ALPINE COUNTY BEHAVIORAL HEALTH SERVICES

Compliance Plan

Fiscal Year 2018/2019

ACBHS Mission

The mission of Alpine County Behavioral Health Services (ACBHS) is to provide safe, ethical and accessible services that inspire personal growth and development through strength-based behavioral health programs and supportive connections.

Introduction

Alpine County Behavioral Health Services (ACBHS) is committed to comply with all applicable federal and state standards of professionalism, conduct, and integrity, and has created this Compliance Plan toward that effort. Compliance Plans are designed to establish a culture within the behavioral health system that promotes prevention, detection, and resolution of conduct that do not conform to federal and state law, and ethical business practices.

Mission Statement

The ACBHS mission is to provide safe, ethical and accessible services that inspire personal growth and development through strength-based behavioral health programs and supportive connections. 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. Services must also be provided in an ethical and honest manner.

As ACBHS 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:

- Establishing program oversight by designating a Compliance Officer and implementing a regulatory Compliance Committee to monitor compliance efforts and enforce practice standards;

- Implementing compliance, practice, and documentation standards through the development of written standards and procedures;

- Conducting appropriate training and education on practice standards and procedures regarding applicable laws, regulations, and policies;

- 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;

- Developing effective lines of communication between the Compliance Officer and ACBHS staff for reporting suspected fraud, waste, and abuse;

- 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; and

- Enforcing disciplinary standards through well-publicized guidelines.

Legally-Mandated Compliance Activities

Office of Inspector General (OIG), U.S. Department of Health and Human Services
The creation of compliance program guidance 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. The OIG has developed and issued compliance program guidance directed at a variety of segments in the health care industry. The development of these types of compliance program guidance 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) https://oig.hhs.gov/

ACBHS Compliance Program and Regulatory Compliance Committee

The ACBHS Compliance Plan Program is monitored in accordance with this document and the ACBHS Code of Ethics.

The successful implementation and maintenance of the ACBHS Compliance Program depends on the efforts and support of all ACBHS staff and administrators. As a very small behavioral health program, staff wear "many hats." To guide compliance efforts, ACBHS has appointed a Quality Improvement (QI)/Compliance Officer.

In coordination with the functions performed by the QI/Compliance Officer, a regulatory Compliance Committee was formed to oversee and monitor the Compliance Program. In this very small county, this regulatory Compliance Committee is a function of the Quality Improvement Committee (QIC) and is referred to as the "QIC" throughout this document. The QIC works in coordination with the Leadership Team and ad hoc team(s) assigned to design and implement system improvement projects, to review departmental procedures and to detect potential and actual violations.

ACBHS Code of Ethics

In an effort to clearly define the expectations of department staff, ACBHS has developed a written Code of Ethics, which has been approved by the ACBHS Compliance Committee.

- As a standard component of new staff orientation, new hires receive the Code of Ethics.
  - The new staff member is required to sign an affirmation that they have received and reviewed the Code of Ethics. This affirmation is maintained in the personnel file of each employee.

- Annually, each existing staff member is given a copy of the Code of Ethics.
  - Staff are required to sign an affirmation that they have received and read a copy of the Code of Ethics. This affirmation is maintained in the personnel file of each employee.

Statement of Policy on Ethical Practices

ACBHS expects that all personnel will conduct themselves in a manner consistent with the highest professional standards and the ethical codes of their profession. ACBHS places great importance on

its reputation for honesty and integrity. To that end, the Leadership Team expects that the conduct of employees will comply with these ideals.

All ACBHS employees, volunteers, and organizational and individual contract providers are expected to assist in the detection and prevention of fraud, abuse and waste through compliance with the following law, regulations, and policies of the county. In addition, ACBHS expects that all individuals will conduct themselves in a manner consistent with the professional standards of their position. Alpine County places great importance on its reputation for honesty and integrity. To that end, ACBHS expects that the conduct of affiliated staff will comply with these ideals.

Each employee, volunteer, and contract provider is expected to be familiar with this Compliance Plan and the processes necessary to perform his/her duties, and/or how to obtain the requisite information needed to perform duties, in a manner consistent with legal, regulatory, and departmental requirements. Staff is also expected to understand and comply with the ACBHS Code of Ethics. Employees acting in violation of the Compliance Plan or otherwise disregarding the standards of Alpine County may be subject to progressive disciplinary action, up to and including termination.

ACBHS, as part of its Compliance Plan, has developed and implemented detailed policies setting forth standards of conduct specifically applicable to the services. These policies have been communicated to all department employees and contracted organizational providers, as appropriate. ACBHS employees and contracted organizational providers are expected to be familiar with the detailed policies applicable to their activities and are required to adhere to such policies. These policies are reviewed annually and updated as necessary.

Component I: Compliance Program Oversight

The ACBHS 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.

QI/Compliance Officer

The QI/Compliance Officer has the responsibility of developing a corrective action plan and providing oversight to the ACBHS 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 QI/Compliance Officer reports directly to the ACBHS Director.

The Leadership Team provides oversight to the Compliance Program and ensures implementation of all compliance activities.

The primary functions of the QI/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 QI/Compliance Officer also reviews changes in billing codes, directives from payers, and other relevant rules and regulations.

The QI/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 department staff are excluded from participation in federal health care programs;
- Investigating allegations of improper conduct and monitoring corrective action;
- Serving as the main contact for staff reporting of potential wrongdoing;
- Conducting/arranging for background checks of employees, including fingerprint checks when applicable; and
- Other duties as assigned.

NOTE: It is critical that those serving in the area of compliance monitoring function in a manner that is sufficiently independent, free from conflicts of interest, and not be swayed by their operational duties. It must also be clear to all members of the staff that anyone charged with the duties of QI/Compliance Officer has direct access to the Director.

Leadership Team

The Leadership Team is responsible for the supervision of the compliance efforts of Alpine County Behavioral Health Services. The Leadership Team, through the QIC, will oversee all of the compliance efforts of ACBHS.

Quality Improvement Committee (QIC)

In coordination with the QI/Compliance Officer, the ACBHS QIC performs vital functions to assure compliance with state and federal regulations.

Members of the QIC are appointed by the ACBHS Director and may include:

- Director of Behavioral Health Services
- Director of Health and Human Services
- Alcohol and Drug Program Specialist
- Behavioral Health Clinical Coordinator
- QI/Compliance Officer; HIPAA Privacy and Security Officer' Behavioral Health Services Coordinator
- Consumer and/or family members
- Contract providers
- Other agencies
- Other staff, as designated

The QIC is responsible for the following oversight activities:

- Receives reports on compliance violations and corrective actions from the QI/Compliance Officer;
- Advises the QI/Compliance Officer on matters of compliance violations and corrective actions;
- Advises the ACBHS Director on compliance matters;
- Advises ACBHS 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.

The QIC is also 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 QI Chart Review Checklist.
- Notes documentation deficiencies and results in "backing out" billing and/or stopping billing until the chart meets compliance standards.

- Provides staff with feedback on the number of services and dollars lost to documentation discrepancies (dollars for services backed out).
- Records documentation deficiencies in the QI minutes and on a QI checklist.
- Reviews charts with deficiencies to determine if all deficiencies have been corrected and/or addressed.
- Reviews additional charts of those staff who have repeated problems.
- For charts with problems still outstanding by the second review, the QI/Compliance Officer will discuss the documentation issues with the Clinical Coordinator.
- 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 II: Compliance and Practice Standards

As a component of the broader Compliance Program, ACBHS has designed processes for combating fraud and unethical conduct through the development of this ACBHS 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 are reviewed annually by the QIC to determine their continued compliance and relevance. Policies are updated as needed.

The related policies and procedures are as follows:

- Medi-Cal Service Verification
- Staff and Provider Verification – Exclusion and Status Lists
- Ownership Disclosure of Staff and Contract Providers; Conflicts of Interest
- 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

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 list is not exhaustive, 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.

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 ACBHS 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: ACBHS 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 ACBHS. 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 (e.g., billing for crisis services when only a routine assessment was delivered).

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

1. Claims are to be submitted only for services that staff finds to be reasonable and medically necessary.

2. Medi-Cal will only pay for services that meet the definition of medical necessity.

3. Staff are required to document and support the appropriateness of services that have been provided to a client in his/her chart.

C. Service Documentation

1. 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.

2. One of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation demonstrates medical necessity, that the mental health treatment is appropriate 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.

3. 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.

4. 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.
    - Service plans and progress notes are written within timeliness guidelines and meets documentation standards including measurable objectives, signatures, and dates.

- Documentation provides a written record if the case is involved in litigation, and serves as a means of communication for other providers involved with the case.

5. Timely documentation is essential. ACBHS has implemented standards regarding timeliness of treatment plan and progress note documentation.
   - See policies # AC-303 and AC-302 for these timeliness standards.

6. 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 (e.g., an electronic signature), if proper safeguards are established. See policy #AC-304 for more information about electronic signatures.

D. Improper Inducements, Kickbacks, and Self-Referrals

1. 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.

2. 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.

3. Potential risk factors in this area include:
   - Client referrals to a ACBHS employee's private practice;
   - Financial arrangements with outside entities to whom the practice may refer federal reimbursement related mental health business (for example, a local FQHC);
   - 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

1. ACBHS has developed standards and procedures regarding the retention of compliance, business, and mental health records. This system addresses the creation, distribution, retention, and destruction of documents. The guidelines include:
    - The length of time that ACBHS or a provider's mental health and substance use disorder records are to be retained.
    - Management of records, including protecting them against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and/or damage.
    - The destruction of records after the period of retention has expired.
    - The disposition of records in the event the provider's practice is sold or closed.

2. The Federal Alcohol and Drug confidentiality regulations restrict the disclosure and use of "patient identifying" information about individuals in substance use disorder treatment. Patient-identifying information is information that reveals that a person is receiving, has received, or has applied for substance abuse treatment. The regulations protect each client's identity as a participant in, or applicant for, substance use disorder treatment. Because ACBHS is a fully integrated behavioral health program, all staff providers, including those who provide only mental health services, are held to the confidentiality and privacy standards of HIPAA <u>and</u> 42 CFR, Part 2.

3. For more information, please refer to the ACBHS Departmental policies and procedures and the Alpine County HIPAA policies and procedures pertaining to record retention, and confidentiality and security issues.

Compliance Program Documentation

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

A. Compliance Log

Documentation of violation investigations and results is maintained by the QI/Compliance Officer in the Compliance Log. Information from the Compliance Log is summarized, and system-level issues are reviewed with the QIC quarterly. Suggestions, feedback, and changes to the system from the QIC are documented in the Compliance Log and in the QIC minutes.

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 QI/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 supporting reference materials, etc.;

- Name of the person responsible for providing feedback to provider, if appropriate; and
- The corrective action taken, as applicable.

B. Compliance Program Materials

Documents related to the Compliance Program are maintained electronically by the QI/Compliance Officer. Compliance-related materials include the following documents:

- The ACBHS Compliance Plan
- The ACBHS Compliance policies and procedures, as well as any changes or updates
- The ACBHS Code of Ethical Conduct
- A description of the compliance officer's role
- A summary of education and training efforts
- A description of the internal reporting system
- Plans for ongoing monitoring and enforcement
- Descriptions of any other steps to correct inappropriate actions.

Component III: Staff 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. Staff 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 ACBHS. Phone calls, email, and regular team meetings are used to notify staff of changes in policies or procedures.

Compliance 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 provides 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 ACBHS Code of Ethics.

In addition, training includes 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.

Coding and Billing Training

Training on accurately documenting services is an ongoing mission of Alpine County. This training includes:

- Coding requirements;
- Claim development and submission practices;
- Signing a form required to be authorized by a physician without the physician’s 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;
- Staff and clinical team meeting agendas to include discussions of compliance activities and QI system-level issues, when applicable; and
- New staff orientation training including specific discussion and training on compliance issues.

Training Log

The QI/Compliance Officer maintains a log of all training activities, including Compliance Program training. 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 sign an acknowledgement that they have received compliance training and that they understand the material. These acknowledgements are maintained by the QI/Compliance Officer.

Ongoing Education

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

- The Compliance Plan is posted on the shared behavioral health server, accessible via all computers.

- All Compliance policies and procedures are posted on the shared behavioral health server.
  - For employees who prefer paper copies of the Plan and Policies/Procedures, hard copies will be provided.

- Periodic Compliance trainings are scheduled to maintain and enhance all employees' understanding of the Compliance Program.

Training Timelines

1. New employees are trained as soon as possible after their start date; and

2. Employees receive refresher training on an annual basis, or as appropriate.

Component IV: Internal Monitoring and Auditing Activities

Overview

ACBHS conducts various auditing and monitoring activities as a component of the Compliance Program. These processes ensure that the Compliance Plan is working; that individuals are carrying out their responsibilities in an ethical manner; that staff and providers are appropriate licensed and are free from conflicts of interest; and that claims are being submitted appropriately.

Monitoring Staff and Providers – License and Status Checks; Disclosures

In order to ensure delivery of the highest quality mental health services, ACBHS is committed to complying with all relevant laws and regulations related to the verification of status of contract providers, ACBHS staff, and applicants. The ACBHS verification process ensures quality of client care, ethical conduct, and professionalism.

A. It is expected that all individuals and entities that have access to the ACBHS Electronic Health Record (EHR) or are involved in Medi-Cal billing are verified on the following lists for the status indicated for each list:

1. Social Security Number Verification Service (SSNVS)
   https://www.ssa.gov/employer/ssnv.htm
   - Upon contract/hire, verify the individual's social security number.

2. National Plan and Provider Enumeration System (NPPES) – National Provider Identifier (NPI)
   https://npiregistry.cms.hhs.gov/
   - During certification/recertification and upon hire, verify that the NPI number(s) and related information are accurate, for both individual and organizational/entity providers.

3. Federal OIG List of Excluded Individuals and Entities (LEIE):
   https://oig.hhs.gov/exclusions/index.asp
   - Monthly, verify that the individual/organization is NOT an excluded individual or entity.

4. Excluded Parties List System (EPLS) via the System Award Management (SAM) system
   https://www.sam.gov/
   - Monthly, verify that the individual/organization is NOT an excluded individual or entity.

5. CA Medi-Cal List of Suspended and Ineligible Providers:
   http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
   - Monthly, verify that the individual is NOT a suspended or ineligible provider.

6. California Licensing Boards
   https://www.breeze.ca.gov

- Monthly, verify that the provider's license has NOT expired and that there are no current limitations on the license.

7. California Revoked and/or Suspended Substance Use Counselor List
   http://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx
   - Monthly, verify that the individual is NOT a suspended or ineligible provider.

8. California Association of DUI Treatment Programs (CADTP)
   https://www.cadtp.org/counselors/
   - Monthly, verify that the provider's certification has NOT expired and that there are no current limitations on the certification.

9. California Consortium of Addiction Programs and Professionals (CCAPP)
   https://ccappcredentialing.org/index.php/verify-credential
   - Monthly, verify that provider's certification has not expired and that there are no current limitations on the certification.

Individuals who are subject to verification include clinical staff, clerical staff, case managers, Executive Committee members, medication support team staff, fiscal staff, contract psychiatrists and telepsychiatrists, substance abuse staff, and organizational providers. Currently, peer mentors are not verified, as they do not have access to the EHR.

Frequency of Verification Checks

Verification will occur as follows:

- Prior to contracting with individuals and organizations,
- Prior to hiring staff; and
- As noted, at least monthly for current staff and contract providers.
- As noted, during initial certification and subsequent recertifications.

ACBHS is responsible for verifying individual and organizational/entity contract providers, ACBHS staff, and ACBHS applicants. Verification documentation is maintained by Quality Improvement (QI) staff in departmental personnel files.

Organizational providers are required to verify that their own employees and applicants are not on the Exclusion Lists. Verification documentation is maintained by provider in its personnel files and may be requested by ACBHS as a contract monitoring activity.

Adverse Findings

ACBHS responds to adverse findings by ordering the individual or entity to immediately cease filing claims for services under ACBHS, and denying further access to the EHR system.

- For involved staff, mitigation and disciplinary action follow the Memorandum of Understanding with the Alpine County Employee's Association Miscellaneous Bargaining Unit.
- For contract providers, contracts may be immediately terminated, as warranted.
- An applicant who is identified as an excluded provider will not be hired. ACBHS will not enter into contracts with individual or organizational providers that are identified as excluded.

- Organizational providers must report immediately to the ACBHS Director any adverse findings related to their employees.

B. In order to ensure professionalism and ethical conduct, and as a safeguard against conflicts of interest, ACBHS complies with state regulation in collecting disclosures of ownership, control, and relationship information from its managing staff and providers, and its providers' managing staff, regardless of for-profit or non-profit status.

    - Individuals, network providers, subcontractors, and ACBHS employees must disclose to ACBHS any financial interest, official position, ownership interest, or any other financial or business relationship that they (or a member of their immediate family, or persons in their employ) has with ACBHS employees, vendors, or contractors.

    - ACBHS requires network providers, or any person with a 5% or more (direct or indirect) ownership interest in a network provider, to submit fingerprints, when applicable.

    - As a condition of contract, ACBHS also requires network providers to consent to criminal background checks, including fingerprinting, when required to do so by DHCS, or by the level of screening based on risk of fraud, waste, or abuse, as determined for that category of provider.

    - Disclosure information is collected and required to be reported as follows:
        - At the time of hire (for ACBHS staff);
        - At the time of contract execution between a network provider and ACBHS;
        - Upon renewal of each contract;
        - Annually; and
        - When there is a change in ownership interest.

    - If, in the future, any individual, contract, contract provider/organization, or ACBHS staff obtains ownership, control interest, or partnership interest in the ACBHS operations, in other contracts held by ACBHS, or in ACBHS network providers, the individual or provider must disclose this updated information to ACBHS within 35 days of the change.

    - ACBHS will terminate the contract of any provider that does not submit timely and accurate disclosure information about any person with a 5% or greater (direct or indirect) ownership interest in the provider.

Billing Auditing Activities

Routine auditing and monitoring activities helps ensure that services are billed accurately billed, accounted, and charted. There are several types of audits and monitoring activities that occur under the Compliance Program:

1) Claims Submission Process: The "final approved" progress note in the Anasazi electronic health record automatically triggers the billing process. The administrative assistant consults with the Clinical Coordinator to verify or correct any instances of questionable coding. This process is completed on 100% of the charts.

2) Timeliness of Chart Documentation: Timeliness of chart documentation is monitored in weekly Access Team, QIC meetings, and in periodic chart review. This monitoring is documented in the Access Team and QIC minutes.

3) Chart Audit: The QI/Compliance Officer, or designee, conducts a monthly random audit of five (5) charts to compare billing with chart documentation. This audit, which is also a component of the QI program, 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 QI regulations);
    c. Services provided are reasonable and necessary; and
    d. Incentives for unnecessary billing do not exist.

4) Medi-Cal Service Verification: ACBHS routinely verifies that services billed to Medi-Cal were actually provided to beneficiaries. Verification methods include a monthly survey that is randomly sent to clients, verifying the services that they received in a previous month.

5) Medi-Cal Denial Reports: Designated ACBHS fiscal staff, in coordination with the QI/Compliance Officer, review Medi-Cal Denial Reports quarterly to identify potential compliance issues.

    a. To help to identify any potential compliance issues, the denials are reviewed and resolved on an ongoing basis 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 Clinical Coordinator and Administrative Assistant. Potential compliance issues are reported to the Director.

    b. 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 Clinical Coordinator for resolution. The billing process is not initiated until all outstanding issues are resolved.

    c. Prior to monthly billing, multiple error reports are run and identified 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 Numbers are verified
- Suspense Report is completed

6) System Level Monitoring: The Quality Improvement Committee (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 is analyzed and reviewed with data from other comparable counties.
    a. An administrative assistant will provide data quarterly to the department on the number of clients, service utilization and cost and staff productivity.

7) Standards 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 government regulations and standards.

Component V: Reporting Fraud, Waste, and Abuse

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

To ensure this communication standard, ACBHS has determined that the QI/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 QI/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 to back out any erroneous claims.
- 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 (protection for "whistleblowers").
- Policies and procedures that implement these standards in detail.

Reporting Suspected Violations

1. Per federal regulations and ACBHS requirements, staff must report behavior that a reasonable person would, in good faith, believe to be erroneous or fraudulent. These activities may include, but are not limited to, the following:

    - Violations of standards surrounding coding and billing; medical necessity criteria; service documentation; signature requirements; and improper inducements, kickbacks, and self-referrals.

    - Violations of ethical standards as outlined in the ACBHS Code of Ethics.

2. Staff may report violations of the Compliance Program directly to the QI/Compliance Officer.

    a. Staff may contact the QI/Compliance Officer directly at (530) 694-1328, nellis@alpinecountyca.gov.

    b. Staff may also make a report via the ACBHS Compliance Hotline at (530) 721-1839.

3. Reports may be made anonymously.

Documenting Reports of Suspected Fraud, Waste, or Abuse
Documentation of violation investigations and results is maintained by the QI/Compliance Officer in the Compliance Log.

1. Information from the Compliance Log is summarized and reviewed with the QIC.

2. Suggestions, feedback, and changes to the system from these meetings are documented in the Compliance Log.

Non-Retaliation
As evidence of commitment of ACBHS to this process, staff will not be subject to retaliation for reporting suspected misconduct or fraud.

Confidentiality
The QI/Compliance Officer maintains the anonymity of the persons involved in the reported suspected 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.

County Reporting of Medi-Cal Fraud, Waste, or Abuse to DHCS
If ACBHS identifies any potential fraud, waste, or abuse, ACBHS immediately reports the activity to the California Department of Health Care Services (DHCS) "Stop Medi-Cal Fraud" unit.

- ACBHS may contact DHCS via:
    - The Stop Fraud hotline (1-800-822-6222); or
    - The online complaint form at http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx .

Component VI: Investigations of Non-Compliance and Mitigation Efforts

Upon receipt of a report or reasonable indications of suspected non-compliance, the QI/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 QI/Compliance Officer may initiate an investigation of an alleged compliance violation based on information from one of several sources:

- Employee reports to the QI/Compliance Officer or a supervisor/manager
- 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 QI/Compliance Officer, in coordination with the Leadership Team and the QIC, 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 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.

Feedback to Staff

It is the responsibility of ACBHS to advise staff of audit findings and inform staff of the corrective actions needed. The QI/Compliance Officer, in coordination with designated clinical staff, will provide feedback and guidance 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 or the magnitude of the non-compliance issue

cannot be remedied through a plan of correction, 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.

Office of Inspector General Notes:

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 website at http://oig.hhs.gov/. 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: Disciplinary Standards

If an investigation yields valid evidence of non-compliance, the QI/Compliance Officer, in coordination with the Leadership Team and the QIC, will develop a plan of correction to address the violation, which may include disciplinary action for staff.

The range of disciplinary actions that may be taken follow the Memorandum of Understanding with the Alpine County Employee's Association Miscellaneous Bargaining Unit.

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 Log 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: https://oig.hhs.gov/

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 diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, including Asperger's Syndrome and PDD-NOS
- 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, including Bipolar 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:

- Autistic Disorders
- Intellectual Disability
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- 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

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 EPSDT regulations also apply).

C. Impairment 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 healthcare-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.