LCBHS

LAKE COUNTY
BEHAVIORAL HEALTH SERVICES

Compliance Plan

Fiscal Year 2020/2021 Update

FINAL 10/01/2021

LCBHS Purpose

The purpose of Lake County Behavioral Health Services is to improve the quality of life for the people of Lake County suffering from mental illness or substance use disorders by offering recovery-oriented services.

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Introduction

Lake County Behavioral Health Services (LCBHS) 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 instances of conduct that do not conform to federal and state law, and ethical business practices.

Purpose Statement

The purpose of LCBHS is to improve the quality of life for the people of Lake County experiencing mental illness or substance use disorders by offering recovery-oriented services.

As LCBHS pursues this purpose, 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. The LCBHS 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, policies, 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 LCBHS does not fail in its efforts to adhere to all applicable state and federal laws and regulations;

- Developing effective lines of communication between the Compliance Officer and LCBHS 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), 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. In the past several years, 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/

A. LCBHS Compliance Program and Regulatory Compliance Committee

The Compliance Program is monitored in accordance with this document and the LCBHS Code of Conduct.

The successful implementation and maintenance of the LCBHS Compliance Program depends on the efforts and support of all LCBHS staff and Management. To guide compliance efforts, LCBHS has appointed a Compliance Officer, Stephanie Wilson.

In coordination with the functions performed by the Compliance Officer, a regulatory Compliance Committee was formed to oversee and monitor the Compliance Program. In this 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 Management Team and other team(s) assigned to design and implement system improvement projects; to review departmental procedures; and to detect potential and actual violations.

B. LCBHS Code of Conduct

In an effort to clearly define the expectations of staff, LCBHS has developed a written Code of Conduct. which has been approved by the QIC.

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

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

C. Statement of Policy on Ethical Practices

LCBHS expects that all personnel will conduct themselves in a manner consistent with the professional standards of their profession. Lake County places great importance on its reputation for honesty and integrity. To that end, LCBHS expects that the conduct of employees will comply with these ideals.

All LCBHS employees, volunteers, and 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, LCBHS expects that all individuals will conduct themselves in a manner consistent with the professional standards of their position. LCBHS places great importance on its reputation for honesty and integrity. To that end, LCBHS expects that the conduct of affiliated staff will comply with these ideals.

Each employee and contract service provider is expected to be familiar with this Compliance Plan and the processes necessary to perform their duties, and/or how to obtain the requisite information needed to perform duties, in a manner consistent with legal, regulatory, and departmental requirements. Staff and contract providers are also expected to understand and comply with the LCBHS Code of Conduct. Employees and contract providers that act in violation of the Compliance Plan or otherwise disregard the standards of LCBHS may be subject to progressive disciplinary action, up to and including termination of employment or contract.

LCBHS, as part of its Compliance Plan, has developed and implemented detailed policies that set the standards of conduct specifically applicable to the services. These policies have been communicated to all department employees and contract organizational service providers, as appropriate. LCBHS 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 successful implementation and maintenance of the LCBHS Compliance Program depends on the efforts and support of all LCBHS staff and Management. To guide these efforts and perform day-to-day operations, LCBHS has appointed a Compliance Officer.

In coordination with the functions performed by the Compliance Officer, a Management Team oversees and monitors the Compliance Program as a whole. The Management Team works in turn with the QIC 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 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.

A. Compliance Officer

The Compliance Officer has the responsibility of developing a corrective action plan and supplying oversight to LCBHS adherence to the Compliance Plan. This individual is empowered to bring about change and is responsible for overseeing the implementation and day-to-day operations of the Compliance Program. The Compliance Officer reports directly to the LCBHS Director.

The Compliance Officer has access to the Management Team and provides the credibility to ensure that necessary changes will be successfully engaged.

The primary functions of the Compliance Officer are to oversee the compliance activities and implement the requirements of the guidelines, including serving as the contact point for reports of suspicious behavior and questions about internal policies and procedures. The Compliance Officer also reviews changes in billing codes, directives from payors, and other relevant rules and regulations.

Compliance Officer duties include:

- Overseeing and monitoring the implementation of the compliance program;
- Establishing methods, such as periodic audits, to improve the program's efficiency and quality of services, and to reduce the program's vulnerability to fraud and abuse;
- Periodically revising the compliance program in light of changes in the needs of the program or changes in the law;
- Developing, coordinating, and participating in a compliance training program;
- Determining if any service delivery 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;
- Arranging for background checks of staff and other providers, including fingerprint checks when applicable; and
- Other duties as assigned.

In addition to the Compliance Officer, the LCBHS Management Team has important functions to assure compliance with state and federal regulations.

NOTE: It is critical that staff serving in the area of compliance 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 Compliance Officer has direct access to the LCBHS Director.

B. Management Team

In coordination with the Compliance Officer, the LCBHS Management Team performs vital functions to ensure compliance with state and federal regulations. The Management Team is appointed by the LCBHS Director and includes representation from:

- Director
- Compliance Officer/Manager
- Staff Analyst in Administration
- Fiscal Manager
- MHSA Manager
- SUDS Manager
- Mental Health Manager
- Operations Staff Services Specialist
- Deputy Director of Administration
- Deputy Director of Clinical Services
- Other Staff (as assigned)

In coordination with the Compliance Officer, the Management Team is responsible for the following compliance activities:

- Receiving reports on compliance violations and corrective actions from the Compliance Officer;
- Advising the Compliance Officer on matters of compliance violations and corrective actions;
- Advising the LCBHS Director on compliance matters;
- Developing and maintaining the Compliance Plan;
- Advising LCBHS staff on compliance matters;
- Ensuring that an appropriate record-keeping system for compliance files is developed and maintained;
- Ensuring that compliance training programs are developed, assigned to staff, and documented;
- Ensuring that an internal review and audit system is developed and implemented to ensure the accuracy of the claims documentation and submission process to all payors, which include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action; and
- Meeting as needed, but no less than once per quarter.

C. Quality Improvement Committee (QIC)

The QIC is actively involved in ensuring successful compliance. The QIC is responsible for performing the following activities related to compliance and practice standards:

- Annually reviews a minimum of 40 charts for documentation practices using a QIC 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 QIC minutes.
- Reviews charts with deficiencies to determine if all deficiencies have been corrected and/or addressed.
- Provides the staff and other providers with feedback on the number of services and dollars lost to documentation discrepancies (dollars for services backed out).
- Reviews additional charts of those staff and other providers who have repeated problems.
- For charts with problems still outstanding by the second review, the QI Coordinator will discuss the documentation issues with the staff's supervisor.
- Conducts an analysis of 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, LCBHS has designed processes for combating fraud and unethical conduct through the development of this LCBHS Compliance Plan. Implementation of this Compliance Plan is accomplished through written policies and procedures, and efforts are documented through various mechanisms.

A. Policies and Procedures

The purpose of the Compliance policies and procedures is to provide guidance to staff in an effort to reduce the possibility of erroneous claims and fraudulent activities. Policies and procedures clearly identify risk areas and establishing internal controls to counter those risks. These controls include practice standards regarding timely access; 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. Policies are updated as needed.

The related policies and procedures are as follows:

- Network Adequacy (#161)
- Out-of-Network Access (#274)
- Medi-Cal Service Verification (#128)
- Staff and Provider Verification and Exclusion Lists (#130)
- Ownership Disclosure of Staff and Contract Providers; Conflicts of Interest (#129)
- Compliance Program Standards (#148)
- Oversight of the Compliance Program (#149)
- Compliance Standards for Risk Areas and Potential Violations (#150)
- Compliance Auditing and Monitoring Activities (#151)
- Compliance Training (#152)
- Reporting Suspected Fraud, Waste, and Abuse (#154)
- Compliance Investigation and Corrective Action (#155)
- Disciplinary Guidelines (#156)

B. Areas of Risk

In order to successfully implement the Compliance Program, risk areas must be identified and addressed. Compliance policies and procedures have been developed to address these risk areas and serve to implement the standards necessary to avoid these types of violations.

The following areas of risk have been among the most frequent subjects of investigations and audits by OIG. Staff are expected to be familiar with these potential violations and work to maintain compliance with the standards surrounding each area of risk. This list is not exhaustive, but a starting point for an internal review of potential areas of vulnerability.

1. Coding and Billing

   a. *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 issue includes instances when staff claim units of service (UOS) that were not actually provided (e.g., delivering less than 90 minutes of a group counseling session, but billing for all 90 minutes).

   b. *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). NOTE: Medi-Cal: LCBHS 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 and LCBHS policy #141-Medical Necessity Criteria).

   c. *Double billing, which results in duplicate payment.* Double billing occurs when a person bills for the same item or service more than once or another party billed the Federal health care program for an item or service also billed by LCBHS. Although duplicate billing can occur due to simple error, the knowing submission of duplicate claims, which may be evidenced by systematic or repeated double billing, can create liability under criminal, civil, and/or administrative law.

   d. *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."

   e. *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.

   f. *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.

   g. *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.

   h. *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 practice overcharges some clients, while undercharging others).

i. 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).

j. 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.

2. Medically Necessary Services – Claims are to be submitted only for services that staff finds to be reasonable and necessary (i.e., meet medical necessity). Medi-Cal will only pay for services that meet the definition of medical necessity. Staff are required to document and support the appropriateness of services that have been provided to a client in their chart.

3. Service Documentation – Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. This documentation also serves as verification that this service was delivered and the claim is accurate as submitted.

   One of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation 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.

   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, including billing for actual UOS delivered; and d) the identity of the service provider. Chart documentation serves as a legal recording of services delivered and a communication mechanism for other care providers.

   Documentation ensures that:

   - Client charts are 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 identity of the provider.
   - Diagnostic codes used for claims submission are supported by documentation and the client chart.
   - Appropriate health risk factors are identified. The client's progress; their response to, and any changes in, treatment; and any revision in diagnosis are documented.
   - Documentation includes all necessary components including date; service code; duration of service; location; and signature with title.
   - Client treatment plans and progress notes are written within timeliness guidelines and meet 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.

a. Timely Documentation

- Timely documentation is essential. LCBHS has implemented standards regarding the timeliness of assessments; treatment plans; and progress notes. See relevant policies for these timeliness standards:
    - #142 (Clinical Assessments and Reassessments)
    - #143 (Client Treatment Plans)
    - #146 (Progress Notes)

b. Signature Requirements

- Provider Signatures: Provider signatures are required to provide a minimum level of assurance that the provider is qualified to deliver the level of service being billed. The Centers 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.

- Client Signatures: Clients must document their participation in group counseling sessions by signing in each session via confidential sign-in sheets. During each session, the group providers verify that the names on the sign-in sheet match those individuals in attendance. LCBHS maintains these sign-in sheets as evidence of client participation and to verify that services billed were actually delivered.

4. 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 LCBHS 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.

5. Record Retention – LCBHS 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 LCBHS and its providers retain client records.
    - Management of records, including protecting 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.

    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.

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

C. Compliance Program Documentation

To ensure successful implementation of the compliance standards, to track compliance violations, and to demonstrate its commitment to compliance, LCBHS has developed the following documentation procedures:

1. Compliance Log – Documentation of violation investigations and results is maintained by the Compliance Officer or designee in the Compliance Log. Information from the Compliance Log is summarized and system-level issues are reviewed with the QIC on a quarterly basis. Suggestions, feedback, and changes to the system from the QIC are also documented 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 direct or anonymous contact with Compliance Officer, routine audit, monitoring activities, etc.);
    - Name of the staff member(s) involved;
    - Name of the client(s) or chart number(s) involved;
    - Specific information regarding the nature of the allegation, including 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.

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

    - LCBHS Compliance Plan
    - LCBHS Compliance policies and procedures, as well as any changes or updates
    - LCBHS Code of Conduct
    - Compliance Log

3. Management Team Minutes – The Minutes contain the following materials:

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

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* 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 practice and any applicable regulations; and

2) Each staff member understands that compliance is a condition of continued employment.

Training clearly communicates the compliance policies and procedures to all staff, as well as to contract providers. Phone calls, e-mail, and regular meetings are used to notify staff of changes in policies or procedures.

A. 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 related policies; and the role of each staff member in the operation of the Compliance Plan.

Compliance standards training provides information on how to follow the law, and is tailored to the needs of the medical and clinical staff; case managers; and administrative and support staff. It also reviews the LCBHS Code of Conduct.

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 law.

B. Coding and Billing Training

Training on accurately documenting services is an ongoing mission of Lake 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 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.

C. Training Log

The 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 complete an acknowledgement that they have received compliance training and that they understand the material. These acknowledgements are maintained as part of the Training Log.

D. Ongoing Education

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

- The Compliance Plan is posted on the shared behavioral health server, accessible via all staff 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 may be printed.

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

E. 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

A. Overview

LCBHS 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; and that LCBHS complies with the Medi-Cal Parity Rule around network adequacy.

B. Monitoring Staff and Providers – License and Status Checks

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

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

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

    b. 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.

    c. Federal OIG List of Excluded Individuals and Entities (LEIE):
    https://oig.hhs.gov/exclusions/index.asp
        - Prior to hire/contract, and monthly thereafter, verify that the individual/organization is NOT an excluded individual or entity.

    d. Excluded Parties List System (EPLS) via the System Award Management (SAM) system
    https://www.sam.gov/
        - Prior to hire/contract, and monthly thereafter, verify that the individual/organization is NOT an excluded individual or entity.

    e. CA Medi-Cal List of Suspended and Ineligible Providers:
    http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
        - Prior to hire/contract, and monthly thereafter, verify that the individual is NOT a suspended or ineligible provider.

f. California Licensing Boards
https://www.breeze.ca.gov
- Prior to hire/contract, and monthly thereafter, verify that the provider's license has NOT expired and that there are NO current limitations on the license.

g. California Revoked and/or Suspended Substance Use Counselor List
http://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx
- Prior to hire/contract, and monthly thereafter, verify that the individual is NOT a suspended or ineligible provider.

h. California Association of DUI Treatment Programs (CADTP)
https://www.cadtp.org/counselors/
- Prior to hire/contract, and monthly thereafter, verify that the provider's certification has NOT expired and that there are NO current limitations on the certification.

i. California Consortium of Addiction Programs and Professionals (CCAPP)
https://ccappcredentialing.org/index.php/verify-credential
- Prior to hire/contract, and monthly thereafter, 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; management team members; medication support team staff; fiscal staff; contract psychiatrists and telepsychiatrists; substance abuse staff; and organizational providers.

2. Frequency of Verification Checks

a. 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.

b. LCBHS is responsible for verifying individual and organizational/entity contract providers, LCBHS staff, and LCBHS applicants. Verification documentation is maintained by designated QI staff.

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

3. Adverse Findings

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

        1) An applicant who is identified as an excluded provider will not be hired.

        2) LCBHS will not enter into contracts with individual or organizational providers that are identified as excluded.

        3) For existing staff, mitigation and disciplinary action follow the Memorandum of Understanding (MOU) between Lake County and the Lake County Employees Association (LCEA) as warranted.

        4) For existing contract providers, contracts may be immediately terminated, as warranted.

            a) A designated LCBHS staff member makes a good faith effort to give affected beneficiaries written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination.

            b) DHCS must also be notified when a provider contract has been terminated, either by the provider or by LCBHS. DHCS may be notified by email at: DHCSMPF@dhcs.ca.gov.

        5) Organizational providers must report immediately to the LCBHS Director any adverse findings related to their employees.

        6) Any inappropriate payments or overpayments due to providers who have been suspended, debarred, or excluded may be subject to recovery and/or be the basis for other sanctions by the appropriate authorities.

4. Triggering Recertification Events and Reporting to DHCS

    a. LCBHS monitors the monthly status checks for "triggering recertification events." These events include changes in ownership; changes in scope of services; remodeling of the provider facility; changes in location; and contract termination. These types of events may require Medi-Cal recertification by DHCS.

        1) DHCS must be notified within two (2) business days of notification or discovery of the triggering event. DHCS may be notified by email at: DHCSMPF@dhcs.ca.gov.

C. Monitoring Staff and Providers – Disclosures; Conflicts of Interest

In order to ensure professionalism and ethical conduct, and as a safeguard against conflicts of interest, LCBHS 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.

1. Individuals, network providers, subcontractors, and LCBHS employees must disclose to LCBHS 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 LCBHS employees, vendors, or contractors.

2. LCBHS 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.

3. As a condition of contract, LCBHS 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.

4. Disclosure information is collected and required to be reported as follows:

    a. At the time of hire (for LCBHS staff);
    b. At the time of contract execution between a network provider and LCBHS;
    c. Upon renewal of each contract;
    d. Annually; and
    e. When there is a change in ownership interest.

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

6. LCBHS 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.

D. 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. Progress Note and Billing Review: QI staff review reports in Anasazi to determine if the information on the electronic scheduler and Progress Notes are correctly entered for the billable services. Fiscal staff check for possible duplicate billings prior to submitting claims.

2. Chart Audit: The Compliance Officer, or designee, conducts a quarterly random audit of six (6) charts to compare billing with chart documentation. This audit 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 standards);
    c. Services provided are reasonable and necessary; and
    d. Incentives for unnecessary billing do not exist.

3. Medi-Cal Service Verification: LCBHS routinely verifies that services billed to Medi-Cal were actually provided to clients. Verification methods include 1) periodically obtaining client confirmation (via signature) at the time of service; and 2) periodically mailing letters to clients to verify services.

4. Medi-Cal Denial Reports: The Compliance Officer, or designee, reviews 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. 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 designated staff. 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 designated staff 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

5. System Level Monitoring: The QIC annually reviews data on service utilization, clients with high service utilization patterns; staff productivity; cost of services; and cost per client information.

    a. The Account Clerk provides data quarterly to the LCBHS evaluation consultant on the number of clients, service utilization, service cost, and staff productivity. Graphs are then produced for QIC and Management Team review.

6. 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 policies are ineffective or outdated, they are updated to reflect changes in regulations and standards.

E. Compliance with the Parity Rule and Network Adequacy Standards

1. Per federal regulations, LCBHS is required to comply with the Medi-Cal Parity Rule around network adequacy. The Parity Rule applies to both adult and pediatric providers of outpatient specialty and non-specialty mental health services. LCBHS is required to demonstrate compliance with network adequacy standards for outpatient specialty mental health services.

2. Refer to relevant DHCS guidance and LCBHS policies #161 (Network Adequacy Standards) and #274 (Out-of-Network Access and Single Case Agreements) for detailed information around network adequacy standards.

F. Investigation and Corrective Action

1. When compliance issues are reported by staff or detected via auditing/monitoring activities, the Compliance Officer will initiate an investigation.

2. If non-compliance is evidenced, the Compliance Officer will follow a course of corrective action outlined in this Compliance Plan and in policy #155 (Compliance Investigation and Corrective Action).

Component V: Reporting Suspected Fraud, Waste, and Abuse

LCBHS 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 process creates an open-door policy for reporting possible misconduct to the Compliance Officer, and evidences the commitment of LCBHS to successfully implement and monitor the Compliance Plan.

To ensure this communication standard, LCBHS has determined that the Compliance Officer may be contacted directly by staff to report activity that may violate the ethical and legal standards and practices of the Compliance Program.

Staff are also encouraged to seek guidance from the Compliance Officer if they are unsure about whether they are following the compliance policies and procedures correctly; if they need additional training; or if they have specific concerns or questions about the Compliance Program.

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

- The requirement that staff report behavior that a reasonable person would, in good faith, believe to be erroneous or fraudulent.
- A confidential process for reporting erroneous or fraudulent behavior.
- 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.

A. Reporting Suspected Violations

1. Per federal regulations and LCBHS 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 LCBHS Code of Ethics.

2. Staff may report violations of the Compliance Program directly to the Compliance Officer Stephanie Wilson by email at Stephanie.Wilson@lakecountyca.gov or by telephone at (707) 274-9101.

    a. Staff may contact the Compliance Officer directly at (707) 274-9101; or Stephanie.Wilson@lakecountyca.gov.

    b. Staff may also make a report via the LCBHS Compliance Hotline at 1-833-305-2020.

3. Reports may be made anonymously.

B. Documenting Reports of Suspected Fraud, Waste, or Abuse

Documentation of violation investigations and results is maintained by the 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.

C. Non-Retaliation

1. As evidence of commitment of LCBHS to this process, staff are not subject to retaliation for reporting suspected misconduct or fraud.

D. Confidentiality

The 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.

E. County Reporting of Medi-Cal Fraud, Waste, or Abuse to DHCS

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

- LCBHS must contact DHCS via:
    - Stop Fraud hotline (1-800-822-6222); or
    - 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 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 (CAP) will be developed to correct and mitigate the compliance issue.

The Compliance Officer may initiate an investigation of an alleged compliance violation based on information from one of several sources:

- Employee reports to the 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 Compliance Officer, in coordination with the Management Team and Risk Management Department, will develop a CAP to address the violation. As determined by the type of violation, the CAP may include:

- Development of internal changes in policies, procedures, and/or the Compliance Program;
- Re-training of staff;
- Internal discipline of staff;
- 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 LCBHS to advise staff of their audit findings and inform staff of the corrective actions needed. The Compliance Officer, in coordination with designated QI staff and the staff member's supervisor, 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 or the magnitude of the non-compliance issue cannot be remedied through a plan of correction, the case may be sent to the federal OIG 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 did not 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 Compliance Officer, in coordination with the Management Staff Committee and the QIC, will develop a CAP to address the violation, which may include disciplinary action for staff.

The range of disciplinary actions that may be taken follow the Lake County MOU with the Lake County Employee Association (LCEA).

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/

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 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:

- Intellectual Disability
- Autistic Disorders
- 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 included

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

B. Impairment Criteria

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

1. A significant impairment in an important area of life functioning, *OR*
2. A probability of significant deterioration in an important area of life functioning, *OR*
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current 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.