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## Behavioral Health: Managing the Increased Scrutiny of Medicaid Fraud, Abuse and Waste.

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### *Presentation Goals*

- Review how the Deficit Reduction Act adds significantly more risk for those who bill Medicaid.
- Identify the types of documentation problems most often revealed by government audits/enforcement actions.
- Identify challenges in behavioral health that contribute to these documentation problems.
- Offer ways to address these high risk areas.



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2

## *Deficit Reduction Act (DRA)*

- Created to get a handle on out of control government spending, including Medicaid expenditures.
- Its impact will dramatically increase scrutiny of those who provide, document and bill Medicaid services.



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3

## *Pre-DRA Enforcement Efforts*

- Federal government focused primarily on Medicare anti-fraud efforts.
- Medicaid anti-fraud activities were left mostly to the states.
- Federal government not satisfied with the level of Medicaid anti-fraud enforcement by the states.



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### *DRA Gives States More Incentive*

- States get 10% increase of any recoveries if they pass a False Claims Act at least as rigorous as the Federal False Claims Act.
- Of 13 states for which the OIG has rendered a decision, 8 have had their state False Claims Act approved.



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### *DRA Provides Greater Federal Involvement*

- Establishes a Medicaid Integrity Program designed to provide greater federal oversight to fight fraud, abuse and waste.
- Attempts to mirror the Medicare Integrity Program which has proven highly successful in reducing improper payments.



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## *DRA Education Requirement*

Providers who receive five million dollars or more in Medicaid reimbursement must have:

- Written P & P providing detailed discussion of False Claims Act for employees, contractors and agents, including whistle-blower provisions.
- Written P & P for all employees describing provider's strategies for detecting and preventing fraud, abuse and waste.
- Include above in employee handbook, if one exists.



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## *Consequences of Education Requirement*

- More staff have better understanding of improper documentation and billing.
- More staff understand the protections for reporting.
- More staff become aware that they may be entitled to 15% to 30% of any recoveries from a successful whistle-blower suit.



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### *DRA Increases Personnel Devoted To Fight Fraud*

- Pre-DRA: Centers for Medicare and Medicaid (CMS) had only **8** FTE's devoted to fraud and abuse.
- DRA Requires hiring **100** FTEs to fight fraud and abuse.  
  
Authorizes the hiring of contractors to conduct audits to ensure integrity of Medicaid program.



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### *DRA Adds Substantial Resources Against Fraud*

- Medicaid Integrity Program gets \$255 million for 2006 – 2010; \$75 million annually thereafter.
- HHS OIG gets \$125 million for next five years.
- The government expects to get a return that is many, many times that invested.



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10

### *What If The DRA Does Not Apply To A Provider?*

- Increased scrutiny not confined to those who must meet DRA's education requirement.
- Therefore, if providers provide, document and bill for Medicaid services, they will be at increased risk.
- Requirements have a way of becoming a "best practice" expectation for those to whom a requirement may not technically apply.



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11

### *So, what does all this mean?*

- Organizations who provide Medicaid services are going to be scrutinized as never before.
- Failure to put into place (or strengthen existing) systems, processes and mechanisms designed to comply with Medicaid rules and regulations will be at heightened risk for compliance problems.



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### *Documentation Risk Areas For Behavioral Health*

- Lack of medical necessity
- Billing for non-billable services
- Billing for services not rendered
- Missing documentation
- Progress notes do not support services billed
- Missing/improperly documented treatment plans
- Excessive time claimed for treatment duration
- Unqualified staff providing services



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### *Challenges In Documentation Posed By:*

- Establishing Medical Necessity
- The Medicaid Rehabilitation Option
- The Recovery Model of Treatment



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14

## *Establishing Medical Necessity*

### *Medical Necessity*

- Becoming even more important in behavioral health.
- No universally accepted definition.
- However, key components of medical necessity widely acknowledged.
- The term is primarily a financial term and secondarily a clinical term.



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## *Medical Necessity: Basic Components*

*Medically necessary mental health and/or substance abuse services are those that can be:*

- 1) reasonably expected to prevent, diagnose, alleviate, prevent the worsening of, improve, correct, or cure**
- 2) the signs, symptoms, impairments and/or functioning associated with the DSM-IV-TR (or other required diagnostic) manual**
- 3) using generally accepted practices**
- 4) in the least restrictive, most cost-effective manner**
- 5) individualized to the client's condition/needs and not for the convenience of the client or clinician.**

Adapted from "Medical Necessity" by  
Derek Jansen, Ph., MPH, BlacPoint Associates



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16

*Challenges of 2008 Rehabilitation Rule Changes -  
and Their Impact on Creating "Recovery Model" Systems*

*Rehabilitation Rule Changes*

- Strong move by CMS to move mental health rehabilitation services to a more formal model as already seen in the fields of Speech and Physical Therapies.
- Closer association between licensed professionals and those unlicensed staff working with client – think of definitions such as "incident to" or "under the direction of".
- The Rehab work will need to be driven by the licensed professional!



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17

*Challenges of 2008 Rehabilitation Rule Changes -  
and Their Impact on Creating "Recovery Model" Systems*

*Rehabilitation Rule Changes*

- Two critical areas to consider
  - Client plan goals will need to be clearly stated, meaningful, and related to identified mental health issues
  - documentation will need to address, for each billed service contact, how the service is moving the client closer to written/outlined goals



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18

*Challenges of 2008 Rehabilitation Rule Changes -  
and Their Impact on Creating "Recovery Model" Systems*

*Recovery Model*

- The term is not conducive to clear industry definition.
- Intrinsically "client centered", expansive, and unconventional in defining what constitutes a "service" that can benefit the client.
- Potential Major Conflict to Resolve – Medicaid and CMS rules continue primarily based on the "Medical Model"... "The professional defines the problem and outlines a course of treatment".
- How does one create/foster a Recovery Model, while maintaining compliance to documentation and billing guidelines/regulations?



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19

*Challenges of 2008 Rehabilitation Rule Changes -  
and Their Impact on Creating "Recovery Model" Systems*

*Recovery Model*

- Develop/Adopt an organizational definition of the Recovery Model.
- Provide effective training and move toward the creation of a Recovery Model organizational culture. Provide a clear understanding/definition of what a recovery oriented service system looks like.
- Provide effective training on what recovery oriented activities are billable/reimbursable under Medicaid, and which are not!



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*Challenges of 2008 Rehabilitation Rule Changes -  
and Their Impact on Creating "Recovery Model" Systems*

*Recovery Model*

- Example: the client wants to manage his/her own funds. Medicaid billable rehabilitation services may include working with the client to overcome disorganized thinking related to budgeting.
- Example: The client wants to attend a weekly social gathering of card players, and asks staff to teach them how to play before going. Attending weekly social gathering will assist client in his/her re-integration into the community – a goal now established in the organization's Recovery Model paradigm. Staff teaches client how to play... however staff also understand that the actual teaching of the game is not reimbursable/billable to Medicaid.



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21

*Identifying Areas of Risk*

- Medicaid Mental Health programs differ from State-to-State.
- It is essential that someone in your organization have a comprehensive, working knowledge of your State's particular Medicaid mental health regulations.
- Mental Health regulations will likely be divided into 2 main categories
  - Outpatient (Community Mental Health Services)
  - Inpatient Psychiatric Hospitalization
- In conjunction with the organization's compliance program, the organization's Medicaid expert should coordinate/participate/ conduct a comprehensive assessment of current service practices.



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22

## *Identifying Areas of Risk*

- Fiscal – Billing Procedures/Practices  
Denied Claims
- Clinical – Documentation/Clinical Record:  
Who performed service - Qualifications  
Necessary elements contained in  
individual clinical records to justify  
services billed, etc.



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23

## *Identifying Areas of Risk – Fiscal Practices*

### **Billing Procedures/Practices**

- Improper billing practices/procedures can immediately establish a “pattern” across your system.
- Does your system have safeguards that ‘catch’ mistakes?  
For example: relationship between staff positions/  
qualifications and billing/procedure codes
- Review your organizations internal system for consistency  
and compliance with State Medicaid regulations/guidelines
- MIP Audits will be generated in part by “data mining”. Are  
you aware of your billing patterns – would anything  
standout in comparison to others in your State?



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24

## *Identifying Areas of Risk – Fiscal Practices*

### **Denied Claims**

- What is your organization's practice for monitoring denied claims?
- An 'effective' Compliance Program should include someone looking and problem solving billing submissions being kicked back. Correct the problem.
- A high denied claims rate could trigger an MIP audit.



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25

## *Identifying Areas of Risk – Clinical Practices/Documentation*

### *Four Areas of Risk in an MIP Audit*

- Qualifications of staff
- Assessment - establishing medical necessity
- Individualized Treatment Plan – addresses identified need...consumer participation in creation
- Progress notes - documentation of each discreet service billed



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## *Identifying Areas of Risk – Clinical Practices*

### *Qualification of Staff*

- Using your State’s Medicaid regulations as guidelines -
  - Review policies to determine: who is providing what services, what do they bill, and what ‘billing/procedure codes’ are they using?
  - Review job descriptions/specifications for education and experience.
  - Conduct a random audit to insure compliance with the above.
  - Consider creating a Scope of Practice/Billing Grid (see example)



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## *Identifying Areas of Risk – Documentation*

### *Assessment – where medical necessity is initially established*

- Highly critical area that presents a significant risk to Medicaid mental health services.
- An MIP audit will likely start by examining assessment documentation of medical necessity to determine if diagnostic elements have been established, and if so - is there an “impairment” that warrants treatment/services.
- Physical health has objective findings when establishing a diagnosis and need for service (diagnostic imaging, lab reports, etc.).
- Mental Health has no such luxury – establishing diagnosis and impairment consists of basically two somewhat ‘subjective’ elements: practitioner observation and client reporting.



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28

## *Identifying Areas of Risk – Documentation*

### *Assessment*

- Is diagnostic criteria, outlined in Diagnostic & Statistical Manual (DSM) IV TR, consistently being documented in the individual client record?
- Is there a clear link/connection between the diagnosis and functional impairments indicating a need for services?
- Does the assessment contain all the necessary elements outlined in your State's Medicaid regulations/guidelines?



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29

## *Identifying Areas of Risk – Documentation*

### *Individualized Treatment Plan*

- Is there a plan in place that establishes observable/measurable goals?
- Are the goals related to problems/functional impairments identified in the assessment and medical necessity?
- Does the plan list interventions, who will provide services?
- Does the plan give time-frames for reaching goals?
- Does the plan comply with State Medicaid regulations/guidelines (if specified) - including evidence of client participation?



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30

## *Identifying Areas of Risk – Documentation*

### *Progress Notes – the necessary elements*

- Identify the problem being addressed that is on the treatment plan.
- Document service provided (group, individual therapy, rehabilitation, etc.).
- Interventions provided are consistent with goals on client plan.
- Describes briefly client's condition and response to interventions.
- Document what issues the client should work on until next visit.



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31

## *The Medicaid Integrity Program & Your Compliance Program*

*Two reasons a comprehensive / effective Compliance Program is critical in light of the DRA and MIP*

- Effective “Auditing and Monitoring” activities could dramatically reduce the fiscal impact of an MIP audit.  
(Reduced disallowances = lower extrapolated \$\$)
- An MIP audit report sent to OIG/CMS could trigger a False Claim Act (FCA) investigation. Your Compliance Program will be part of this investigation, and may well play a role in determining \$\$ damages



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32

## *The Medicaid Integrity Program & Your Compliance Program*

*“Auditing and Monitoring” – Are you auditing your highest risk areas?*

*What are you doing with the information?*

- Are you issuing repayment for errors?
- Are you using the information to correct system errors?
- Are you using this information to conduct more focused audits?



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33

## *Examples of Federal Audits and \$\$ Recoveries*

*Medicaid: Community Mental Health Services*

*Targeted Case Management (TCM) – population included those with mental illness*

- **Indiana:** Received \$144 million in Federal Financial Participation (FFP)  
Recommended recoupment after audit = \$21 million
- **Illinois:** Received \$89 million in FFP  
Recommended recoupment after audit = \$5.9 million
- **Minnesota:** Received \$179 million in FFP for TCM  
Recommended recoupment after audit = \$3.7 million
- **Iowa:** Received \$33 million in FFP for TCM  
Recommended recoupment after audit = \$1.5 million



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34

## *Conclusion and Summary*

- Passage of the DRA and creation of the Medicaid Integrity Program (MIP) places significant new risk of audit by Federal/State contractors.
- Organizations now must provide training to staff – training that increases the possibility of a Qui Tam or Whistleblower lawsuit.
- It is critical that organizations have effective compliance programs in place designed to monitor/correct/prevent improper billing and documentation practices.
- Documentation practices that provide a clear path leading from well established medical necessity, to treatment plans, to effective services is critical.
- If it hasn't been done already, take the time to conduct a comprehensive review of your system.  
(Suggested Evaluation Tool provided, or create your own).



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35