. But it's still troubling to note that more than half of adults with a mental illness received no treatment in 2012-13.[1] In addition, one in five adults said they were not able to get the treatment they needed for their mental illness. Even states with more universal access to healthcare report these problems.

Jacobs

Also troubling is the persistent amount of mental health fraud that occurs. By whatever yardstick you use, healthcare fraud costs us all dearly. Estimates put the price of healthcare fraud at between 3% and 10% of total expenditures, which were $3 trillion in 2014[2]; that equates to between $90 billion and $300 billion in bogus charges that health plans and federal payers—and you and I—paid for.

And although healthcare fraud affects everyone through higher bills or co-pays, the mentally ill often suffer twice—once through lack of services or lack of adequate services and again if they are responsible for paying for their healthcare. Many of the mentally ill also face physical challenges, too, such as substance abuse, alcohol abuse, or infirmities that come with age.

Inadequate and non-existent care

Imagine being in an inpatient facility, transitional care, or a group home where the mentally ill patients do nothing but sit in chairs, watch TV, and eat fast food for dinner. That's not care, that's cruelty. And unfortunately, instances of alleged fraud continue almost non-stop.

Consider these recent examples:

- In July 2016, federal prosecutors in Miami announced charges against three people accused of bilking Medicare out of $1 billion over 14 years for care that wasn't necessary or wasn't received. The main defendant is accused of using patients within the 20 skilled-nursing and

assisted-living facilities he operates to bill Medicare for mental health, prescription drug, and home care services.[3]

- St. Joseph's Hospital Health Center in New York agreed earlier this year to pay $3.2 million to settle charges that it presented falsified claims for mental health services provided by unqualified staff members. The allegedly falsified Medicaid claims were in conjunction with mobile-crisis outreach services provided over nine years.[4]
- Also in July, Florida's attorney general announced charges against three defendants accused of defrauding Medicaid of $100,000 by charging mental health services never performed for children with Medicaid IDs.[5] In this age of electronic health records, imagine the lingering effects of a false diagnosis as these children age.
- Five mental health hospitals in Massachusetts owned by Universal Health Services are the focus of a Department of Justice investigation into possible billing fraud.[6] The Fortune 500 company has been the subject of a federal investigation for the past three years and was fined $6.9 million in 2012 to resolve allegations of fraudulent Medicaid billing for psychiatric counseling and treatment of adolescents.

Although strides are being made in curbing the most egregious abuses, partial hospitalization programs (PHP) are another area ripe for abuse. PHPs generally involve intense outpatient services that are delivered at community mental health centers (CMHC) or the ambulatory department of a hospital. Unfortunately, some CMHCs provide services that equate to little more than residential day-care and bill for mental health services that go undelivered.

Compliance officers can help to ferret out bogus claims

Although medical and mental health coverages have expanded greatly since the passage of the Affordable Care Act, the atmosphere that makes billing fraud and abuse possible hasn't changed much. The stigma that continues to be attached to mental illness and potential confidentiality issues discourage patients and their families from voicing concerns over irregularities.

For mental health practitioners, proper documentation is essential to comply with federal and state law and to support documentation for claims. Such documentation is necessary to "fully disclose the extent of the services," along with care and supplies that may have been furnished to patients.

Proper documentation not only helps patients by ensuring they are receiving the care described, it also can protect practitioners from any potential litigation or investigation. Documentation should include the services rendered and billing codes that accurately reflect those services. Undocumented services never should be billed, nor should services be coded at a higher level than treatment reflects. It should go without saying, but providers should never bill for any "chance, momentary social encounters between a therapist and a patient."

On the patient side, claims should be checked carefully to ensure that the charges match the services received. Even when the patient has federal insurance, co-pays increasingly are required, and the service actually rendered may have a lower co-pay than what was billed. With increasingly high deductibles across the board, patients should pay close attention to all medical claims.

Health plans and other payers owe it to themselves to run analytics on claims for each provider. For example, billing in excess of 24 hours for any provider would be an obvious red flag, but few fraud attempts would be so blatant.

More likely, it would be a provider who consistently bills at the top end of the claim range for any condition or a provider who bills several intensive, 90-minute sessions each work day.

Regardless of who pays the bill, we all end up paying for fraud, waste, and abuse. In the case of mental illness, those who are denied adequate care continue to pay.

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