Fraudsters Exploit Mental Health Epidemic

Jennifer Trussell
Consultant

Much is written about the epidemic of mental health needs and the hesitancy of many to seek care due to the stigma surrounding treatment. However, the epidemic has an even darker side – the scourge of fraud and the fraudsters who take advantage of those who do seek treatment. This article overviews the broad scope of behavioral health fraud, including inpatient and specialty programs.

Mental Health Services Spectrum

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that mental health and substance use disorder treatment spending from all public and private sources was expected to total over $280 billion in 2020, an increase from $171 billion in 2009. Medicaid and private health insurance are considered the largest payers of mental health care. Medicare pays for both outpatient and inpatient mental health care. This ranges from outpatient screening and counseling to inpatient psychiatric care. Family counseling, psychiatric testing, treatment drugs, and medication management are also covered in some instances. More information regarding mental health services covered by original Medicare can be found here. A useful coverage pamphlet is also available. Mental health services are an important Medicare benefit as it is estimated that 20% of those ages 55 years or older experience some type of mental health concern.

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Common Fraud Schemes

The scope of mental health-related fraud schemes is as broad as the types of services offered, and fraud can be found in almost every aspect of mental health treatment. Criminals target these programs due to the broad coverage, lucrative reimbursement, and vulnerability of those seeking behavioral health services. Investigations and enforcement of fraud in mental health care

can be particularly challenging, especially given the sensitivity of working with witnesses receiving treatment.

Outpatient Treatment

Testing and Evaluation Services

Outpatient treatment for mental illness begins with screening and testing services. This commonly includes evaluations for a variety of mental health disorders, such as depression, anxiety, bipolar, post-traumatic stress, personality, and eating disorders. A false diagnosis is often used by unethical clinicians to justify expensive and unnecessary treatment services.

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In one case, a clinical psychologist and the co-owner of two psychological services companies contracted with nursing homes in eight states to provide psychological testing services to residents. Evidence presented at trial showed that during a six-year period, the companies submitted over $25 million in Medicare claims, the vast majority of which were for psychological testing services that residents did not need or receive. The two were convicted at trial, sentenced to a combined 264 months imprisonment, a monetary judgment of over $8.9 million, and the forfeiture of a home and over $525,000 in currency.

Individual and Group Psychotherapy

Medicare pays for individual and group psychotherapy in certain circumstances. However, Medicare is clear that they do not pay for activity therapy that is for recreation and attention-diverting purposes. Nor does Medicare pay for support groups for the purpose of socializing – programs often offered in conjunction with adult day care services. In some cases, false billing is related to services that are rendered but are noncovered activity programs. In other cases, the clinician (ranging from a psychiatrist or psychologist to certain licensed social workers) provides the services but inflates the amount of time, misrepresents the credentials of the individual providing the service, and/or bills for services not rendered.

In a Detroit-area case, an adult day care center and group home owner was accused of conspiring with a fraudulent psychotherapy company to falsely bill more than $19 million for services. The

owner admitted during her guilty plea proceeding of falsely billing Medicare for medically unnecessary and nonrendered individual and group therapy at her adult day care, using beneficiaries that resided in her group homes. The owner was sentenced to 40 months in prison in addition to restitution.

In a Virginia case, a licensed psychiatrist created a scheme to inflate billing by seeing patients for only five to 10 minutes but billing Medicare, Medicaid, and TRICARE for services that were up to 63 minutes long. According to court documents, the psychiatrist instructed his staff to double, triple, and even quadruple book appointment times, resulting in numerous instances where he billed for more than 24 hours of services a day. The psychiatrist was sentenced to 27 months in prison, and a former employee was sentenced to 15 months in prison for her role in the scheme.

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Inpatient Treatment

Of great concern is any fraud scheme that results in medically unnecessary hospitalization, especially situations involving psychiatric care. In an egregious False Claims Act case, Universal Health Services (UHS) and related entities agreed to pay a combined total of $122 million for a multifaceted scheme involving inpatient mental health treatment. UHS owned and provided management to almost 200 acute care inpatient psychiatric hospitals and residential psychiatric/behavioral treatment facilities across the United States. The government alleged that over a 12-year period, UHS admitted beneficiaries who were not eligible for inpatient or residential treatment and failed to properly discharge beneficiaries when they no longer required inpatient care. UHS and the entities were additionally accused of billing for services not rendered, improper and excessive lengths of stay, failure to provide adequate staffing (including training and staff supervision), improper use of physical and chemical restraints and seclusion, and various administrative violations regarding assessment and treatment plans. In a separate but related civil settlement, one of the entities also paid $5 million to resolve allegations it provided free or discounted transportation services to induce Medicare and Medicaid patients to seek treatment at their inpatient detoxification rehabilitation program or intensive outpatient program.

Treatment Program and Facility Fraud

The treatment of mental illness often requires a multidisciplinary approach – utilizing both inpatient and outpatient care combined with various treatment modalities. As such, programs including Community Mental Health Centers (CMHCs) and Partial Hospitalization Programs (PHPs) were developed. More information regarding CMS (Centers for Medicare & Medicaid Services) coverage of CMHC and PHP services can be found in this MLN Booklet.

Community Mental Health Centers

CMHCs provide services for the prevention and treatment of mental illness in community-based outpatient settings. Residents of group homes can be targeted by unscrupulous providers for medically unnecessary adult day care activities misrepresented as profitable CMHC care. In other cases, patients are recruited from CMHCs to even higher-paying PHPs – putting profit over patients.

In a case that combines both CMHC and PHP services, a mental health facilities company was involved in a scheme that fraudulently billed Medicare and Florida Medicaid over $63 million during a seven-year period. According to court documents, Health Care Solutions Network Inc. (HCSN) operated PHPs and CMHCs in three locations in Florida and North Carolina. At HCSN's CMHC facilities, the employees would routinely submit false billings for patients who watched movies, attended barbeques, or were not present at the CMHC. The owner of HCSN also orchestrated a scheme that focused on the recruitment and admittance of ineligible patients who were patients residing in assisted living facilities (ALFs). The owner paid kickbacks to the ALFs for patients who suffered from dementia or mental retardation and could not benefit from PHP services and would then extensively falsify records to bill Medicare. Fifteen defendants were charged for their roles in the scheme. The owner eventually pleaded guilty and was sentenced to serve 168 months in prison in addition to paying over $28 million in restitution.

Partial Hospitalization Programs

Medicare Part B covers PHPs as they are considered intensive coordinated outpatient care for the treatment of severe mental illness. However, they are often owned and billed by hospitals and inpatient-based entities, which, in turn, can be highly reimbursed for PHP care.

In a high-profile case, the former president of Houston hospital Riverside General, his son, and a co-conspirator group home owner were sentenced to 45 years, 20 years, and 12 years, respectively, for their roles in a seven-year scheme to defraud Medicare regarding PHP services. Evidence at a five-week trial showed that the hospital owner paid kickbacks to patient recruiters and owners/operators of group homes in exchange for Medicare beneficiaries for their PHP program. Many of these beneficiaries did not qualify for or need PHP services, and some were suffering from Alzheimer's and could not participate in treatment. Others rarely saw a psychiatrist and did not receive intensive psychiatric treatment even when needed. In total, the hospital and satellite locations submitted approximately $158 million for false and fraudulent PHP claims.

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In another egregious case, the owner of American Therapeutic Corporation (ATC) was sentenced to 35 years in prison for her role in a PHP scheme in the Miami area. Evidence at trial showed that the owner and her co-conspirators paid bribes and kickbacks to owners/operators of assisted living facilities and halfway houses in exchange for delivering ineligible patients to attend ATC's PHPs in seven locations. Medicare was often billed for services not rendered using falsified records, and in one case the patient was in a nonresponsive neurovegetative state. The patients were often paid kickbacks to attend PHPs that were not legitimate programs. ATC billed Medicare more than $205 million for fraudulent services. The conspirators used another company in an extensive money laundering scheme. The owner was sentenced to pay more than $87 million in restitution (jointly and severally with her co-defendants, who had previously been sentenced to 50 and 30 years in prison). At the time of sentencing, they were the longest prison sentences imposed in a Medicare Fraud Strike Force case.

The Silent Victims

The need for mental health care is not only prompted by personal circumstances but also by headline-grabbing events. Pandemics, weather-related disasters, economic recessions, wars, and political matters weigh heavy on society – often triggering a large-scale rise in the need for care and a deficit of trusted mental health professionals to provide treatment. The scammers

don’t hesitate to fill this void – preying on vulnerable individuals who often do not report this type of fraud out of fear or embarrassment. It is the duty of everyone in the field of program integrity to watch for this type of fraud, protect the silent victims, and ensure the scammers are brought to justice.

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