Siskiyou County Health and Human Services Agency
Behavioral Health Division

Compliance Plan FY 17/18

Implemented July 2017

Introduction

Our Mission:

To promote the prevention of and recovery from mental illness and substance abuse for individuals, families and communities we serve by providing accessible, caring and culturally competent services.

As Siskiyou County Health and Human Services, Behavioral Health Division (BHD) pursues this mission; each employee is expected to conduct his or her work with the highest standards of ethics and integrity. Each employee will conduct all business activities in an ethical and law-abiding fashion. Each employee will maintain a service culture that builds and promotes the awareness of compliance. Our commitment to compliance includes:

1. Conducting internal monitoring and auditing through the performance of periodic audits to ensure that we do not fail in our efforts to adhere to all applicable state and federal laws and regulations;
2. Implementing compliance and practice standards through the development of written standards and procedures;
3. Designating a Compliance Officer to monitor compliance efforts and enforce practice standards;
4. Conducting appropriate training and education on practice standards and procedures regarding applicable laws, regulations, and policies;
5. Establishing mechanisms to investigate, discipline, and correct non-compliance and respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities;
6. Developing open lines of communication, including discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct; establishing an electronic notification process *(i.e., desktop P&P manual, e-mails)* for dissemination of new or changed information to keep employees updated on compliance activities, and providing clear and ethical business guidelines for staff to follow;
7. Enforcing disciplinary standards through well-publicized guidelines.

Legal Mandates for Compliance Activities The MHP and its' compliance activities are governed by State and Federal regulations including W&I Code, Probate Code, Penal Code, Health and Safety Code, CCR Title 9, and HIPAA. In addition:

Office of Inspector General (OIG), Department of Health and Human Services

The creation of compliance program guidances is a major initiative of the OIG in its effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent conduct. In the past several years, the OIG has developed and issued compliance program guidances directed at a variety of segments in the health care industry. The development of these types of compliance program guidances is based on our belief that a health

care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations, and program requirements. (Federal Register/Vol. 65, No. 194, October 5, 2000). http://www.hhs.gov/oig.

Behavioral Health Division Code of Ethical Conduct

In an effort to clearly define the expectations of department staff, BHD has developed a written *Code of Ethical Conduct*. This document, which has been approved by the BHD Compliance Committee, will be distributed annually to all BHD staff to serve as a guideline for appropriate conduct and behavior.

- Annually, each staff member will be required to sign an acknowledgement that he/she has received and read a copy of the *Code of Ethical Conduct*. Each staff member is expected to be familiar with the detailed policies applicable to their activities and is required to adhere to such policies. This acknowledgement will be maintained by the Compliance Officer
- This acknowledgement form will be re-signed on an annual basis after reviewing the BHD *Code of Ethical Conduct*

Behavioral Health Division Compliance Plan

The BHD Compliance Plan will be monitored in accordance with this document and the BHD *Code of Ethical Conduct* prepared by the BHD Compliance Committee. In addition, the Committee will review key issue areas. The key issue areas will be determined by the Agency and Division Director, and the Deputy Director with advice from the Committee.

Behavioral Health Division Compliance Committee

The BHD Compliance Committee will be appointed by the BHD Director and may include:

- Health and Human Services Director or BHD Director
- Deputy Director of Administration
- Alcohol and Drug Program Manager
- Compliance Officer
- HIPAA Privacy and Security Officer
- Quality Improvement Coordinator
- Other Agency Representation
- Fiscal Representative
- Other Staff Dept.

Statement of Policy on Ethical Practices

BHD expects that all personnel will conduct themselves in a manner consistent with the highest professional standards and the ethical codes of their profession. BHD places great importance on its reputation for honesty and integrity. To that end, the Executive Committee expects that the conduct of employees will comply with these ideals.

Each BHD employee is expected to be familiar with this Compliance Plan and the appropriate processes necessary to perform his/her duties, and/or how to obtain the requisite information pertinent to performing his/her duties, in a manner consistent with legal, regulatory, and

departmental requirements. Staff is also expected to understand and comply with the BHD *Code of Ethical Conduct.* Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of the BHD *Code of Ethical Conduct* may be subjected to progressive disciplinary action, up to and including termination.

BHD will adhere to all applicable federal, state and local laws, and regulations and to its' contractual agreement with DHCS in the performance of its day-to-day activities. In addition, BHD will inform its providers and/or organizational service providers of this intention. Where uncertainty regarding federal, state, and local law and regulations exists, each employee will seek guidance from a knowledgeable Supervisor. Supervisors may contact Siskiyou County's Compliance Officer or Deputy Director as the situation warrants.

BHD, as part of its Compliance Plan, has developed and implemented detailed policies setting forth standards of conduct specifically applicable to the services. These policies will be available electronically and communicated to all department employees, and contracted organizational service providers, as appropriate. BHD employees and outside service providers are expected to be familiar with the detailed policies applicable to their activities and are required to adhere to such policies.

Component I. Conducting Auditing and Internal Monitoring

Overview

BHD conducts an ongoing evaluation process as a component of the Compliance Plan. This process determines if the Compliance Plan is working, whether individuals are carrying out their responsibilities in an ethical manner, and that claims are being submitted appropriately.

Auditing and monitoring are different concepts. *Auditing* consists of retrospectively testing the established monitoring systems to ensure they are functioning as prescribed. *Monitoring* uses systems to direct and correct day-to-day operations. Monitoring systems are real-time and broad in scope to facilitate appropriate management action.

Auditing Activities

A routine audit helps determine if any problem areas exist and provide the ability to focus on the risk areas that are associated with those problems. There are several types of audits that occur under the Compliance Program:

- Billing Chart Review:

BHD conducts a monthly random review of ten charts to compare the previous month's billing with chart documentation. This review seeks to confirm that:

a. Bills are accurately coded and reflect the services provided (as documented in the client's chart);
b. Documentation is being completed correctly and in a timely manner (per Policy and Procedure Clin 16-06);
c. Services provided meet medical necessity criteria; and
d. Incentives for unnecessary billing do not exist.

- Standards and Procedures Review:

Policies and procedures are reviewed and evaluated on an ongoing basis by the Compliance Committee to determine if they are current and complete. If they are ineffective or outdated, they are updated to reflect changes in government regulations and standards.

- System Level Monitoring:

The Management Team reviews service and cost utilization data. The Compliance Committee and Supervisors review monthly data on staff productivity and service data (i.e., service codes used.)

- Medi-Cal Denial Reports:

To help to identify any potential compliance issues, the denials are reviewed and resolved on an ongoing basis under the contract with Kingsview as the EOB's (835) are made available by DHCS on ITWS. The Anasazi Denial/Pend Report is also reviewed on a monthly basis. Noncompliance issues such as, incorrect CIN#, Other Health Insurance, etc. are resolved by the Fiscal Department. Potential compliance issues are reported to the UR Coordinator.

Prior to beginning the monthly billing process, a comparison is done of the staff time entered into Anasazi vs. the payroll time. Any discrepancies are sent to the staff person to be fixed. The billing process is not initiated until all outstanding issues are resolved and corrected.

Prior to monthly billing, multiple error reports are run and identified and issues are resolved:

- No Show Appointments with a Duration
- Kept Appointments with a Zero Duration
- Duplicate Services
- No Valid Diagnosis on Date of Service
- No Final/Approved Progress Note for Service
- Staff Credentials / NPI#'s are verified
- Suspense Report is completed
- Verify that services are not billed in excess of 8-hours
- Unresolved Report

- Timeliness of Chart Documentation:

Timeliness of progress note documentation is monitored on a monthly basis via the Anasazi Audit Listing Report per Policy Clin 16-06. Any issues are reported to the Behavioral Health Supervisors, or designee.

Monitoring Activities

BHD's monitoring activities are on-going and include monitoring of billing, timesheets, and chart documentation to assure that all services are accurately billed, accounted for, and charted.

1) Claims Submission Process:

- 1st week: MMEF is loaded onto system
- 2nd week: Audit reports are run and any issues are reported to the Behavioral Health Supervisor, or designee, for correction, as applicable. Audit reports are run weekly to compare staff reported time and billing. A discrepancy list is created and distributed for correction
- 3rd week: Client Payments are typically entered daily, but at a minimum of weekly for the previous month. Audit reports are re-run and updated. Providers/Staff are verified via the OIG website
- Approximately the 15th of each month, the Billing Process begins:
  Run Audit Reports. Verify Client payments batches are closed/posted. Verify client adjustment batches are closed/posted. Verify 3rd party payments are posted. Verify server credentials (License numbers and expiration date). Verify Staff NPI numbers. Verify Pay Source priority. Check Financial Reviews for expiration, start date. Check duplicate services. 3rd party suspense report; no F/A note, valid diagnosis, Payor source. 3rd party coverage; services going to self-pay, M/Cal-HF overlapping, Verify CIN# is entered correctly, check effective dates. Share of cost report; check if any have been met. Post HIPAA 5010 837P claim reports. Insurance: post HIPAA 837P report. Preview client self-pay statements. Post UMDAPS. Check unapplied payments report. Print Client statements

2) Timeliness of Chart Documentation:
   Timeliness of chart documentation is monitored in monthly UR chart reviews, monthly Anasazi reports to Supervisors, and quarterly QIC meetings. This may be documented in the UR Logs and/or QIC minutes.

3) Non-Final Approved Report:
   Timeliness of progress notes are monitored monthly, or as needed.

Component II. Implementing Compliance and Practice Standards

As a component of the broader Compliance Program, BHD has designed processes for combating fraud and unethical conduct through the development of this BHD Compliance Plan. Implementation of this Compliance Plan is accomplished through written policies and procedures, and efforts are documented through various mechanisms.

Policies and Procedures

The purpose of the Compliance policies and procedures is to reduce the possibility of erroneous claims and fraudulent activities by clearly identifying risk areas and establishing internal controls to counter those risks. These controls include practice standards regarding client care, personnel matters, and compliance with federal and state laws.

The policies and procedures serve to identify and implement these standards necessary to successful compliance. These policies and procedures will be reviewed annually by the Compliance Committee to determine their continued viability and relevance.

The Compliance policies and procedures are as follows:

- Auditing and Monitoring Activities
- Disciplinary Guidelines
- Education and Training About False Claims Acts
- Implementation of the Compliance Program
- Non-Compliance Investigation and Corrective Action
- Oversight of the Compliance Program
- Program Standards
- Reporting Suspected Fraudulent Activity
- Service Verification
- Standards for Risk Areas and Potential Violations
- Training

Areas of Risk

In order to successfully implement the Compliance Program, risk areas must be identified and addressed. Compliance policies and procedures have been developed to address these risk areas and serve to implement the standards necessary to avoid these types of violations.

The following areas of risk have been among the most frequent subjects of investigations and audits by OIG. Staff is expected to be familiar with these potential violations and work to maintain compliance with the standards surrounding each area of risk. This is not an exhaustive list, but rather a starting point for an internal review of potential areas of vulnerability.

A. Coding and Billing

1. *Billing for services not rendered and/or not provided as claimed.*
   A claim for a mental health service that the staff person knows or should know was not provided as claimed. This includes presenting or causing to be presented a claim for an item or service that is based on a code that will result in a greater payment to BHD than the code that is applicable to the service actually provided;

2. *Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary.*
   A claim for health equipment, medical supplies, and/or mental health services that are not reasonable and medically necessary and are not warranted by a client's documented condition. This includes services which are not warranted by the client's current and documented mental health condition (medical necessity).

   Medi-Cal: BHD operates under a State waiver implementing the managed mental health services as construed in Chapter 11, Title 9, CCR, which specifies medical necessity requirements. All persons served in mental health must meet the state guidelines for medical necessity (see Attachment A).

3. *Double billing which results in duplicate payment.*
   Double billing occurs when a person bills for the same item or service more than once or another party billed the Federal health care program for an item or service also billed by BHD. Although duplicate billing can occur due to simple error, the knowing submission

of duplicate claims, which may be evidenced by systematic or repeated double billing, can create liability under criminal, civil, and/or administrative law and will be subject to disciplinary action, up to and including termination.

4. *Billing for non-covered services as if covered.*
   Submitting a claim using a covered service code when the actual service was a non-covered service. "Necessary" does not always constitute "covered".

5. *Knowing misuse of provider identification numbers, which results in improper billing.*
   A provider has not yet been issued a provider number, so he/she uses another provider's number. Staff need to bill using the correct provider number, even if that means delaying billing until the provider receives the correct provider number.

6. *Unbundling (billing for each component of the service instead of billing or using an all-inclusive code).*
   Unbundling is the practice of a provider billing for multiple components of a service that must be included in a single fee. For example, if a client receives Day Treatment services and medication services are included as part of that service, then medication services can not be billed separately.

7. *Failure to properly use coding modifiers.*
   A modifier, as defined by the federal CPT-4 manual and/or CSI coding manual, provides the means by which a provider can indicate a service or procedure that has been performed.

8. *Clustering.*
   This is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period of time (in reality, this overcharges some clients while undercharging others).

9. *Up coding the level of service provided.*
   Up coding is billing for a more expensive service than the one actually performed (e.g., billing for crisis services when the service provided was a routine assessment).

10. *Claim from an Excluded Provider.*
    A claim for a mental health service or other item or service furnished during a period that the provider who furnished the services was excluded from the program under which the claim was made.

B. Medically Necessary Services

Claims are to be submitted only for services that the provider finds to be reasonable and medically necessary. The OIG recognizes that staff should be able to deliver any services they believe are appropriate for the treatment of their clients. However, a provider should be aware that Medi-Cal will only pay for services that meet the definition of medical necessity. Staff will be required to document and support the appropriateness of services that have been provided to a client in his/her chart.

C. Service Documentation

Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. All progress notes must be completed and final approved on the same date of service. If unavoidable circumstances necessitate documentation of a service after the date of service delivery, the note shall be documented as a "late entry progress note" and completed and final approved no later than five (5) working days after the date of service. This documentation serves a second function when a bill is submitted for payment, namely, as verification that the bill is accurate as submitted. Therefore, one of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation demonstrates medical necessity and the appropriate mental health treatment for the client and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

For claiming purposes, the client chart is used to validate a) the site of the service; b) the appropriateness of the service provided; c) the accuracy of the billing; and d) the identity of the service delivery staff member. Chart documentation serves as a legal recording of services delivered and a communication mechanism for other care providers.

Documentation ensures that the:

- Client chart is complete and legible.
- Documentation for each encounter includes the reason for the encounter; any relevant history; assessment of clinical impression or diagnosis; plan of care; and date and legible identity of the provider.
- Diagnostic codes used for claims submission are supported by documentation in the client's chart.
- Appropriate health risk factors are identified. The client's progress; his or her response to, and any changes in treatment; and any revision in diagnosis are documented.
- Documentation includes all necessary components including the client's name and number; date; service code; duration of service; location; and signature with title.
- ***Mental Health Treatment Plans*** are completed and submitted within sixty (60) calendar days from the admission date. Updated Treatment Plans must be written and submitted prior to the expiration of the previous Treatment Plan. And, meets QA documentation standards including measurable objectives, signatures, and dates.
- ***Alcohol and Drug Treatment Plans*** are completed within thirty (30) calendar days from the admission date. The provider reviews and documents the client's progress every thirty (30) days after signing the initial Treatment Plan. And an updated Treatment Plan will be completed every ninety (90) calendar days.

Signature Requirements

Signatures/electronic are required to provide a minimum level of assurance that the provider is qualified to deliver the level of service being billed. The Center for Medicare and Medicaid Services (CMS) accepts a signature other than the provider's personal signature (i.e., a computerized signature), if proper safeguards are established.

Such safeguards may include the following:

- Computer generated notes are electronically signed by the clinician.
- Written guidelines to providers which prohibit the use of their code by another physician, intern, resident, or other individual and which state that Medi-Cal/Medicare payment may be denied if these safeguards have been violated.
- Mental health services provided by masters student trainees delivering mental health services must have all progress notes co-signed by a licensed professional staff.

Supervisory Review of Clinical Documentation
Each clinical supervisor may select charts for each of his/her clinicians each month. The supervisor will review the documentation practices in these charts and provide feedback to the clinician during the supervisory session.

D. Improper Inducements, Kickbacks, and Self-Referrals

Remuneration for referrals is illegal because it can distort medical decision-making, cause over-utilization of services or supplies, increase costs to Federal programs, and result in unfair competition. Remuneration for referrals can also affect the quality of client care by encouraging staff to order services based on profit rather than the client's best medical interests.

Potential risk factors in this area include:

- Client referrals to a BHD employee's private practice;
- Financial arrangements with outside entities to whom the practice may refer federal mental health business;
- Joint ventures with entities supplying goods or services to the provider or its clients (for example, medical equipment referrals);
- Consulting contracts or medical directorships;
- Office and equipment leases with entities to which the provider refers;
- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit;
- Waiving co-insurance or deductible amounts without a good faith determination that the client is in financial need or failing to make reasonable efforts to collect the cost-sharing amount;
- Inappropriate crisis care;
- "Gain sharing" arrangements;
- Physician third-party billing;
- Non-participating physician billing limitations;
- "Professional courtesy" billing;
- Rental of physician office space to suppliers; and
- Others.

E. Record Retention

BHD has established standards and procedures regarding the creation, distribution, retention and destruction of compliance, business, and medical records. The guidelines include:

a. The length of time that BHD or a provider's mental health records are to be retained.
b. Management of the mental health record including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and/or damage.
c. The destruction of the mental health records after the period of retention has expired.
d. The disposition of the mental health records in the event the provider's practice is sold or closed.
e. The Federal Alcohol and Drug confidentiality regulations restrict the disclosure and use of "patient identifying" information about individuals in substance abuse treatment. Patient-identifying information is information that reveals that a person is receiving, has received, or has applied for substance abuse treatment. What the regulations protect is not the individual's identity per se, but rather his or her identity as a participant in or applicant for substance abuse treatment.

Compliance Program Documentation

To ensure successful implementation of the compliance standards, to track compliance violations, and to document the department's commitment to compliance, BHD has developed the following documentation procedures:

Compliance Log
Documentation of violation investigations and results will be maintained by the Compliance Officer in the Compliance Log. Information from the Compliance Log will be summarized and system level issues may be reviewed with the QIC, and Compliance Committee. Suggestions, feedback, and changes to the system from the QIC, and Compliance Committee are also documented in the Compliance Log. The Compliance Log contains the following materials:

- The date or general time period in which suspected fraudulent action occurred;
- Name of the reporting party and/or source of the allegation (via compliance hotline, direct contact with Compliance Officer, routine audit, monitoring activities, etc.);
- Name of the provider(s) involved;
- Name of the client(s) or chart number(s) involved; (although materials protected by attorney-client privilege will be filed separately)
- Specific information regarding the investigation, including copies of interview notes, supporting reference materials, etc.;
- Name of the person responsible for providing feedback to the staff person, if appropriate; and
- The corrective action taken, as applicable.

Compliance Program Binder
The components of the Compliance Program are kept in a binder. This binder contains the following materials:

- The BHD Compliance Plan
- The BHD Compliance Policies and Procedures, as well as any changes or updates

- The BHD Code of Ethical Conduct
- The Compliance Log

The Compliance Committee Minutes Binder
The Minutes binder contains the following materials:

- Signed and dated minutes indicating those present and absent
    1. Any changes made in policies and procedures
    2. A summary of education and training efforts
    3. Plans for ongoing monitoring and enforcement
    4. Descriptions of any other steps to correct inappropriate actions

- All agendas
- Any materials distributed

Compliance Hotline
BHD has developed an employee Compliance Hotline to report possible compliance violations. The Compliance Officer will track complaints from this reporting mechanism.

Component III. Oversight of Compliance through a Compliance Officer

The successful implementation and maintenance of the BHD Compliance Program depends on the efforts and support of all BHD staff and administrators. To guide these efforts and perform day-to-day operations, BHD has appointed a Compliance Officer. In coordination with the functions performed by the Compliance Officer, a Compliance Committee was formed to oversee and monitor the Compliance Program. The Compliance Committee works in coordination with the Management Team, as well as the Quality Improvement Committee to review departmental procedures and to detect potential and actual violations.

This multi-layered system of support ensures that the practices and standards of the Compliance Plan are fully implemented and maintained. The participation of the oversight committees reinforces the department's continuing efforts to improve quality of care in an environment that promotes integrity, ethical conduct, and adherence to applicable laws.

Compliance Officer
The Compliance Officer has the responsibility of developing a corrective action plan and providing oversight of BHD's adherence to the Compliance Plan. This individual is empowered to bring about change and is responsible for overseeing the implementation and day-to-day operations of the Compliance Program.

The Management Team provides oversight to the Compliance Officer and ensures implementation of all compliance activities. The primary functions of the Compliance Officer are to oversee the compliance activities and implement the requirements of the guidelines, including serving as the contact point for reports of suspicious behavior and questions about internal policies and procedures. The Compliance Officer also reviews changes in billing codes, directives from payers, and other relevant rules and regulations.

Compliance Officer duties include:

- Overseeing and monitoring the implementation of the compliance program;
- Establishing methods, such as periodic audits, to improve the program's efficiency and quality of services, and to reduce the program's vulnerability to fraud and abuse;
- Periodically revising the compliance program in light of changes in the needs of the program or changes in the law;
- Developing, coordinating, and participating in a compliance training program;
- Determining if any of the practice staff are excluded from participation in federal health care programs;
- Investigating allegations of improper conduct and monitoring corrective action;
- Serving as the 'responsible' person for staff reporting of potential wrongdoing;
- Conducting/arranging for background checks of employees including checking finger prints against a national data bank; and
- Other duties as assigned

Role of the Management Team

The Management Team is responsible for the supervision of the compliance efforts of Siskiyou County Behavioral Health. The Management Team, through the Compliance Committee, will oversee all of BHD's compliance efforts.

Role of the Compliance Committee

In coordination with the Compliance Officer, the BHD Compliance Committee performs vital functions to assure compliance with state and federal regulations. The Compliance Committee is responsible for the following compliance activities:

- Receives reports on compliance violations and corrective actions from the Compliance Officer;
- Advises the Compliance Officer on matters of compliance violations and corrective actions;
- Advises the BHD Director on compliance matters;
- Advises BHD staff on compliance matters;
- Develops and maintains the Compliance Plan;
- Ensures that an appropriate record-keeping system for compliance files is developed and maintained;
- Ensures that compliance training programs are developed and made available to employees and that such training is documented;
- Ensures that a departmental review and audit system is developed and implemented to ensure the accuracy of the claims documentation and submission process to all payers, which will include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action; and
- Meets as needed, but no less than twice per year.

Quality Improvement Committee (QIC)

The QIC is actively involved in ensuring successful compliance. The QIC is responsible for performing the following activities related to compliance and practice standards:

- Annually reviews a minimum annual sample of 10% of the charts for documentation practices using a QIC checklist.
- Notes documentation deficiencies and results in 'backing out' billing and/or stopping billing until the chart meets compliance standards.
- Records documentation deficiencies in the QIC minutes and on a QIC checklist.
- Reviews charts with deficiencies to determine if all deficiencies have been corrected and/or addressed.
- Provides the clinician with feedback on the number of services and dollars lost to documentation discrepancies (dollars for services backed out).
- Reviews additional charts of those clinicians who have repeated problems.
- For charts with problems still outstanding by the second review, the Quality Assurance Manager will discuss the documentation issues with the clinician's supervisor.
- Monitors the types of charting and compliance issues found during chart reviews and provide system level training to address any systemic problems
- Annually reviews policies and procedures and compliance standards to ensure that these standards are relevant and up-to-date.

Component IV. Conducting Appropriate Training and Education

Education and training is an important part of any compliance program. There are two primary areas for training: *Compliance Standards* and *Coding and Billing*.

Compliance training has two goals:

1) All employees receive periodic training on how to perform their jobs in compliance with the standards of the Compliance Plan and any applicable regulations; and
2) Each employee understands that compliance is a condition of continued employment.

Training clearly communicates the compliance policies and procedures to all staff, as well as to independent contractors whose services are billed under the BHD's provider number. Memos, informational notices, E-mail, and/or monthly meetings are used to notify staff of changes in policies or procedures.

A. Compliance Standards Training

Training on compliance standards covers the operation and importance of the Compliance Program, the consequences of violating the standards and procedures outlined in the Compliance Plan, and the role of each employee in the operation of the Compliance Plan. Compliance standards training will provide information on how to follow the law and will be tailored to the needs of the clinical staff and physicians, case management staff, and support staff. It will also review the BHD *Code of Ethical Conduct.*

In addition, training will include several clear examples of noncompliant behavior. For example, training for the billing staff might include a discussion of how submitting claims based on codes that do not reflect the services actually provided violates the Compliance Plan and may violate the law.

B. Coding and Billing Training

Training on accurately documenting services is an ongoing mission of Siskiyou County. This coding and billing training includes:

- Coding requirements
- Claim development and submission practices
- Signature Authorization
- Proper documentation of services rendered
- Proper billing standards and procedures and submission of accurate bills for services
- Legal sanctions for submitting deliberately false or reckless billings
- Ongoing training for staff on policy changes
- Unit meeting agendas to include discussions of compliance activities and QIC system level issues, when applicable; and
- New staff orientation training including specific discussion and training on compliance issues

Training Log

The Compliance Officer will maintain a log of all training activities. This log provides information on the date of the training, names of attendees, type and topics of training, location of the training, trainer's name(s), duration of the training, and number of CEUs earned, if applicable.

Staff will sign an acknowledgement that they have received compliance training and that they understand the material. These acknowledgements will be maintained as part of the Training Log.

Ongoing Education

To regularly communicate new compliance information and to assure that staff receives the most recent information, BHD has implemented the following communication mechanisms:

- The Compliance Plan is posted on the desktop of all computers.
- All Compliance policies and procedures are posted on the desktop of all computers.
- Scheduled periodic Compliance trainings

Training Timelines

New employees are trained as soon as possible after their start date and employees receive refresher training on an annual basis, or as appropriate.

Training(s) will be scheduled periodically to maintain and enhance all employees' understanding of the Compliance Plan.

Component V. Responding to Detected Offenses and Developing Corrective Action Initiatives

Upon receipt of a report or reasonable indications of suspected non-compliance, the Compliance Officer will investigate the allegations to determine whether a significant violation of applicable law or the requirements of the Compliance Program has occurred. If so, a corrective action plan will be developed to correct and mitigate the compliance issue.

The Compliance Officer may initiate an investigation of an alleged compliance violation based on information from one of several sources:

- Employee reports via the Compliance Officer, the employee Compliance Hotline, or a supervisor
- Routine audits and self-assessments
- Monitoring activities that may detect such warning indicators as the number and/or types of claim rejections, challenges to medical necessity, and/or high volumes of unusual charge or payment adjustment transactions

If an investigation yields valid evidence of non-compliance, the Compliance Officer, in coordination with the Compliance Committee, will develop a plan of correction to address the violation. As determined by the type of violation, the corrective action may include:

- Development of internal changes in policies, procedures, and/or the Compliance Program
- Re-training of staff
- Internal discipline of staff
- The prompt return of any overpayments
- Reporting of the incident to the appropriate federal department
- Referral to law enforcement authorities; and/or
- Other corrective actions as deemed necessary

Subsequent investigations may be conducted to determine if corrective action has been followed by the appropriate staff member(s). If the subsequent investigation indicates that corrective action was not taken, staff may be subject to disciplinary action and/or the case may be sent to the federal Office of the Inspector General to be reviewed for possible civil and criminal action.

Component VI. Developing Open Lines of Communication

BHD is committed to the success of the compliance process. An important component of the Compliance Program is to provide staff with open lines of communication for reporting suspected fraudulent activity, as well as to provide access to compliance information when needed. This process creates an open-door policy for reporting possible misconduct to the Compliance Officer and evidences the commitment of BHD to successfully implement and monitor the Compliance Plan.

To ensure this communication standard, BHD has determined that the Compliance Officer may be contacted directly by staff to report activity that may violate the ethical and legal standards and practices of the Compliance Program. Staff is also encouraged to seek guidance from the Compliance Officer if they are unsure about whether they are following the compliance policies

and procedures correctly, if they need additional training, or if they have specific concerns or questions about the Compliance Program.

To promote meaningful and open communication, the Compliance Program includes the following:

- The requirement that staff report behavior that a reasonable person would, in good faith, believe to be erroneous or fraudulent
- A confidential process for reporting erroneous or fraudulent behavior
- A standard that a failure to report erroneous or fraudulent behavior is a violation of the compliance program
- A simple procedure to process reports of erroneous or fraudulent behavior
- A coordinated process between the compliance program and the fiscal department to synchronize billing and compliance activities. Suspense billing reports in the electronic health record are used to identify possible erroneous claims, and prevent them from being submitted. The erroneous claims are voided before the monthly billing cycle
- A confidential process that maintains the anonymity of the persons involved in the reported possible erroneous or fraudulent behavior and the person reporting the concern. However, there may be certain occasions when a person's identity may become known or may need to be revealed to aid the investigation or corrective action process
- Standards that outline that there will be no retribution for reporting behavior that a reasonable person acting in good faith would have believed to be erroneous or fraudulent
- Policies and procedures that implement these standards in detail

Feedback to Staff

It is part of BHD's responsibility to advise staff of their audit findings and inform them of the corrective actions needed. The Compliance Officer, in coordination with the supervisors and/or Quality Assurance Manager, will provide feedback to staff. Staff who have been informed of non-covered services or practices, but continue to bill for them, or staff whose claims must consistently be reviewed because of repeated over-utilization or other abuse practices, could be subjected to administrative actions.

These actions include suspension from participation in the Medi-Cal/Medicare programs and assessment of a civil monetary penalty. This penalty could be an amount up to $10,000 for each false or improper item or service claimed and an additional assessment of up to three times the amount falsely claimed.

Subsequent audits are conducted to determine if corrective action has been taken. If the subsequent audit indicates that corrective action was not taken, the case may be sent to the federal Office of the Inspector General to be reviewed for possible civil and criminal action.

Health care professionals convicted of program-related crimes after December 4, 1980, will be suspended from participation in the Medi-Cal/Medicare programs.

OIG Note:

According to the Healthcare Disclosure Statute, a provider can be prosecuted for his or her failure to disclose a known overpayment to the Medicare carrier even if the payment was not fraudulently obtained. Overpayments or errors that are not believed to be fraudulent should be reported directly to the entity responsible for handling those claims. However, fraudulent claims that have occurred in a provider's own organization can be disclosed to the OIG through its Provider Self-Disclosure Protocol. Instructions on how to submit a voluntary disclosure under this protocol can be downloaded from the OIG's Web site at www.hhs.gov/oig/oigreg/selfdisclosure.pdf. The OIG points out those providers may want to consult an attorney prior to disclosing information.

NOTE: Although voluntarily disclosing fraud and abuse does not preclude prosecution, the OIG considers the act of doing so a "mitigating factor in [its] recommendations to prosecuting agencies." Expect closer scrutiny by the government if there is a refund or a large overpayment. A May 2000 program memorandum from HHS to intermediaries and carriers indicated that any repayment equal to or greater than 20 percent of a Plan's total annual Medi-Cal/Medicare payments would prompt further inquiry.

The Compliance Plan should require that detected misconduct be corrected promptly. Although the final OIG guidance didn't specify a timeframe, the draft guidance suggested that misconduct be corrected within 90 days of detection. The program should also provide for an internal investigation of all reported violations. When problems are detected, determine whether a flaw in the compliance program failed to anticipate the problem or whether the program's self-policing procedures failed to prevent the violation.

Component VII. Enforcing Disciplinary Standards through Well-Publicized Guidelines

The Compliance Plan clearly outlines consistent and appropriate sanctions for compliance violations while, at the same time, is flexible enough to account for mitigating or aggravating circumstances. The ranges of disciplinary actions that may be taken closely follow the Siskiyou County Memorandum of Understanding and the Siskiyou County General Unit Union guidelines.

The BHD corrective action plan for compliance issues is outlined below:

A. The range of disciplinary activities taken follow the Siskiyou County MOU and the Siskiyou County General Unit Union guidelines:

"Disciplinary Action" means dismissal (except dismissal for medical reasons), demotion, reduction in pay, or suspension without pay, written warning, and verbal warnings.

Each of the following constitutes cause for discipline of an employee:

- Incompetence
- Inefficiency
- Inexcusable neglect of duty
- Willfully disobeying a reasonable order or refusal to perform the job as required

- In possession of/or under the influence of, or trafficking in habit forming drugs and/or narcotics while at work or on County property
- Unauthorized absence without leave
- Conviction of a felony or conviction of a misdemeanor related to the performance of duties of the job. A plea or verdict of guilty or a conviction following a plea of nolo contendere to a charge of a felony or any offense involving moral turpitude is deemed to be conviction within the meaning of this section
- Discourteous treatment of the public or other employees
- Improper political activity as defined in the Government Code
- Misuse of County property or damage to public or private property resulting from misuse or negligence
- Violation of the Code of Ethical Conduct (Conflict of Interest Code)
- Abuse or misuse of sick leave, vacation, or other employee benefits
- Gambling on County premises
- Failure to properly report absenteeism
- Excessive tardiness
- Refusal to take and subscribe any oath or affirmation which is required by law in connection with employment
- Other conduct either during or outside of duty hours which is of such a nature that it causes discredit to the department or to the County
- Violation of any State law or County ordinance requiring confidentiality of records or information
- Inability to perform the duties of the position as a result of the removal of "deputy" status by an appropriate elected official
- Inability to perform the deputies of the position due to loss or inability to obtain required licenses

B. Job duty statements include the *Code of Ethical Conduct*, documentation standards within expectations for an employee's assigned unit, timeliness of documentation, and consequences of inaccurate documentation.

C. New employees, and all staff on an annual basis, are required to sign a signature page stating their understanding of the documentation and professional conduct expectations outlined above.

D. BHD follows the 'Chain of Command' system regarding the MOU that outlines progressive stages of feedback to address any issues of noncompliance. These may include outlining the Chain of Command:

- *Verbal Warning*
- *Written Warning*
- *Written in Annual Evaluation or during Probationary Period*
- *Written in the Departmental Personnel File*
- *Reduction in pay*
- *Suspension without pay*
- *Demotion*

- *Dismissal*

E. The following Siskiyou County Health and Human Services Agency committees and/or departments will monitor and manage Compliance issues:

- Compliance Committee
- Management Team
- Quality Improvement Committee
- Utilization Review (UR) Team

Office of Inspector General Notes:

The OIG recommends that a Mental Health Plan's enforcement and disciplinary mechanisms ensure that violations of the compliance policies will result in consistent and appropriate sanctions, including the possibility of termination. At the same time, OIG advises that the Mental Health Plan's enforcement and disciplinary procedures be flexible enough to account for mitigating or aggravating circumstances. The procedures might also stipulate that individuals who fail to detect or report violations of the compliance program may also be subject to discipline. Disciplinary actions could include: Warnings (oral); reprimands (written); probation; demotion; temporary suspension; termination; restitution of damages; and referral for criminal prosecution. Inclusion of disciplinary guidelines in in-house training and procedure manuals is sufficient to meet the "well publicized" standard of this element.

OIG suggests that any communication resulting in the finding of non-compliant conduct be documented in the compliance files by including the date of incident, name of the reporting party, name of the person responsible for taking action, and the follow-up action taken. Another suggestion is for counties to conduct checks to make sure all current and potential practice employees are not listed on the OIG or GSA lists of individuals excluded from participation in Federal health care or Government procurement programs.

The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) provides information to health care providers, patients, and others regarding individuals and entities that are excluded from participation in Medicare, Medicaid, and other Federal health care programs. Information is readily available to users in two formats on over 18,000 individuals and entities currently excluded from program participation through action taken by the OIG.

The on-line searchable database allows users to obtain information regarding excluded individuals and entities sorted by 1) the legal bases for exclusions; 2) the types of individuals and entities excluded by the OIG; and 3) the States where excluded individuals reside or entities do business. In addition, users may query the database in order to ascertain whether a particular individual or entity is currently excluded from program participation by submitting pertinent information regarding the subject. Users may obtain data sorted by name, profession or specialty, city, state, zip code, or sanction type. Users may input information in any of these fields and will receive a list of currently excluded individuals and entities, which meet the criteria entered.

In addition to the on-line searchable database, the OIG provides information on excluded individuals and entities in a downloadable database file format, which allows users to download

the data to their personal computers and either set up their own databases or combine it with their existing data. Monthly exclusion supplements to the downloadable database file are posted on the OIG web site, as will separate files containing individuals and entities that have been reinstated each month.

OIG Web address: http://www.exclusions.oig.hhs.gov/

Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plans

Must have *all,* A, B, *and* C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, excluding Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Disorder
- Other Conditions that may be a Focus of Clinical Attention, except Medication Induced Movement Disorders, which are included

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present

B. Impairment Criteria

Must have at least *one* of the following as a result of a mental disorder(s) identified in the diagnostic ("A") criteria; Must have *one*, 1, 2, 3 *or* 4:

1. A significant impairment in an important area of life functioning, *or*
2. A probability of significant deterioration in an important area of life functioning, *or*
3. A probability the child will not progress developmentally as individually appropriate, *or*
4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

C. Intervention Related Criteria

Must have *all*, 1, 2, *and* 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, *and*
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable that child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*
3. The condition would not be responsive to physical health care based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.