Not Conducting Internal Billing Audits? Think Again.

By Nancy Nager and Kenneth Davis

For the past decade, there has been increased government scrutiny of Medicare and Medicaid payments to providers of community mental health services. In 2003, Medicare paid mental health care providers more than $26 billion – a quarter of all mental health care expenditures in the U.S. Upon investigation, nearly half of these services did not meet Medicare/Medicaid program requirements, resulting in $718 million in improper payments, according to the Department of Health and Human Services.[1]

Spiraling costs have resulted in a dramatic rise in federal and state audits of mental health care service providers. Providers and those responsible for billing services in the mental health care community should take note. Consider these facts:

- In 2003, mental health service providers over-billed the State of Indiana by more $33.4 million because of billing errors. Of 200 randomly selected Medicare Rehabilitation Option services, 64 did not meet Federal and State reimbursement requirements.[2]

- In 2005, a former owner and chief executive officer of a Camden, NJ mental health counseling center was sentenced to state prison for submitting more than $137,900 in fraudulent bills to Medicaid.[3]

- In 2006, mental health care providers over-billed the State of Illinois by more than $11 million due to non-compliance with either the Federal requirements of the state Medicaid manual, the requirements of the approved State plan, the Illinois Administration Code and/or payment rate schedules.[4]

- In October 2008, Dominion Health Care, a mental health care provider in North Carolina, agreed to reimburse the North Carolina Department of Health and Human Services more than $1.6 million for improperly providing services or improperly billing Medicaid. The agreement requires that Dominion meet high performance benchmarks, and that all of Dominion's future claims be manually reviewed for compliance with Medicaid requirements before it can receive future Medicaid payments.[5]

Why the increased scrutiny? In the early to mid 1990's the Health Care Financing Administration (HCFA), now known as Centers for Medicare and Medicaid Services (CMS), discovered a 319 percent rise in Medicare payments to community mental health centers.[6] In response, the government launched Operation Restore Trust, a partnership between HCFA, the Department of Human Services Office of Inspector General (OIG) and the public to identify Medicare and Medicaid billing fraud and abuse. Poor billing practices and lax oversight has cost the government billions of dollars. According to a recent CMS report, in 2007 the national paid claims error rate for the Medicare FFS Program was 3.7 percent, totaling $10.2 billion in improper payments.[7]

Improved technology, increased funding for federal agencies, better oversight and improved inter-agency communication has made it easier to identify offenders. Included in the government's arsenal is its willingness to share up to 25 percent of what it recovers with whistle blowers. With health care costs escalating (over $2.2 trillion in 2007) and a troubled economy, the government is likely to step up its investigative efforts.

Keeping billing and clinical staff current with changing requirements, regulations and increased paperwork can be daunting. While fraud continues to be a problem, OIG reports that most non-compliance issues are due to human error. The most common of these billing mistakes are:

- Billing for services that are not rendered or provided as claimed;
- Submitting claims that are not reasonable or necessary;
- Double billing resulting in duplicate payment; and
- Billing for non covered services as if covered.

Non-compliance audits are expensive, both in terms of cost and unwanted publicity. Hours of staff time are needed to research and answer the government's claims. OIG investigators are required to interview staff, patients, vendors and board members. The negative publicity around such cases can severely damage an organization's reputation and take years to correct.

What to do? OIG recommends all health care providers, community mental health providers included, conduct baseline reviews and develop compliance programs to reduce the risk of billing errors and government audits.

Baseline reviews provide a benchmark to evaluate an organization's non-compliance risk. They look at an organization's efforts to comply with current laws and regulations; determine how well the staff understands the regulations; indicate whether internal controls and documentation are sufficient, and identify problems, if they exist. Baseline reviews are typically conducted through interviews, a thorough evaluation of documentation including medical records, financial records and an analysis of management control systems. They are a critical first-step in developing a compliance program and an important tool in an organization's defense, if the government comes knocking.

There's no cookie-cutter approach to designing a compliance program; what works for one organization may not work for another. What's important, according to OIG, is that providers have a mechanism to ensure that their claims are accurate. The burden of proof is on the provider, no matter its size. This situation can be a real hardship for small organizations or group practices with limited staff resources, and some may opt to do nothing because the effort can be daunting.

To assist organizations in developing effective compliance programs, OIG has published guidelines, which include:

- Designating a compliance officer
- Conducting internal monitoring
- Implementing compliance practice standards
- Providing appropriate staff education
- Responding quickly and appropriately to detected offenses; developing corrective actions
- Developing open communication and transparency
- Determining and enforcing disciplinary standards

Whether you choose to conduct a baseline review with internal staff, or rely on an outside consultant, OIG strongly recommends that individuals charged with this responsibility be sufficiently independent so that a true baseline can be established, as well as be well-versed in health care compliance regulation and law.[8] Independence ensures that internal controls are effectively monitored and that there is organizational adherence to billing standards, regulations and requirements.

Increased understanding and better management control of billing practices will minimize billing mistakes and expedite the payment of claims, a good thing in an economic downturn.

[1] Cynthis Shirk, "Medicaid and Mental Health Services", National Health Policy Forum, The George Washington University, Background paper no. 66, October 23, 2008

[2] "Medicaid Community Mental Health Centers (CMHC) The Department of Health and Human Services And The Department of Justice Health Care Fraud and Abuse Control Program Annual Report For FY 2008

[3] Office of the Attorney General, New Jersey Department of Law and Public Safety, "Convicted Camden Counseling Center CEO Sentenced to Prison for $138,000 Insurance Fraud" January 24, 2005

[4] Department of Health and Human Services Office of the Inspector General Review of Medicaid Community Mental Health Providers in Illinois, September 2006

[5] Medical News Today, "North Carolina Department of Health and Human Services Settles With Dominion Healthcare" November 6, 2008

[6] Paula E. Hartman-Stein, "HCFA Orders Crackdown on Fraud, Questionable Billing Procedures" The National Psychologist, November 18, 1998

[7] Improper Medicare Fee-For-Service Payments Report - May 2008 Report, Centers for Medicare and Medicaid Services

[8] Federal Register Department of Health and Human Services Office of Inspector General OIG Program