SECTION 5, CHAPTER 4, POLICY 011

STANDARDS FOR RISK AREAS AND POTENTIAL VIOLATIONS

POLICY NUMBER:	5-4-011
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	03.22.2021
EFFECTIVE:	03.01.2021
SUPERSEDES # :	Supersedes Policy #'s: PP 404 Standards for Risk Areas and Potential Violations (10-16-08)

A. PURPOSE: The purpose of this policy is to identify risk areas and potential Yolo County Health and Human Services Agency (HHSA) Behavioral Health Compliance Program ("Compliance Program") violations and provide procedures to address the risks and reduce the potential occurrence of violations

B. RELATED DOCUMENTS: N/A

C. DEFINITIONS:

1. **Applicable State Contracts:** are the Mental Health Plan contract and other State contracts forfederal and/or state funded behavioral health care programs (i.e., substance use disorder services) to which the requirements of the Medicaid Managed Care regulations apply.

2. **Abuse:** means provider practices that are inconsistent with sound fiscal, business, or medicalpractices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

3. **Behavioral Health Employees:** means HHSA employees that participate in the provision of behavioral health services, including administrators and management.

4. **Beneficiary:** means any person certified as eligible for services under the Medi-Cal program. In the behavioral health field, the term "beneficiary" may also be used interchangeably with behavioral health consumer, client, patient, or person who is eligible to receive Medi-Cal specialty mental health services from the Mental Health Plan (MHP), depending on the service setting and the preference of the beneficiary

5. **Fraud:** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

6. **A Credible allegation of fraud**: may be an allegation, which has been verified by HHSA or the California Department of Health Care Services (DHCS), from any source, including but not limited to the following:
    a. *Fraud hotline complaints.*
    b. *Claims data mining.*
    c. *Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.*

7. **Medicaid:** means Medical assistance provided under a State plan approved under Title XIX of the Social Security Act.

8. **Medi-Cal:** is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low-income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS.

9. **Mental Health Plan (MHP):** is an entity that enters into a contract with the Department of Health Care Services (DHCS) to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in the California Code of Regulations (CCR),Title 9, Chapter 11. A MHP may be a county, counties acting jointly or another governmental or non-

governmental entity.

10. **Waste:** is overutilization of services, needless expenditure of funds or consumption of resources or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs caused by deficient practices, poor system controls or bad decisions. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

D. POLICY: In order to successfully implement the Compliance Program required by federal Medicaid Managed Care regulations, the Mental Health Plan (MHP) Contract between Yolo County HHSA and the State Department of Health Care Services (DHCS), and other applicable State contracts for behavioral health services, 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.

All Yolo County HHSA behavioral health employees are expected to be familiar with the Compliance Plan and the appropriate processes necessary to perform his or her duties and how to obtain the requisite information in order to perform those duties in a manner consistent with legal, regulatory, Yolo County HHSA and County requirements. Behavioral Health employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of Yolo County HHSA or the County may be subjectedto progressive disciplinary action up to and including termination.

Network Providers shall be required to have a Compliance Program that address the provisions set forth in State/Federal guidelines and Yolo County contracts and/or policies. Network Provider staff shall be expected to understand and comply with Compliance organizational policies. Compliance Plans shall be sent to Yolo County HHSA at minimum, the timeframes outlined in Yolo County HHSA provider monitoring policies, when there have been significant updates to the Compliance Program or upon request from Yolo County HHSA or DHCS.

E. PROCEDURE: The following areas of risk have been identified as high risk areas. All clinical documentation should follow guidelines outlined in the Yolo County HHSA BH Documentation Manual and associated policies and procedures, and be in accordance with state and federal guidelines. Employees and contract providers are expected to be familiar with these potential violations and work to maintain compliance with the standards surrounding each area of risk.

1. **Claims and Billing:**
    a. Billing for services not rendered and/or not provided as claimed.

    b. A claim for a behavioral health service that the staff person knows or should know was not provided as claimed, or 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 Yolo County HHSA than the code that is applicable to the service actually provided.

    c. 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 Yolo County HHSA. 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.

    d. Failure to properly use coding modifiers. A modifier, as defined by the federal Current Procedural Terminology (CPT) manual 4th edition; the Healthcare Common Procedure Coding System (HCPCS) code; and/or CSI coding manual, provides the means by which a provider can indicate a service or procedure that has been performed.

    e. Claiming for 2 or more staff/providers, claiming for a shared service without properly splitting the time.

    f. Claiming for more time than was actually spent on the service provided.

    g. Claiming incorrectly for a service – such as billing for an outpatient service activity when the service provided was linkage and brokerage, or billing for a medication support service when the service provided was not related to medication support.

    h. Claiming for a service that does not have complete documentation to support the claim.

    i. Providing documentation that does not match the claim.

    j. Submitting claims for equipment, medical supplies and services that are not reasonable and necessary. A claim for health equipment, medical supplies and/or behavioral 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).

k. 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".

l. 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.

m. 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.

n. Clustering. Clustering 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).

o. Up-coding. Up-coding is billing for a more expensive service than the one actually performed.

p. Claim from an Excluded Provider. A claim for a behavioral 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.

q. False Claims – A claim or bill for a service that is false or fraudulent. Examples of this prohibited activity include:

a. Claiming for a service that was not provided;

b. Claiming for a service that has no required documentation;

c. Claiming for a service that was not authorized, if authorization is required;

d. Claiming for a service when there is no assessment or current authorized/signed Client/Service Plan;

e. Claiming for a service as if it is covered when it is not (e.g. claiming for transportation as linkage and brokerage when no linkage or brokerage was provided);

f. Providing incorrect National Provider Identification (NPI) number(s), this may result in improper billing;

g. Providing incorrect client/consumer/patient number(s), this may result in improper billing.

2. **Improper Inducements, Kickbacks, and Self-Referrals**: Yolo County HHSA prohibits remuneration for PHI, ePHI, and/or referrals. PHI shall only be disclosed in accordance policies addressing Confidentiality and Privacy of Behavioral Health Client Information. Additionally, remuneration for referrals is prohibited as 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:

   a. Client referrals to a HHSA employee's private practice;

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

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

   d. Consulting contracts or medical directorships;

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

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

   g. 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;

      i. Inappropriate Emergency Department or Crisis care;
      ii. "Gain sharing" arrangements;
      iii. Physician third-party billing;
      iv. Non-participating physician billing limitations;
      v. "Professional courtesy" billing;

vi. Rental of physician office space to suppliers; and
vii. Others.

3. **<u>Inappropriate Business Relationships – Conflict of Interest:</u>** Employees shall not engage in inappropriate business relationships that may involve fraud, have an actual or appearance of a conflict of interest, or actual or appearance of unethical behavior. Yolo County's PMR 20 and HHS Standards of Conduct outlines these relationships, but examples include:
    a. Client referrals to a County of Yolo employee's private practice or business;

    b. Financial arrangements with outside entities to whom the County of Yolo and/or its Departments or Divisions may refer for business (for example, an employee having a financial arrangement with one of our contracted providers);

    c. Joint ventures with entities supplying goods or services to the provider or its clients (for example, an employee having an ownership position in a company that provides housing to our clients);

    d. Consulting contracts or Medical Directorships (for example, an employee having a consulting contract with one of our contracted providers); and

    e. Soliciting, accepting or offering any gift or gratuity of monetary value to or from those who may benefit;

Employees shall not conduct inappropriate business activities that may involve fraud. Examples include:

a. "Gain-Sharing" arrangements (for example, profit sharing arrangements where those involved in the arrangement share benefits that possibly compromise or undermine client care);

b. Physician Third-Party billing (for example, billing secondary Medicare or Medi-Cal without first billing other insurance or payer sources);

c. Nonparticipating physician billing limitations (for example, Provider B renders services but is not a Medicare or Medi-Cal provider – i.e., not a participating provider – and has the service billed under another practice provider's name – Provider A – who is a participating provider);

d. "Professional Courtesy" billing (for example, providing services at a

discount to anyone – including professionals – when all clients are not given the same discounts);

e. Any other activity that can be interpreted as obtaining money, goods or services to which one may not be entitled.

Note: Employees are expected to avoid the possible perception of improper inducements, inappropriate business relationships, and inappropriate business activities. If there is a possibility that a client, a coworker, or the public may perceive an inducement, business relationship or business activity as being improper, discuss it with a supervisor or manager BEFORE you act.

4. **Record Retention:** Standards and procedures are required regarding the retention of behavioral health compliance, business, and client health records, including electronic records. This system shall address the creation, distribution, retention and destruction of documents. The guidelines shall include:

   a. The length of time that HHSA's behavioral health records are to be retained.

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

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

5. **Auditing and Monitoring Activities:** The Behavioral Health Compliance Officer, in conjunction with the Behavioral Health Compliance Committee, Fiscal Department and the Behavioral Health Quality Management Program 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.

   As part of its Compliance Plan, Yolo County HHSA BH conducts on-going program evaluation through auditing and monitoring processes. These processes determine if the Compliance Plan is working, whether individuals are carrying out their responsibilities in an ethical manner and that claims are being submitted appropriately. In its oversight of the Compliance Program, the Yolo County HHSA BH Compliance Officer and the Compliance Committee shall review findings from monitoring and auditing activities, this includes and is not limited to:

a. Utilization Management Program: The Utilization Management Program is responsible for assuring that beneficiaries have appropriate access to specialty mental health services (SMHS) as required in California Code of Regulations, Title 9, §1810.440(b)(1)-(3) and the Mental Health Plan (MHP) contract.

b. Reporting results from Auditing and Monitoring Activities: Any compliance issues that are detected through these activities shall be reported to the Yolo County HHSA BH Compliance Officer immediately. The Yolo County HHSA BH Compliance Officer shall document all incidences of non-compliance on the Compliance Log. This information shall be reported at least quarterly to the Compliance Committee. For more information on these oversight committees and their responsibilities, please refer to policies that address *Oversight of the Behavioral Health Compliance Program.*

c. Investigation and Corrective Action: When compliance issues including potential fraud, waste or abuse are reported by staff or detected via auditing/monitoring activities, the Yolo County HHSA BH Compliance Officer shall initiate an investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed. If non-compliance is evidenced, the Yolo County HHSA BH Compliance Officer shall follow a course of corrective action outlined in the Compliance Plan and any policies related to *Non-Compliance Investigation and Corrective Action*.

F. REFERENCES:

1. *Oversight of the Behavioral Health Compliance Program Policy*
2. *Auditing and Monitoring Activities Policy*
3. *Yolo County* HHSA *Behavioral Health Clinical Documentation Manual*

Approved by:

Karen Larsen _____ 3/24/2021

Karen Larsen, Director **Date**
Yolo County Health and Human Services Agency