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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.

Challenges with compliance

Throughout the investigation, challenges can arise. Behavioral health recipients most likely have some medical issue that qualifies them for the behavioral health services. If a recipient has mental health issues in their background, there are many instances where a provider will try and use that against the MFCU to say the recipient cannot be trusted due to their mental health issues. The MFCU tries to combat this issue by interviewing several recipients who also are not receiving the services from the provider. That way, the argument can be made that a pattern or course of conduct is shown, and it is not just one recipient with mental health issues making the allegations.

The other challenge sometimes faced by the MFCU is determining the level of fraud taking place. Is it a case involving an individual service provider that is not actually going into the community and providing behavioral health services? Or is it a company in which fraud has permeated throughout the business, and direction regarding false billings comes from an owner or office manager? The strategies of the investigation and prosecution differ depending on the target of the investigation.

In Nevada, we have seen lots of fraud happening at the company level. In many of these cases, there are straw owners put in place by fraudsters with criminal history, qualification issues, or who simply do not want to go on paper as being affiliated with the business. Many times, these puppeteers behind the fraud call themselves "consulting companies" to try and legitimize themselves. The straw owners roped in by these consultants are

then linked up with service providers and billers affiliated with the consultants. The consultants then direct the fraudulent billing behind the scenes while the actual named owner might be clueless or might not know the level of fraud being done under their company's name.[7]

How Medicaid has created behavioral health providers within the system also creates issues. Medicaid does not require any qualifications to open a behavioral health company; the owner just has to affiliate with someone who can qualify as a medical professional. The unsuspecting owners are selected from within the community—including from churches, or seminars directed toward recruiting owners. These "owners" are sold a dream of owning a business and making a difference. The only thing the puppeteer or "consultant company" requires is a percentage off the top of the billing as a "consultant fee." The problem is that these owners then get in deep with the fraud occurring within their companies. Since the application and contract of the business are all under this unsuspecting owner's name, these owners could be hesitant to report issues to Medicaid or law enforcement. In the alternative, the owners get used to the lifestyle of making significant money each month and have no issue turning a blind eye because of the money earned.[8]

Although there are challenges, prosecutions and convictions of these behavioral health providers can support compliance through deterrence. Convictions can include multiple felonies, significant monies to be repaid to Medicaid, prison, and, most significantly, exclusion from the Medicaid and Medicare program.

The exclusion program

The exclusion program operated at the federal and state levels is arguably the best deterrent to keep fraudulent providers out of the Medicaid and Medicare system. Exclusion sends a message to providers regarding a significant collateral consequence tied to Medicaid fraud convictions or civil settlement agreements that could also trigger exclusion.

The Office of Inspector General (OIG) maintains exclusions at the national level. This exclusion is nationwide and very broad in terms of limiting any involvement of a convicted Medicaid fraudster from being employed in any capacity by any facility or practice that accepts any federal healthcare funds (e.g., Medicare, Medicaid, TriCare). A Medicaid fraud offense conviction may exclude a Medicaid provider for a minimum of five years and could go as long as a lifetime ban.[9] After the exclusion term is over, the excluded party is not automatically reinstated. That provider must petition the OIG for reinstatement; but it is not automatic they are allowed back in. The OIG upholds federal exclusion, but many state Medicaid agencies also maintain their own exclusion database for fraudulent providers on the state level.

Understanding deterrence efforts from a defense perspective

The goals of enforcement in the behavioral health space are unquestionably laudatory: to preserve access to and minimize the cost of necessary behavioral health services for the most vulnerable among us. However, every enforcement initiative and each individual case presents significant challenges to MFCU. While no provider wants to hear they are the target of an investigation, there are unique aspects of behavioral health enforcement actions that can be utilized by the provider (and/or their counsel) to ameliorate the harm that might result from an investigation and/or prosecution.

Understanding the enforcement authority

In Nevada, as in most states, the MFCU is entrusted with the primary jurisdiction to investigate and prosecute Medicaid provider fraud and patient abuse or neglect in medical facilities. In this regard, its function is comparable to other enforcement agencies responsible for prosecuting healthcare fraud, such as the U.S.

Attorney's Office in your district or the local district attorney's offices. The MFCU is unique, as it has dual civil and criminal authority. While this provides it with a wide range of tools to combat fraud, it also offers an opportunity to the provider faced with allegations of fraud.

From the perspective of defending a behavioral fraud case pursued by the MFCU, the first goal must be steering the investigation toward a civil resolution. Criminal resolutions often cascade adverse effects on the provider, including state licensure enforcement, loss of privileges at facilities, and loss of important private insurance contracts, and Medicaid debarment—to say nothing of the significant personal impact of a criminal conviction. A civil settlement with your MFCU can often be structured to minimize these draconian results. Like any civil settlement, the provider (and/or their counsel) should push for language in which they do not explicitly admit wrongdoing and instead seek a resolution based on the "uncertainties of litigation."

Several, but not all, MFCUs are at least partially self-funded. While this means the costs associated with investigations and prosecutions will almost certainly comprise part of any settlement, this also provides the MFCUs with an incentive to resolve a case civilly and not criminally. This is not to suggest that significant financial penalties are not effective tools of deterrence. Anecdotally, it is rare that providers who pay significant fines are recidivists. The most egregious fraudsters generally move out of the behavioral health space; the "honest" providers who have made legitimate errors are usually willing to learn from and correct their mistakes. That being said, from the defense perspective, it is almost always preferable to resolve an issue by paying money to the government than experience the ramifications of a criminal conviction.

Understanding the provider and the services

With the understanding that the first goal in any enforcement action should be to persuade the MFCU that a civil resolution is appropriate, such a goal is not realistic without a proper command of the facts and circumstances of the case under investigation. Simply asking for a civil resolution is unlikely to be successful; the burden lies with the provider (and/or their counsel) to marshal sufficient facts demonstrating that a civil resolution is the just outcome under the circumstances. From a defense perspective, this means an in-depth understanding of the service under investigation, the precise billing conventions for that service, and an understanding of the structural dynamics of the provider entity, including, specifically, who bears responsibility for submitting claims to Medicaid.

While the MFCU possesses vast experience in enforcement actions and, over time, develops expertise in specific types of services and service providers, it cannot possibly bear the same knowledge as the provider. On occasion, the MFCU's understanding of a specific service—or the way it believes a service "should" be provided—is at odds with medical or practical realities. A significant part of the provider's (and/or their counsel's) goal should be to educate the MFCU on the service and how it is provided. If there is ambiguity in how the service is described, this is an opportunity to persuade enforcement authorities that a civil resolution is appropriate. Even better, the definition of coding for the service at issue is so unclear that no enforcement is warranted at all.

Understanding how the particular service is coded is equally important from a loss standpoint. In many cases, the provider can demonstrate some service was rendered—even if that service is not as complex as or otherwise different from the service for which a claim was submitted. Enforcement authorities could assume that all services billed by the provider were submitted improperly, and the loss amount equals the amount paid for that service. It is often effective to argue that the loss equals the delta between the service billed and the service actually performed.

Finally, in defending a behavioral health investigation or prosecution, it is crucial to understand the workflow of claims in the provider's office. Whether the MFCU is pursuing criminal charges or a civil complaint, investigators will inevitably attempt to speak to the provider's biller. If possible, defense counsel should speak to the biller

immediately to understand who is responsible for choosing codes (i.e., whether the biller has any discretion in coding), the instructions they've received from the provider, and their expertise. In addition, it is incumbent upon defense counsel to speak to as many "insiders"—employees and contractors of the provider—to best understand the provider's culture and the level of control they exercises over the practice.

Conclusion

State MFCUs are vitally important in enforcing healthcare fraud—especially in the behavioral health space. Given the nature of the services rendered and the patients receiving these services, they face unique challenges in prosecuting these cases. Moreover, there is ample room for ambiguity in billing and coding these services. To achieve the maximum possible deterrent effect, a high degree of interaction and communication between the MFCU and the provider community is warranted.

Takeaways

- If presented with the opportunity to open a behavioral health company and the offer sounds too good to be true, it most likely is.
- Do not sign documents if they are blank or you are being directed to sign for services you know you did not provide.
- Be aware of what is billed under your National Provider Identified number because when dealing with Medicaid, you must police your own number.
- Understand the scope of your local Medicaid Fraud Control Unit's (MFCU) enforcement authority. Does it have civil enforcement authority, and is the MFCU self-funded?
- Knowledge, knowledge, knowledge: What is the service under review, how is it billed, and who is responsible for submitting the claim? Tap into the provider's superior understanding of the service rendered.

1 Nevada Attorney General's Office, "Medicaid Fraud Control Unit (MFCU)," accessed September 12, 2022, https://ag.nv.gov/About/Criminal_Justice/Medicaid_Fraud/.
2 "Jurisdiction of Attorney General in cases involving Medicaid fraud; establishment of Medicaid Fraud Control Unit; duties and powers; recovery of reasonable costs and expenses," Chapter 228, Nev. Rev. Stat. § 228.410 (2019), https://www.leg.state.nv.us/nrs/nrs-228.html#NRS228Sec410.
3 Nevada Attorney General's Office, "Medicaid Fraud Control Unit (MFCU)."
4 Nevada Attorney General's Office, "Behavioral Health," accessed September 12, 2022, https://ag.nv.gov/About/Criminal_Justice/Medicaid_Fraud/Behavioral_Health/.
5 Nevada Attorney General's Office, "What type of crimes does MFCU investigate?", accessed September 12, 2022, https://ag.nv.gov/About/Criminal_Justice/Medicaid_Fraud/Crime_Types/.
6 Nev. Rev. Stat. § 422.570 (2014).
7 Nevada Attorney General's Office, "Attorney General Ford Announces Sentencing of Former Las Vegas Medicaid Provider Shonna Nicole Marshall," news release, February 16, 2022, https://ag.nv.gov/News/PR/2022/Attorney_General_Ford_Announces_Sentencing_of_Former_Las_Vegas_Me
8 Nevada Attorney General's Office, "Attorney General Ford Announces Sentencing of Former Medicaid Provider Business Owner Lavell James Worthy, Jr.," news release, May 19, 2021, https://ag.nv.gov/News/PR/2021/Attorney_General_Ford_Announces_Sentencing_of__Former_Medicaid_Pro
9 U.S. Department of Health & Human Services, Office of Inspector General, "Exclusion Programs," accessed

September 12, 2022, https://oig.hhs.gov/exclusions/index.asp.