Inyo County Health and Human Services-Behavioral Health

Compliance Plan

Updated by Inyo County Compliance Officer in July 2021
Review with Compliance Committee Scheduled August

Mission Statement

The mission of Inyo County Health and Human Services- Behavioral Health (ICHHS-BH) is:
Providing High Quality and Culturally Responsive Behavioral Health Services to Strengthen Well-Being and Resilience through Hope, Healing, and Support for Individuals and Families within Our Community

To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care respectful of a person's family, language, and culture. As ICHHS-BH 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; and bulletin boards to keep staff, vendors, and contractors updated regarding compliance activities and to provide clear and ethical business guidelines for them to follow;
7. Distributing provider notices; and
8. 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.

Inyo County Code of Conduct for Behavioral Health

In an effort to clearly define the expectations of ICHHS-BH staff, the department has developed a written *Code of Conduct,* which has been approved by the Inyo County Employee's Association. This document will be distributed to all employees of the department to serve as a guideline for appropriate conduct and behavior.

- Each staff member shall be required to sign an acknowledgement that he/she has received and read a copy of the *Code of Conduct*. This acknowledgement will be maintained in a file by the Compliance Officer.

- This acknowledgement form shall be re-signed after reviewing the MHP *Code of Conduct* on an annual basis.

- The Code of Conduct will be signed by both the staff and a program representative.

ICHHS-BH Compliance Plan

The ICHHS-BH Compliance Plan will be monitored in accordance with this document and the MHP *Code of Conduct* prepared by the ICHHS-BH Compliance Committee. In addition, the Committee will review key issue areas. The key issue areas will be determined by the Deputy Director with advice from the Committee.

ICHHS-BH Compliance Committee

The ICHHS-BH Compliance Committee will be appointed by the Director and will include representation from:

- HHS Assistant Director
- Deputy Director of Behavioral Health
- PIQA Manager/Compliance Officer
- Clinical Program Chiefs
- SUD Supervisor
- Fiscal Manager/Management Analyst
- Other Agency Representation, as appropriate
- Other Staff, as appropriate

Statement of Policy on Ethical Practices

ICHHS-BH expects that all personnel will conduct themselves in a manner consistent with the highest professional standards and the ethical codes of their profession. ICHHS-BH places great importance on its reputation for honesty and integrity. To that end, ICHHS-BH Plan expects that the conduct of employees will comply with these ideals.

Each ICHHS-BH employee is expected to be familiar with this Compliance Plan and the appropriate processes necessary to perform his/her duties, and/or how to obtain the requisite information pertinent to performing his/her duties, in a manner consistent with legal, regulatory, and departmental requirements. Staff is also expected to understand and comply with the MHP *Code of Conduct*. Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of Inyo County may be subjected to progressive disciplinary action up to and including termination, in accordance with County Personnel Rules, MOU's with labor associations, or Professional licensing body.

ICHHS-BH will adhere to all applicable federal, state and local laws and regulations in the performance of its day-to-day activities. In addition, ICHHS-BH will inform its providers and/or contractors of this intention. Where uncertainty regarding federal, state, and local law and regulations exists, each employee shall seek guidance from a knowledgeable supervisor or manager. Supervisors may contact County Counsel or Inyo County's Compliance/Privacy Officer, as the situation warrants.

ICHHS-BH, as part of its Compliance Plan, will develop and implement detailed policies setting forth standards of conduct specifically applicable to the services delivered. These policies will be communicated to all Behavioral Health Division employees, and outside contractors as appropriate.

ICHHS-BH 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

ICHHS-BH 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 Components

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

1) Utilization Review and Chart Audit: The licensed quality assurance staff conducts quarterly reviews on a total of at least 6 charts annually to compare billing with chart documentation. A summary of the results of the audit are documented and reported to members of the Compliance Committee. This audit seeks to confirm that:
    a. Service listings are accurately represented 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 QA regulations);
    c. Services provided are reasonable and medically necessary; and
    d. Incentives for unnecessary billing do not exist.

2) Standards and Procedures Review: The Compliance policies and procedures are reviewed and evaluated annually by the QIC and the Compliance Committee 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.

3) System Level Monitoring: The Compliance Committee annually reviews data on service utilization, clients with high service utilization patterns, staff productivity, cost of services, and cost per client information. The Compliance Committee reviews the following information and makes recommendations for improvement as needed: Productivity, Medi-Cal/non-Medi-Cal ratio, chart audit results, fiscal impacts of disallowances, authorization services, Medi-Cal denial reports, cost utilization data, revenue/claims, utilization rates and consistency of the authorization process. When available, service utilization and cost utilization data will be analyzed and reviewed with data from other comparable counties. This monitors if services provided are reasonable and necessary. In addition, these reviews determine if there are any incentives for unnecessary services. Fiscal staff and assigned mental health staff will provide the above data on a monthly, quarterly, and/or yearly basis as appropriate.

4) Medi-Cal Denial Reports: The HHS Fiscal Manager reviews Medi-Cal Denial Reports quarterly to identify potential compliance issues and provide a report to the Compliance Committee.

Monitoring Activities

ICHHS-BH monitoring activities are an on-going process that monitors billing, timesheets, and chart documentation to assure that all services are accurately billed, accounted for, and charted.

1) Claims Submission Process:
   a.) Clinical staff enters their services into the EHR system via Progress Notes entry screen. Services and notes may be edited by clinical staff up until the point that the services are locked for claiming.
   b.) Claims are created on a monthly basis. Prior to locking the services for billing. Fiscal staff runs several reports to review and identify potential issues that could impact billing. For example, reports are run to identify changes in client's eligibility, services that do not have progress notes, potential duplicate services, clients lacking payors and/or assignment of benefits, missing diagnosis, and Juvenile Center services that may or may not be appropriate for billing. Fiscal staff informs clinical staff of these potential billing issues and corrections are made to services where appropriate prior to creating a Medi-Cal Claim.
   c.) Productivity reports are created monthly, In Addition; some staff members have requested weekly reports of services as a quality check to ensure prompt and accurate entry of their services in to the EHR.

2) Chart Documentation: The assigned supervisor or quality assurance staff meets on a weekly basis or as needed with program staff to review/pre-audit selected charts, insuring that the chart is complete and up to date; the chart review will insure that medically necessity is properly documented and that the treatment plans and services delivered (as described in the progress notes) are appropriate and internally consistent. The meeting will also be used as an opportunity to provide one-on-one or group training as needs are identified in the monitoring process.

3) Timeliness of Chart Documentation: Progress notes are expected to be submitted within 3 days of the service provided. A monthly report of services without progress notes is reviewed and corrected prior to billing.

Component II. Implementing Compliance and Practice Standards

As a component of the broader Compliance Program, ICHHS-BH has designed processes for combating fraud and unethical conduct through the development of this ICHHS-BH Compliance Plan. Implementation of this Compliance Plan is accomplished through written policies and procedures, and efforts are documented through various mechanisms.

Policies and Procedures
The purpose of the Compliance policies and procedures is to reduce the possibility of erroneous claims and fraudulent activities by clearly identifying risk areas and establishing internal controls to counter those risks. These controls include practice standards regarding client care, personnel matters, and compliance with federal and state laws.

The policies and procedures serve to identify and implement these standards necessary to successful compliance. These policies and procedures will be reviewed annually by the Compliance Committee to determine their continued viability and relevance.

The Compliance policies and procedures are as follows:

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

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

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

A. Coding and Billing

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

   A claim for a behavioral health service that the staff person knows or should know was not provided as claimed. This includes presenting or causing to be presented a claim for an item or service that is based on a code that will result in a greater payment to ICHHS-BH 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 necessary and are not warranted by a client's documented medical condition. This includes services which are not warranted by the patient's current and documented medical condition (medical necessity);

   Medi-Cal: ICHHS-BH 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 ICHHS-BH. 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. *Knowingly misuse of provider identification numbers, which results in improper billing.*

   Staff need to bill using the correct provider number, even if that means delaying billing until the provider receives the correct provider number. For example; a provider has not yet been issued a provider number so uses another provider's 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.

10. Claim from an Excluded Provider.

A claim for a mental health service or other item or service furnished during a period that the provider who furnished the services was excluded from the program under which the claim was made.

B. Reasonable and Necessary Services

Claims are to be submitted only for services that the provider finds to be reasonable and 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.

Upon request, the provider should be able to provide documentation, such as a client's medical record, to support appropriateness of a service that the provider has provided.

C. Service Documentation

Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. This same 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 is necessary to determine medical necessity and the appropriate medical 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.

Central to compliance is the appropriate documentation of diagnosis and treatment. For billing 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.

Documentation also assures that the:

- Medical record 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 and the medical record.
- Appropriate health risk factors are identified. The client's progress; his or her response to, and any changes in, treatment; and any revision in diagnosis are documented.
- Documentation includes all necessary components including date; service code; duration of service; location; and signature with title.
- Client Care Plans are written within time guidelines and meets documentation standards including measurable objectives, signatures, and dates.

Signature Requirements

Signatures are required to provide a minimum level of assurance that the provider is qualified to deliver the level of service being billed. The Center for Medicare and Medicaid Services (CMS) accepts a signature other than the provider's personal signature (i.e., a computerized signature), if the county can satisfy the carrier that proper safeguards are established.

Such safeguards may include the following:

- Dictated notes are signed by the clinician dictating the note. Computer generated notes are considered signed within the E H R.
- Written guidelines to staff 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 a carrier finds these safeguards have been violated.

Supervisory Review of Clinical Documentation

Each clinical supervisor will randomly select two charts for each of his/her clinicians each month. The supervisor will review the documentation practices in these charts and provide feedback to the clinician during the supervisory session.

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 ICHHS-BH 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 Emergency Department or 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

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

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

COMPLIANCE PROGRAM DOCUMENTATION

To ensure successful implementation of the compliance standards, to track compliance violations, and to evidence the department's commitment to compliance, ICHHS-BH has developed the following documentation procedures:

Compliance Log

Documentation of violation investigations and results will be maintained by the Compliance Officer in the Compliance Log. Information from the Compliance Log will be summarized and system level issues will be reviewed with the QIC on a quarterly basis. Suggestions, feedback, and changes to the system from the QIC and 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 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 investigation, including copies of interview notes, supporting reference materials, etc.;
- Name of the person responsible for providing feedback to the staff person, if appropriate;
- The corrective action taken, as applicable.

The Compliance Committee Documentation

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
    5. Compliance log
- ICHHS-BH Compliance Plan
- ICHHS-BH Compliance Policies and Procedures
- ICHHS-BH Code of Conduct
- All agendas
- Any materials distributed

Component III. Oversight of Compliance through a Compliance Officer

The successful implementation and maintenance of the ICHHS-BH Compliance Program depends on the efforts and support of all ICHHS-BH staff and administrators. To guide these efforts and perform day-to-day operations, ICHHS-BH has appointed a Compliance Officer.

In coordination with the functions performed by the Compliance Officer, a Compliance Committee was formed to oversee and monitor the Compliance Program as a whole. The Compliance Committee works in turn with the Quality Improvement Committee 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.

Compliance Officer

The Compliance Officer and/or designee have the responsibility of developing a corrective action plan and supplying oversight to ICHHS-BH's adherence to the Compliance Plan. This individual is empowered to bring about change and is responsible for overseeing the implementation and day-to-day operations of the Compliance Program.

The Compliance Officer has access to top management 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;
- Ensuring that documentation deficiencies that results in 'backing out' billing and/or stopping billing until the chart meets compliance standards.
- Conducting an analysis of the types of charting and compliance issues found during chart reviews and provide system level training to address any systemic problems.
- 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 practice staff are excluded from participation in federal health care programs;
- Investigating allegations of improper conduct and monitoring corrective action;

- Serving as the 'responsible' person for staff reporting of potential wrongdoing;
- Conducting/arranging for background checks of employees including checking finger prints against a national data bank; and
- Other duties as assigned.

Role of the Board of Supervisors

The Board of Supervisors (BOS) is ultimately responsible for the oversight of the compliance efforts of ICHHS-BH Plan (ICHHS-BH). The BOS, through the Compliance Committee, will oversee all of ICHHS-BH's compliance efforts.

Compliance Committee

In coordination with the Compliance Officer, the ICHHS-BH Compliance Committee performs vital functions to assure compliance with state and federal regulations. The Compliance Committee is responsible for the following compliance activities:

- Receiving reports on compliance violations and corrective actions from the Compliance Officer for training opportunities;
- Advising the Compliance Officer on matters of compliance violations and corrective actions;
- Advising the ICHHS-BH Deputy Director on compliance matters;
- Developing and maintain the Compliance Plan;
- Advising ICHHS-BH staff on compliance matters;
- Ensuring that an appropriate record-keeping system for compliance files is developed and maintained;
- Recording documentation deficiencies in the Compliance Committee meeting minutes.
- Reviewing charts with deficiencies to determine if all deficiencies have been corrected and/or addressed.
- Ensuring that compliance training programs are developed and made available to employees and that such training is documented;
- Ensuring that a departmental review and audit system is developed and implemented to ensure the accuracy of the claims documentation and submission process to all payors, which will include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action; and
- Meeting as needed, but no less than once a quarter.

The Compliance Committee reviews the following information and makes recommendations for improvement as needed: Productivity, Medi-Cal/non-Medi-Cal ratio, chart audit results, fiscal impacts of disallowances, beneficiary satisfaction (including complaints), authorization services, Medi-Cal denial reports, cost utilization data, revenue/claims, utilization rates and consistency of the authorization process. In addition, the Compliance Committee reviews minutes of Q-II and CQIC meetings that review the annual Quality Improvement Plan and Program Improvement Project.

Quality Improvement Committee (QIC)

The QIC meets quarterly and is designed to insure active contributions can be made by all mental health stakeholders. The QIC receives summary information of utilization rates and client accessibility, beneficiary satisfaction (including complaints), and progress toward meeting goals

in the annual quality improvement work plan and reviews system-level quality issues and discusses options for improving service delivery. In addition, the QIC annually reviews policies and procedures and compliance standards to ensure that these standards are relevant and up-to-date. Minutes from these meeting are forwarded to the Compliance Committee for review.

Component IV. Conducting Appropriate Training and Education

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

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

Training clearly communicates the compliance policies and procedures to all physicians and staff, as well as to independent contractors whose services are billed under the ICHHS-BH provider number. Memos, informational notices, E-mail, and/or monthly meetings are used to notify staff of changes in policies or procedures.

A. Compliance Standards Training

Training on compliance standards covers the operation and importance of the Compliance Program, the consequences of violating the standards and procedures outlined in the Compliance Plan, and the role of each employee in the operation of the Compliance Plan.

Compliance standards training will provide information on how to follow the law and will be tailored to the needs of the clinical staff and physicians, case management staff, and support staff. It will also review the ICHHS-BH Code of Conduct.

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

B. Coding and Billing Training

Training on accurately documenting services is an ongoing mission of Inyo County. This 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;
- Unit meeting agendas to include discussions of compliance activities and QIC system level issues, when applicable; and

- New staff orientation training including specific discussion and training on compliance issues.

Training Log

The MHP 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, ICHHS-BH has implemented the following communication mechanisms:

- New policies and information are posted in a central location on the S drive.
- Scheduled periodic Compliance trainings through Q-II Staff Meetings.

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. Position-specific training for Behavioral Health staff will occur during the Q-II Utilization Review meetings. Position-specific training for fiscal staff will occur one-on-one as needed and in group training as appropriate.

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

Upon receipt of a report or reasonable indications of suspected non-compliance, the Compliance Officer will investigate the allegations to determine whether a significant violation of applicable law or the requirements of the Compliance Program has occurred. If so, a corrective action plan will be developed to correct and mitigate the compliance issue.

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

- Employee reports via the Compliance Officer or a supervisor.
- Routine audits and self-assessments
- Monitoring activities that may detect such warning indicators as the number and/or types of claim rejections, challenges to medical necessity, and/or high volumes of unusual charge or payment adjustment transactions

If an investigation yields valid evidence of non-compliance, the Compliance Officer, in coordination with the Compliance Committee, will develop a plan of correction to address the violation. As determined by the type of violation, the corrective action may include:

- Development of internal changes in policies, procedures, and/or the Compliance Program;
- Re-training of staff;
- Internal discipline of staff;
- The prompt return of any overpayments;
- Reporting of the incident to the appropriate federal department;
- Referral to law enforcement authorities; and/or
- Other corrective actions as deemed necessary.

Subsequent investigations may be conducted to determine if corrective action has been followed by the appropriate staff member(s). If the subsequent investigation indicates that corrective action was not taken, staff may be subject to disciplinary action and/or the case may be sent to the federal Office of the Inspector General to be reviewed for possible civil and criminal action.

Component VI. Developing Open Lines of Communication

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

To ensure this communication standard, ICHHS-BH 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 is 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 a 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 ICHHS-BH's responsibility to advise staff of their audit findings and inform them of the corrective actions needed. The Compliance Officer, in coordination with the clinical supervisor and/or Quality Improvement Coordinator, will provide feedback to staff. Staff who have been informed of non-covered services or practices, but continue to bill for them, or staff whose claims must consistently be reviewed because of repeated over-utilization or other abuse practices, could be subjected to administrative actions.

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

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

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

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

Discussion Point: The range of disciplinary actions taken may include warnings, reprimands, probation, demotion, temporary suspension, discharge, restitution and referral for criminal or civil prosecution. All disciplinary actions should be well documented.

When a violation has been discovered, corrective action will be taken. This may include retraining, changing policies and procedures, discipline of staff, or other changes to the compliance program. The compliance program will be periodically reviewed and modified to address specific and/or systemic violations.

The ICHHS-BH corrective action plan for compliance issues is outlined below:

A. The range of disciplinary activities taken follow the Inyo County Personnel Policies and Procedures:

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

Each of the following constitutes cause for discipline of an employee:
- Falsifying personnel records or County records or providing false information concerning employment qualifications;
- Incompetence;
- Inefficiency;
- Inexcusable neglect of duty; and
- Willfully disobeying a reasonable order or refusal to perform the job as required.

B. Staff performance will be evaluated regarding compliance with the *Code of Conduct*, documentation standards within expectations for an employee's assigned unit, timeliness of documentation, and consequences of inaccurate documentation.

C. New employees are required to sign a signature page stating their understanding of the documentation and professional conduct expectations outlined above.

D. ICHHS-BH follows the 'Chain of Command' system regarding the MOU that outlines progressive stages of feedback to address any issues of noncompliance. These may include outlining the Chain of Command.
- *Oral Warning*
- *Counseling Memo*

- *Written Warning*
- *Written in Annual Evaluation or during Probationary Period*
- *Letter of Reprimand*
- *Denial of Merit Advancement Within Range*
- *Suspension without pay*
- *Demotion*
- *Dismissal*

E. The following Inyo County Services committees and/or departments will monitor and manage Compliance issues:
   - Quality Improvement Committee (QIC)
   - Compliance Committee
   - Personnel Department
   - Health and Human Services Executive Management Team

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.dhhs.gov/progorg/oig/cumsan/index.htm