

Behavioral Health Billing



Universal Behavioral Health Billing Systems

Billing Properly for Behavioral Health Services: Be Part of the Solution

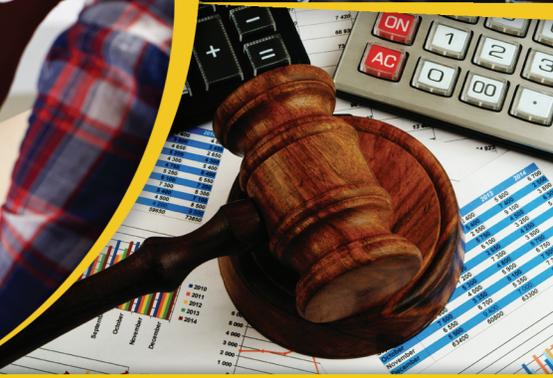
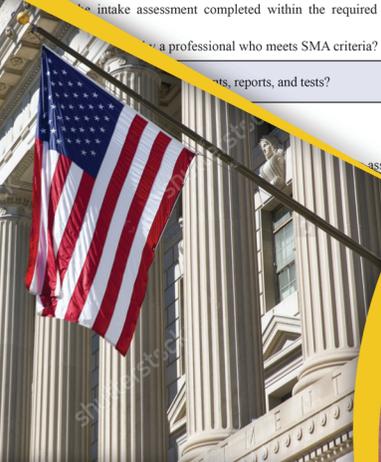
Payments to behavioral health providers is real a...
 Payment Error Rate Measurement (PERM) report, ov...
 88 percent of all Children's Health Insurance Program (CHI...
 ation errors, number of units billed errors, and policy violations. [...]
 addressing them can ensure timely payment of claims and reduction in [...]

MM	DD	YY	MM	DD	YY	CODE	CHARGES	PROVIDER ID#
10	18	15	10	18	15	90785	\$215	0123456789
10	25	15	10	25	15	90834	\$250	0123456789
11	02	15	11	02	15	90785	\$215	0123456789
11	09	15	11	09	15	90834	\$250	0123456789
11	16	15	11	16	15	90785	\$215	0123456789
11	23	15	11	23	15	90834	\$250	0123456789
11	30	15	11	30	15	90785	\$215	0123456789

Documentation Review

providers should develop and maintain documentation (paper or electronic) that is sufficient to support the service, therapy, or activity billed.[2] Documentation should be complete, and meet State (SMA) requirements.

Do Your Clinical Records for Each Patient Include:	Check for
Documentation to show eligibility for services?	<input type="checkbox"/>
Consent for treatment signed by the beneficiary or designated person responsible?	<input type="checkbox"/>
Behavioral health intake assessments with indicated diagnosis, identified problems, and medical need for each treatment service recommended?	<input type="checkbox"/>
Intake assessment completed within the required SMA time frame?	<input type="checkbox"/>
Assessment completed by a professional who meets SMA criteria?	<input type="checkbox"/>
Assessments, reports, and tests?	<input type="checkbox"/>
Assessment?	<input type="checkbox"/>
Assess?	<input type="checkbox"/>





Content Summary

This booklet discusses the laws and regulations that govern billing for behavioral health services, presents an overview of types of coverage and delivery systems allowed, discusses common types of billing errors and improper payments for Medicaid-covered behavioral health services, and explains how to avoid them. In addition, the booklet discusses how to report improper payments; fraud, waste, and abuse; and measures that providers may take to prevent fraud, waste, and abuse.

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Introduction

Strengthening Medicaid program integrity is a priority for the U.S. Department of Health and Human Services (HHS). To accomplish this, the Centers for Medicare & Medicaid Services (CMS), in partnership with the States, is increasing educational outreach for behavioral health services. This booklet should improve awareness of and engage providers in efforts to reduce billing errors and fraud, waste, and abuse in Medicaid.

After reading this booklet, providers should be able to:

- Document and bill Medicaid-covered services correctly;
- Reduce the number of rejected claims for Medicaid services;
- Direct their business office personnel to resources for proper billing guidance;
- Report both inadvertent overpayments and suspected fraud, waste, and abuse; and
- Identify opportunities to improve care for patients with behavioral health needs.

Mental health incorporates a person's social, psychological, environmental, and emotional well-being and helps determine how they cope with life.[1] Diagnosable mental illnesses affect a person's ability to perform major life activities.[2] Substance use disorders occur when the use of alcohol or drugs significantly impairs the ability to meet home, work, school, or other responsibilities.[3] Improvement and even recovery is possible with proper treatment and support for individuals with mental illnesses and substance use disorders.

“Medicaid is the single largest payer for mental health services” and plays a significant role in financing beneficiary substance use disorder services.[4] Currently, 12 percent of Medicaid beneficiaries over age 18 and 6 percent of adolescent beneficiaries have a substance use disorder or issue.[5] Mental health and substance use disorder services are collectively referred to as behavioral health services.

Improper payments occur when Medicaid funds are used to pay the wrong entity, the wrong amount, for services not received, or for services not supported by documentation. The risk of improper payments to behavioral health providers is real and can pose problems for the provider. The Payment Error Rate Measurement (PERM) program samples Medicaid claims and identifies projected dollars spent in error. The 2013 PERM report projects that Medicaid paid approximately \$894 million in error for psychiatric, mental health, and behavioral health services under Medicaid Fee-For-Service (FFS) and \$23 million in error for the same category of services under the Children's Health Insurance Program (CHIP).[6]

Providers should bill properly. Providers who receive Medicaid overpayments (whether self-identified or identified by the State after any appropriate reconciliation and opportunity for a hearing) must return those funds to the State within 60 days of identifying the overpayment.[7] Also, providers that improperly bill for services can be removed from Medicaid participation and may face criminal and civil monetary penalties.[8]

Regulations and Guidance

States should have an approved Medicaid medical assistance plan that outlines eligibility and covered services as well as how States reimburse for services. The Medicaid statute outlines mandatory and optional covered services. The statute does not identify any specific service as a behavioral health service, but several Medicaid services such as rehabilitative or clinic services may furnish behavioral health services. States also adopt their own laws, regulations, and administrative code for their respective Medicaid services, as well as their own manuals and procedures, in addition to following federal requirements. Providers should know how to locate these resources in the States where they provide services.

Several Federal laws have recently been passed or amended that may improve access to behavioral health services. A brief summary of the law follows, with a focus on behavioral health provisions. It is important for behavioral health providers to know Federal laws and requirements when furnishing services to Medicaid-eligible individuals.

Social Security Act Section 1905(a)

Section 1905(a) of the Social Security Act (the Act) authorizes a number of services coverable under the Medicaid program to diagnose and treat behavioral health issues. Some of those services are:

- Diagnostic, screening, preventive, and rehabilitative services recommended by a licensed provider “for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”;^[9]
- Inpatient psychiatric hospital services for children and adolescents under 21 and for those 65 and older who have mental disabilities are covered;^[10] and
- Individuals age 22 to 64 who need services that are more intensive may be able to receive needed services covered by Medicaid in intermediate care facilities, depending on what the State plan allows.^[11, 12, 13, 14, 15]

Waiver or demonstration programs, discussed below, may cover some services not allowed in section 1905(a). Check with your State for a list of covered behavioral health services.

Social Security Act Section 1905(r)

Section 1905(r) of the Act requires each State’s Medicaid plan to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals who are eligible for and enrolled in Medicaid and who are under age 21.^[16, 17, 18, 19] Treatment services above any tentative utilization limits set by a State may require prior authorization, but services provided under the EPSDT service may only be limited based on a determination of medical necessity.^[20, 21] Check with your State Medicaid Agency (SMA) for additional coverage or billing requirements when providing services to eligible individuals under age 21.

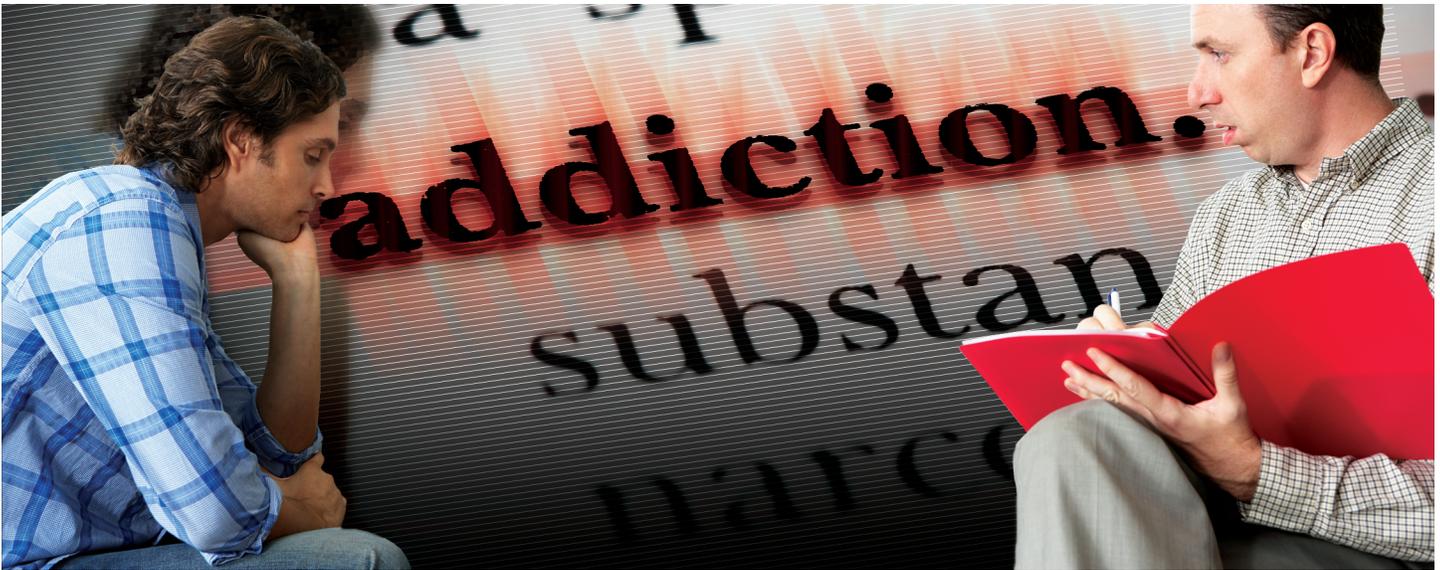
For behavioral health, mandatory EPSDT services include a comprehensive mental health development assessment; health education; and “such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered” through screening, even if those services are not covered under the Medicaid State plan for other individuals.^[22]

Social Security Act Sections 1915(c), 1915(i), and 1115

Federal law gives States the flexibility to change their systems and improve coverage for individuals with behavioral health illnesses or conditions through approved alternative authorities. Section 1915(c) enables States to provide home and community-based services (HCBS) under a written plan of care that allow individuals who would require an institutional level of care to remain in the community.^[23] Section 1915(i) uses a State plan amendment to provide HCBS services to the elderly and disabled regardless of whether they would need to be institutionalized.^[24] Section 1115 demonstration projects allow States to try unique approaches to service delivery and treatment.^[25, 26] Each of these laws allows States to remove barriers, design services that target the needs of specific populations, and test delivery approaches.

Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires that financial obligations



(for example, copays and deductibles) and treatment limitations (for example, visit limits) applicable to behavioral health benefits provided by group health plans and health insurance issuers be no more restrictive than the most common requirements or limitations applied to substantially all medical and surgical benefits.[27, 28] Sections 1932(b) (8), 1937(b)(6), and 2103(c)(6) of the Act generally require Medicaid managed care organizations, Medicaid alternate benefit plans (ABPs), and the Children’s Health Insurance Program (CHIP) to comply with parity requirements adopted by MHPAEA. CMS published a proposed rule in April 2015 that addresses the application of parity requirements pursuant to these statutes.[29]

Affordable Care Act

The Affordable Care Act expanded the application of the Federal parity protections under MHPAEA.[30] Additionally, for the new adult population added by the Affordable Care Act, the ABPs provide basic coverage. These are modeled after certain benchmark coverage options, but include Essential Health Benefits and, for children under age 21, comprehensive EPSDT services.[31, 32, 33, 34]

Overview of State Medicaid Behavioral Health Services

Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorders. Individuals with a behavioral health disorder also use significant health care services—nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved individuals with a mental disorder, substance abuse problem, or both.[35]

In 2009, Medicaid was the second largest payer of substance abuse services, at 21 percent.[36]

States have significant flexibilities in the Medicaid program to design and furnish behavioral health services in a way that fits within each State’s Medicaid rules and regulations and each State’s delivery systems. States use the laws noted above individually or in combination to furnish medically necessary services to eligible individuals. Services may fall into one of several categories, including screening services, additional diagnostic services, and services to treat the condition.



Medicaid-Covered Behavioral Health Services

Screenings

Federal Medicaid benefits include the option for States to establish a benefit category for adults for screening eligible individuals to determine the existence of diseases, including behavioral health illnesses or conditions. If a State elects to provide behavioral health screenings under its State plan, requirements such as who can provide screenings, how often they can be provided, and what is included in the screening can vary by State. Check with the SMA for requirements.

State Medicaid programs must offer EPSDT screenings for Medicaid-eligible individuals who are under 21 years old. See the discussion of section 1905(r) above.[37] States may require specific screening tools under EPSDT. Many States recommend providers follow the American Academy of Pediatrics’ (AAP) “Bright Futures” periodicity schedules for screening and preventive care.[38, 39] Substance use screening services for children and adolescents should also be part of the EPSDT benefit.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) helps providers identify individuals at risk for alcohol or substance use issues. Many State Medicaid plans cover SBIRT services in a variety of settings, which can lead to savings for their Medicaid programs.[40, 41] SBIRT is just one of several screening or assessment tools that States may allow providers to use to identify substance use disorders. A referral may be required if the provider determines the individual needs additional or more intensive treatment; such services may need prior authorization or may have limited coverage, provided any limitations do not violate the requirements of MHPAEA.[42]

The Center for Medicaid and CHIP Services issued a series of informational bulletins on effective practices, including the use of medication-assisted treatment, to identify and treat substance use disorders covered under Medicaid.[43, 44]

Covered Diagnoses and Services

The State Medicaid Manual, the Centers for Disease Control and Prevention (CDC), and many State plans define “mental illness” by referencing the Diagnostic and Statistical Manual of Mental Disorders.[45, 46, 47]

For outpatient services, States may place thresholds on the amount, duration, and scope of behavioral health services before requiring a prior authorization for additional services. Prior authorization or a determination of

medical necessity may be required prior to any services being provided, or a State may allow some services to be provided prior to authorizing additional services. However, providers may not be reimbursed if services are determined not to be medically necessary for an individual. For example, Washington does not limit the number of outpatient mental health visits; however, when a beneficiary reaches 15 mental health visits and meets access to care standards, they must be referred to the Regional Service Network for services.[48] Providers are responsible for tracking services and should request prior authorization for services beyond established thresholds in a State plan or waiver program. This helps providers ensure continuity of care for their patients who need more intensive care.

For long-term care in nursing facilities, the SMA requires Medicaid-certified nursing facilities to develop a plan of care[49] to describe the diagnoses, the covered services and treatments, and that the issue has persisted for at least 3 to 6 months and has significantly disrupted the individual’s living situation.[50] Nursing facility patients diagnosed with mental illness should be reviewed annually.[51]

For nursing facility care, most State Medicaid plans include coverage for core behavioral health services for eligible individuals if the services are medically necessary and included in the individual’s plan of care.[52] Services typically include outpatient assessment and treatment, inpatient services, and emergency services and crisis intervention. Waivers may allow beneficiaries to receive additional services, such as case management and community support services, rehabilitation services, and day treatment services.[53, 54] Check with your SMA for specific services available.

Delivery Systems

SMAAs use a variety of health care delivery systems for Medicaid services to manage costs, use of services, and quality of care. Currently almost 80 percent of Medicaid enrollees receive medical services through a managed care delivery system. In addition, States continue to furnish some services or services for specific populations through an FFS model. While managed care is increasingly furnishing behavioral health services, many SMAAs continue to “carve out” or separate behavioral health services from existing medical managed care programs. “Carved out” behavioral health services are generally provided on an FFS basis through a behavioral health managed care contract or through a primary care case management program. Providers should check with the SMA for additional information on service delivery requirements including the use of telemedicine to furnish services to patients in rural areas or who are unable to travel long distances to receive services.

Proper Billing for Behavioral Health Services

Each State has different billing requirements related to provider types, categories of services, and the specific services for which the provider can bill. Providers should bill correctly or return overpayments within 60 days of identifying or learning of them. Providers that discover claims billed incorrectly should contact their SMA for potential payment adjustments.[55, 56]

Most States provide general billing information and instructions for providers. These usually include billing:

- **Format**—for example, paper or digital form;[57, 58]
- **Time**—for example, the provider may only bill for the time spent in the face-to-face encounter;[59, 60]
- **Fees**—for example, psychotherapy fees include preparation, progress notes, communication with other providers, written reports, and referrals;[61]
- **Codes**—for example, the specific individual therapy code is used for psychotherapy with the individual alone, individual and family, or family alone;[62] and,
- **Scope of services**—for example, group sessions involve two to eight individuals.[63]

Providers of behavioral health services should be familiar with their SMA's eligibility verification and billing requirements.

Who Can Bill?

States establish requirements that providers should meet when furnishing and billing for services. Requirements include State-specific licensure requirements and other requirements specified in State law related to the provision of a service.

In general, to be eligible to bill for behavioral health services, providers should:

- Meet Federal Medicaid and State qualifications for participation;
- Bill only for services that are within the scope of their clinical practice as defined by the appropriate State licensing entity;^[64] and
- Bill only for services that are covered under Medicaid for their provider type.

Providers may have to meet additional certification requirements, such as additional training, to provide SBIRT. It is important for providers to stay current with State licensing and certification requirements.

How Do I Validate Medicaid Eligibility?

Patients should be eligible for services and enrolled with the SMA on the date they receive the services. Each provider should check the beneficiary's State-issued Medicaid card. In addition, validate eligibility through telephone or computer-based State eligibility systems.

How Frequently Can I Bill?

States can set provider-billing frequency for Medicaid medical and behavioral health services under the State plan. Although developed for Medicare, CMS notified States of the National Correct Coding Initiative (NCCI) methodologies compatible with Medicaid services.^[65, 66] Under NCCI, CMS limits same-day billing for certain paired codes of services and practitioner types.

There is no Federal restriction on the same-day billing of behavioral health and primary care services, but some States could have restrictions. As of 2010, 70 percent of States surveyed allowed Medicaid reimbursement for mental health visits on the same day as medical visits.^[67, 68] States may have differing policies. For example, in California, the Medi-Cal Billing Manual allows Medicaid reimbursement for services for the same day for the same recipient if the claim contains an appropriate repeat procedure code.^[69] However, in Utah, a single provider may not include psychotherapy service with an Evaluation and Management (E/M) code. "The two services must be significant and separately identifiable."^[70]

Using Appropriate Treatment Codes

Each SMA specifies the codes that Medicaid reimburses.^[71] To ensure reimbursement for services furnished, providers should only use appropriate State Medicaid treatment codes.

Healthcare Common Procedure Coding System (HCPCS) codes are generally used to bill for Medicaid services. HCPCS is two separate and different sets of codes, referred to as Level I Current Procedural Terminology (CPT) codes and Level II codes.^[72] Most States use both Level I and Level II codes for Medicaid claims. Providers and their staff should be sure to follow their State-specific billing requirements to ensure proper billing.



Telemedicine Codes

For providers furnishing services via telemedicine, States may select from a variety of HCPCS codes (T1014 and Q3014) and CPT codes to identify, track, and receive reimbursement. Providers use the same CPT and HCPCS codes as with face-to-face services; however, providers must use modifiers (GT, U1-UD) after the code. Be sure to check with the SMA for specific guidance on how to bill for services furnished via telemedicine in each State.

General Guidelines

In addition to the appropriate International Classification of Diseases, 10th Revision—Clinical Modification (ICD-10-CM) diagnosis code and CPT code, EPSDT provider billing guidelines for all States require that providers fill in the EPSDT referral indicators in the appropriate location on the claim form (CMS-1500, field 24H; 837 Professional 2300 Loop, elements CRC01–CRC03) to receive proper payment for referred EPSDT services.[73, 74, 75, 76]

A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. For example, do not bill for family and individual therapies separately, known as “unbundling,” when the therapy was provided to the individual with family present.[77]

Some States require supporting documentation when billing for extended psychotherapy sessions. For example, claims for individual psychotherapy sessions that last longer than 1 hour should include documentation describing the clinical circumstances that required the additional time.[78, 79]

Improper Payments

According to the 2013 PERM report, nearly 89 percent of Medicaid FFS improper payments resulted from documentation errors, number of units billed errors, and policy violations.[80] A 3-year summary of similar data also revealed that mistakes in the number of units billed accounted for the highest dollar errors among mental health services claims.[81] Billing for the correct number of units according to established Medicaid policies improves the timeliness of your reimbursement and the overall integrity of Medicaid. Check with the SMA for additional documentation, billing, and policy requirements.



Documentation

The most common documentation errors are missing progress notes, physician orders, and plans of care.[82] Providers should develop and maintain paper or electronic documentation that is sufficient to support each service, therapy, or activity they bill.[83] Documentation for behavioral health services should include a plan of care that describes the:

- Specific services to be provided;
- Services schedule;
- Types of providers who will deliver the services; and
- Patient reevaluation and the plan of care update schedule.[84]

As providers implement the plan, they should keep a timely record of:

- Services they provide to the beneficiary;
- Relevance of those services; and
- Beneficiary's progress toward achieving the plan goals.[85, 86]

Providers should review the plan of care regularly to determine if services are still necessary. Check the State's Medicaid regulations for the required frequency of this review. If the plan of care needs revision, the care team should provide a detailed explanation about the need for additional or revised services, the frequency of those services, and their relationship to the treatment goals listed in the plan of care.[87]

Medicaid has rejected many claims because the provider either did not have a plan of care on file, did not have progress notes for a specific date of service, or they failed to provide them in a timely manner in an audit or review.

Example: A Medicaid provider filed a claim for visiting a beneficiary in an inpatient facility, but failed to provide any progress notes.

Example: A Medicaid provider received an Additional Documentation Request letter from a medical review contractor, but failed to submit any documentation by the deadline.

Number of Units Error

A number of units error represents a miscalculation of the time or quantity of a service, item, or medication. Examples of this type of error include:

- Using a 1-hour code for a 15-minute procedure;
- Billing for three units of service when only two are in the documentation; and
- Billing a prescription for 30-days when the pharmacy dispensed only a 14-day supply.

Example: The psychiatrist's office mistakenly billed 90837 Psychotherapy, 60 minutes with patient instead of 90832 Psychotherapy, 30 minutes with patient for a 30-minute visit.

Policy Violations

Federal and State entities expect providers to know the policies that govern the services they furnish to Medicaid beneficiaries. This includes documentation rules and proper coding procedures, what services are covered, and who is eligible for those services.

Example: Some behavioral health treatment plans include medication therapy. Medicaid regulations require that pharmacies offer beneficiaries counseling on the medications they dispense. Medicaid denied a pharmacy's claims because the pharmacy could not offer documentation that the required counseling was offered to beneficiaries.[88]

Example: State law requires that providers record progress notes the same day they provide the services. A Medicaid provider submitted progress notes to support an inpatient claim dated 1 month after the date the provider performed the service.

What Providers Can Do to Avoid and Correct Errors

Implement Internal Processes

Preventing improper billing starts with the provider. Implementing effective internal controls ensures the provider documents beneficiary services properly and bills them appropriately. Here are just a few suggestions:

- Be aware of and seek professional, State, and Federal training, seminars, technical opportunities, etc., offered to providers and staff that deal directly and specifically with proper billing practices, procedures, and policies to enhance billing competencies and improve billing practices;
- Make sure the assessments, reassessments, individual plans of care, and physician orders are reviewed as required, and that they are current and signed;
- Perform internal monitoring and auditing of documentation to ensure that documentation is complete, current, and sufficient to support the services billed, and supports the plan of care;
- Implement other internal processes to ensure State and Federal requirements are met; and
- Make sure to back up electronic health records (EHRs) daily.

Establish Compliance Programs

Providers can play a significant role in the fight against fraud, waste, and abuse by implementing preventive strategies, including a compliance program. The HHS Office of Inspector General (HHS-OIG) issued voluntary compliance program guidance that includes seven components to help providers and suppliers develop an effective compliance program.[89] The components include a compliance officer, effective communication, written policies, procedures, and standards of conduct, appropriate staff education and training, enforcement of disciplinary standards, internal monitoring, and a prompt response to detected offenses through appropriate corrective action.[90]

While implementation of a compliance program is voluntary for various providers and suppliers,[91] the Affordable Care Act[92, 93] requires the Secretary of HHS to establish, as a condition of enrollment in Medicare and Medicaid, a compliance program containing core elements for providers or suppliers within a particular industry or category.[94]

Train and Educate Staff

Providers should train staff members and make sure they understand antifraud efforts. They should also provide proper training to increase awareness of Medicaid billing requirements, specifically as they relate to behavioral health services in their State. Many SMAs provide training for providers and their staff on Medicaid compliance, requirements, and proper billing practices.

Additionally, providers and their staff should receive training on and be knowledgeable about the False Claims Acts (FCAs). The civil FCA is a Federal law under which substantial damages and civil penalties may be imposed on a person or entity who knowingly presents or causes to be presented a false claim for payment or uses or makes a false record or statement material to get a false claim paid by the government.[95] There is also a criminal FCA that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any Federal health care program.[96] Many States have adopted their own civil and criminal FCA laws; providers should be aware of their State's FCA. Providers receiving at least \$5 million annually from Medicaid are required to provide FCA education to their staff.[97]

Providers and their staff should receive training on Federal debarment and exclusions requirements. Under Federal law, Medicaid cannot make payments for services furnished by an excluded provider or entity.[98]

Identify Excluded Individuals and Entities

CMS recommends that all providers conduct employee exclusion searches on a regular basis to determine whether the provider's employees and contractors have been excluded. Providers can search by name for the exclusion status of their employees through the HHS-OIG's List of Excluded Individuals and Entities (LEIE) at http://oig.hhs.gov/exclusions/exclusions_list.asp on the HHS-OIG website. The General Services Administration also maintains the System for Award Management (SAM) to record and report the eligibility of individuals and entities to receive government reimbursement for services like Medicaid. Visit <https://www.sam.gov/portal/SAM/#1> on the Internet for access to this database.

Consequences of Fraud and Abuse

Program integrity is a priority for CMS, the HHS-OIG, and the States. CMS is committed to preventing Medicaid funds from being diverted to unscrupulous activities. Through the Medicaid Integrity Program (MPI), CMS contracts with entities to review provider activities, audit claims, identify improper payments, provide education to providers



on protecting Medicaid program integrity, and assist States in their program integrity efforts.[99] The following are examples of providers that did not follow Medicaid rules.

The owner of a not-for-profit Medicaid-approved company in North Carolina engaged in a scheme to defraud Medicaid of at least \$3.4 million in fraudulent reimbursement for mental health services. The owner used the National Provider Identifiers (NPIs) of former licensed associates to bill for services that were either provided by unlicensed individuals or not provided at all. The owner was sentenced to 30 months in prison and ordered to pay \$3.1 million in restitution to Medicaid.[100]

A Nevada provider received a 1-year suspended jail sentence along with 100 hours of community service and restitution of \$15,400 for submitting false claims for behavioral health services. The provider created fraudulent documentation supporting claims submitted for rehabilitative therapy services that Medicaid beneficiaries did not receive. Claims submitted included billing services for beneficiaries that had moved out of the State.[101]

A nonprofit organization in Michigan settled allegations that its behavioral health unit submitted false claims to Medicaid for services provided by a practitioner with a lapsed license; services that did not comply with Medicaid supervision and documentation requirements; and services that were billed using codes for a higher level of service than was provided. The organization entered into an agreement with the U.S. Attorney's office to implement a compliance program and hire an independent organization to review its claims for behavioral health services under penalty of a potential exclusion from Federal health care programs.[102]

Report Suspicious Activity

Providers who have identified improperly billed claims should report them to the SMA immediately. Report any acts of fraud to your State Medicaid Fraud Control Unit (MFCU) or SMA. A link to a list of their contact information is available at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html on the CMS website.

You may also contact HHS-OIG:

Office of Inspector General
U.S. Department of Health and Human Services
ATTN: Hotline
P.O. Box 23489
Washington, D.C. 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: <https://forms.oig.hhs.gov/hotlineoperations/>

Conclusion

“Medicaid is the single largest payer for mental health services” and plays a significant role in financing beneficiary substance use disorder services.[103] The risk of significant overpayments to behavioral health providers is real. Failure to be aware of and follow Medicaid’s rules and billing requirements places providers at financial and professional risk.

The information in this booklet can help providers improve the quality and accuracy of their Medicaid billing. Implementing measures such as verifying documentation accuracy, establishing a compliance program, educating staff, and checking for excluded providers will help maintain program integrity. Always consult the SMA for details on covered services, eligibility, and billing requirements.

To see the electronic version of this booklet and the other products included in the “Billing Behavioral Health” Toolkit, visit the Medicaid Program Integrity Education page at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

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January 2016



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