Avoiding Fraud and Abuse Claims in Addiction Treatment: Tips for Getting and Staying in Compliance

(The following is an Executive Summary of the presentation Zach Rothenberg gave at the Impact BH Conference in Indian Wells, CA on January 30, 2017.)

Until relatively recently, most addiction treatment services were considered a luxury item: recovering addicts would pay cash for their time getting clean in fancy facilities. Insurance companies generally weren't asked to reimburse for treatment and the government was not incentivized to regulate or supervise treatment programs.

That started to change in 1996, when the Mental Health Parity Act required that insurance companies provide equal benefits for mental health care and physical care. This Act had no teeth until in 2010 the Affordable Care Act imposed penalties for not providing comparable coverage.

With insurance companies now required to pay for addiction treatment, the industry expanded quickly, and rehab facilities are no longer only for rich patients who can pay cash. But with that expansion comes additional oversight and potential exposure to charges of fraud and abuse in submitting claims.

Insurance companies and state and federal governments are increasingly scrutinizing the addiction treatment industry for fraudulent or abusive practices. The consequences of noncompliance are significant, from insurance companies refusing to reimburse for services to civil litigation leading to money damages and penalties, to criminal investigations and potential jailtime. Even if you have done nothing wrong, an audit or investigation can be costly and time consuming.

Many of these investigations fall under the terms of state and federal "false claims" statutes, which generally prohibit the preparation and/or submission of false claims for payment to private insurers or to state and federal programs like Medicaid and Medicare. These statutes impose serious penalties, including triple damages, on violators, and give "whistleblowers" a financial incentive to report fraud because they are entitled to a portion of any recovery.

While guidelines and regulations are complex and the landscape is constantly changing, here are five hot areas of focus for private, state, and federal authorities, and which therefore require particular vigilance:

1. Billing: It should go without saying that addiction treatment facilities need to be extremely careful about their **billing practices** in order to avoid charges of fraud and abuse. Proper documentation of medical necessity is crucial, as is accuracy of billing and coding.

Both the substance of an insurance claim and the billing process are open to scrutiny. Insurance companies are particularly vigilant about the accuracy of claims. Upcoding, the practice of billing for more than what you have done, is a clear example of fraud. Some addiction treatment facilities, however, have a tendency to do the opposite

and submit a claim for a lower level of care, particularly if a patient has exceeded their maximum days at a certain level of care. Even if you bill for less than you have done, as can be the case with “step-down billing” or “downcoding,” insurance companies have argued that this should still be considered an inaccurate claim that constitutes fraud.

Bottom line: you must perform the services for which you bill the insurance company.

1. Referrals and Marketing: Addiction treatment facilities also need to be cautious about referrals and marketing procedures in order to avoid allegations of **kickbacks**. Unlike other industries, healthcare providers are not allowed to pay for referrals from other providers. Because medical decisions should be made only for clinical reasons, without regard to any financial considerations among the referring parties, there should not be any financial incentive to refer patients to a given provider.

While some anti-kickback rules apply only to licensed healthcare professionals like physicians, there are other rules that apply more broadly — to anyone billing insurance for healthcare services. In the context of addiction treatment, we have seen many variations of these mutually beneficial (albeit illegal) relationships, such as sober living houses “brokering” patients to outpatient treatment facilities (a practice sometimes known as “bed vouchers”), or physicians directing patients from a particular inpatient program to a specific sober living arrangement.

On the marketing side, while treatment facilities may employ call centers to answer calls from advertising, it is problematic for them to pay marketers per successful signup. Rather, payment should be structured so that there is little incentive to coerce a potential customer or to oversell a treatment program. Ideally, marketers should be paid “fair market value” for their time and effort, regardless of the number of successful referrals they procure.

1. Patient Financial Responsibility: Addiction treatment centers, like other healthcare providers, have been targeted by insurance companies for reducing **patient financial responsibilities** by routinely waiving coinsurance payments and copayments, or by offering cash discounts. In the case of coinsurance, where the patient is obligated to contribute a percentage of the charges billed by an out of network provider, the routine waiver of these fees by a non-contracted provider is likely to prompt investigation, and potentially litigation. In addition, Medicare has a long standing prohibition against fee waivers and some states prohibit the practice as well. These practices may save the patient money and increase volume for treatment centers, but insurance companies are likely to consider this a form of fraud.

While it may be okay to waive a copayment in a unique case of clearly documented financial hardship, or in certain circumstances to offer a prompt payment discount, these practices should not be advertised or done on a routine basis.

1. Procuring Insurance: Another area of potential fraud and abuse is **procuring insurance** on behalf of patients and then billing the insurance company for treating these patients. Again, this is not unique to addiction treatment, but there have been several recent high profile cases, such as the recent allegations against the owner of Community Recovery of Los Angeles, which was accused of enrolling hundreds of patients without their knowledge and paying their premiums while billing insurance for over $175 million worth of treatments over a period of four years.

Procuring insurance for your own patients is a dangerous game, and one that is increasingly receiving the scrutiny of insurance companies and government regulators alike. In our experience, “red flags” are raised for insurance companies where: (1) insurance applications identify new addresses inconsistent with a patient’s previous information, (2) applications use addresses linked to an addiction treatment provider, (3) insurance premiums are routinely paid by someone unrelated to the beneficiary, and (4) the insurance policy is maintained only for so long as the beneficiary is in treatment.

1. Urine Drug Testing: Many addiction treatment centers rely heavily on **Urine Drug Testing** (UDT). This multimillion dollar industry has come under intense scrutiny, since the potential for unnecessary testing, kickbacks, and false claims are very high.

In order to avoid investigation, here are some best practices:

- Make sure that all tests are ordered by a physician with clearly documented medical necessity. Avoid “standing orders” that test urine more frequently than is medically necessary for treatment.
- Ensure that the results of the UDT are being reviewed and acted on. If the results are being ignored, then the medical necessity of the testing is clearly suspect.
- Do not bill insurance of testing that is not ordered by a physician based on medical necessity. If you are testing for other reasons, consider segregating those tests and separately billing the patient directly for them.

- Make sure that the lab is licensed in the state where the test is ordered *and* performed.
- Do not mark-up the price of tests performed by another facility.
- Avoid kickback programs that pay physicians or treatment facilities per test.
- Do not accept non-financial inducements, such as free specimen cups, for referrals.

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