Alpine County
Behavioral Health Services

Compliance Plan

Updated April 2016

ACBHS Mission:

Alpine County Behavioral Health Services (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.

Introduction

Alpine County Behavioral Health Services (ACBHS) is committed to comply with all applicable Federal and State standards and has created this Compliance Plan in that effort. Compliance

Plans are designed to establish a culture within the mental health system that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and ethical business practices.

Mission Statement
Alpine County Behavioral Health Services (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.

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:

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

Legal Mandates for Compliance Activities

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.

ACBHS Code of Ethics

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

- Annually, each staff member will be required to sign an acknowledgement that he/she has received and read a copy of the *Code of Ethics*. Each staff member is expected to be familiar with the detailed policies applicable to their activities and is required to adhere to such policies. This acknowledgement will be maintained in each employee's working file, by the Administrative Assistant.
- This acknowledgement form will be re-signed on an annual basis after reviewing the ACBHS *Code of Ethics*.

ACBHS Compliance Plan

The ACBHS Compliance Plan will be monitored in accordance with this document and the ACBHS *Code of Ethics* prepared by the ACBHS QIC. In addition, the Committee will review key issue areas. The key issue areas will be determined by the Leadership Team (Director, Clinical Coordinator and Behavioral Health Services Coordinator) with advice from the Committee.

ACBHS QIC

The ACBHS QIC will be 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
- Quality Improvement Program Coordinator / Compliance Officer / HIPAA Privacy and Security Officer / Behavioral Health Services Coordinator
- Consumer and/or Family Member Representatives
- Contracted Agency Representatives
- Other Agency Representation
- Other Staff

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.

Each ACBHS employee 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 will adhere to all applicable federal, state and local laws and regulations in the performance of its day-to-day activities, and will inform its providers and/or organizational service providers of this intention. Where uncertainty regarding federal, state, and local law and regulations exists, each employee will seek guidance from a member of the Leadership Team, as the situation warrants.

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 will be communicated to all department employees, and contracted organizational service providers, as appropriate. ACBHS 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
ACBHS conducts an ongoing evaluation process as a component of the Compliance Plan. This process determines if the Compliance Plan is working, whether individuals are carrying out their responsibilities in an ethical manner, and that claims are being submitted appropriately.

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

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

- Standards and Procedures Review
  Policies and procedures are reviewed and evaluated annually by the Leadership Team 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.

- Billing Chart Review
  ACBHS conducts a monthly random review of five charts to compare the previous month's billing with chart documentation. This review seeks to confirm that:
  a. Bills are accurately coded and reflect the services provided (as documented in the client's chart);
  b. Documentation is being completed correctly and in a timely manner (per QA regulations);
  c. Services provided meet medical necessity criteria; and
  d. Incentives for unnecessary billing do not exist.

- System Level Auditing
  The Quality Improvement/Compliance Committee 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. An administrative assistant will provide data quarterly to the department on the number of clients, service utilization and cost and staff productivity.

- Medi-Cal Denial Reports
  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.

  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.

  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

- Quality Improvement Process
  The Quality Improvement Committee (QIC) reviews a report generated by the administrative assistant that lists all charges by client number, clinician, and number of minutes billed. The QIC matches this billing information to the progress note in the chart to determine if the billing code is accurate; meets QI requirements; and compares the minutes billed to the documented activity. This review is completed annually on a minimum of 10% of the charts for clients not receiving services from our contracted psychiatric providers. Ten percent of charts of consumers who are seen by our

psychiatric providers are also reviewed annually. In any case, where a clinician is found to have an inordinate number of errors in their charts, the committee will review an additional 10% of the remaining charts of that individual.

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

Monitoring Activities
ACBHS monitoring activities are day-to-day, on-going processes that monitor billing, timesheets, and chart documentation to assure that all services are accurately billed, accounted for, and charted.

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 UR Team, bi-monthly QI/Compliance Committee meetings and in periodic chart review. This monitoring may be documented in the UR Log and/or QI minutes.

Component II. Implementing 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 will be reviewed annually by the QIC to determine their continued viability and relevance. The Compliance policies and procedures are as follows:

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

- Standards for Risk Areas and Potential Violations
- Training

Areas of Risk

In order to successfully implement the Compliance Program, risk areas must be identified and addressed. Compliance policies and procedures have been developed to address these risk areas and serve to implement the standards necessary to avoid 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 behavioral health service that the staff person knows or should know was not provided as claimed. This error 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 behavioral health services that are not reasonable and medically necessary and are not warranted by a client's current and documented condition.

   Short Doyle Medi-Cal: For mental health services, 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 he/she uses another provider's number. Staff need to bill using the correct provider number, even if that means delaying billing until the provider receives the correct provider number.

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

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

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

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

10. *Claim from an Excluded Provider*.
    A claim for a 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.

B. Medically-Necessary Services

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

C. Service Documentation

Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. Provider staff must complete progress notes within 24 hours from the date of service. Staff who are able to "final approve" their own notes will complete final approval of progress notes within the same 24-hour period. For staff whose notes require Clinical Coordinator signature and are final approved by the Supervisor, final approval must be completed no more than 30 days from the date of service, although in most circumstances notes will receive final approval well before the 30 days.

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 behavioral health treatment for the client

and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

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

Documentation ensures that the:

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

Signature Requirements

Signatures/electronic 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 electronically signed by the clinician.
- Written guidelines to providers which prohibit the use of their code by another physician, intern, resident, or other individual and which state that Medi-Cal/Medicare payment may be denied if these safeguards have been violated.
- Mental health services provided by staff without a Bachelor's degree in a mental health related field or two years of experience delivering mental health services must have all progress notes co-signed by a licensed professional staff until the experience/education requirement is met.

- Substance Use Services must be provided by licensed professional staff, or staff registered/certified as a substance use counselor per State law and regulation. The Clinical Coordinator may require that staff newly registered with a State-approved certifying organization have progress notes co-signed by a licensed professional or a certified substance use counselor until such time that the supervisor is confident that the staff member understands and complies with documentation standards.

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

E. Record Retention

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

- The length of time that ACBHS or a provider's behavioral health records are to be retained.
- Management of the behavioral health record including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and/or damage.
- The destruction of the behavioral health records after the period of retention has expired.

- The disposition of the behavioral health records in the event the provider's practice is sold or closed.
- The Federal Alcohol and Drug confidentiality regulations (42 CFR, Part 2) restrict the disclosure and use of "patient identifying" information about individuals in substance use treatment. Patient-identifying information is information that reveals that a person is receiving, has received, or has applied for substance abuse treatment. What the regulations protect is not the individual's identity *per se*, but rather his or her identity as a participant in or applicant for substance use 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 and 42 CFR, Part 2.

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:

Compliance Log
Documentation of violation investigations and results will be maintained by the QI Officer in the Compliance Log. Information from the Compliance Log will be summarized and system level issues may be reviewed with the QIC. 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 QI Officer, routine audit, monitoring activities, etc.);
- Name of the provider(s) involved;
- Name of the client(s) or chart number(s) involved; (although materials protected by attorney-client privilege will be filed separately)
- Specific information regarding the investigation, including copies of interview notes, supporting reference materials, etc.;
- Name of the person responsible for providing feedback to the staff person, if appropriate; and
- The corrective action taken, as applicable.

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

- The ACBHS Compliance Plan
- The ACBHS Compliance Policies and Procedures, as well as any changes or updates
- The ACBHS Code of Ethical Conduct
- The Compliance Log

The QIC Minutes Binder
The Minutes binder contains the following materials:

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

Compliance "Hotline" for Reporting Possible Compliance Violations
ACBHS has provided the QI Officer with a dedicated cell phone to ensure effective open lines of communication with Departmental staff to facilitate reporting of possible compliance violations. All staff are provided with the phone number. The QI Officer will track complaints from this reporting mechanism.

Component III. Oversight of Compliance through a Compliance Officer

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 QI Officer. In coordination with the functions performed by the QI Officer, a QIC was formed to oversee and monitor the Compliance Program. 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.

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 groups 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 QI Officer has the responsibility of developing a corrective action plan and providing oversight to ACBHS'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 Leadership Team provides oversight to the QI and Compliance Program and ensures implementation of all compliance activities.

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

The QI 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 "responsible" person for staff reporting of potential wrongdoing;
    - Allowing for anonymous reporting;
    - Reporting directly to the Director of Behavioral Health Services any indication any indications of potential wrong-doing in the department; and
    - Conducting an analysis of the actions taken by the department in response to the report that is received by the department.
- Conducting/arranging for background checks of employees including checking finger prints against a national data bank; 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, that they will 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 compliance officer has direct access to the director.]

The QI Officer for ACBHS will share compliance duties with several people within and outside the organization. The duties enumerated above will be divided between personnel inside and outside the department.

Role of the 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 ACBHS's compliance efforts.

Role of the QIC

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

The QIC is responsible for the following compliance activities:

- Receives reports on compliance violations and corrective actions from the QI Officer;
- Advises the QI 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 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 checklist.
- Notes documentation deficiencies and results in 'backing out' billing and/or stopping billing until the chart meets compliance standards.
- Records documentation deficiencies in the QI minutes and on a QI checklist.
- Reviews charts with deficiencies to determine if all deficiencies have been corrected and/or addressed.
- Provides the clinician with feedback on the number of services and dollars lost to documentation discrepancies (dollars for services backed out).
- Reviews additional charts of those clinicians who have repeated problems.
- For charts with problems still outstanding by the second review, the QI Coordinator 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 IV. Conducting Appropriate Training and Education

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

Compliance training has two goals:

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

ACBHS clearly communicates the compliance policies and procedures to all staff, as well as to independent contractors whose services are billed under the ACBHS provider number. Phone calls, email, and/or staff and clinical team 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 ACBHS *Code of Ethical Conduct.*

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

B. Coding and Billing Training

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

- Coding requirements;
- Claim development and submission practices;
- Signing a form for 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 Officer will maintain a log of all training activities. This log provides information on the date of the training, names of attendees, type and topics of training, location of the training, trainer's name(s), duration of the training, and number of CEUs earned, if applicable.

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

Ongoing Education

To regularly communicate new compliance information and to assure that staff receives the most recent information, 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.
- Scheduled periodic Compliance trainings.

Training Timelines

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

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

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

Upon receipt of a report or reasonable indications of suspected noncompliance, it is important that the QI Officer and QIC look into the allegations to determine whether a significant violation of applicable law or the requirements of the compliance program has occurred, and if so, take decisive steps to correct the problem. Such steps may involve a corrective action plan, the return of any overpayments, a report to the government and/or a referral to law enforcement authorities.

The Compliance Program includes a set of monitors or warning indicators. These indicators may include the number and/or types of claim rejections; challenges to medical necessity; and/or high volumes of unusual charges or payment adjustment transactions. A plan of correction to address the violations and activities will be developed to systematically address the issues and the changes in policy necessary to prevent further problems.

Component VI. Developing Open Lines of Communication

ACBHS 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 QI 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 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 Officer if they are unsure about whether they are following the compliance policies and procedures correctly, if they need additional training, or if they have specific concerns or questions about the Compliance Program.

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

- The requirement that staff report behavior that a reasonable person would, in good faith, believe to be erroneous or fraudulent.
- A confidential process for reporting erroneous or fraudulent behavior.
- A standard that a failure to report erroneous or fraudulent behavior is a violation of the compliance program.
- A simple procedure to process reports of erroneous or fraudulent behavior.
- A coordinated process between the compliance program and the fiscal department to synchronize billing and compliance activities. Suspense billing reports in the electronic health record are used to identify possible erroneous claims, and prevent them from being submitted. Fiscal staff shall coordinate with the Clinical Coordinator for verification of the validity of claims. The erroneous claims are voided before the monthly billing cycle.
- A confidential process that maintains the anonymity of the persons involved in the reported possible erroneous or fraudulent behavior and the person reporting the concern.

However, there may be certain occasions when a person's identity may become known or may need to be revealed to aid the investigation or corrective action process.

- Standards that outline that there will be no retribution for reporting behavior that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.
- Policies and procedures that implement these standards in detail.

Feedback to Staff

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

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

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

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

OIG Note:

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

The Compliance Plan clearly outlines consistent and appropriate sanctions for compliance violations while, at the same time, is flexible enough to account for mitigating or aggravating circumstances. The ranges of disciplinary actions that may be taken closely follow the Memorandum of Understanding with the Alpine County Employee's Association Miscellaneous Bargaining Unit.

Our Compliance Plan requires that detected misconduct be corrected promptly. OIG guidance suggests that misconduct be corrected within 90 days of detection. Our Compliance Plan provides for an internal investigation of all reported violations. When problems are detected, our program requires that the department 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.

The ACBHS corrective action plan for compliance issues is outlined below.

I. The range of disciplinary activities follow Attachment B, the Memorandum of Understanding with the Alpine County Employee's Association Miscellaneous Bargaining Unit:

Discipline includes but is not limited to suspension without pay, demotion, reduction in pay within the employee's salary range, and dismissal. Disciplinary action shall be taken only for just and sufficient cause which shall include the following.

1. *Absence without authorized leave.*
2. *Incompetency.*
3. *Inefficiency.*
4. *Dishonesty.*
5. *Neglect of duty.*
6. *Fraud in securing appointment.*
7. *Being under the influence of or use of any controlled substance, narcotic or alcohol while on duty.*
8. *Conviction of a felony or job-related misdemeanor.*
9. *Abusive or discourteous treatment of the public or other employees.*
10. *Disorderly or immoral conduct while on duty.*
11. *Insubordination or willful disobedience.*
12. *Misuse of County property.*
13. *Failure to abide by the rules, regulations and policies established by the County that are presently in force.*
14. *Evident unfitness or unsuitability for services; inability or incapacity to perform assigned job duties.*
15. *Refusal or knowing failure to perform work in accordance with County or state job safety requirements.*
16. *Breach of confidentiality as covered by County or departmental policy.*

17. *Engaging in any employment activity, or enterprise, which is incompatible, or in conflict with, or detrimental to, duties as a County employee, or to the duties, functions, or responsibilities of his/her department.*
18. *Engaging in discriminatory activity or sexual harassment against one or more persons protected under County policy and state or federal law as described in Section 10.3 of this Agreement.*
19. *Violation of concerted activities provision.*
20. *Improper political activity conducted in violation of statute or judicial decision.*

The County may begin discipline at any level, depending upon the employee's conduct but shall practice progressive discipline when warranted under the facts. Prior to initiating any discipline as hereinafter provided, the appointing authority considering discipline consisting of dismissal, suspension without pay, demotion or reduction of wages shall first review the matter with the Personnel Department.

Verbal warnings and written reprimands shall be considered part of the progressive disciplinary process but shall not be subject to an appeal or entitle the employee to a Skelly hearing. In the case of a written reprimand placed in the employee's personnel file, the employee may submit a written response within ten (10) calendar days of receipt of the reprimand and may request in writing within ten (10) calendar days of receipt of the reprimand a meeting with the Department Head and the employee's chosen representative.

The following procedure is hereby established for disciplinary action taken by a department head against employees under this Memorandum of Understanding.

A. *Administrative Leave. Upon approval of the CAO, an employee against whom disciplinary action is proposed may be immediately placed on administrative leave, with pay, upon verbal notification pending a notice of intended disciplinary action. Administrative leave with pay is not considered disciplinary action. In addition and only in circumstances where the CAO, in his/her sole opinion, believes that the employee's continued active duty status might constitute a hazard to the employee or others, or prolong acts or omissions of serious improper conduct including, but not limited to: theft of county property, sexual harassment, allegations of a criminal nature, excluding infractions, and violence in the workplace, the CAO may determine to place an employee in a status of summary suspension without pay. If a disciplinary action is not subsequently ordered and/or affirmed, the employee so affected shall be restored all base pay and benefits lost as a consequence of the summary suspension.*

B. *Initial Notice of Intended Disciplinary Action and Skelly Rights. Prior to the proposed imposition of disciplinary action, the department head shall give written notice to the employee. The written notice of intended disciplinary action shall be personally delivered to the employee or sent to the employee by certified mail to the employee's last known mailing address. If the affected employee cannot be served in person or if for any reason the affected employee refuses or*

fails to take receipt of the notice, service shall be deemed complete three (3) days after the attempted service. The contents of the written notice shall include, but need not be limited to, the following:

1. *A statement in ordinary and concise language outlining in detail the specific violations of department and/or County rules, regulations, ordinances, policies, or any state or federal law that the employee is alleged to have violated.*
2. *The contemplated disciplinary action and the reason(s) for that specific action.*
3. *Copies of all materials pertaining to the charges, including but not limited to, tape recordings, reports, memorandums, transcripts, witness statements, and all other available materials and evidence.*
4. *Notice that the employee may request a pre-disciplinary hearing within ten (10) calendar days of delivery or mailing of the intended disciplinary action notice. Such request must be made in writing and addressed to the department head. The pre-disciplinary hearing may be waived by the employee, either by written waiver or by failure to submit the written request for pre-disciplinary hearing within the time allowed. The pre-disciplinary hearing shall be before the Alpine County Administrative Officer or his/her designee as the Skelly Hearing Officer. The employee shall be afforded a reasonable opportunity to respond orally or in writing at the hearing.*
5. *A complete statement of the employee's rights and responsibilities as they pertain to the Disciplinary Action and Appeals Procedure including the employee's right to be represented during such hearings and any other step in the appeal process.*

C. Final Notice of Disciplinary Action. Within fourteen (14) calendar days following the pre-disciplinary hearing, or as soon after as reasonably possible if the disciplinary action is still contemplated, the Skelly Hearing Officer shall serve upon the employee a determination after hearing. In the event disciplinary action is sustained, the determination shall include Notice of Disciplinary Action setting forth the decision of the Skelly hearing officer and the order of discipline, which shall include the effective date of the disciplinary action.

D. Effective Date of Discipline. Discipline imposed pursuant to this section shall not be effective until either (a) the employee waives or does not request a Skelly hearing within ten (10) calendar days of receiving Notice of the intended disciplinary action; or, (b) the date that the Skelly Hearing Officer provides Notice of their determination after hearing in the Notice of Final Disciplinary Action to the employee, whichever is later.

E. Administrative Appeals Process. All members of the bargaining unit having successfully completed the applicable probationary period, shall have the right to appeal, in writing and addressed to the Department Head, any form of punitive

or disciplinary action affecting compensation and pay of the employee, including but not limited to, termination, demotion, suspension, and reduction in pay within ten (10) calendar days of the discipline becoming effective. If an employee fails to appeal within the prescribed ten (10) calendar day time period, all further appeal steps are waived. All time requirements in this Section are subject to modification or waiver by mutual consent of the parties.

1. *Binding Arbitration. If the employee timely files an appeal of disciplinary action in writing, the County shall, within ten (10) calendar days of receipt of such appeal, request a list of five (5) arbitrators from the State Mediation and Conciliation Service (CSMCS). After receipt of the list of potential arbitrators, the Parties shall, within ten (10) calendar days, confer to strike names from the list in alternating fashion, with the Party holding the first strike determined by coin toss. The last arbitrator on the list shall be selected. Alternatively, the employee and County may by mutual agreement, select a different arbitrator to hear the appeal.*
2. *Arbitration hearings shall be conducted pursuant to the Arbitration Hearings Procedure contained in Section 31 of this MOU.*

F. Notwithstanding the above Appeal Process, the only appeal process available to employees covered by the State Merit System Services is to the California State Personnel Board.

II. The following Departmental committees and/or positions will monitor and manage our Compliance issues:
- Leadership Team
- QIC
- QI Officer

III. All Behavioral Health Services employees annually and upon hire, sign the *Code of Ethical Conduct*, documentation standards within expectations for an employee's assigned unit, timeliness of documentation, and consequences of inaccurate documentation.

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

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

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

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

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

In addition to the on-line searchable database, the OIG provides information on excluded individuals and entities in a downloadable database file format, which allows users to download the data to their personal computers and either set up their own databases or combine it with their existing data. Monthly exclusion supplements to the downloadable database file are posted on the OIG web site, as will separate files containing individuals and entities that have been reinstated each month.

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

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

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

A. Diagnoses

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

Included Diagnoses:

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

Excluded Diagnoses:

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

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

B. Impairment Criteria

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

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

C. Intervention Related Criteria

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

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

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