

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**VULNERABILITIES IN CMS'S
AND CONTRACTORS'
ACTIVITIES TO DETECT AND
DETER FRAUD IN
COMMUNITY MENTAL
HEALTH CENTERS**



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EXECUTIVE SUMMARY: VULNERABILITIES IN CMS'S AND CONTRACTORS' ACTIVITIES TO DETECT AND DETER FRAUD IN 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 services to approximately 25,000 Medicare beneficiaries. Arrests by Medicare Fraud Strike Forces indicate that some parts of the country have a higher prevalence of CMHC fraud, including areas in Florida, Louisiana, and Texas. A recent Office of Inspector General (OIG) study found that approximately half of CMHCs exhibited questionable billing in 2010, most of which were in Florida, Louisiana, and Texas. Other OIG studies have found problems with the Centers for Medicare & Medicaid Services' (CMS) oversight of contractors.

HOW WE DID THIS STUDY

We collected information and documentation from CMS, Medicare Administrative Contractors (MAC), and Zone Program Integrity Contractors (ZPIC) regarding activities to detect and deter fraudulent CMHC billing in 2010. We also analyzed Medicare claims data from the National Claims History Outpatient File to determine the extent to which Medicare paid CMHCs subject to payment suspensions, revocations, or selected autodenial edits in 2010.

WHAT WE FOUND

One of nine MACs we reviewed performed activities to detect and deter CMHC fraud in 2010, and most of these were part of a CMS-led special project. Activities to detect and deter CMHC fraud varied substantially among ZPICs in 2010, with one ZPIC performing almost all such activities. Most of these activities were part of the same CMS-led special project. Other MACs and ZPICs performed minimal activities to detect and deter fraudulent CMHC billing, despite having jurisdiction over fraud-prone areas. Additionally, Medicare paid CMHCs that did not comply with its requirements after their revocations were effective and while their revocations were being approved. Medicare also could have prevented payments to potentially fraudulent CMHCs by consistently applying an autodenial edit across Florida CMHCs.

WHAT WE RECOMMEND

We recommend that CMS (1) implement additional CMHC fraud mitigation activities in all fraud-prone areas, (2) develop a system to track revocation recommendations and improve revocation communication with contractors, (3) coordinate activities to deter CMHC fraud in Florida, and (4) follow up on payments made to CMHCs after the effective dates of their billing privilege revocations. CMS concurred with all four recommendations.

TABLE OF CONTENTS

Objectives	1
Background	1
Methodology	10
Findings.....	13
One of nine MACs we reviewed performed activities to detect and deter CMHC fraud in 2010, and most were part of a CMS-led special project.....	13
Activities to detect and deter CMHC fraud varied substantially among ZPICs in 2010	14
Medicare paid CMHCs that did not comply with its requirements in 2010 and could have prevented payments to potentially fraudulent CMHCs.....	18
Conclusion and Recommendations.....	21
Agency Comments and Office of Inspector General Response.....	23
Appendixes	24
A: Number of Community Mental Health Centers and Medicare Payments by State, 2010	24
B: Medicare Administrative Contractor Jurisdictions.....	25
C: Zone Program Integrity Contractor Zones	26
D: Medicare Administrative Contractor Activities To Detect and Deter Fraud, 2010	27
E: Zone Program Integrity Contractor Activities To Detect and Deter Fraud, 2010	28
F: Agency Comments.....	29
Acknowledgments.....	32

OBJECTIVES

To determine the extent to which:

1. the Centers for Medicare & Medicaid Services (CMS) and selected contractors performed activities to detect and deter fraudulent billing by community mental health centers (CMHC) in 2010 and
2. Medicare paid CMHCs that were subject to payment suspensions, revocations, or selected electronic edits because of suspected fraud.

BACKGROUND

Medicare Part B covers partial hospitalization programs (PHP) that CMHCs provide to Medicare beneficiaries.¹ During 2010, 206 CMHCs in 25 States received approximately \$218.6 million for providing PHP services to approximately 25,000 beneficiaries.² See Appendix A for the number of CMHCs and total Medicare payments to CMHCs by State in 2010.

PHP Services and Requirements

PHPs are intense, structured outpatient mental health treatment programs.³ They are designed for patients moving from an inpatient level of psychiatric care to outpatient care or for patients at risk of relapse or hospitalization.⁴

To qualify for PHPs, Medicare beneficiaries must:

- have a mental disorder that severely interferes with multiple areas of their daily lives, including social, vocational, and/or educational functioning;⁵
- be cognitively and emotionally capable of participating in treatment;⁶ and
- be under an individualized treatment plan established and periodically reviewed by a physician.⁷

¹ Social Security Act, § 1832(a)(2)(J), 42 U.S.C. § 1395k(a)(2)(J).

² In 2010, 24 States and 1 territory had CMHCs that received Medicare reimbursement. Hereinafter, we refer to the States and territories as States.

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

⁴ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.1.

⁵ *Ibid.*, ch. 6, § 70.3.

⁶ *Ibid.*

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

Additionally, PHPs must offer individual, group, family, occupational, and activity therapies.⁸ Beneficiaries must receive a minimum of 20 hours of covered services per week.⁹

To be eligible for Medicare reimbursement for PHPs, CMHCs must offer the following:

- outpatient services,
- 24-hour emergency services,
- screening services, and
- PHPs.¹⁰

Medicare reimburses CMHCs only for PHPs; other payers, including Medicaid, may cover the other three types of services.¹¹

CMHC Medicare Fraud

Findings from an Office of Inspector General (OIG) report and results of Federal investigations indicate that CMHCs may be particularly vulnerable to fraud, waste, and abuse involving PHP services. They also indicate that certain areas are more prone to CMHC fraud than others. For example, an OIG report on questionable billing patterns in CMHCs found that approximately 82 percent (84 of 102) of CMHCs exhibiting questionable billing were located in Florida, Louisiana, and Texas.¹² Eight cities within those States contained high percentages of CMHCs with questionable billing.

The Medicare Fraud Strike Force (Strike Force) is an essential component of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint effort between the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) to combat health care fraud.¹³ Strike Force teams are designed to identify and investigate fraud and prosecute perpetrators quickly. They are composed of Federal prosecutors, agents from OIG and the Federal Bureau of Investigation, and

⁸ 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.

⁹ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.B.1.

¹⁰ Social Security Act, § 1861(ff)(3)(B)(i)(I), 42 U.S.C. § 1395x(ff)(3)(B)(i)(I); Public Health Service Act, § 1913(c)(1), 42 U.S.C. § 300x-2(c)(1); 42 CFR §§ 410.2 and 410.110.

¹¹ Social Security Act, § 1866(e)(2), 42 U.S.C. § 1395cc(e)(2).

¹² OIG, *Questionable Billing by Community Mental Health Centers*, OEI-04-11-00100, August 2012.

¹³ Medicare Strike Force teams are located in Miami, Tampa, Baton Rouge, Houston, Dallas, Los Angeles, Detroit, Brooklyn, and Chicago.

in some cases State and local law enforcement agencies. Strike Force teams are supported by data analysts and CMS program experts.¹⁴

Strike Force investigations have led to charges against several CMHC operators in a few key cities from 2009 to 2012. For example, four CMHC owners and managers in Miami pleaded guilty to or were convicted of Medicare fraud in 2011. These individuals manipulated patients' charts, diagnoses, and lengths of stay to fraudulently bill Medicare approximately \$205 million for medically unnecessary PHP services from 2003 to 2010.¹⁵ In another case, a Strike Force team charged seven individuals in Baton Rouge in April 2012 for allegedly fraudulently billing Medicare approximately \$225 million from 2005 to 2011.¹⁶ In December 2011, Strike Forces arrested three individuals in Houston for allegedly participating in a scheme that resulted in more than \$90 million in fraudulent billing from 2006 to 2011.¹⁷ These schemes involved fraudulent billing for mental health services, including PHP services.

The previously mentioned OIG report identified eight cities that had high percentages of questionable billing CMHCs. Independent of the report, Strike Force activities led to CMHC operator arrests in three of these same cities (Baton Rouge, Houston, and Miami). We identified these cities as prone to CMHC fraud (see Figure 1).

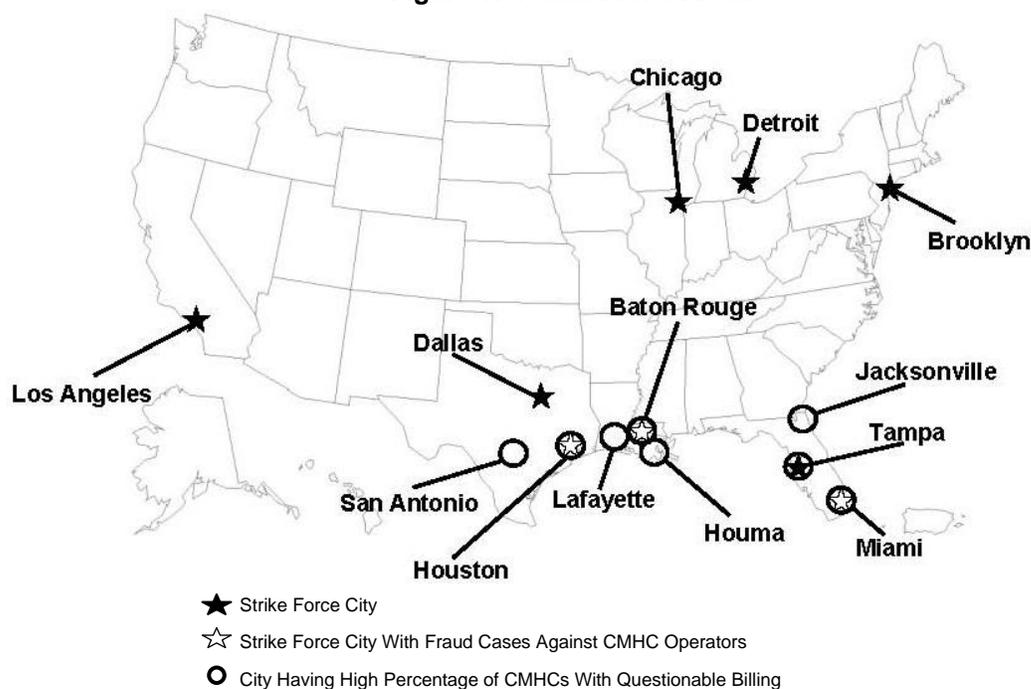
¹⁴ HHS, *Strike Force Formed to Target Fraudulent Billing of Medicare Program by Health Care Companies*. Accessed at <http://www.hhs.gov/news/press/2007pres/05/20070509c.html> on February 24, 2012.

¹⁵ 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/11-crm-1074.html> on August 23, 2011.

¹⁶ DOJ, *Medicare Fraud Strike Force Charges 107 Individuals for Approximately \$453 Million in False Billing*. Accessed at <http://www.justice.gov/opa/pr/2012/May/12-ag-568.html> on June 20, 2012.

¹⁷ DOJ, *Owners of Houston Mental Health Company and Assisted Living Facility Indicted for Alleged Roles in \$90 Million Medicare Fraud Scheme*. Accessed at <http://www.justice.gov/opa/pr/2011/December/11-crm-1639.html> on February 24, 2012.

Figure 1: Fraud-Prone Areas



Source: OIG analysis of HEAT Strike Force Cities, DOJ press releases, and CMHCs with questionable billing.

CMS and Medicare Contractor Coordination

CMS contractors assist in the oversight and administration of Medicare. Oversight tasks include detecting and deterring fraud; administrative tasks include processing Medicare claims. CMS directs contractor activities by issuing statements of work, publishing program manuals, and offering technical guidance. CMS also may inform contractors of oversight or administrative activities that have been successful in other jurisdictions. Contractors may consider implementing, but are not required to implement, these activities in their own jurisdictions.

CMS approval is required before certain contractor-initiated sanctions may be implemented.¹⁸ For example, CMS responds to Zone Program Integrity Contractors' (ZPIC) recommendations to suspend Medicare payments to providers.¹⁹ Once a suspension has been imposed, Medicare Administrative Contractors (MAC) review either 100 percent of claims or

¹⁸ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.9.2.1 (Rev. 282, January 1, 2009). This provision was moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.2.1.

¹⁹ The initial approval is for a payment suspension period of up to 180 days, with the option to extend for an additional 180 days. Providers may not appeal suspensions. CMS determines which action, if any, ZPICs should take. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.9.2.4 (Rev. 282, January 1, 2009). This provision has been moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.2.4.

providers.¹⁹ Once a suspension has been imposed, Medicare Administrative Contractors (MAC) review either 100 percent of claims or a statistical sample to determine the percentage of suspended claims that are payable.²⁰

In some instances, CMS approval is required to implement revocations of providers' and suppliers' Medicare billing privileges.²¹ There is no timeframe or requirement for CMS to approve or deny ZPIC recommendations for revocation, and providers and suppliers may continue to bill Medicare in the intervening time. Provider and supplier billing privileges may be revoked for 1 to 3 years, and providers may not reenroll in Medicare or receive payment during that time. Once provider billing revocations are finalized, MACs are instructed to document these providers and suppliers in the Provider Enrollment, Chain and Ownership System.²²

MACs

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated that the Secretary of HHS replace current claims payment contractors, such as fiscal intermediaries (FI), with MACs.^{23, 24} CMS

¹⁹ The initial approval is for a payment suspension period of up to 180 days, with the option to extend for an additional 180 days. Providers may not appeal suspensions. CMS determines which action, if any, ZPICs should take. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.9.2.4 (Rev. 282, January 1, 2009). This provision has been moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.2.4.

²⁰ *Ibid.*, ch. 3, § 3.9.2.3.1 (Rev. 282, January 1, 2009). This provision has been moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.2.3.1.

²¹ CMS and/or MACs may revoke a provider's or supplier's Medicare billing privileges for several reasons. MACs must obtain CMS approval to revoke a provider's or a supplier's billing privileges resulting from instances in which the provider or supplier submits a claim for services or supplies that could not have been furnished on the date of service. MACs may revoke a provider's or a supplier's billing privileges for any of the other listed reasons without CMS approval. The length of the revocation depends on the type of infraction. Providers and suppliers may appeal revocations. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2.

²² CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2.D.

²³ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, § 911; Social Security Act, § 1874A; HHS, *Report to Congress, Medicare Contracting Reform: A Blueprint for a Better Medicare*, February 7, 2005.

²⁴ CMS has contracts with three different types of MACs to process three different types of Medicare claims, including (1) durable medical equipment (DME), (2) home health and hospice (HH&H), and (3) other Part A and Part B claims (A/B). Four DME MAC jurisdictions (which cover the entire country) are responsible for processing all durable medical equipment claims. Four HH&H MAC jurisdictions (which also cover the entire country) are responsible for processing all home health and hospice claims. Lastly, 15 A/B MAC jurisdictions (which also cover the entire country) are responsible for processing all other Part A and Part B claims. This report covers only A/B MACs, and we will refer to these contractors simply as MACs.

established 15 jurisdictions in which MACs operate.²⁵ Each jurisdiction covers multiple States.²⁶ CMS typically contracts with a different private company to serve as a MAC in each jurisdiction.

As of November 2012, MACs were operational in 12 jurisdictions.²⁷ Appendix B provides a map of MACs and the States in each jurisdiction. However, not all providers in the States listed in Appendix B are under the jurisdiction of the MAC for their States. Some CMHCs in a State with an active MAC are still under the jurisdiction of an FI.²⁸

MACs are responsible primarily for processing and paying Medicare claims correctly, reliably, and in as timely a fashion as possible.²⁹ To accomplish this, MACs process claims and collaborate with CMS and other contractors to ensure that claims are paid correctly.³⁰

MACs also are responsible for preventing Medicare from paying for inappropriate services by educating providers on appropriate billing methods.³¹ They also review claims for errors using computer processing tools; update coverage determinations; and recoup any overpayments that they, or any other contractor, identify.³² MACs are also responsible for promoting the fiscal integrity of Medicare by detecting and deterring fraud.³³

MACs are expected to perform a number of activities to detect fraud. For example, MACs screen beneficiary complaints, perform medical record

²⁵ Over the next several years, CMS plans to further consolidate the MACs for Parts A and B from 15 to 10 jurisdictions. CMS, *A/B MAC Jurisdictions*. Accessed at <https://www.cms.gov/MedicareContractingReform/> on November 30, 2011.

²⁶ Jurisdictions also may cover territories.

²⁷ The 12 MACs operational by November 2012 were for jurisdictions 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, and 15. A contract for jurisdiction 6 was awarded in January 2009 but was subject to a bid corrective action and protest; the MAC is expected to be operational in January 2013. Also, a contract for jurisdiction 7 was not awarded as of November 2012. Jurisdiction F, which consolidated jurisdictions 2 and 3, became operational in February 2012. Jurisdiction H, which consolidated jurisdictions 4 and 7, became operational in November 2012. Until consolidation is complete, some FIs and carriers continue to process Medicare claims in jurisdiction 6.

²⁸ Until March 2006, CMHCs were allowed to select their own claims payment contractors. Some CMHCs continue to use these contractors. CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1 § 20.

²⁹ CMS, *Part A and Part B Medicare Administrative Contractor Statement of Work, Attachment J-1, Master*, § C.4.4.a, September 2011.

³⁰ This includes preventing improper payments by reviewing claims. CMS, *Medicare Program Integrity Manual*, Pub. No 100-08, ch. 3, § 3.3.1

³¹ *Ibid.*, ch. 1, § 1.3, and ch. 3, § 3.1.

³² *Ibid.*, ch. 1, § 1.3.1.B; and ch. 3, § 3.8.

³³ CMS, *Part A and Part B Medicare Administrative Contractor Statement of Work, Attachment J-1, Master*, §§ C.4.4.a and C.5.13, September 2011.

reviews, conduct site visits to problematic providers when instructed by CMS, and refer providers suspected of fraud to ZPICs for investigation.³⁴

MACs collaborate with CMS and ZPICs to deter fraud.³⁵ In some instances, CMS or MAC approval is required to implement ZPIC recommendations to revoke the billing privileges of providers and suppliers.³⁶ MACs may also independently revoke the billing privileges of providers and suppliers.³⁷ MAC approval is also required to implement ZPIC recommendations to deactivate providers that have not billed Medicare in a calendar year.³⁸ Once deactivated, providers must reenroll before they may bill Medicare.³⁹

MACs and ZPICs also work together to create autodenial edits, which are electronic payment system controls intended to prevent payment for potentially fraudulent claims.^{40, 41} These edits analyze claims' attributes and automatically prevent Medicare from paying claims based on suspicious attributes. For example, some edits prevent payment for all services submitted by suspicious providers. Other edits prevent payment for certain types of services for beneficiaries identified as part of a fraud scheme for specific services.

Lastly, MACs must ensure that Medicare does not pay sanctioned providers (i.e., those with payment suspensions, revoked billing privileges, deactivations, or Federal health care program exclusions).⁴²

ZPICs

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made a number of changes related to Medicare contractors, including authorizing CMS to replace the current Program Safeguard Contractors

³⁴ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, §§ 4.3 and 4.6.2; ch. 3, § 3.1; ch. 10, § 22. Accessed at <http://www.cms.gov/manuals/downloads/pim83c03.pdf> on March 23, 2011; CMS, *Part A and Part B Medicare Administrative Contractor Statement of Work, Attachment J-1, Master*, § C.5.12.1.5, September 2011.

³⁵ *Ibid.*, § C.1.4.1.1, September 2011.

³⁶ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2.

³⁷ *Ibid.*, ch. 15, § 15.27.

³⁸ *Ibid.*, ch. 15, § 15.27.1.

³⁹ There is no set amount of time before which these providers may not reenroll. *Ibid.*, ch. 15, § 15.27.1.

⁴⁰ CMS, *ZPIC IDIQ Umbrella Statement of Work*, § 2.2, May 2009.

⁴¹ ZPICs may also recommend overpayment recoupment and civil monetary penalties to deter potential fraud.

⁴² CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.19.1; ch. 15, § 15.27.1; ch. 3, § 3.9 (Rev. 282, January 1, 2009). This provision has been moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.

(PSC) with ZPICs.⁴³ CMS established seven zones in which ZPICs operate. Each zone covers multiple States.⁴⁴ A private company serves as a ZPIC in each zone.

As of November 2012, ZPICs were operational in six of the seven zones.⁴⁵ Appendix C provides a map of ZPICs and the States in each zone. However, not all providers in the States listed in Appendix C are under the jurisdiction of the ZPIC for their States. Some CMHCs in a State with an active ZPIC are still under the jurisdiction of a PSC.⁴⁶

ZPICs are responsible primarily for detecting and deterring Medicare fraud.⁴⁷

Detecting Fraud. ZPICs perform a number of activities to detect fraud. For example, ZPICs identify potential fraud through internal sources, such as data analysis, and external sources, such as referrals from MACs.⁴⁸

ZPICs investigate providers they have identified as potentially fraudulent.⁴⁹ ZPICs may conduct a range of activities when investigating providers, but their Statement of Work and CMS manuals do not specify any required activities. For example, ZPICs may opt to perform prepayment and postpayment reviews of claims submitted by providers under investigation to determine medical necessity. They also may conduct onsite audits to examine records and interview providers under investigation.

Deterring Fraud. ZPICs collaborate with law enforcement, CMS, and MACs to deter fraudulent provider billing.⁵⁰ For example, ZPICs refer cases of suspected fraud to OIG, DOJ, or other law enforcement agencies for criminal investigation.⁵¹ ZPICs also may recommend that CMS suspend payments to providers because of potential fraud and overpayments. They may recommend that CMS or MACs revoke the billing privileges of providers and suppliers for noncompliance with

⁴³ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, § 911.

⁴⁴ Zones also may cover territories.

⁴⁵ The six ZPICs operational by November 2012 were in zones 1, 2, 3, 4, 5, and 7. The contract for zone 6 was awarded in September 2011 and had not become operational as of November 2012.

⁴⁶ This is a holdover from when CMHCs were allowed to select their own contractors.

⁴⁷ CMS, *ZPIC IDIQ Umbrella Statement of Work*, § 1.1.4, May 2009; CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.2.2.

⁴⁸ *Ibid.*, ch. 4, § 4.2.2; ch. 2, § 2.2.

⁴⁹ *Ibid.*, ch. 4, § 4.7.1.

⁵⁰ *Ibid.*, ch. 4, § 4.2.2.

⁵¹ *Ibid.*, ch. 4, § 4.18.1.

Medicare requirements.⁵² ZPICs also may recommend that MACs deactivate providers that have not billed Medicare in over 1 year. Further, ZPICs design autodenial edits that MACs implement to prevent Medicare from paying potentially fraudulent claims.⁵³

South Florida High-Risk Provider Enrollment Project

CMS periodically undertakes temporary special projects to address Medicare fraud, waste, and abuse. For these projects, CMS negotiates separate contracts containing requirements and performance metrics that differ from the requirements and metrics in the original contracts. In 2009 and 2010, CMS conducted a special project, the South Florida High-Risk Provider Enrollment Project, which targeted fraud among especially susceptible provider types, including CMHCs, in South Florida.⁵⁴

As part of the above project, CMS contracted with the jurisdiction 9 MAC and zone 7 ZPIC to conduct specific actions designed to detect and deter CMHC fraud in Palm Beach, Broward, and Miami-Dade Counties, Florida (i.e., South Florida).⁵⁵ For example, the MAC conducted site visits to all South Florida CMHCs in its jurisdiction to verify their existence and operations. CMS used the results of these site visits, along with other information, to create a fraud-risk score for each of these CMHCs. CMHCs with high fraud-risk scores were subject to ZPIC investigation, which could result in referrals to law enforcement, payment suspensions, or revocations of billing privileges.

As of May 2011, the South Florida High-Risk Provider Enrollment Project had resulted in revocations for 239 providers and suspensions for 8.⁵⁶ It also resulted in a cost avoidance of approximately \$156 million by using edits.

Related OIG Work

Previous OIG reports have found vulnerabilities in Medicare payments to CMHCs. A 2012 report found that about half of CMHCs had questionable billing in 2010. Approximately two-thirds of the questionable billing

⁵² Ibid., ch. 15, § 15.27.2, and ch. 3, § 3.9 (Rev. 282, January 1, 2009). This provision has been moved to CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.

⁵³ CMS, *ZPIC IDIQ Umbrella Statement of Work*, § 2.2, May 2009.

⁵⁴ The project also targeted fraud among other providers, including Comprehensive Outpatient Rehabilitation Facilities and Independent Diagnostic Testing Facilities.

⁵⁵ First Coast Service Options, Inc., is the MAC for most providers in Florida. SafeGuard Services, LLC, is the ZPIC for most providers in Florida.

⁵⁶ These figures represent all provider types, not just actions performed for CMHCs.

CMHCs were located in eight metropolitan areas, all of which were in Florida, Louisiana, and Texas.⁵⁷

Further, two 1998 reports found that Medicare paid \$229 million for unallowable and questionable PHP services provided by CMHCs in five States over a 12-month period.⁵⁸ 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. Additionally, OIG found that 60 percent of States did not require CMHCs to be licensed or certified.⁵⁹ This creates a vulnerability whereby dishonest individuals have an opportunity to establish CMHCs and improperly bill Medicare for PHP services.

Previous OIG reports have also found problems with CMS oversight of contractor operations. A 2010 report found that Recovery Audit Contractors performed minimal activities to deter fraud, and CMS did not provide any formal training to the contractors regarding the identification and referral of potential fraud.⁶⁰ Additionally, a 2007 report found that PSCs performed substantially different levels of activities to detect fraud across jurisdictions. For example, PSCs investigated between 99 and 1,266 providers and referred between 4 and 44 cases to OIG for criminal or civil investigation in 2005. The variation in activities was not related to oversight responsibility or budget.⁶¹

METHODOLOGY

Scope

We limited our review to the activities that CMS and selected MACs and ZPICs performed to detect and deter fraud among CMHCs under their jurisdictions in 2010. We also reviewed Medicare payments to CMHCs that were subject to payment suspensions, revocations, or selected autodenial edits by the MACs and ZPICs in our review.

⁵⁷ OIG, *Questionable Billing by Community Mental Health Centers*, OEI-04-11-00100, August 2012.

⁵⁸ These five States are Alabama, Colorado, Florida, Pennsylvania, and Texas. OIG, *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers*, OAS-04-98-02145, October 1998; *Review of Partial Hospitalization Services Provided Through Community Mental Health Centers*, OAS-04-98-02146, October 1998.

⁵⁹ Ibid.

⁶⁰ CMS contracts with Recovery Audit Contractors to identify improper payments of Medicare Part A and Part B claims. OIG, *Recovery Audit Contractors' Fraud Referrals*, OEI-03-09-00130, February 2010.

⁶¹ OIG, *Medicare's Program Safeguard Contractors: Activities To Detect and Deter Fraud and Abuse*, OEI-03-06-00010, July 2007.

We selected 2010 because it was the first year that ZPICs were operational in three areas prone to CMHC fraud. We defined locations as fraud-prone areas if they (1) were Strike Force cities, (2) had cases against CMHC operators from 2009 to 2012, and (3) were identified in an OIG report as having high percentages of CMHCs with questionable billing.⁶² Using these criteria, we found that the cities prone to CMHC fraud were Miami, Baton Rouge, and Houston.

We limited our review to those MACs and ZPICs operational for more than 2 months in 2010 to allow contractors sufficient time to perform CMHC oversight activities.⁶³ In 2010, Medicare reimbursed \$117 million to the 123 CMHCs under the jurisdiction of the 9 MACs in our review, and \$185 million to the 164 CMHCs under the jurisdiction of the 3 ZPICs in our review.⁶⁴

We did not review other activities that CMS and its contractors performed to oversee CMHCs.

Data Collection

In September 2011, we sent information requests to CMS and the 9 MACs and 3 ZPICs in our review to identify activities they performed to detect and deter CMHC fraud in 2010. These requests included multiple-choice options based on expected responses, as well as open-ended questions to allow for elaboration. We requested that respondents submit documentation to support their responses.

We also collected Medicare PHP claims submitted by CMHCs using 100-percent paid claims data from CMS's National Claims History (NCH) Outpatient File from January 1 to December 31, 2010. This included all 2010 claims data for CMHCs under the jurisdictions of the MACs and ZPICs in our review, including those in the fraud-prone areas of Miami, Baton Rouge, and Houston.

Data Analysis

We reviewed information and documentation submitted by CMS, MACs, and ZPICs to determine the number and identify the type of activities to detect and deter CMHC fraud each entity performed in 2010. We also

⁶² We reviewed DOJ press releases to identify cities where CMHC operators were arrested for Medicare fraud from 2009 to 2012.

⁶³ We reviewed MAC jurisdictions 1, 3, 4, 5, 9, 10, 12, 13, and 14. We reviewed ZPIC zones 4, 5, and 7.

⁶⁴ Ninety-six of these CMHCs were in both MAC jurisdictions and ZPIC zones. The totals under the jurisdictions of the two types of contractors were not the same because the MAC jurisdictions and ZPIC zones overlapped only in certain areas of the country. The 9 MACs and 3 ZPICs in our review had oversight for a total of 191 unique CMHCs to which Medicare reimbursed a total of \$191 million in 2010.

reviewed PHP claims data to determine the dollar amount that Medicare paid CMHCs that were subject to payment suspensions, revocations, or selected autodenial edits.

MAC Activities. To determine the extent to which MACs performed activities to detect and deter fraud in the 123 CMHCs under their jurisdiction, we determined the number and identified the type of such activities MACs performed in 2010. We defined MAC activities to detect fraud as: (1) conducting site visits, (2) screening beneficiary complaints, (3) referring providers to ZPICs for investigation, and (4) performing medical record reviews. We defined MAC activities to deter fraud as: (1) approving revocations, (2) approving deactivations, (3) implementing revocations, (4) implementing suspensions, and (5) implementing autodenial edits.

ZPIC Activities. To determine the extent to which ZPICs performed activities to detect and deter fraud in the 164 CMHCs under their jurisdiction, we determined the number and identified the type of such activities ZPICs performed in 2010. We defined ZPIC activities to detect fraud as: (1) investigating providers for potential fraud, (2) conducting prepayment and postpayment review of claims, and (3) performing onsite audits. We defined ZPIC activities to deter fraud as: (1) referring providers to OIG for criminal investigation, (2) recommending suspensions, (3) recommending revocations, (4) recommending deactivations, and (5) creating autodenial edits.

Additionally, we asked ZPICs to estimate the level of potential fraud among the CMHCs in their respective jurisdictions.

CMS Activities. We also determined the number of CMHC suspension and revocation recommendations that CMS received, approved, and denied. Additionally, we determined the extent to which CMS paid CMHCs that were subject to payment suspensions, revocations, or selected autodenial edits. We identified the dates that ZPICs recommended these activities and the dates that CMS and/or MACs performed them. Then we used the NCH Outpatient File to determine the dollar amount Medicare paid these CMHCs after ZPICs recommended the activities and after they were performed.

Limitations

CMS, MACs, and ZPICs submitted documentation to substantiate their responses to our information request; however, these data were self-reported. Our findings also cannot be projected to all MACs and ZPICs because not all were operational at the time of our review. Additionally, the fraud-prone areas identified in this report are not

intended to be a comprehensive list of areas in which CMHC fraud, waste, and abuse may occur.

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.

FINDINGS

One of nine MACs we reviewed performed activities to detect and deter CMHC fraud in 2010, and most of these were part of a CMS-led special project

MACs' primary responsibility is to process and pay Medicare claims submitted by a variety of providers, including CMHCs. MACs are also responsible for detecting and deterring Medicare fraud. However, only the jurisdiction 9 MAC, which includes the fraud-prone area of Miami, performed activities to detect and deter CMHC fraud in 2010. Most of these activities were part of the South Florida High-Risk Provider Enrollment Project.

For example, as part of the above project, CMS directed the MAC to conduct site visits at 57 of the 63 CMHCs under its jurisdiction and assign each a fraud-risk score. Because all CMHCs visited had high fraud-risk scores, the MAC referred all 57 to ZPICs for investigation. Additionally, the jurisdiction 9 MAC screened and followed up on five beneficiary complaints against CMHCs in Florida. Table 1 describes the numbers of CMHCs that MACs referred to ZPICs for investigation in 2010, and Table D-1 in Appendix D describes the other activities that MACs performed to detect CMHC fraud in 2010.⁶⁵

Table 1: Numbers of CMHCs That MACs Referred to ZPICs for Investigation, 2010

Jurisdiction	Number of CMHCs	Medicare Payments to CMHCs*	Percentage of Medicare Payments to CMHCs*	Number of CMHCs Referred to ZPICs for Investigation	Percentage of Total CMHCs Referred to ZPICs for Investigation	Fraud-Prone Areas**
9	63	\$55 million	47%	57	100%	Miami
4	22	\$49 million	42%	0	0%	Houston
Seven Others***	38	\$12 million	11%	0	0%	
Total	123	\$117 million	100%	57	100%	

*Figures in column have been rounded.

**Not all fraud-prone areas were included in our review because the jurisdiction 7 MAC, which includes Baton Rouge, was not operational in 2010.

***This includes MACs for jurisdictions 1, 3, 5, 10, 12, 13, and 14. No other jurisdictions had operational MACs in 2010.

Source: OIG analysis of MAC activity data and documentation.

⁶⁵ The jurisdiction 9 MAC performed medical record review on a number of CMHCs in 2010, but it stopped once it referred the CMHCs to ZPICs for investigation. The MAC stated that it did so because medical record review educated the CMHCs on how to hide fraudulent billing patterns.

Additionally, the jurisdiction 9 MAC approved revocations for four CMHCs and a deactivation for one. The jurisdiction 9 MAC also implemented these revocations and the deactivation, as well as payment suspensions of five CMHCs, preventing Medicare from paying these providers. The MAC also implemented an autodenial edit against 965 beneficiaries that a ZPIC identified as part of a fraud scheme. Table D-2 in Appendix D describes the activities that the MACs performed to deter CMHC fraud in 2010.

In contrast, the other eight MACs in our review, which include the fraud-prone area of Houston, performed no activities to detect or deter CMHC fraud in 2010. Combined, the CMHCs under these eight MACs received more than half of all Medicare payments to CMHCs in 2010 (\$62 million of \$117 million). However, these eight MACs referred none of the 60 CMHCs in their jurisdictions to ZPICs for investigation in 2010. They also did not conduct site visits or screen complaints regarding CMHCs in 2010. Additionally, the other eight MACs in our review did not prevent Medicare payments to CMHCs that were subject to sanctions. These eight MACs did not independently revoke the billing privileges of any CMHCs, nor did they approve or implement any revocations, deactivations, payment suspensions, or autodenial edits concerning CMHCs.

Activities to detect and deter CMHC fraud varied substantially among ZPICs in 2010

ZPICs are responsible for preventing fraud by (1) detecting and investigating potential fraud and (2) deterring fraudulent billing by referring cases to law enforcement and recommending that CMS or MACs sanction providers.⁶⁶ All three ZPICs we reviewed performed activities to detect and deter CMHC fraud in 2010. However, the zone 7 ZPIC was responsible for almost all such activities, mostly as part of the South Florida High-Risk Provider Enrollment Project. The other two ZPICs we reviewed performed far fewer activities to detect and deter fraud among the 100 CMHCs under their jurisdiction. The number of these activities was not consistent with the estimated level of CMHC fraud in their zones, which include the fraud-prone areas of Baton Rouge and Houston.

⁶⁶ Sanctioned providers are those with payment suspensions, revoked billing privileges, or deactivations.

One ZPIC was responsible for most CMHC investigations and almost all other ZPIC activities to detect fraud

The three ZPICs in our review investigated 55 of the 164 CMHCs under their jurisdiction in 2010. The zone 7 ZPIC, which includes the fraud-prone area of Miami, investigated 78 percent (50 of 64) of its CMHCs in 2010. This corresponds to the ZPIC’s estimation that at least 50 percent of CMHC claims in its zone were potentially fraudulent. Table 2 describes the number of CMHCs under ZPIC investigation in 2010.

Table 2: Numbers of CMHCs Under ZPIC Investigation, 2010

Zone	Number of CMHCs	Medicare Payments to CMHCs*	Percentage of Medicare Payments to CMHCs*	Number of CMHCs Under Investigation	Percentage of Total CMHCs Under Investigation	Fraud-Prone Areas
7	64	\$56 million	30%	50	91%	Miami
5	77	\$78 million	42%	4	7%	Baton Rouge
4	23	\$50 million	27%	1	2%	Houston
Total	164	\$185 million	100%	55	100%	

*Figures in column have been rounded.

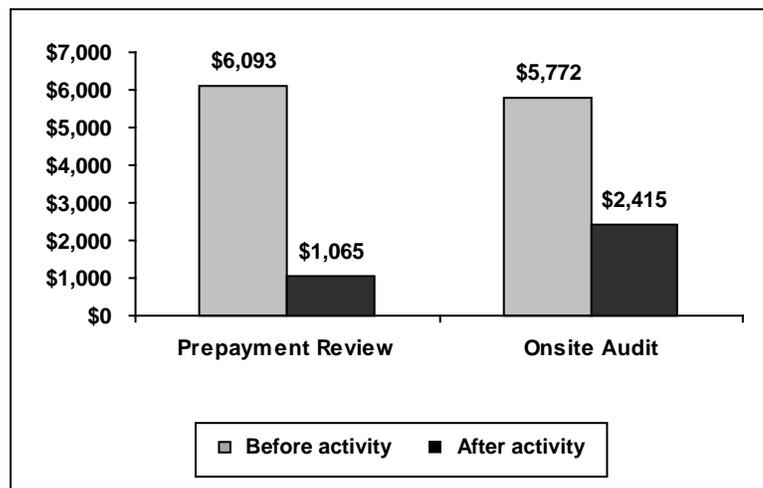
Source: OIG analysis of ZPIC activity data and documentation.

Additionally, the zone 7 ZPIC performed almost all other activities to detect fraudulent CMHC billing in 2010, largely as part of the South Florida High-Risk Provider Enrollment Project.⁶⁷ For example, CMS directed the ZPIC to perform prepayment reviews and conduct onsite audits when investigating CMHCs in South Florida. As a result, the ZPIC performed prepayment reviews for 44 CMHCs and conducted onsite audits for 39 CMHCs in 2010.⁶⁸ Medicare payments to these CMHCs decreased substantially after the ZPIC performed such actions. For example, average Medicare payments per day to CMHCs subject to prepayment review decreased approximately 80 percent after the ZPIC began reviewing their claims. Figure 2 describes the average Medicare payment per day for CMHCs with prepayment reviews and onsite audits in 2010.

⁶⁷ The zone 7 ZPIC performed postpayment review of claims for one CMHC in 2010.

⁶⁸ Thirty-four of these CMHCs experienced both a prepayment review and an onsite audit.

Figure 2: Average Medicare Payment per Day for CMHCs With Prepayment Reviews and Onsite Audits, 2010



Source: OIG analysis of MAC and ZPIC documentation and 2010 PHP claims.

In contrast, the other two ZPICs in our review, which include the fraud-prone areas of Baton Rouge and Houston, investigated 5 percent of CMHCs in their zones in 2010. This does not correspond to the ZPICs' estimates that at least 50 percent of the CMHC claims in their zones were potentially fraudulent in 2010. For example, the zone 5 ZPIC investigated 5 percent (4 of 77) of the CMHCs in its zone. The zone 5 ZPIC initiated investigations into two CMHCs by conducting claims analysis, and it initiated investigations into two others by following up on complaints. While investigating these four CMHCs, the zone 5 ZPIC performed a prepayment review for one CMHC and performed four postpayment reviews on two CMHCs to determine whether any overpayments had been made. The ZPIC also conducted an onsite audit for one CMHC.

Additionally, the zone 4 ZPIC investigated 4 percent (1 of 23) of CMHCs in its zone, initiating the investigation by conducting claims analysis. During this investigation, the zone 4 ZPIC performed one onsite audit for the CMHC and no prepayment or postpayment reviews. Table E-1 in Appendix E describes the activities ZPICs performed to detect fraud among CMHCs in 2010.

One ZPIC was responsible for most CMHC referrals to law enforcement and almost all other ZPIC activities to deter fraud

The three ZPICs in our review referred nine CMHCs to law enforcement in 2010 for criminal or civil investigation. The zone 7 ZPIC, which includes the fraud-prone area of Miami, referred eight of the nine CMHCs

to law enforcement.⁶⁹ These CMHCs allegedly altered patient files, altered patient diagnoses, and paid kickbacks to patient recruiters. In 2010, these eight CMHCs received approximately \$5.6 million from Medicare (see Table 3).

Table 3: CMHCs That ZPICs Referred to Law Enforcement for Investigation, 2010

Zone	Number of CMHCs	Medicare Payments to CMHCs*	Percentage of Medicare Payments to CMHCs*	Number of CMHCs Referred to Law Enforcement	Medicare Payments to CMHCs Referred to Law Enforcement	Fraud-Prone Areas
7	64	\$56 million	30%	8	\$6 million	Miami
5	77	\$78 million	42%	0	\$0	Baton Rouge
4	23	\$50 million	27%	1	\$1 million	Houston
Total	164	\$185 million	100%	9	\$7 million	

*Figures in column have been rounded.

Source: OIG analysis of ZPIC activity data and documentation.

Additionally, the zone 7 ZPIC recommended sanctions (payment suspensions, billing privilege revocations, or deactivations) for 41 unique CMHCs in 2010. CMS and MACs approved sanctions for 32 of the 64 (50 percent) CMHCs in the ZPIC's zone.⁷⁰ In 2010, these CMHCs received approximately \$28 million from Medicare. Sixteen of these CMHCs submitted false information or did not operate at the addresses listed on their enrollment applications. Five others were suspected of billing Medicare fraudulently. The ZPIC also created an autodenial edit against 965 beneficiaries identified as part of a fraud scheme.

In contrast, the other two ZPICs in our review, which include the fraud-prone areas of Baton Rouge and Houston, performed far fewer activities to deter fraudulent CMHC billing in 2010. For example, the zone 5 ZPIC referred none of its 77 CMHCs to law enforcement and recommended that CMS suspend payments to 1 CMHC in 2010. The suspended CMHC was in Baton Rouge, and it inappropriately copied patient records. In 2010, this CMHC received approximately \$56,000 from Medicare.

The zone 4 ZPIC referred only one CMHC to law enforcement in 2010, representing 4 percent (1 of 23) of CMHCs in its zone. This CMHC was in Houston, and it was suspected of submitting false claims for patients. In 2010, this CMHC received approximately \$1.3 million from Medicare.

⁶⁹ All of the CMHCs that the zone 7 ZPIC referred to law enforcement were in Florida.

⁷⁰ Three of the five CMHCs for which CMS suspended payments in 2010 also had their billing privileges revoked in 2010. The single deactivated CMHC did not bill in 2010, and therefore it was not included in the total of 64 CMHCs under the ZPIC.

As of November 2012, this CMHC had not been indicted for fraud. The zone 4 ZPIC did not recommend that CMS or MACs sanction any CMHCs in its zone. Table E-2 in Appendix E describes the activities ZPICs performed to deter CMHC fraud in 2010.

Medicare paid CMHCs that did not comply with its requirements in 2010 and could have prevented payments to potentially fraudulent CMHCs

CMS and its contractors did not coordinate activities to deter fraud across all Florida CMHCs in 2010. For example, Medicare paid five CMHCs after the effective dates that their billing privileges were revoked for noncompliance with Medicare requirements. Medicare also paid nine CMHCs between the time their revocations were recommended and the time they were finalized. Additionally, Medicare contractors could have prevented payments to seven potentially fraudulent CMHCs if they had consistently applied an auto deny edit for all CMHCs in Florida.

MACs paid approximately \$640,000 to five noncompliant CMHCs in Florida after their revocations were effective

CMS and the jurisdiction 9 MAC, which includes the fraud-prone area of Miami, approved the zone 7 ZPIC's recommendations that 31 CMHCs have their billing privileges revoked in 2010 for noncompliance with Medicare requirements. However, Medicare paid a total of approximately \$640,000 to five of these CMHCs during an average of 18 weeks after the effective dates of their billing privilege revocations. Four of these CMHCs were not providing core services required for Medicare participation, such as screening patients or offering outpatient services.

The jurisdiction 9 MAC did not implement or finalize the revocations for these five CMHCs, allowing them to receive Medicare payments. Either CMS or MAC approval is required to revoke providers' or suppliers' billing privileges. MACs should be able to identify all providers with revoked billing privileges because only MACs ensure that Medicare does not pay providers with revocations. However, CMS and the MAC identified different providers with revoked billing privileges in 2010.⁷¹ For example, eight of the ten CMHCs for which CMS revoked billing privileges in 2010 were not documented by the MAC. This includes all five CMHCs that were paid after the effective dates that their billing privileges were revoked. Table 4 describes CMHC revocations identified by CMS and its contractors in 2010.

⁷¹ There was an overlap of two CMHCs for which both CMS and the MAC reported revocations. CMS and the MAC reported 12 unique CMHCs with revocations in 2010.

Table 4: CMHC Revocations Identified by CMS and Contractors in 2010

Source of Revocation Data	Number With Revoked Billing Privileges
Zone 7 ZPIC	22
CMS	10
Jurisdiction 9 MAC	4
Total*	1
Unique CMHCs	31

*Total reflects the CMHCs that the zone 7 ZPIC, CMS, and the jurisdiction 9 MAC agree had revoked billing privileges.

Source: OIG analysis of CMS, MAC, and ZPIC revocation documentation.

MACs paid approximately \$2.5 million to nine CMHCs in Florida after they were recommended for revocation

Medicare paid approximately \$2.5 million to nine CMHCs between the time the ZPIC recommended their billing privileges be revoked and the time their revocations were finalized.⁷² CMS took an average of 42 weeks to finalize these revocations, with a range of 5 to 57 weeks. Medicare paid approximately \$2.4 million to four of these CMHCs, whose revocations were finalized between 39 and 46 weeks after ZPICs recommended their revocations.

Medicare did not pay 18 CMHCs after their revocations were recommended or finalized. These 18 CMHCs had their revocations reviewed and finalized within an average of 16 weeks. Additionally, 13 of these CMHCs had their revocations reviewed and finalized within an average of 17 days.

Medicare contractors did not consistently apply an autodenial edit across all Florida CMHCs

In 2010, Medicare contractors allowed seven CMHCs in Florida to bill for beneficiaries identified as part of a fraud scheme. This was, in part, because not all CMHCs in Florida were under the oversight of the same contractor. Applying an effective autodenial edit across all Florida CMHCs could have prevented approximately \$520,000 in potentially fraudulent billing by CMHCs in 2010.

Of the 72 CMHCs in Florida that received Medicare payments in 2010, 64 operated under the oversight of the jurisdiction 9 MAC and/or zone 7 ZPIC and 8 were under the jurisdiction of a PSC and/or an FI.

⁷² Medicare paid one CMHC after the ZPIC recommended its billing privileges be revoked and after its revocation was finalized. There is no required timeframe for CMS or MACs to approve or deny ZPIC recommendations for revocations, and providers may continue to bill Medicare in the intervening time.

The jurisdiction 9 MAC implemented a local autodenial edit in 2010 to deter a fraud scheme in which South Florida CMHCs billed for prolonged PHP services for beneficiaries. According to the jurisdiction 9 MAC and zone 7 ZPIC, CMHCs were billing Medicare for unusually long durations of PHP services for beneficiaries, some for almost an entire year (362 days).⁷³ The MAC and ZPIC identified 965 beneficiaries who were part of this fraud scheme. The MAC implemented an autodenial edit that prevented the CMHCs under its oversight from providing more than 60 days of services in a calendar year to those beneficiaries. The zone 7 ZPIC reported that the autodenial edit saved Medicare approximately \$370,000 in denied claims from these CMHCs in 2010.

However, the FI did not implement the same autodenial edit for the CMHCs under its oversight. CMHCs under each set of contractors served the same population, submitting claims for the same 602 beneficiaries and often operating within 5 miles of one another. Seven CMHCs under the oversight of the FI billed for 115 of the 965 beneficiaries identified in the fraud scheme. Medicare reimbursed these CMHCs approximately \$520,000 after the MAC implemented the edit to prevent payment for additional PHP services provided to the same 115 beneficiaries. These seven CMHCs billed Medicare for an average of 149 days of PHP services for these beneficiaries.

⁷³ OIG, *Questionable Billing by Community Mental Health Centers*, OEI-04-11-00100, August 2012. PHPs should closely resemble short-term inpatient programs. They are not intended to provide prolonged services. CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 6, § 70.3.

CONCLUSION AND RECOMMENDATIONS

CMS and some of its contractors are responsible for ensuring the integrity of the Medicare program, including the prevention of fraudulent billing. Strike Force investigations indicate that some parts of the country have a higher prevalence of CMHC fraud, including portions of Florida, Louisiana, and Texas. Additionally, OIG found that approximately half of CMHCs exhibited questionable billing in 2010, most of which were in these three States.⁷⁴

In 2010, the 9 MACs and 3 ZPICs in our review oversaw CMHCs in much of the country, including fraud-prone areas of Florida, Louisiana, and Texas. Almost all MAC and ZPIC activities to detect and deter CMHC fraud were performed by the jurisdiction 9 MAC and zone 7 ZPIC, both of which include Florida. Most activities performed by these contractors were part of the South Florida High-Risk Provider Enrollment Project.

However, CMS, the jurisdiction 9 MAC, and the zone 7 ZPIC demonstrated vulnerabilities while detecting and deterring CMHC fraud. Better communication and coordination between CMS and these contractors could have prevented approximately \$3.6 million in Medicare payments for potentially fraudulent CMHC services. Prior OIG reports have found similar vulnerabilities for other providers, such as home health agencies and independent diagnostic testing facilities.⁷⁵ Therefore, the vulnerabilities identified in this report may extend to other types of providers.

We recommend that CMS:

Implement Additional CMHC Fraud Mitigation Activities in All Fraud-Prone Areas

These activities may include aspects of CMS's South Florida High-Risk Provider Enrollment Project, such as coordinating with MACs and ZPICs to conduct unannounced postenrollment site visits, subject CMHCs suspected of fraud to prepayment review, refer highly suspicious CMHCs to law enforcement, sanction noncompliant or potentially fraudulent CMHCs, and/or implement edits to mitigate fraud schemes. Specifically, CMS should work with MACs and ZPICs covering fraud-prone areas, such as parts of Louisiana and Texas, to implement these activities.

⁷⁴ OIG, *Questionable Billing by Community Mental Health Centers*, OEI-04-11-00100, August 2012.

⁷⁵ OIG, *Miami Independent Diagnostic Testing Facilities' Compliance With Medicare Standards*, OEI-05-09-00560, August 2011; and *CMS and Contractor Oversight of Home Health Agencies*, OEI-04-11-00220, December 2012.

Develop a System To Track Revocation Recommendations and Improve Revocation Communication With Contractors

This system should flag recommendations to which CMS or its contractors have not responded within a specified timeframe (e.g., within 30 days of receipt) and require documentation to justify why any cases exceed this timeframe. For cases that exceed this timeframe, CMS should consider implementing safeguards (e.g., prepayment reviews and payment suspensions) to prevent payments to providers recommended for revocation while it determines appropriate action. Doing so could have prevented approximately \$2.5 million in Medicare payments to nine noncompliant CMHCs during the average of 42 weeks between the time their revocations were recommended and the time they were finalized.

Additionally, CMS should coordinate with MACs and ZPICs to improve its communication concerning revocations. While CMS or MAC approval is required to revoke providers' billing privileges, only MACs document revocations in the Provider Enrollment, Chain and Ownership System. MACs then use edits to ensure that providers with revocations do not receive Medicare payments. CMS should also document providers with revocations in the system to ensure that these providers do not inappropriately receive Medicare payments.

Coordinate Activities To Deter CMHC Fraud in Florida

Florida is the only State in our review with CMHCs under both FIs and MACs. CMS should coordinate FI and MAC activities to deter fraud in Florida so that all CMHCs operating there are subject to the same activities. This can prevent the shift of a fraud scheme from a CMHC under the oversight of one contractor to another. It will also ensure the consistency of activities to deter fraud, including edits. Lastly, it would help contractors track fraud schemes across all CMHCs in Florida, which would allow contractors to more accurately inform CMS of billing vulnerabilities. Further, CMS should consider consolidating all CMHCs in Florida under the oversight of the same contractors.

Follow Up on Payments Made to CMHCs After the Effective Dates of Their Billing Privilege Revocations

In a separate memorandum, we referred to CMS the CMHCs that Medicare paid after having their billing privileges revoked. CMS should follow up on payments made to these CMHCs. Such payments should not have been made. Additionally, CMS should ensure that edits are in place and are functioning properly to prevent payments to CMHCs with revoked billing privileges.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations and acknowledged that CMHCs' partial hospitalization program services have historically been vulnerable to fraud, waste, and abuse. Therefore, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for CMHCs. These include screening measures, such as licensure checks for new enrolling providers and unannounced site visits for revalidating providers.

With regard to the first recommendation, CMS stated that it will review the work performed by ZPICs and MACs to ensure that they are pursuing appropriate additional CMHC fraud mitigation activities using lessons learned from the South Florida High-Risk Provider Enrollment Project.

With regard to our second recommendation, CMS stated that it has developed and implemented a tracking system used by the revocation team that delineates revocation-specific tasks, status, request dates, contact dates, and other applicable information. CMS also stated that it established a set of guidelines to ensure that revocation recommendations are addressed in a timely manner.

With regard to our third recommendation, CMS stated that it will draft a Technical Direction letter to the affected MACs about coordinating CMHC edits.

With regard to our final recommendation, CMS will attempt to recover the overpayments made to CMHCs with revoked billing privileges consistent with the agency's policies and procedures. CMS also stated that it has ensured that properly functioning edits are in place to prevent inappropriate Medicare payments to CMHCs with revoked billing privileges.

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 F.

APPENDIX A

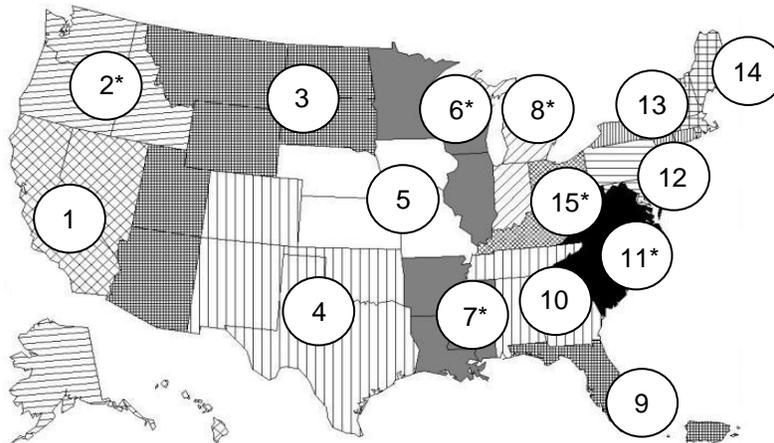
Number of Community Mental Health Centers (CMHC) and Medicare Payments by State, 2010		
State	Total Number of CMHCs*	Total Medicare Payment
Florida	72	\$82,389,314
Louisiana	57	\$60,725,138
Texas	23	\$50,403,363
Mississippi	4	\$6,728,693
Tennessee	4	\$4,007,575
Massachusetts	10	\$3,192,482
Georgia	3	\$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

*Not all CMHCs included in this table were included in this study.

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

APPENDIX B

Medicare Administrative Contractor Jurisdictions



Medicare Administrative Contractors and Operational Dates:

Jurisdiction 1, Palmetto GBA, LLC, September 2008: American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands.

Jurisdiction 2,[†] not operational: Alaska, Idaho, Oregon, and Washington.

Jurisdiction 3,[†] Noridian Administrative Services, LLC, March 2007: Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming.

Jurisdiction 4,[‡] Trailblazer Health Enterprises, LLC, June 2008: Colorado, New Mexico, Oklahoma, and Texas.

Jurisdiction 5, Wisconsin Physicians Service, June 2008: Iowa, Kansas, Missouri, and Nebraska.

Jurisdiction 6,^{*} not operational: Illinois, Minnesota, and Wisconsin.

Jurisdiction 7,[‡] not operational: Arkansas, Louisiana, and Mississippi.

Jurisdiction 8, Wisconsin Physicians Service, August 2012: Indiana and Michigan.

Jurisdiction 9, First Coast Service Options, Inc., March 2009: Florida, Puerto Rico, and Virgin Islands.

Jurisdiction 10, Cahaba Government Benefit Administrators, September 2009: Alabama, Georgia, and Tennessee

Jurisdiction 11,^{*} Palmetto Government Benefit Administrators, June 2011: North Carolina, South Carolina, Virginia, and West Virginia.

Jurisdiction 12, Highmark Medicare Services, Inc., December 2008: Delaware, Maryland, New Jersey, Pennsylvania, and Washington, D.C.

Jurisdiction 13, National Government Services, Inc., November 2008: Connecticut and New York.

Jurisdiction 14, National Heritage Insurance Company, June 2009: Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Jurisdiction 15,^{*} Cigna Government Services, June 2011: Kentucky and Ohio.

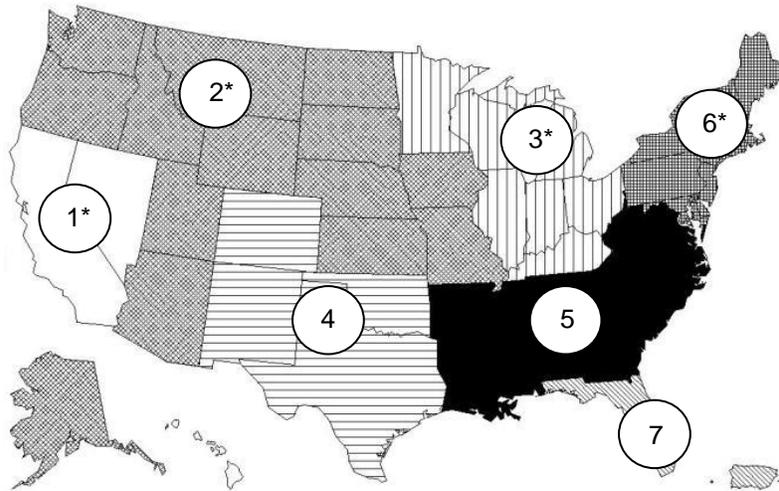
^{*} Jurisdiction was not included in our review because it was not operational for more than 2 months in 2010.

[†] Jurisdictions were consolidated into Jurisdiction F under Noridian Administrative Services in February 2012.

[‡] Jurisdictions were consolidated into Jurisdiction H under Novitas in November 2012.

APPENDIX C

Zone Program Integrity Contractor Zones



Zone Program Integrity Contractor Zones and Operational Dates:

Zone 1,* SafeGuard Services, LLC, December 2010: American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands.

Zone 2,* AdvanceMed Corporation, February 2011: Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

Zone 3,* Cahaba Safeguard Administrators, LLC, April 2012: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Zone 4, Health Integrity, LLC, February 2009: Colorado, New Mexico, Oklahoma, and Texas.

Zone 5, AdvanceMed Corporation, December 2009: Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Zone 6,* Cahaba Safeguard Administrators, LLC, not yet operational: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington, D.C.

Zone 7, SafeGuard Services, LLC, February 2009: Florida, Puerto Rico, and Virgin Islands.

* Zone was not included in our review because it was not operational for more than 2 months in 2010.

APPENDIX D

Medicare Administrative Contractor Activities To Detect and Deter Fraud, 2010

Jurisdiction	Number of CMHCs	Medicare Payments to CMHCs*	Site Visits	Screened/ Followed Up on Complaints	Total Activities	Fraud-Prone Areas**
9	63	\$55 million	57	5	62	Miami
4	22	\$49 million	0	0	0	Houston
Seven Others***	38	\$12 million	0	0	0	
Totals	123	\$117 million	57	5	62	

*Figures in column have been rounded.

**Not all fraud-prone areas were included in our review because the jurisdiction 7 Medicare Administrative Contractor (MAC), which includes Baton Rouge, was not operational in 2010.

***This includes MACs for jurisdictions 1, 3, 5, 10, 12, 13, and 14. No other jurisdictions had operational MACs in 2010.

Source: Office of Inspector General (OIG) analysis of MAC activity data and documentation.

Jurisdiction	Number of CMHCs	Medicare Payments to CMHCs*	Approve Revocations	Approve Deactivations	Implement Autodeny Edits	Implement Suspensions	Implement Revocations	Total Activities	Fraud-Prone Areas**
9	63	\$55 million	4	1	1***	5	4	15	Miami
4	22	\$49 million	0	0	0	0	0	0	Houston
Seven Others†	38	\$12 million	0	0	0	0	0	0	
Totals	123	\$117 million	4	1	1	5	4	15	

*Figures in column have been rounded.

**Not all fraud-prone areas were included in our review because the jurisdiction 7 MAC, which includes Baton Rouge, was not operational in 2010.

***This autodeny edit included 965 beneficiaries who were part of the same fraud scheme.

†This includes MACs for jurisdictions 1, 3, 5, 10, 12, 13, and 14. No other jurisdictions had operational MACs in 2010.

Source: OIG analysis of MAC activity data and documentation.

APPENDIX E

Zone Program Integrity Contractor Activities To Detect and Deter Fraud, 2010

Zone	Number of CMHCs	Medicare Payments to CMHCs*	Prepayment Review	Onsite Audits	Postpayment Review	Total Activities	Fraud-Prone Areas
7	64	\$56 million	44	39	1	84	Miami
5	77	\$78 million	1	1	4	6	Baton Rouge
4	23	\$50 million	0	1	0	1	Houston
Total	164	\$185 million	45	41	5	91	

* Figures in column have been rounded.

Source: Office of Inspector General (OIG) analysis of Zone Program Integrity Contractor (ZPIC) data and documentation.

Zone	Number of CMHCs	Medicare Payments to CMHCs*	Suspensions Recommended	Revocations Recommended	Deactivations Recommended	Autodeny Edits Recommended	Total Activities	Fraud-Prone Areas
7	64	\$56 million	5	40	1	1**	47	Miami
5	77	\$78 million	1***	0	0	0	1	Baton Rouge
4	23	\$50 million	0	0	0	0	0	Houston
Total	164	\$185 million	6	40	1	1	48	

* Figures in column have been rounded.

**This autodeny edit included 965 beneficiaries who were part of the same fraud scheme.

***This suspension was recommended in Louisiana. Because the Medicare Administrative Contractor for the jurisdiction that included Louisiana was not operational during 2010, a fiscal intermediary implemented this suspension.

Source: OIG analysis of ZPIC data and documentation.

APPENDIX F

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 20 2012

TO: Daniel R. Levinson
Inspector General

FROM: ~~Matthew J. Avner~~
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Vulnerabilities in CMS and Contractors' Activities to Detect and Deter Fraud in Community Mental Health Centers" (OEI-04-11-00101)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the HHS OIG's report entitled, "Vulnerabilities in CMS and Contractors' Activities to Detect and Deter Fraud in Community Mental Health Centers." OIG's objectives for this draft report were to determine the extent to which: (1) CMS and its selected contractors performed activities to detect and deter fraudulent billing by community mental health centers (CMHC) in 2010; and (2) Medicare paid CMHCs that were subject to payment suspensions, revocations, or selected electronic edits because of suspected fraud.

As stated in OIG's report, CMHCs' partial hospitalization program (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 regulations (CMS 6028-FC¹), newly enrolling CMHCs fit within the moderate risk category and are subject to unannounced physical site visits in addition to other screening measures such as licensure checks. Those CMHCs already enrolled in Medicare will have to revalidate their Medicare enrollment beginning this year and will be subject to an unannounced physical site visit as part of the revalidation process.

In addition, CMS implemented the Fraud Prevention System (FPS) in June of 2011, which applies predictive analytic technology to claims prior to payment to identify aberrant and suspicious billing patterns. CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly imposes administrative action when warranted. The FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service claims, including those submitted by CMHCs, home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies claims. CMS is

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.

building reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by all major provider and supplier types, including CMHCs.

The CMS would like to express our gratitude to OIG for conducting this evaluation. CMS' responses to the OIG recommendations follow.

OIG Recommendation 1

The OIG recommends that CMS implement additional CMHC fraud mitigation activities in all fraud-prone areas.

CMS Response

The CMS concurs with this recommendation and will review the work performed by Zone Program Integrity Contractors (ZPICs) and Medicare Administrative Contractors (MACs) to assure that they are pursuing appropriate additional CMHC fraud mitigation activities in all fraud-prone areas using the lessons learned from the South Florida project's review of CMHC activity.

OIG Recommendation 2

The OIG recommends that CMS develop a system to track revocation recommendations and improve revocation communication with contractors.

CMS Response

The CMS concurs with this recommendation. CMS has established a set of guidelines for ZPICs and MACs to ensure revocation recommendations are addressed in a timely manner. In the established guidelines, CMS requires ZPICs and MACs to submit revocation requests to a designated CMS revocation email mailbox which ensures requests are addressed accurately and consistently. In addition, CMS has developed and implemented a tracking system used by the revocation team which delineates the revocation-specific tasks, status, request dates, contact dates, etc.

OIG Recommendation 3

The OIG recommends that CMS coordinate activities to deter CMHC fraud in Florida.

CMS Response

The CMS concurs with this recommendation. CMS will be drafting a Technical Direction letter to the affected MACs about coordinating these CMHC edits.

OIG Recommendation 4

The OIG recommends that CMS follow up on inappropriate payments made to CMHCs with revoked billing privileges.

CMS Response

The CMS concurs with this recommendation. CMS has ensured that edits are in place and are functioning properly to prevent inappropriate Medicare payments to CMHCs with revoked billing privileges. When a revocation is entered into the Provider Enrollment, Chain, and Ownership System, edits are triggered in the appropriate claims systems which prevent claims from being paid with dates of service on or after the date of revocation.

In addition, CMS has reviewed the claims from OIG, and will attempt to recover the overpayments consistent with the agency's policies and procedures. However, collection on these debts may be difficult since these CMHCs are no longer billing Medicare. CMS will refer uncollectable debts to Treasury for collection in accordance with the Debt Collection Improvement Act.

Again, CMS appreciates the opportunity to comment on this draft report and we 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.

Evan Godfrey 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 Latrice Rollins; central office staff who contributed include Sandy Khoury, Scott Horning, and Debra Roush.

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