Yolo County
Department of Alcohol, Drug, and
Mental Health

Compliance Plan

Original: February 22, 2005
Revised: May 25, 2010

Initial Preparation by:
I.D.E.A. Consulting
in collaboration with
ADMH Quality Improvement

Yolo County
Department of Alcohol, Drug, and Mental Health
Compliance Plan

Introduction

What is Compliance and why do we have to be concerned?

Compliance refers to adherence to federal health care program requirements. The two programs of prime interest are Medicare and Medicaid. Medicaid is referred to as Medi-Cal in the State of California.

Medicare is a health insurance program for 1)people 65 years of age and older; 2) people with severe disabilities under the age of 65; and 3) people of any age with End-Stage Renal Disease. Standard Medicare covers outpatient, inpatient and partial hospitalization benefits for mental health care. Medicare will pay for mental health services provided by certain specialty providers including; psychiatrists, clinical psychologists and clinical social workers.

Medicaid is a health insurance program that provides medical and medically related services to the most vulnerable populations. In general, Medicaid provides three types of health services: 1) health insurance for low-income families and individuals with disabilities; 2) long-term institutional and or community-based care for older Americans and individuals with disabilities; and 3) supplemental co-payments coverage for low-income Medicare beneficiaries. Medicaid is a joint Federal and State program. The Medicaid benefit package is determined by each state based on broad Federal guidelines. In general, each state must cover 10 categories of 'mandatory services" identified in statue, such as inpatient and outpatient services, laboratory and X-ray services, nursing facility services, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under the age of 21. In addition states have the option to cover one or more of up to 33 "Optional services" under Medicaid, such as case management, personal care services, inpatient psychiatric services for under 21, prescribed drugs and a variety of professional services. We receive payments from both of these programs and therefore are required by law to have a Compliance Program and to prevent fraud and abuse in our agency. The False Claims Act is a federal statue that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs outlined above. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

Who monitors fraud and abuse?

- U.S. Department of Health and Human Services, Office of Inspector General (OIG)
- US Department of Justice (DOJ), Federal Bureau of Investigation (FBI)
- State Medicaid Fraud Control Units (MFCUs)
- US Centers for Medicaid and Medicare Services (CMS - formerly HCFA)

- Internal Revenue Service (IRS)
- And more….

Definitions:

- **Auditing** is the methodological review and examination of records or accounts to check the accuracy of the information.
- **Monitoring** for the purposes of this document means to systematically test processes on an ongoing basis to document compliance with policies, procedures, laws or regulations.
- **Fraud** is an intentional deception or misrepresentation that an individual knows or should know to be false that could result in some unauthorized benefit to you or another, including any agency.
- **Waste** is the careless or needless expenditure of funds or consumption of resources that results from deficient practices, poor systems controls or bad decisions. **Waste** may or may not provide personal gain.
- **Abuse** is the intentional, wrongful or improper use of resources or the misuse of rank, position or authority that causes the loss or misuses of resources.

Mission Statement

The mission of the Yolo County Department of Alcohol, Drug and Mental Health (ADMH) is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life. To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

As ADMH 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 internal bulletin boards 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; and

7. Enforcing disciplinary standards through well-publicized guidelines.

Legal Mandates for Compliance Activities

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.

ADMH Code of Ethical Conduct

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

- Each staff member shall be required to sign an acknowledgement that he/she has received and read a copy of the *Code of Conduct*. This acknowledgement will be maintained in a file by the Compliance Officer.
- This acknowledgement form shall be re-signed after reviewing the ADMH *Code of Conduct* on an annual basis.

ADMH Compliance Plan

The ADMH Compliance Plan will be monitored in accordance with this document and the ADMH *Code of Ethical Conduct* prepared by the ADMH Compliance Committee. In addition, the Committee will review key issue areas. The key issue areas will be determined by the Director with advice from the Committee. As with all ADMH operations and function, the Board of Supervisors ultimately oversees compliance operations via the Director of the Department.

ADMH Compliance Committee

The ADMH Compliance Committee will be appointed by the Director and will include representation from:

- Director
- Deputy Director, Programs
- Deputy Director, Operations
- Medical Director
- Compliance/Privacy Officer
- Quality Management
- Program Manager, Children's Services
- Program Manager, Adult Services

- Other Agency Representation
    - County Counsel (as needed for consultation)
    - County Security Officer (as needed for consultation)
- Other Staff

Statement of Policy on Ethical Practices
ADMH expects that all personnel will conduct themselves in a manner consistent with the highest professional standards and the ethical codes of their profession. ADMH places great importance on its reputation for honesty and integrity. To that end, the Management Team expects that the conduct of employees will comply with these ideals.

Each ADMH 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 ADMH *Code of Conduct*. Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of Yolo County may be subjected to progressive disciplinary action, up to and including termination.

ADMH will adhere to all applicable federal, state and local laws and regulations in the performance of its day-to-day activities. In addition, ADMH 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 shall seek guidance from a knowledgeable supervisor or manager. Supervisors may contact County Counsel or Yolo County's Compliance/Privacy Officer, as the situation warrants.

ADMH, as part of its Compliance Program, will develop and implement detailed policies setting forth standards of conduct specifically applicable to the services. These policies will be communicated to all department employees, and contracted organizational service providers, as appropriate. ADMH 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
ADMH conducts an ongoing evaluation process as a component of the Compliance Plan. This process determines if the Compliance Program 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.

Review Activities

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

1) Peer Review: Peer Review is managed by Quality Management (QM). QM facilitates peer reviews where clinical staff reviews charts of their peers. AVATAR is utilized in obtaining necessary information. This process is completed annually on 5% of the ADMH clinical charts.

2) Utilization Review: This is a process to review charts and can be conducted by clinical managers, clinical supervisors, and/or clinical staff. This review seeks to confirm that:
   a. Bills are accurately coded and accurately reflect the services provided (as documented in the client's chart);
   b. Documentation is being completed correctly and in a timely manner (per quality improvement regulations);
   c. Services provided meet medical necessity criteria; and
   d. Incentives for unnecessary billing do not exist.

3) Policy and Procedures Review: The policies and procedures are reviewed and evaluated annually by the QIC to determine if they are current and complete. If they are ineffective or outdated, they are updated to reflect changes in state and federal government regulations and standards.

4) System Level Monitoring: The QIC annually reviews data on service utilization, clients with high service utilization patterns, staff productivity, cost of services, and cost per client information. When available, service utilization and cost utilization data will be analyzed and reviewed with data from other comparable counties.

5) Compliance Reviews: These are reviews conducted by the Compliance Officer of the providers contracted to provide mental health services. These reviews cover the required policies and procedures a provider should have, mandated paperwork, and chart reviews.

Monitoring Activities

The ADMH management team in conjunction with the Compliance Officer oversees the ongoing monitoring activities in the following areas:

- Contracts –administrative Service Analysts monitor terms of contracts.
- Utilization Management – oversees Medi-Cal site certification and authorization for services.

- Fiscal – monitors timeliness and accuracy of billing.
- Utilization Review – assess the appropriateness of clinical documentation including accurate coding.

ADMH utilizes a medial records system for its internal billing and charting.

Reporting Results from Auditing and Monitoring Activities
The auditing activities listed above will be conducted directly by the Compliance Officer (or his/her designee) or by a committee of which the Compliance Officer is a member. Any compliance issues that are detected through these activities will be reported to the Compliance Officer immediately. If a designee is responsible for conducting a specific audit, that designee will promptly notify the Compliance Officer of any detected compliance issues.

While performing the on-going monitoring activities outlined above, designated staff will immediately report any detected incidences of non-compliance directly to the Compliance Officer.

The Compliance Officer will document all incidences of non-compliance on the Compliance Log. This information will be reported to the Compliance Committee. The Compliance Officer will summarize the Compliance Log and report it to the Quality Improvement Committee quarterly and the Quality Leadership Committee annually.

Investigation and Corrective Action
When compliance issues are reported by staff or detected via auditing/monitoring activities, the Compliance Officer will initiate an investigation. If non-compliance is evidenced, the Compliance Officer will follow a course of corrective action outlined later in this Compliance Plan.

Component II. Implementing Compliance and Practice Guidelines

As a component of the broader Compliance Program, ADMH has designed processes for combating fraud and unethical conduct through the development of this ADMH 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:

- Compliance Program Standards
- Compliance Auditing and Monitoring Activities
- Implementation of the Compliance Program
- Standards for Risk Areas and Potential Violations
- Oversight of the Compliance Program
- Compliance Training
- Non-Compliance Investigation and Corrective Action
- Reporting Suspected Fraudulent Activity
- Disciplinary Guidelines
- Guidelines concerning Federal False Claims Act and the Deficit Reduction Act

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 are 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 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.*
   These are claims 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);

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 known 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.*
   This is the submission of a claim using a covered service code when the actual service was a non-covered service. "Necessary" does not always constitute "covered".

5. *Known misuse of provider identification numbers, which results in improper billing.*
   This is when a provider who has not yet been issued a provider number 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. 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 Attachment A).

C. Service Documentation

Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. 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 ensures 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 date; service code; duration of service; location; and signature with title.
- Client Care Plans are written within time guidelines and meets documentation

standards including measurable objectives, signatures, and dates.

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 proper safeguards are established.

Such safeguards may include the following:

- Dictated notes are signed by the clinician dictating the note. Computer generated notes are hand signed by the clinician. Charts/notes requiring a co-signature are hand signed by the supervising 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.
- Electronic signatures may be accepted as long as the Electronic Health Record (EHR) can establish with certainty that the provider who provided the service is the one who documented it into the EHR.

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 an ADMH 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;
- Physician third-party billing;
- Non-participating physician billing limitations;
- "Professional courtesy" billing;
- Rental of physician office space to suppliers; and
- Others.

E. Record Retention

The provider should develop standards and procedures regarding the retention of compliance, business, and medical records. This system would establish standards and procedure regarding the creation, distribution, retention, and destruction of documents. The guidelines include:

a. The length of time that a provider's records are to be retained.
b. Management of the medical record including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and/or damage.
c. The disposition of the client charts in the event the provider's practice is sold or closed.

COMPLIANCE PROGRAM DOCUMENTATION

To ensure successful implementation of the compliance standards, to track compliance violations, and to document the department's commitment to compliance, ADMH 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 will be reviewed with the QIC on a quarterly basis. Suggestions, feedback, and changes to the system from the QIC 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;
- 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.

Hotline Log

ADMH is developing an employee hotline to report possible compliance violations. The Compliance Officer will track complaints from this reporting mechanism via a unique record. Information from the Hotline Log will be cross-referenced in the Compliance Log.

Compliance Program Binder
The components of the Compliance Program are kept in a binder (although materials protected by attorney-client privilege will be filed separately). This binder contains the following materials:

- The ADMH Compliance Plan
- The ADMH Compliance Policies and Procedures, as well as any changes or updates
- The ADMH Code of Ethical Conduct
- A description of the compliance officer's role
- The duty statements of employees
- A summary of education and training efforts
- A description of the internal reporting system
- Plans for ongoing monitoring and enforcement
- Descriptions of any steps to correct inappropriate actions

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
- The standards of ethics for ADMH employees

Component III. Oversight of the Compliance Program

The successful implementation and maintenance of the ADMH Compliance Program depends on the efforts and support of all ADMH staff and administrators. To guide these efforts and perform day-to-day operations, ADMH 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 turn with the County Board of Supervisors, as well as the Quality Improvement Committee, to review departmental procedures and to detect potential and actual violations. In addition, when there is a need for counsel, the Compliance Officer may contact County Counsel to seek assistance.

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 to ADMH'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 Compliance Officer has access to the Management Team and provides the credibility to ensure that necessary changes will be successfully made.

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 payors, 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 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.

Compliance Committee

In coordination with the Compliance Officer, the ADMH 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 ADMH Director on compliance matters;
- Develops and maintain the Compliance Plan;
- Advises ADMH staff on compliance matters;
- 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 payors, which will include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action; and
- Meets as needed, but no less than once a quarter.

Management/Supervisor Responsibilities

- Create an environment of honesty and ethics within each manager/supervisor's span of control. This can be accomplished by providing employees clear direction regarding work expectations and legal requirements.
- Reduce opportunities for fraud, waste and abuse by implementing strong internal controls that detect and deter dishonest behavior.
- Ensure that staff are aware of the options available for reporting fraud, waste and abuse and other compliance issues.
- Establish an environment free from intimidation and retaliation to encourage open communication.

Individual Responsibility

- Perform duties in a way that promotes the public trust and ensures proper expenditures and use of county assets and property.
- Employees, contractors, volunteers and other designated individuals have a duty to report actual or suspected violations of law, regulations or policy including fraud, waste and abuse to appropriate authorities.
- Cooperate with investigations of compliance issues.

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 practice 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 physicians and staff, as well as to independent contractors whose services are billed under the ADMH 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 ADMH *Code of 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 Yolo County. This training includes:

- Coding requirements;
- Claim development and submission practices;
- Signature requirements;
- 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; and
- New staff orientation training.

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 Communication

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

- Staff emails informing all staff of new information and policies.
- Policies and Procedures are posted online on the intranet.
- 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.

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 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 24-Hour Hotline (1-800-391-7440), 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

ADMH 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 ADMH to successfully implement and monitor the Compliance Plan.

To ensure this communication standard, ADMH 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 are 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, including an employee hotline.
- 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 to back out any erroneous claims.
- A confidential process that maintains the anonymity of the persons involved in reporting possible erroneous or fraudulent behavior. 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 ADMH's responsibility to advise staff of their audit findings and inform them of the corrective actions needed. The Compliance Officer, in coordination with the clinical supervisor and/or Quality Improvement Coordinator, 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 http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf. The OIG points out that 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

Disciplinary Standards for ADMH Staff

ADMH 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 range of disciplinary actions that may be taken closely follow the Yolo County Memorandum of Understanding and the Yolo County Bargaining and Supervisor Union and the Managers Union guidelines.

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

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

   Each of the following constitutes cause for discipline of an employee:
   - Falsifying personnel records or County records or providing false information concerning employment qualifications;
   - Every instance of misfiling of client record materials will result in an official write up;
   - Incompetence;
   - Inefficiency;
   - Repeatedly failing to detect or report violations;
   - Inexcusable neglect of duty; and
   - Willfully disobeying a reasonable order or refusal to perform the job as required.

B. ADMH 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

Disciplinary Standards for Providers

Each of the following constitutes cause for discipline of a provider:
- Inappropriate billing and/or coding practices; and
- Persistently negligent documentation practices.

In response to inappropriate or fraudulent practices of a provider, expanded documentation requirements may be implemented. These requirements may include:

- Requiring all progress notes be submitted with billings;
- More frequent reviews

Oversight of Disciplinary Issues

The following ADMH committees and/or departments will monitor and manage Compliance issues:

- Quality Improvement Committee
- Compliance Committee
- Personnel Department

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://oig.hhs.gov/fraud/exclusions.html

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

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. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply)

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.

Compliance Log

Name of the Reporting Party (May be anonymous):

Date or Time Period Action Occurred:

Name of Provider/Staff:

Name of Client:

Specific Information of the Situation:

Name of the Person Responsible for Providing Feedback to the Staff Person:

Staff Response:

Follow-up Action Taken:

☐ **Resolved**
Date:

☐ **Not Resolved (Reason)**

Date or Time Period Action Occurred:

Signature: _____ Date: _____

DEFICIT REDUCTION ACT AND THE FALSE CLAIMS ACT POLICY OVERVIEW

THIS COMPONENT ESTABLISHES THE POLICY THAT THE DEFICIT REDUCTION ACT AND THE FALSE CLAIMS ACT ARE ENCORPORATED INTO THIS AGENCY'S COMPLIANCE PLAN.

FALSE CLAIMS ACT (FCA) FEDERAL AND STATE

The Federal FCA is divided into two main categories, Civil and Criminal.

Civil – This portion of the act prohibits any individual/group/agency from knowingly submitting or causing to be submitted a false or fraudulent claim for payment to the U.S. Government. The civil penalty for each individual claim, that is each service billed, is three times the amount of that claim plus between $5,000 to $10,000 fine for each claim. Reference U.S.C. Section 3729.

It is important to note that the government does not need to prove intent to defraud for the civil act to be enforced, only that the claims were not valid. A claim can be considered invalid for a number of reasons including:

- Missing progress notes, that is lack of documentation
- Progress notes fail to speak to the service billed
- Lack of documented medical necessity
- Billing for individual services that were actually part of a bundled service
- Failure to report overpayment
- Duplicate billings
- Billed services were outside the scope of practice of the individual delivering them

An FCA lawsuit may be filed by either the U.S. Government or by a private citizen. A lawsuit brought by a private citizen is referred to as "Qui Tam" or Whistleblower." In the case of the Qui Tam lawsuit the individual initiating the lawsuit is eligible to receive a percentage of the money recovered, typically 10 to 25%.

There is a Federal Whistleblower protection law, reference 31 USC Section 3730 (h) which protects employees against discharge, demotion, suspension, threats, harassment, or discrimination by the employer because of the lawful acts done by the employee in cooperating with the FCA. This includes initiating the lawsuit, testifying for the lawsuit or assisting in the investigation of an FCA claim.

Criminal – This portion of the act differs in that it involves willful misrepresentation, either verbally or in document form, for financial gain. And can include;

- Deliberately falsifying documents for financial gain
- Deliberately covering up or hiding information about a false claim
- Lying to an investigator

- Obstructing an investigation

In criminal cases there is the possibility of up to five years imprisonment in addition to financial penalties.

California FCA has many similarities to the Federal civil FCA. There is no requirement to prove intent to defraud for financial gain, only that the claim submitted is not valid. Claims are considered invalid for the same reasons they are not considered valid under the Federal civil FCA (see above). The state FCA carries similar financial penalties including tripling the amount of each claim, with up to $10,000 additional penalty for each claim. As in the Federal FCA, there can be a Qui Tam lawsuit filed by an individual with similar protection and entitlement to a percentage of the amount recouped, typically between 15 to 33%.

California Whistleblower protection is similar to the Federal Qui Tam protection. California law, Code Section 12653, provides protection by preventing employers from making, adopting or enforcing any rules, regulations or policies that would prevent an employee from disclosing information to a government or law enforcement agency related to a false claims action. The statute also states that no employer shall fire, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee because of the filing of a false claims action or by disclosing information to a government or law enforcement agency investigating a false claims violation. This includes any testimony for or assistance with the investigation of an FCA violation.

The Federal Deficit Reduction Act of 2005 establishes a Medicaid Integrity Program similar to the Medicare Integrity Program. The programs purpose is to detect fraud, waste and/or abuse in federal, state and local health care programs. This act also made compliance programs mandatory, not voluntary, for agencies receiving over $5,000,000 in Medicaid funds.

Any individual who commits any of the following acts shall be liable for three times the amount of damages which the state or political subdivision sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state or to the political subdivision for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state or political subdivision for a civil penalty of up to $10,000 for each claim. This is not an exhaustive list but represents the acts which would likely be germane to ADMH.

- Submitting, or causing to be submitted, a false claim for payment or approval to the government
- Making or causing to be made a false record or statement which will be used to receive a statement from the government
- Conspiring to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or political subdivision.

- Failing to disclose the inadvertent submission of a false claim to the state or the political subdivision within a reasonable time after the claim is discovered to be false.

The following is a list, not an exhaustive list, of the activities subject to DRA penalties and consequences as they may pertain to ADMH.

- All claims submitted to the Auditor/Controller
- Daily records or other documents rendered for services to Medi-Cal or Medicare.
- Billing or claiming services not rendered or using inaccurate billing codes.
- Payroll, time cards, or quarterly studies.
- Any and all components used for claiming against grants where funds begin as Federal
- Client travel or expense reimbursement without proper proof of the lawful ability to drive or of the expenditure
- Payments or services to individuals using false identity
- Contract providers using incomplete, inaccurate, false or faulty invoicing practices
- Any conditions that do not meet federal or state regulations
- Misuse of funds or county equipment
- Loss of county equipment (theft)
- Falsifying UMDAPS or other eligibility documents by non-disclosure of income, inclusion of non-qualifying dependents, etc.
- Medical ID theft (sharing benefits)
- Using false ID for any county service
- Application for services with false or incomplete information, such as having private insurance or other income earners in the household
- Use of federal funds to provide services to undocumented individuals.