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# Behavioral health compliance through deterrence

By Andrew Schulke and Crane Pomerantz

The problems facing our country regarding access to and obtaining mental and behavioral health has grown over recent years. As part of the expanding need for these types of services, there has also been a rise in fraud against the Medicaid system involving behavioral health providers. Medicaid will do its best to identify fraud and administratively handle most issues that involve fraud, waste, and abuse. However, when the fraudulent conduct is egregious, the Medicaid Fraud Control Unit (MFCU) can step in and handle these providers either through criminal prosecution or civil settlements.[1] The cases in which MFCU works and the messages sent to the provider community can be essential in ensuring compliance by deterring fraudulent providers and keeping necessary Medicaid funds for recipients needing these behavioral health services.

The Nevada MFCU is part of the Office of Attorney General—as are most MFCUs found throughout the country.[2] The unit has two primary objectives: combating fraud and abuse against the Medicaid system by medical services and supplies providers, and protecting elderly and vulnerable adults in medical facilities from abuse and neglect.

The Nevada MFCU is a complaint-driven unit. Citizens and agencies provide complaints regarding fraudulent practices by providers and patient harm. Complaints originate from (i) recipients themselves who complain about the amount/type of services provided; (ii) employees of providers who have witnessed acts of fraud or have been asked to participate in fraudulent acts; (iii) state/federal agencies, including Nevada Medicaid, Managed Care Organizations (MCOs), the Office of the Inspector General (OIG); (iv) law enforcement; and (v) industry contacts.[3]

During the past 10 years, the Nevada MFCU has seen a dramatic rise in the number of complaints/referrals received in the behavioral health arena. To date, most complaints received and criminal cases opened by the Nevada MFCU involve behavioral health providers.[4]

## Cases and investigations

Conduct that constitutes Medicaid fraud that is commonly seen in behavioral health cases may include: (i) services not rendered or not rendered in quantity billed to Medicaid; (ii) lying on the Medicaid application concerning background or experience to get into the Medicaid system; and (iii) lack of accurate records to substantiate the claims submitted to Medicaid.[5]

The Nevada MFCU has worked on numerous prosecutions of fraudulent behavioral health providers dating back to 2009. Services involved in these fraudulent schemes can include basic skills training, psychosocial rehabilitation (PSR), case management, crisis intervention, intensive outpatient therapy, and biofeedback. As

with the MFCU's other investigations, fraudulent behavioral health schemes require considerable investigative and prosecutorial resources.

The investigation of a behavioral health provider can involve pulling historical documents from Medicaid regarding prior education that could have been given to the provider. If the provider was previously put on notice by Medicaid regarding certain improper conduct yet continued the conduct anyway, that is a crucial piece of evidence moving forward. The MFCU will also pull the relevant claim data applicable to the complaint. Interviews of Medicaid recipients and providers will also take place to confirm what services were actually provided. Finally, the investigation might attempt to interview the subject/target, presenting them with the fraudulent conduct found in order to obtain their statements about how the fraud was committed.

Nevada and other states have statutes that criminalize intentionally failing to maintain adequate records to substantiate Medicaid billing.[6] The MFCU has made many successful criminal cases related to records issues—especially in the behavioral health arena. The cases have ranged from issues with the provider having no records at all to substantiate the Medicaid claims to cases where vital information is missing in the records. This needed information might include date of therapy service, start/stop time of service, signatures of providers and recipients, etc. There are also instances where there is a different servicing provider listed on the progress note compared to the provider listed in the claims which allegedly provided the service.

Outside of investigations, the MFCU will also conduct provider education for open cases that are not progressing toward a criminal conviction. The MFCU will educate the provider on the appropriate Medicaid policy and receive a signed acknowledgment that the provider understands the policy in place. That way, if the provider continues with the fraudulent billing, the provider is on notice and is aware of intent to commit fraud. The MFCU will then have a much different conversation with that provider if the fraud continues.

There have been successful cases involving compliance through deterrence and education. Through provider outreach and education, the MFCU will put the provider on notice for criminal activity resulting from their Medicaid fraud actions. Often, the provider might think there are only administrative penalties for Medicaid fraud, but—as they are sometimes shocked to learn—that is not the case.