YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Standards for Risk Areas and Potential Violations**

POLICY

In order to successfully implement the Yolo County Alcohol, Drug & Mental Health Department (ADMH) Compliance Program required by the federal Office of Inspector General (OIG), risk areas and potential violations have been identified and assessed. This policy and procedure has been developed to address these risk areas and serve to implement the standards necessary to avoid these types of violations.

Each ADMH employee is expected to be familiar with the 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.

Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of ADMH may be subjected to progressive disciplinary action up to and including termination.

PROCEDURE

The following areas of risk have been among the most frequent subjects of investigations and audits by the OIG. Staff is expected to be familiar with these potential violations and work to maintain compliance with the standards surrounding each area of risk.

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. Claims that cannot be substantiated as delivered. 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 ADMH 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 necessary and are not warranted by a client's documented medical condition. This includes services that are not warranted by the client's current and

documented medical condition (medical necessity).

Medi-Cal: ADMH operates under a State waiver implementing the managed mental health services as written 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 PP 500 Medical Necessity Determination).

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 ADMH.

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.

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 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 cannot 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.

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. **Reasonable and Necessary Services**

Claims are to be submitted only for services that staff finds to be reasonable and necessary. 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. This documentation also serves as verification that this service was delivered and the claim is accurate as submitted.

One of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation is necessary to determine 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 claims; and d) the identity of the service delivery staff member.

1. Documentation also assures that the:

a. Client chart is complete and legible.

b. 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.

c. Diagnostic codes used for claims submission are supported by documentation and the client chart.

d. 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.

e. Documentation includes all necessary components including date; service code; duration of service; location; and signature with title.

f. Service plans and progress notes are written within time guidelines and meets documentation standards including measurable objectives, signatures and dates.

g. Documentation also provides the record for when the case is involved in litigation and provides a means of communication for other providers involved with the case.

2. Timely documentation of progress notes is also essential. ADMH has implemented the following standard regarding documentation of progress notes:

a. Progress notes should be written on the same day as the service delivery.

b. A progress note shall be documented as Late Entry if it is written up to a maximum of five working days after the service delivery. Late Entry progress notes will only be accepted in unusual circumstances.

D. **Signature Requirements**

Signatures 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 the county can satisfy the carrier that proper safeguards are established.

Such safeguards include the following:

1. Dictated notes are signed by the clinician/doctor dictating the note. Charts/notes requiring a cosignature are hand signed by the supervising clinician and/or other authorized staff as related to their scope of practice standards.

2. Written guidelines to staff provided in MIS training shall be followed regarding security and logon into clinician workstations.

E. **Improper Inducements, Kickbacks, and Self-Referrals**

Remuneration for referrals is illegal because it can distort medical decision-making, cause overutilization 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:

1. Client referrals to a ADMH employee's private practice;

2. Financial arrangements with outside entities to whom the practice may refer federal reimbursement related mental health business (for example, Health Foundation);

3. Joint ventures with entities supplying goods or services to the provider or its clients (for example, medical equipment referrals);

4. Consulting contracts or medical directorships;

5. Office and equipment leases with entities to which the provider refers;

6. Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit;

7. 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;

a. Inappropriate Emergency Department or Crisis care;

b. "Gain sharing" arrangements;

c. Physician third-party billing;

d. Non-participating physician billing limitations;

e. "Professional courtesy" billing;

f. Rental of physician office space to suppliers; and

g. Others.

F. **Record Retention**

ADMH has developed standards and procedures regarding the retention of compliance, business and mental health records, including electronic records. This system addresses the creation, distribution, retention and destruction of documents. The guidelines include:

1. The length of time that ADMH's records are to be retained.

2. Management of the chart including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption and/or damage.

3. The destruction of the charts after the legal period of retention has expired.

For more information, please refer to the ADMH Departmental Policies and Procedures and the ADMH HIPAA Policies and Procedures, pertaining to record retention and security issues.

G. **Auditing and Monitoring Activities**

The ADMH Compliance Officer, in conjunction with various oversight committees such as the QIC, will conduct routine audits of client charts, service utilization and cost data, and Medi-Cal Denial reports to assess the level of compliance to the above standards.

For more information on these activities, please see the PP 403 ADMH Auditing and Monitoring Activities policy and procedure.

REFERENCES

500 Medical Necessity Determination
PP 403 ADMH Auditing and Monitoring Activities
ADMH HIPAA Policies and Procedures

APPROVED BY:

ADMH Director | Date