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QUESTIONABLE BILLING BY COMMUNITY MENTAL HEALTH CENTERS

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EXECUTIVE SUMMARY: QUESTIONABLE BILLING BY COMMUNITY MENTAL HEALTH CENTERS
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WHY WE DID THIS STUDY

During 2010, 206 community mental health centers (CMHC) received an estimated $218.6 million for providing partial hospitalization program (PHP) services to approximately 25,000 Medicare beneficiaries with mental disorders. Past Office of Inspector General (OIG) studies have found vulnerabilities in Medicare payments to CMHCs for PHPs. Additionally, in 2011, four CMHC owners and managers in Miami-Dade County, Florida, were convicted of fraudulently billing Medicare approximately $200 million for medically unnecessary PHP services from 2002 to 2010.

HOW WE DID THIS STUDY

We developed nine questionable billing characteristics based on past OIG work and input from Centers for Medicare & Medicaid Services (CMS) staff. We used 2009 and 2010 Medicare claims from CMS's National Claims History File to identify CMHCs that had unusually high billing for at least one of nine OIG questionable billing characteristics in 2010 and the metropolitan areas where these CMHCs were located. We also determined whether the percentage of CMHCs with questionable billing varied according to whether States had licensure or certification requirements.

WHAT WE FOUND

In 2010, approximately half of CMHCs met or exceeded thresholds that indicated unusually high billing for at least one of nine questionable billing characteristics. Approximately one-third of these CMHCs had at least two of the characteristics. Additionally, approximately two-thirds of CMHCs with questionable billing were located in eight metropolitan areas. Finally, 90 percent of CMHCs with questionable billing were located in States that do not require CMHCs to be licensed or certified.

WHAT WE RECOMMEND

We recommend that CMS (1) increase its monitoring of CMHCs' Medicare billing and fraud prevention controls, (2) enforce the requirement that certifying physicians be listed on the PHP claims submitted by CMHCs, (3) finalize and implement the proposed conditions of participation for CMHCs, and (4) review and take appropriate action against CMHCs with questionable billing that we identified. CMS concurred with all four recommendations.

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OBJECTIVES

1. To identify questionable billing by community mental health centers (CMHC) in 2010.
2. To determine the extent to which questionable billing by CMHCs varied by geographic location and the existence of State licensure or certification requirements.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1990 authorized Medicare Part B to reimburse CMHCs for providing partial hospitalization programs (PHP).[1] PHPs are intense, structured, outpatient mental health treatment programs.[2] A CMHC provides PHPs for individuals with mental illness who reside in or near the community where the CMHC is located.[3] During 2010, 206 CMHCs received an estimated $218.6 million for providing PHP services to approximately 25,000 Medicare beneficiaries.

Past Office of Inspector General (OIG) studies found vulnerabilities in Medicare payments to CMHCs, such as billing for medically unnecessary or undocumented PHP services.[4] Additionally, four CMHC owners and managers in Miami-Dade County, Florida, were convicted of Medicare fraud in 2011. These individuals manipulated patients' charts, diagnoses, and lengths of stay to fraudulently bill Medicare approximately $200 million for medically unnecessary PHP services from 2002 to 2010.[5] This fraud scheme involved doctors, other providers, and marketers who referred Medicare beneficiaries to these CMHCs and received financial kickbacks.

[1] The Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, § 4162.

[2] Social Security Act, § 1861(ff)(3)(A), 42 U.S.C. § 1395x(ff)(3)(A).

[3] Social Security Act, § 1861(ff)(3)(B)(i)(I); Public Health Service Act, § 1913(c)(1); Centers for Medicare & Medicaid Services (CMS), *Medicare State Operations Manual*, Pub. No. 100-07, ch. 2, § 2252I; CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.4.1.1.A.

[4] OIG, *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers*, OAS-04-98-02145, October 1998; OIG, *Review of Partial Hospitalization Services Provided Through Community Mental Health Centers*, OAS-04-98-02146, October 1998.

[5] Department of Justice (DOJ), *Owner of Miami-area mental health care corporation convicted on all counts for orchestrating $205 million Medicare fraud scheme*. Accessed at http://www.justice.gov/opa/pr/2011/August/ on August 23, 2011.

PHP Services and Requirements

Beneficiaries who participate in PHPs must have mental disorders that severely interfere with multiple areas of their daily lives, including social, vocational, and/or educational functioning.[6] PHPs provide outpatient services to beneficiaries who have been discharged from inpatient psychiatric care. Beneficiaries can thus participate in PHPs in a community setting in lieu of continued inpatient care. PHPs also provide outpatient services to beneficiaries with mental disorders whose physicians certify that they would relapse or require hospitalization in the absence of PHPs.[7, 8] Additionally, Medicare beneficiaries may participate in PHPs only if services

- are reasonable and necessary for the diagnosis or active treatment of the individuals' conditions and
- are reasonably expected to improve or maintain the individuals' conditions.[9]

PHPs must offer a combination of individual, group, family, occupational, and activity therapies. Educational and diagnostic services may also be provided.[10] There are no specific limits on the length of time that Medicare covers PHPs.[11] However, participating beneficiaries must receive a minimum of 20 hours of services weekly.[12] Additionally, PHP beneficiaries must be able to cognitively participate in these services.[13] PHPs are not medically reasonable or necessary for beneficiaries who cannot actively participate because of a cognitive disorder, such as Alzheimer's disease or severe dementia.[14]

Physicians must develop an individualized treatment plan for each PHP beneficiary, which includes treatment goals and describes the coordinated

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[6] CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.

[7] 42 CFR § 410.43(a)(3), 42 CFR § 424.24(e), CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, §§ 70.3.B.1 and 70.3B.5.

[8] The national provider identifier for the certifiying physician is required on PHP claims. CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 25, § 75.5.

[9] Social Security Act, § 1861(ff)(2), 42 U.S.C. § 1395x(ff)(2).

[10] Social Security Act, § 1861(ff)(2), 42 U.S.C. § 1395x(ff)(2); 42 CFR § 410.43(a)(4); CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.2.

[11] CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.1.C.3.

[12] CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.

[13] Ibid.

[14] 42 CFR § 410.43(c)(7); CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.1.

services that will be provided.[15] The plan must include the type, amount, duration, and frequency of services.[16] The plan should also document continued efforts to restore the beneficiary to a higher level of functioning to permit discharge from the PHP. The plan must also demonstrate the continued need for PHP services to maintain the individual's condition and prevent relapse or hospitalization.[17]

Additionally, physicians must supervise PHP services and periodically evaluate beneficiaries to ensure that their treatment goals are being met. Physicians are required to recertify beneficiaries' need for PHP services 18 days after their admissions and at least every 30 days thereafter.[18]

Oversight of Medicare Participation and Billing by CMHCs

The Medicare program has limited ability to oversee the quality, health, and safety of care provided in CMHCs because these providers do not have conditions of participation (CoP). CoPs are standards that help ensure the quality and safety of Medicare and Medicaid providers' care.[19] However, in 2011, CMS proposed a rule to establish CoPs for CMHCs and noted that "there are currently only limited circumstances in which CMS can terminate a facility based on the result of a complaint investigation. Without CoPs in place, CMS' oversight of CMHCs is severely limited."[20] Additionally, CMHCs are not required to be accredited by an accreditation agency or licensed or certified by their States.[21] This is unlike CMS's oversight of other providers, such as hospitals and long-term-care facilities.

CMS Oversight of CMHCs. CMS regional offices are responsible for approving or denying CMHCs for Medicare participation. A regional office conducts one site visit to a CMHC when notified by a Medicare Administrative Contractor (MAC) that a CMHC has applied for Medicare enrollment and has been in operation for an entire business quarter.[22]

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[15] 42 CFR § 424.24(e)(2); CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.5.c.

[16] 42 CFR § 424.24(e)(2).

[17] CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.5.c.

[18] CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.5.b.

[19] CMS has developed CoPs for 19 provider types, including home health agencies, psychiatric hospitals, and long-term-care facilities. CMS, *Conditions for Coverage and Conditions of Participation*. Accessed at http://www.cms.gov/CFCsAndCoPs/ on June 17, 2011.

[20] 76 Fed. Reg. 35684 (June 17, 2011).

[21] Government Accountability Office (GAO), *Medicare: Lessons Learned From HCFA's Implementation of Changes to Benefits*, GAO-HEHS-0031, January 2000.

[22] CMS, *Medicare State Operations Manual*, Pub. No. 100-07, ch. 2, §§ 2250G and 2252.

However, in the proposed rule to establish CoPs, CMS noted that many "CMHCs have never had an onsite survey visit by CMS" after initial certification.[23, 24]

CMS contracts with MACs and Zone Program Integrity Contractors (ZPIC) to help ensure the financial integrity of Medicare payments, including those to CMHCs. MACs are responsible for ensuring correct, reliable, and timely payment of claims.[25] They implement claims processing edits to prevent improper payments, educate providers that make improper claims, and collect overpayments.

ZPICs ensure that Medicare funds are appropriately paid and that any improper payments are identified. They proactively identify potential fraud; investigate allegations of fraud; initiate administrative actions to deny or suspend payments where there is evidence of fraud; refer cases to OIG for criminal and civil investigation; and refer cases to CMS for administrative actions, including provider revocations.[26]

Additionally, CMS ensures the financial integrity of Medicare payments through its predictive analytics system. In June 2011, CMS implemented a predictive analytics system that analyzes all Medicare Parts A and B claims to identify potential fraud.[27] This system builds profiles of Medicare providers (e.g., CMHCs) that enable CMS to create risk scores.[28] These risk scores estimate the likelihood of fraud and identify potentially fraudulent claims and billing patterns.

State Oversight of CMHCs. CMHCs must meet applicable State licensing or certification requirements to participate in Medicare; however, not all States have such requirements.[29] The goal of State licensure or certification is to ensure that health care providers meet minimum State standards of quality and safety. States that require CMHCs to be licensed

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[23] 76 Fed. Reg. 35685 (June 17, 2011).

[24] We did not verify whether CMS conducted onsite survey visits prior to CMHCs' Medicare enrollment. Currently, OIG is conducting a study on CMS's and contractors' CMHC oversight activities. OEI-04-11-00101, in progress.

[25] CMS, *Part A and Part B MAC Statement of Work Jurisdiction F*, October 2010.

[26] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.2.2.

[27] CMS, *Predictive Modeling Analysis of Medicare Claims*, MLN Network, November 2011. Accessed at https://www.cms.gov/MLNMattersArticles/Downloads/SE1133.pdf on February 27, 2012.

[28] The predictive analytics system also builds profiles on networks, billing patterns, and beneficiary utilization.

[29] 42 CFR § 410.2.

or certified conduct regular site visits to ensure CMHCs' compliance with State requirements.[30]

Medicare Conditions of Participation and Accreditation. CMS can implement quality standards, such as CoPs, that providers must meet to participate in Medicare.[31] CMHCs do not currently have CoPs, but CMS proposed six CoPs for CMHCs in June 2011, which are expected to be implemented in 2014.[32] Implementation of these CoPs will authorize CMS to conduct regular CMHC site visits to verify compliance.[33]

Upon implementation of CoPs, CMS may also verify compliance with CoPs by using State survey and certification agencies or by granting deeming authority to accreditation organizations.[34] A provider seeking accreditation must submit an application to an accrediting organization and is subject to unannounced site visits. Using the application and site visit results, the accrediting organization determines whether to accredit the provider.[35] Accreditation is required for certain Medicare providers, such as durable medical equipment suppliers.[36] However, CMS currently does not have the statutory authority to grant deeming authority to accreditation organizations for CMHCs. Therefore, these providers are not subject to accreditation requirements.[37]

Related OIG Work

In 1998, OIG found that in a 12-month period, Medicare paid $229 million for unallowable and highly questionable PHP services provided by

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[30] The frequency of site visits varies by State. Site visits may be required yearly, biennially, every 3 years, etc.

[31] 42 CFR part 485.

[32] The six proposed CoPs are personnel qualifications; client rights; admission, initial evaluation, comprehensive assessment, and discharge or transfer of the client; treatment team, client-centered active treatment plan, and coordination of services; quality assessment and performance improvement; and organization, governance, administration of services, and partial hospitalization services. 76 Fed. Reg. 35684–35711 (June 17, 2011).

[33] Ibid.

[34] Having deeming authority means being able to officially determine whether a facility is in compliance with Medicare and Medicaid requirements. Social Security Act §1865(a)(1), 42 CFR 488.6, 76 Fed. Reg. 35685 (June 17, 2011).

[35] CMS, *DMEPOS Accreditation Presentation*. Accessed at http://www.cms.gov/MedicareProviderSupEnroll/downloads/DMEPOSAccreditationPresentation.pdf on March 20, 2012.

[36] The Medicare Improvements for Patients and Providers Act of 2008, P.L. 110-275 § 154(b)(1), required all durable medical equipment, prosthetics, orthotics, and suppliers to meet quality standards for Medicare accreditation by October 1, 2009.

[37] A statutory change is required to use accreditation organizations to verify CMHCs' compliance with CoPs.

14 CMHCs in 5 States. Through medical record review, OIG found that 91 percent (4,959 of 5,431) of the PHP services reviewed did not meet Medicare requirements for reimbursement because: (1) the beneficiaries were ineligible for services, (2) services were not medically reasonable or necessary for the beneficiaries' condition, (3) services were not properly authorized by or furnished under the supervision of physicians, or (4) services were not adequately documented.[38] Additionally, OIG found that 60 percent of all States do not require CMHCs to be licensed or certified.[39] This creates a vulnerability whereby dishonest individuals have an opportunity to establish CMHCs and improperly bill Medicare for PHP services.

In 1999, OIG assessed the appropriateness of Medicare payments for mental health services provided in practitioners' offices, CMHCs, beneficiaries' homes, and custodial care facilities.[40] Of the 303 medical records reviewed, 22 percent revealed that beneficiaries received mental health services beyond what was medically reasonable and necessary. Further, these excessive mental health services were often provided in beneficiaries' homes or by CMHCs.[41]

OIG is conducting a study on the extent to which CMS and its contractors performed oversight activities to detect and deter fraudulent CMHC billing.[42]

METHODOLOGY

We analyzed Medicare PHP claims submitted by all 206 CMHCs in 2010.[43] We also analyzed claims from CMS's National Claims History Carrier (i.e., physician) and Inpatient Standard Analytical Files (i.e., inpatient) from 2009 and 2010.[44] We used the beneficiaries' Health Insurance Claim Numbers to associate their 2009 and 2010 physician and

[38] OIG, *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers*, OAS-04-98-02145, October 1998; OIG, *Review of Partial Hospitalization Services Provided Through Community Mental Health Centers*, OAS-04-98-02146, October 1998.

[39] Ibid.

[40] Mental health services include PHP services such as group, individual, and family therapy. Medicare pays CMHCs only for PHP services.

[41] OIG, *Medicare Part B Payments for Mental Health Services*, OEI-03-99-00130, May 2001.

[42] OEI-04-11-00101, in progress.

[43] We identified Medicare PHP claims submitted by CMHCs in CMS's National Claims History Outpatient file with bill type 76, indicating that the claim was for PHP services. We excluded three CMHCs with a Medicare reimbursement amount of $0 in 2010.

[44] We identified these claims in the Medicare physician National Claims History file with place of service code 53, indicating the service was provided at a CMHC.

inpatient claims with their 2010 PHP claims. These claims were used to identify diagnoses and gather information about the types of services beneficiaries received that were not on the PHP claims.

We matched National Provider Identifiers in the National Plan and Provider Enumeration System and on the PHP claims to obtain addresses for each CMHC. Only 25 States have CMHCs that receive Medicare payments.[45] See Appendix A for the amount of Medicare payments made to CMHCs in each of those States. Additionally, we used CMS's 2010 Enrollment Database to obtain addresses for each beneficiary who received PHP services at a CMHC in 2010.

Finally, we reviewed State health facility licensing and mental health department Web sites and contacted State officials in these departments to determine which States require CMHCs to be licensed or certified.

Identification of CMHCs With Questionable Billing

We first identified all Medicare PHP claims submitted by CMHCs with dates of service ending in 2010. We identified 273,561 claims billed by 206 CMHCs. We also identified all Medicare physician and inpatient claims with dates of service ending in 2009 and 2010. We identified 5.3 million physician claims and 71,602 inpatient claims submitted for the 24,703 beneficiaries who participated in PHPs at CMHCs.

Based on past OIG work and input from CMS staff familiar with fraudulent PHP billing by CMHCs, we developed nine CMHC questionable billing characteristics.

To ensure reliability of the analysis of each characteristic, we focused our analysis of questionable billing on CMHCs that had at least five beneficiaries and were paid at least $10,000 for PHP services in 2010. Eleven of the 206 CMHCs did not meet these criteria. In total, 195 CMHCs were included in this analysis. We calculated the percentage of beneficiaries at each CMHC with each questionable billing characteristic. We considered a CMHC's billing to be unusually high, or questionable, on a characteristic if the percentage of beneficiaries was greater than the 75th percentile plus 1.5 times the interquartile range.[46] The nine characteristics are described below:

1. *Beneficiaries who received only group psychotherapy during their PHP participation*. PHPs must offer a combination of services to treat

[45] CMHCs were located in 24 States and 1 U.S. territory (Puerto Rico). Hereinafter we refer to the 24 States and Puerto Rico collectively as States.

[46] This is a standard exploratory method for identifying members of a population with unusually high values on a given statistic compared to the rest of the population when no benchmarks exist. See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.

beneficiaries' mental health conditions. Past OIG studies found that beneficiaries in CMHCs were likely to receive more group psychotherapy sessions than necessary.[47] Further, CMHCs that provide exclusively group psychotherapy to beneficiaries may be billing for services that are not medically necessary or therapeutic. We identified CMHCs with questionable billing based on the percentage of beneficiaries in each CMHC that had claims indicating only group psychotherapy, Healthcare Common Procedure Coding System (HCPCS) codes G0410 and G0411. See Appendix B for a list of services and the accompanying HCPCS codes used on PHP claims.

2. *Beneficiaries who were not referred to PHPs by health care facilities.* Beneficiaries admitted to PHPs must be under the care of physicians who certify the need for PHP services.[48] Beneficiaries who present themselves (i.e., are not referred by health care facilities) to the CMHCs with orders from the physicians raise questions about whether they were evaluated by physicians and eligible for PHP services. Additionally, past OIG studies have found that some beneficiaries were not certified by physicians to participate in PHPs.[49] We identified CMHCs with questionable billing based on the percentage of beneficiaries in each CMHC with referral code 1 on their PHP claims, indicating that the beneficiaries presented themselves to CMHCs, rather than being transferred from health care facilities.

3. *Beneficiaries who were not evaluated by physicians during their PHP participation*. Physicians must develop an individualized treatment plan for each beneficiary receiving PHP services, which includes treatment goals and describes the coordinated services that will be provided through the PHP. Physicians must also supervise the delivery of PHP services and periodically evaluate beneficiaries to ensure that their treatment goals are being met. Past OIG studies have found that the medical records of PHP beneficiaries lacked physician evaluations, signed plans of care, orders for services, and/or physician progress notes.[50] We identified CMHCs with questionable billing based on the percentage of beneficiaries in each CMHC that did not have PHP or

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[47] OIG, *Medicare Part B Payments for Mental Health Services*, OEI-03-99-00130, May 2001.

[48] 42 CFR § 410.43(a)(3), 42 CFR § 424.24(e), CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, §§ 70.3.B.1 and 70.3B.5.

[49] OIG, *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers*, OAS-04-98-02145, October 1998; OIG, *Review of Partial Hospitalization Services Provided Through Community Mental Health Centers*, OAS-04-98-02146, October 1998.

[50] Ibid.

physician claims indicating professional services by a physician during their PHP participation in 2010.[51]

4. *Beneficiaries with no mental health diagnoses a year prior to participating in PHPs.* Beneficiaries must have mental health disorders that severely interfere with multiple areas of their daily lives, including social, vocational, and/or educational functioning. Past OIG studies have found, and recent convictions of CMHC owners and managers have illustrated, that beneficiaries with no prior histories of mental disorders often received PHP services that were not medically reasonable or necessary.[52, 53] The absence of records of prior inpatient treatment or physician visits for mental disorders raises concerns about whether PHP services were medically reasonable or necessary. We used 2009 and 2010 physician and inpatient claims data to determine whether each beneficiary receiving PHP services at a CMHC had a mental health diagnosis on other Medicare claims prior to receiving PHP services in 2010. We identified CMHCs with questionable billing based on the percentage of beneficiaries in each that did not have a mental health diagnosis between January 1, 2009, and their first date of PHP service in 2010.

5. *Beneficiaries who participated in PHPs at CMHCs outside their communities.* Past OIG work identified concerns regarding PHP services provided to Medicare beneficiaries outside their communities. Beneficiaries who participate in PHPs outside their communities raise concerns about CMHCs' obtaining beneficiary Medicare numbers and billing for services that were not provided or providing PHP services that were not medically reasonable or necessary. We determined the threshold for excessive distances from the CMHC to be 102 miles.[54] We then identified CMHCs with questionable billing based on the percentage of beneficiaries who resided more than 102 miles away.

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[51] We used physician claims because the professional services of physicians, such as psychological assessments and medication management, are not paid as PHP services. Claims for professional services are submitted and paid separately.

[52] OIG, Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers, OAS-04-98-02145, October 1998; OIG, Review of Partial Hospitalization Services Provided Through Community Mental Health Centers, OAS-04-98-02146, October 1998.

[53] DOJ, op. cit.

[54] We determined this distance by using a standard exploratory method for identifying members of a population with unusually high values on a given statistic compared to the rest of the population when no benchmarks exist. See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.

6. *Beneficiaries who participated in PHPs at more than one CMHC.* OIG data analysis indicates that the majority (86 percent) of PHP beneficiaries receive services at one CMHC.[55] Therefore, a high percentage of beneficiaries who participated in PHPs at more than one CMHC may indicate that providers have worked together to share beneficiaries. Sharing beneficiaries is a common fraud scheme and may involve cooperation between managers, physicians, and marketers to solicit beneficiaries or beneficiary Medicare numbers.[56] Beneficiaries who participate in PHPs at more than one CMHC also raise concerns about whether the PHP services were provided and were medically reasonable and necessary. We identified CMHCs with questionable billing based on the percentage of beneficiaries in each CMHC that participated in PHPs at more than one CMHC.

7. *Beneficiaries with cognitive disorders who participated in PHPs.* PHPs are not medically reasonable or necessary for beneficiaries who cannot actively participate because of cognitive disorders, such as Alzheimer's disease or severe dementia. Past OIG studies and recent convictions of CMHC owners and managers have shown that beneficiaries with Alzheimer's disease or severe dementia were receiving PHP services at some CMHCs.[57, 58] Using 2010 physician and inpatient claims, we identified beneficiaries with cognitive disorders who participated in PHPs. See Appendix C for the the diagnosis codes and associated descriptions. We identified CMHCs with questionable billing based on the percentage of beneficiaries in each CMHC with these diagnosis codes.

8. *Beneficiaries with long durations of PHP participation*. There are no specific limits on the length of time that Medicare covers PHPs. CMHC owners and managers have been convicted of Medicare fraud for abusing the ability to bill for PHPs for long periods of time. These individuals manipulated the length of beneficiaries' stays to maximize the number of days Medicare would pay for PHP. We determined the

[55] OIG 2010 Medicare PHP claims data.

[56] CMHC owners and managers, physicians, marketers, and other providers have been convicted of Medicare fraud for working together to solicit beneficiaries to attend CMHCs. DOJ, op. cit.

[57] OIG, Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers, OAS-04-98-02145, October 1998; OIG, Review of Partial Hospitalization Services Provided Through Community Mental Health Centers, OAS-04-98-02146, October 1998.

[58] DOJ, op. cit.

threshold for a long duration of PHP participation to be 147 days.[59] We then identified CMHCs with questionable billing based on the percentage of beneficiaries who received over 147 days of PHP services from the CMHCs.

9. *Beneficiaries who were readmitted to inpatient treatment.* Medicare beneficiaries are eligible for participation in PHPs only if services will prevent relapse or hospitalization. The relapse of a severely mentally ill beneficiary might be unavoidable, but a high percentage of beneficiaries readmitted to inpatient treatment after receiving PHP services at a CMHC raises concerns because PHPs are intended to prevent relapse and hospitalization. Additionally, as shown by past OIG work, CMHCs may discharge beneficiaries to inpatient treatment and then readmit them to avoid questions about lengths of stay. Using 2010 PHP and inpatient claims, we identified beneficiaries who were readmitted to inpatient treatment after PHP services and then returned to the CMHCs.[60] We identified CMHCs with questionable billing based on the percentage of beneficiaries who were readmitted to inpatient treatment and then returned to the CMHCs.

Geographic Analysis of CMHCs With Questionable Billing

We determined whether CMHCs with questionable billing were concentrated in certain metropolitan areas.[61] To do this, using each CMHC's address, we first identified each CMHC's Core Based Statistical Area (CBSA). A CBSA is a region around an urban center that has at least 10,000 people.[62] CBSAs may be categorized as metropolitan or micropolitan. We determined the total number of CMHCs in each metropolitan area and the number of CMHCs that had questionable

[59] We established this duration of stay by using a standard exploratory method for identifying members of a population with unusually high values on a given statistic compared to the rest of the population when no benchmarks exist. See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.

[60] We identified beneficiaries who were in inpatient stays with mental health diagnoses, were discharged to CMHCs within 2 days, and were then readmitted to inpatient treatment with mental health diagnoses within 2 days of discharge from the CMHCs. We also identified beneficiaries who were receiving PHP services and were admitted to inpatient treatment with mental health diagnoses within 2 days of discharge from CMHCs, then readmitted to the CMHCs within 2 days of discharge from inpatient treatment.

[61] We used census data and each CMHC's address to identify the metropolitan area of each. A "metropolitan area" is defined as a core urban area with a population of 50,000 people or more. A "micropolitan area" is defined as a core urban area with a population of at least 10,000, but fewer than 50,000 people. U.S. Census Bureau, *Metropolitan and Micropolitan Definition Files*. Accessed at http://www.census.gov/population/metro/data/def.html on January 10, 2012.

[62] Ibid.

billing.[63] We then calculated the percentage of CMHCs that had questionable billing in each metropolitan area.

State Licensure or Certification Analysis of CMHCs With Questionable Billing

We reviewed State health facility licensing and mental health department Web sites and contacted State officials in these departments to determine whether their States require CMHCs to be licensed or certified. We determined whether questionable billing by CMHCs varied according to whether States had licensure or certification requirements for CMHCs. We analyzed the total number of CMHCs and the number of CMHCs that had questionable billing based on license or certification requirements.

Limitations

The findings in this report are based on our analysis of PHP claims submitted during 2010 and cannot be generalized to any other period.

The nine questionable billing characteristics included in our analysis are not intended to be a comprehensive set of characteristics for identifying Medicare CMHC questionable billing. Additionally, while the presence of these characteristics raises questions about the appropriateness of the PHP claims submitted by CMHCs, we did not conduct a medical record review to determine whether the services billed by CMHCs were inappropriate or fraudulent.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[63] CMHCs were located in 54 metropolitan areas. To ensure reliability of the geographic analysis, we excluded all micropolitan areas and metropolitan areas that did not have at least three CMHCs.

FINDINGS

In 2010, approximately half of CMHCs had questionable billing

In 2010, 102 of 195 (52 percent) CMHCs met or exceeded the threshold that indicated unusually high billing for at least 1 of 9 questionable billing characteristics.

Approximately one-third of the CMHCs with questionable billing met or exceeded the thresholds for multiple characteristics we developed. Specifically, 33 CMHCs met or exceeded the thresholds for 2 or more characteristics, and 2 CMHCs met or exceeded the thresholds for 4 characteristics. None of the CMHCs met or exceeded the thresholds on more than four characteristics. See Table 1 for the number and percentage of CMHCs by the number of questionable billing characteristics.

Table 1: Number and Percentage of Questionable Billing Characteristics for Which CMHCs Met or Exceeded Unusually High Billing Thresholds, 2010

Number of Questionable Billing Characteristics	Number of CMHCs	Percentage of CMHCs
0	93	48%
1	69	35%
2	25	13%
3	6	3%
4	2	1%
Total	**195**	**100%**

Source: OIG analysis of 2010 Medicare PHP, physician, and inpatient claims.

For each questionable billing characteristic, Table 2 shows the median among all CMHCs, the range of unusually high billing, and the number of CMHCs with unusually high billing. Additionally, Table 2 includes the threshold for each characteristic that indicated questionable billing.[64]

[64] We determined these thresholds by using a standard exploratory method for identifying members of a population with unusually high values on a given statistic compared to the rest of the population when no benchmarks exist. See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.

Table 2: CMHCs With Unusually High Billing by Questionable Billing Characteristic, 2010

Questionable Billing Characteristic	Median Among All CMHCs*	CMHCs With Unusually High Billing**		
		Threshold	Range of Billing	Number of CMHCs
Beneficiaries who received only group psychotherapy during their PHP participation	0 percent	6 percent	6 to 100 percent	43
Beneficiaries who were not referred to PHPs by health care facilities	0 percent	9 percent	10 to 100 percent	35
Beneficiaries who were not evaluated by physicians during their PHP participation	2 percent	13 percent	15 to 72 percent	21
Beneficiaries with no mental health diagnoses prior to participating in PHPs	1 percent	10 percent	10 to 24 percent	16
Beneficiaries who participated in PHPs at CMHCs outside their communities	2 percent	15 percent	15 to 72 percent	15
Beneficiaries who participated in PHPs at more than one CMHC	16 percent	66 percent	66 to 97 percent	5
Beneficiaries with cognitive disorders who participated in PHPs	12 percent	40 percent	40 to 50 percent	4
Beneficiaries with long durations of PHP participation	1 percent	44 percent	46 to 50 percent	3
Beneficiaries who were readmitted to inpatient treatment	10 percent	29 percent	30 to 55 percent	3
Total* **				**102**

* The median (i.e., the 50th percentile) indicates that half of all CMHCs were equal to or fell below this value.
** We considered a CMHC's billing to be unusually high if it was greater than the 75th percentile plus 1.5 times the interquartile range.
*** The columns do not sum to the totals because some CMHCs met or exceeded the threshold for more than one characteristic.
Source: OIG analysis of 2009 and 2010 Medicare PHP, physician, and inpatient claims.

In 2010, 43 CMHCs had unusually high percentages of beneficiaries who received only group psychotherapy during their PHP participation

CMHCs that provide only group psychotherapy raise concern because PHPs must offer a combination of services. Further, the CMHCs may be billing for group psychotherapy that is not medically necessary or therapeutic. The percentages of beneficiaries who received only group psychotherapy during their PHP participation at these 43 CMHCs ranged from 6 to 100 percent. At over one-third of these CMHCs (15 of 43), more than 50 percent of beneficiaries received only group psychotherapy.

In 2010, 35 CMHCs had unusually high percentages of beneficiaries who were not referred to PHP by health care facilities

Beneficiaries must have been under the care of physicians who certified the need for PHPs before they can receive such services. However, beneficiaries who present themselves (i.e., were not referred by health care facilities) to the CMHCs may have no record of PHP certification. A high percentage of beneficiaries who present themselves to the CMHCs with orders from physicians raises questions about whether they were evaluated by physicians and eligible for PHP services. The percentages of such

beneficiaries at these CMHCs ranged from 10 to 100 percent. At over half of these CMHCs (19 of 35), 100 percent of beneficiaries were not referred to PHPs by health care facilities.

In 2010, 21 CMHCs had unusually high percentages of beneficiaries who were not evaluated by physicians during their PHP participation

Beneficiaries at these 21 CMHCs did not have claims with HCPCS codes indicating that physician services occurred during their PHP participation for the entire year we reviewed. A high percentage of beneficiaries who were not evaluated by physicians raises concerns about whether services were medically reasonable and necessary. The percentages of such beneficiaries at these 21 CMHCs ranged from 15 to 72 percent. Out of the 282 beneficiaries receiving PHP services at 1 CMHC in Miami-Dade County, Florida, 203 were not evaluated by physicians during their PHP participation.

In 2010, 16 CMHCs had unusually high percentages of beneficiaries with no mental health diagnoses prior to participating in PHPs

Beneficiaries must have mental disorders that severely interfere with multiple areas of their daily lives, including social, vocational, and/or educational functioning. The absence of prior inpatient treatment or physician visits for a mental disorder raises concerns about whether PHP services were medically reasonable and necessary. The percentages of such beneficiaries at these 16 CMHCs ranged from 10 to 24 percent.

In 2010, 15 CMHCs had unusually high percentages of beneficiaries who participated in PHPs at CMHCs outside their communities

A high percentage of beneficiaries that participated in PHPs at CMHCs outside their communities are a concern because the CMHCs may be offering financial kickbacks, obtaining beneficiary Medicare numbers and billing for services that were not provided, or providing PHP services that are not reasonable or necessary. The percentages of such beneficiaries at these 15 CMHCs ranged from 15 to 72 percent. One of these CMHCs, in Broward County, Florida, billed for a beneficiary who resided in Maui County, Hawaii–over 4,000 miles away. The other 77 beneficiaries at this CMHC resided an average of nearly 550 miles away.

In 2010, 15 CMHCs met or exceeded thresholds that indicated questionable billing for other characteristics

Fifteen CMHCs met or exceeded thresholds that indicated questionable billing for at least one of the other four characteristics we developed.

These characteristics were the percentages of beneficiaries who (1) participated in PHPs at other CMHCs, (2) had inappropriate diagnoses for participation in PHPs, (3) had long durations of PHP participation, and (4) were readmitted to inpatient treatment.

Participation in PHPs at Other CMHCs. Five CMHCs had unusually high percentages of beneficiaries who participated in PHPs at more than one CMHC. This may indicate that CMHCs have shared beneficiaries. Additionally, this raises concerns about whether the PHP services were medically reasonable and necessary and whether the services were provided. Three of these five CMHCs had beneficiaries who participated in PHPs at five different CMHCs during 2010.

Cognitive Disorders During PHP Participation. Four CMHCs had unusually high percentages of beneficiaries with cognitive disorders (e.g., Alzheimer's disease or severe dementia) who participated in PHPs. This may indicate that these CMHCs inappropriately billed for services that are not medically reasonable or necessary. Of the 140 beneficiaries served by these 4 CMHCs, 61 percent (85 beneficiaries) had dementia and 31 percent (43 beneficiaries) had Alzheimer's disease diagnoses.

Long Durations of PHP Participation. Three CMHCs had unusually high percentages of beneficiaries who had long durations (i.e., over 147 days) of PHP participation. This may indicate that the CMHCs are providing PHP services that are not medically reasonable or necessary. One of these CMHCs had three beneficiaries who received PHP services for almost the entire year (362 days).

Readmission to Inpatient Treatment. Three CMHCs had unusually high percentages of beneficiaries who were readmitted to inpatient treatment after PHP participation. This may indicate that the CMHCs are providing PHP services that are not preventing relapse and hospitalization, as intended. The percentages of beneficiaries who were readmitted to inpatient treatment and then returned to these three CMHCs ranged from 30 to 55 percent.

Approximately two-thirds of CMHCs with questionable billing were located in eight metropolitan areas

In 2010, 8 of 11 metropolitan areas with at least 3 CMHCs had higher percentages of CMHCs with questionable billing than the national

percentage.[65] The percentages in these metropolitan areas ranged from 61 to 100 percent, compared to the national percentage of 52 percent. These metropolitan areas made up 69 percent (70 of 102) of all CMHCs with questionable billing. All were located in Florida, Louisiana, and Texas. Table 3 shows the number and percentage of CMHCs in these eight areas. The remaining 26 CMHCs with questionable billing were dispersed among 22 other metropolitan areas.

Table 3: Metropolitan Areas With a Higher Percentage of CMHCs With Questionable Billing Than the National Percentage, 2010

Metropolitan Area	Number of CMHCs With Questionable Billing	Total Number of CMHCs	Percentage of CMHCs With Questionable Billing
Jacksonville, FL	3	3	100%
Houston, TX	13	16	81%
Tampa, FL	5	7	71%
Lafayette, LA	2	3	67%
San Antonio, TX	2	3	67%
Houma, LA*	2	3	67%
Miami, FL	32	52	62%
Baton Rouge, LA	11	18	61%
Total	**70**	**102**	**69%**
National	**102**	**195**	**52%**

*Indicates Houma-Bayou Cane-Thibodaux metropolitan area.
Source: OIG analysis of 2009 and 2010 Medicare PHP, physician, and inpatient claims.

The Miami metropolitan area had a higher percentage of CMHCs with questionable billing than the national percentage for six of the nine characteristics. The Baton Rouge metropolitan area had a higher percentage of CMHCs with questionable billing than the national percentage for five of the nine characteristics. See Appendix D for additional information about these eight metropolitan areas by characteristic.[66]

Ninety percent of CMHCs with questionable billing were in States that do not require CMHCs to be licensed or certified

In 2010, approximately half (13 of 24) of States with CMHCs did not require CMHCs to be licensed or certified. Most (167 of 195) of the CMHCs and the majority (92 of 102) of CMHCs with questionable billing were located in these States.

[65] Of the 102 CMHCs with questionable billing, 96 were located in 31 metropolitan areas, 4 were located in micropolitan areas (a core urban area with between 10,000 and 50,000 people), and 2 were located in rural areas. However, this analysis focused on the 11 metropolitan areas that had at least 3 CMHCs.

[66] The other three metropolitan areas included in this analysis were New Orleans, Boston, and Shreveport.

Approximately half (92 of 167) of CMHCs in States that did not require CMHCs to be licensed or certified had questionable billing, and approximately one-third (10 of 28) of CMHCs in other States had questionable billing. Further, States that require CMHCs to be licensed or certified had no CMHCs with questionable billing for five of the nine questionable billing characteristics. Table 4 compares CMHCs with questionable billing in States with and without licensure and certification requirements by characteristic.

Table 4: CMHCs With Questionable Billing Characteristics by State Licensure or Certification Requirements, 2010

	States With Licensure/Certification		States Without Licensure/Certification	
Questionable Billing Characteristic	**Total CMHCs With Questionable Billing**	**Percentage of CMHCs With Questionable Billing (N=28)**	**Total CMHCs With Questionable Billing**	**Percentage of CMHCs With Questionable Billing (N=167)**
Beneficiaries who received only group psychotherapy during their PHP participation	7	25%	36	22%
Beneficiaries who were not referred to PHPs by health care facilities	5	18%	30	`18%
Beneficiaries who were not evaluated by physicians during their PHP participation	1	4%	20	12%
Beneficiaries with no mental health diagnoses prior to participating in PHP	0	0%	16	10%
Beneficiaries who participated in PHPs at CMHCs outside their communities	0	0%	15	9%
Beneficiaries who participated in PHPs at more than one CMHC	0	0%	5	3%
Beneficiaries with cognitive disorders who participated in PHPs	1	4%	3	2%
Beneficiaries with long durations of PHP participation	0	0%	3	2%
Beneficiaries who were readmitted to inpatient treatment	0	0%	3	2%
Total*	**10**	**36%**	**92**	**55%**

*The columns do not sum to the totals because some CMHCs met or exceeded the threshold for more than one characteristic.

Sources: OIG analysis of 2009 and 2010 Medicare PHP, physician, and inpatient claims and State Web sites.

CONCLUSION AND RECOMMENDATIONS

In 2010, Medicare paid approximately $218.6 million to 206 CMHCs for PHP services. Past OIG studies have found vulnerabilities in Medicare payments to CMHCs for PHPs. Additionally, in 2011, four CMHC owners and managers in Miami-Dade County, Florida, were convicted of fraudulently billing Medicare approximately $200 million for medically unnecessary PHP services from 2002 to 2010.

Approximately half of CMHCs had questionable billing for at least one of the nine OIG characteristics we reviewed. Approximately one-third of the CMHCs with questionable billing met or exceeded the threshold for at least two of the nine characteristics. The presence of these characteristics raises questions about the appropriateness of the PHP claims submitted by these CMHCs. However, we did not conduct a medical record review to determine whether the services billed by CMHCs were fraudulent.

Additionally, 8 of 11 metropolitan areas with at least 3 CMHCs had higher percentages of CMHCs with questionable billing than the national percentage. Finally, 90 percent of the CMHCs with questionable billing were located in States that do not require CMHCs to be licensed or certified. All eight metropolitan areas with a higher percentage of CMHCs with questionable billing than the national percentage were located in these States.

Collectively, these findings identify specific vulnerabilities in Medicare payments to CMHCs for PHPs that should be addressed to safeguard the Medicare program.

We recommend that CMS:

Increase its monitoring of CMHCs' Medicare Billing and Fraud Prevention Controls

When using its predictive analytics system to identify CMHCs with high fraud risk scores, CMS should consider, at a minimum, including the OIG questionable billing characteristics used in this evaluation. Further, to increase fraud prevention controls, CMS should instruct MACs to develop and implement national claims processing edits based on these characteristics, as appropriate. For example, edits can be developed or expanded to check for beneficiaries with cognitive disorders.

Additionally, CMS should instruct ZPICs in the identified eight metropolitan areas to monitor CMHCs' billing for PHPs using, at a minimum, these characteristics.

Enforce the Requirement That Certifying Physicians Be Listed on the PHP Claims Submitted by CMHCs

Beneficiaries admitted to PHPs must be under the care of physicians who certify the need for PHP services. CMS should enforce the *Medicare Claims Processing Manual* requirement that the certifying physician be listed on the PHP claim submitted by CMHCs. This provides additional information for CMS to use to verify whether the PHP services billed by CMHCs were medically reasonable and necessary.

Finalize and Implement the Proposed CoPs for CMHCs

CMS should finalize its proposed CoPs for CMHCs and implement them as soon as possible. Without them, the Medicare program has limited ability to oversee the quality, health, and safety of care provided in CMHCs. In States that oversee CMHCs through licensure or certification requirements, CMHCs had lower rates of questionable billing compared to rates in States with no licensure or certification requirements. Similarly, CoPs can help to ensure that all CMHCs are subject to a consistent level of oversight.

Furthermore, after finalizing the CoPs for CMHCs, CMS should establish an appropriate minimum survey cycle to verify CMHCs' compliance with the CoPs. In doing so, CMS should consider seeking statutory authority, if necessary, to grant deeming authority to accreditation organizations. This can assist CMS in ensuring that CMHCs are surveyed according to the established survey cycle.

Review and Take Appropriate Action Against CMHCs With Questionable Billing

In a separate memorandum, we will refer the CMHCs with questionable billing that we identified to CMS for appropriate action. CMS could determine whether the services billed by these CMHCs were inappropriate or fraudulent by conducting medical record reviews; conducting site visits, particularly in States that do not require CMHCs to be licensed or certified; implementing prepay reviews; or referring CMHCs to law enforcement for investigation.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations and provided information about its efforts to address vulnerabilities in Medicare payments to CMHCs for PHPs. Specifically, CMS will provide ZPICs with a copy of this report to incorporate OIG's questionable billing characteristics into their business and investigative processes as appropriate. CMS will also consider incorporating these characteristics into its Fraud Prevention System models. Finally, these characteristics will be considered in the development of a pilot project focused on CMHCs in the three highest risk States of Florida, Texas, and Louisiana.

With regard to the second recommendation, CMS will develop an edit in the claims processing system to ensure that the certifying physicians are listed on the PHP claims submitted by CMHCs.

With regard to the third recommendation, CMS expects to publish the final rule for CMHC CoPs in the spring of 2013. CMS plans to establish a 5-year survey cycle to verify a CMHC's compliance with CoPs. Additionally, CMS will consider seeking statutory authority to grant deeming status to accreditation organizations.

With regard to our fourth recommendation, CMS will share the CMHCs with questionable billing identified in this report with MACs to consider when prioritizing their work. CMS will also share information about these CMHCs with Recovery Audit Contractors to consider as they decide which claims processed by MACs to review.

We support CMS's efforts to address these issues and encourage it to continue making progress. For the full text of CMS's comments, see Appendix E.

APPENDIX A

Number of Community Mental Health Centers and Medicare Payments in Each State, 2010		
State	**Total Number of CMHCs**	**Total Medicare Payment**
Florida	72	$82,389,314
Louisiana	57	$60,725,138
Texas	23	$50,403,363
Mississippi	4	$6,728,693
Tennessee	4	$4,007,575
Massachusetts	10	$3,192,482
Georgia	3	$2,153,531
North Carolina	1	$2,135,432
South Carolina	1	$1,630,377
California	4	$1,614,811
Alabama	6	$841,167
Michigan	1	$748,687
Arizona	1	$541,137
West Virginia	1	$270,169
Connecticut	2	$259,370
Maryland	1	$250,238
New York	1	$177,722
Minnesota	3	$121,685
Illinois	2	$113,998
Nebraska	1	$102,492
Pennsylvania	4	$67,346
Utah	1	$55,915
Iowa	1	$49,584
Missouri	1	$16, 815
Puerto Rico	1	$1,078
Total	**206**	**$218.6 million**

Source: Office of Inspector General analysis of 2010 Medicare Partial Hospitalization Program claims data.

APPENDIX B

Healthcare Common Procedure Coding System Codes Used on Partial Hospitalization Program Claims	
Code	**Description**
90801 or 90802	Behavioral Health Treatments/Services
90801, 90802, 90899	Psychiatric General Services
90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, 90880	Individual Psychotherapy
90846 or 90847	Family Psychotherapy
96101, 96102, 96116, 96118, 96119, or 96120	Psychiatric Testing
G0129	Occupational Therapy
G0176	Activity Therapy
G0410 or G0411	Group Psychotherapy
G0177	Education Training

Source: Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 260.1.1.

APPENDIX C

Number of Beneficiaries With Cognitive Disorders Who Participated in Partial Hospitalization Programs, 2010		
Diagnosis Code	**Description**	**Number of Beneficiaries***
3310	Alzheimer's disease	1,254
29410	Dementia in conditions classified elsewhere without behavioral disturbance	683
29411	Dementia in conditions classified elsewhere with behavioral disturbance	423
317	Mild intellectual disabilities	404
2900	Senile dementia, uncomplicated	361
319	Unspecified intellectual disabilities	353
29040	Vascular dementia, uncomplicated	205
33183	Mild cognitive impairment, so stated	168
29043	Vascular dementia, with depressed mood	119
29021	Senile dementia with depressive features	115
29020	Senile dementia with delusional features	109
3109	Unspecified nonpsychotic mental disorder following organic brain damage	105
33182	Dementia with Lewy bodies	100
29010	Presenile dementia, uncomplicated	95
29013	Presenile dementia with depressive features	77
3180	Moderate intellectual disabilities	73
2903	Senile dementia with delirium	51
29041	Vascular dementia, with delirium	50
29042	Vascular dementia, with delusions	43
29012	Presenile dementia with delusional features	25
29011	Presenile dementia with delirium	18
2908	Other specified senile psychotic conditions	18
2909	Unspecified senile psychotic conditions	17
3181	Severe intellectual disabilities	10
33119	Other frontotemporal dementia	10
3182	Profound intellectual disabilities	4

*Some beneficiaries had more than one cognitive disorder during partial hospitalization program (PHP) participation.
Sources: Centers for Medicare & Medicaid Services, Version 28 Full and Abbreviated Diagnosis Code Titles, Office of Inspector General analysis of 2010 Medicare PHP, physician, and inpatient claims.

APPENDIX D

Percentage of Community Mental Health Centers With Questionable Billing by Metropolitan Area and Characteristic, 2010									
Questionable Billing Characteristic	**National (N=102)**	**Jacksonville (N=3)**	**Houston (N=13)**	**Tampa (N=5)**	**Lafayette (N=2)**	**San Antonio (N=2)**	**Baton Rouge (N=11)**	**Houma (N=2)**	**Miami (N=32)**
Beneficiaries who received only group psychotherapy during their partial hospitalization program (PHP) participation	42%	33%	**54%**	20%	0%	**100%**	0%	0%	**53%**
Beneficiaries who were not referred to PHPs by health care facilities	34%	**100%**	**85%**	**80%**	0%	0%	0%	0%	22%
Beneficiaries who were not evaluated by physicians during their PHP participation	21%	**33%**	0%	0%	0%	0%	**55%**	0%	**25%**
Beneficiaries with no mental health diagnoses a year prior to participating in PHPs	16%	0%	0%	0%	0%	0%	**27%**	**100%**	**19%**
Beneficiaries who participated in PHPs at community mental health centers (CMHC) outside their communities	15%	**67%**	8%	0%	0%	**50%**	**18%**	0%	**16%**
Beneficiaries who participated in PHPs at more than one CMHC	5%	0%	**8%**	0%	0%	0%	**9%**	0%	**9%**
Beneficiaries with cognitive disorders who participated in PHPs	4%	0%	0%	0%	0%	0%	0%	0%	**6%**
Beneficiaries with long durations of PHP participation	3%	0%	**8%**	0%	0%	0%	**9%**	0%	0%
Beneficiaries who were readmitted to inpatient treatment	3%	0%	0%	0%	**100%**	0%	0%	0%	0%

Note: Bold type indicates that the percentage was greater than the national percentage.

Source: Office of Inspector General analysis of 2009 and 2010 Medicare PHP, physician, and inpatient claims.

APPENDIX E

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 12 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Questionable Billing by Community Mental Health Centers (OEI-04-11-00100)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG Draft Report entitled, "Questionable Billing by Community Mental Health Centers" (OEI-04-11-00100). The objectives of this study are to identify questionable billing by community mental health centers (CMHC) in 2010 for partial hospitalization program (PHP) services furnished to Medicare beneficiaries, and to determine the extent to which questionable billing by CMHCs varied by geographic location and state licensure or certification.

CMHCs' PHP services have historically been vulnerable to fraud, waste, and abuse. As such, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group using the authorities granted under Section 6401 of the Affordable Care Act. Under the new screening provisions of CMS 6028-FC[1], all newly enrolling CMHCs are considered a moderate risk provider/supplier and are subject to unannounced physical site visits in addition to other screening measures such as licensure checks. The Affordable Care Act (ACA) gives the Secretary the authority to suspend payments to a provider or supplier pending an investigation of a credible allegation of fraud unless the Secretary determines that there is good cause not to suspend payments. CMS must consult with OIG and, as appropriate, the United States Department of Justice in determining whether a credible allegation of fraud exists before suspending payments on the basis of alleged fraud.

Those CMHCs already enrolled in Medicare will have to revalidate their Medicare enrollment beginning this year. All CMHCs are subject to an unannounced physical site visit as part of the revalidation process. The ACA also enhanced CMS' authority to suspend payments for credible allegations of fraud.

In addition, CMS implemented the Fraud Prevention System (FPS) in June of 2011 which applies predictive analytic technology on claims prior to payment to identify aberrant and

[1] CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

suspicious billing patterns. The FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service claims, including those submitted by CMHCs and Home Health Agencies (HHAs), and durable medical equipment, prosthetics, orthotics, and supplies claims prior to payment. CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly imposes administrative action when warranted. CMS is building reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by all major provider types, including CMHCs. CMS will review the measures of questionable billing identified by OIG and consider incorporating them into models as appropriate.

CMS is also launching a CMHC-PHP pilot targeting the three highest risk states of Florida, Texas, and Louisiana, which encompass all eight of the metropolitan areas with a higher percentage of CMHCs with questionable billing cited in the report.

CMS appreciates OIG's efforts in working with our agency to help identify CHMCs with questionable billing. CMS's response to each of the OIG recommendations follows.

OIG Recommendation 1

CMS should increase monitoring of CMHCs' Medicare billing and fraud prevention controls.

CMS Response

CMS concurs with this recommendation. CMS will provide the Zone Program Integrity Contractors a copy of this report so that they may incorporate it into their business and investigative processes as appropriate. In addition to its more traditional ways of monitoring a variety of providers and claims, CMS is also utilizing the FPS to identify suspicious billing patterns. The FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, and billing patterns. Using these profiles, CMS estimates a claim's likelihood of fraud and prioritizes providers with billing behavior that seem to pose an elevated risk to Medicare for a closer review.

OIG's recommended questionable billing characteristics will be considered in the development of the CMHC-PHP pilot and development of future models for inclusion in the FPS.

OIG Recommendation 2

CMS should enforce the requirement that certifying physicians be listed on the PHP claim submitted by CMHCs.

CMS Response

CMS concurs with this recommendation. CMS will further enforce the Medicare Claims Processing Manual requirement by ensuring that the certifying physician be listed on the PHP claim submitted by CMHCs. This will be done by developing an edit in the claims processing

system requiring the use of the physician's National Provide Identifier (NPI), and not the facility's NPI, to be used in the attending physician field on the claim. CMS is targeting this edit to be implemented with the April 2013 Quarterly Release.

OIG Recommendation 3

CMS should finalize and implement the proposed Conditions of Participation (CoPs) for CMHCs.

CMS Response

CMS concurs with this recommendation. This recommendation reinforces the steps that the CMS/Clinical Standards Group (CSG) within the Office of Clinical Standards and Quality (OCSQ) has already taken to develop the CMHC CoP Final Rule (CMS-3202-F). Publication is expected in Spring 2013. CMS believes the publication of the final rule will help to ensure that all Medicare certified CMHCs are subjected to a consistent level of oversight and will improve the overall quality, health, and safety of care provided in CMHCs.

This recommendation also reinforces the steps that the CMS/Survey & Certification Group (SCG) has already taken to establish a survey cycle to verify a CMHCs compliance with the CoPs. CMS believes that verifying the compliance with the CoPs will help CMS oversee the health and safety of its beneficiaries and fosters good program management. CMS acknowledges that this OIG recommendation will be very helpful in assuring that the Medicare program through survey verification is able to bolster the quality of care provided in CMHCs.

The SCG has planned a five year survey cycle to verify compliance with the CMHC CoPs. The details of the survey and certification process will be specified in the State Operations Manual, which is currently under development. Additionally, CMS appreciates e OIG's recommendation that CMS should consider seeking statutory authority, if necessary, to grant deeming status to accreditation organizations. The SCG will begin discussions on the steps necessary to address this issue.

OIG Recommendation 4

CMS should review and take appropriate action against CMHCs with questionable billing.

CMS Response

CMS concurs with this recommendation. Upon receipt of the files from OIG, CMS will share the CMHCs with questionable billing identified by OIG with the A/B Medicare Administrative Contractors. CMS requests OIG furnish the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.). In addition, CMS requests that Medicare contractor-specific data be written to separate CD-ROMs or sent to a secure portal to better facilitate the transfer of information to the appropriate contractors. CMS will instruct the contractors to consider taking the appropriate actions on the suppliers identified

in this report and the additional claim information when prioritizing their Medicare review strategies or other interventions.

The Recovery Auditors review Medicare Fee-For-Service claims on a post payment basis and are tasked with identifying overpayments. While CMS does not mandate areas for review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Latrice Rollins served as the lead analyst for this study. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Evan Godfrey and Holly Williams; central office staff who contributed include Kevin Farber, Scott Horning, Sandy Khoury, Berivan Demir Neubert, and Debra Roush.

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