NEVADA County
Behavioral Health

Compliance Plan

FINAL 1/06/2020

Introduction

Mission Statement

The mission of Nevada County Behavioral Health (NCBH) is to enable individuals in our community who are affected by mental illness and serious emotional disturbances to achieve the highest quality of life. To accomplish this goal, services must be delivered in the least restrictive, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

As NCBH 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/Quality Assurance Manager to monitor compliance efforts and enforce practice standards;
4. Conducting appropriate training and education on practice standards and procedures regarding applicable laws, regulations, and policies;
5. Establishing mechanisms to investigate, discipline, and correct non-compliance and respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities;
6. Developing open lines of communication, including discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct; establishing an electronic notification process (e-mails) for dissemination of new or changed information to keep employees updated on compliance activities, and providing clear and ethical business guidelines for staff to follow.
7. Enforcing disciplinary standards through well-publicized guidelines.

Legal Mandates for Compliance Activities

Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services

On April 25, 2016, CMS issued in the Federal Register the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. See the related blog co-authored by the CMS Administrator and Center for Medicaid and Center for Medicaid and Chip Services (CMCS) Director, "Medicaid Moving Forward." For questions regarding managed care, please email ManagedCareRule@cms.hhs.gov. Current federal requirements for Program Integrity Safeguards including a Compliance Program to detect fraud, waste and abuse are included in the final rule at Title 42, Code of Federal Regulations (CFR), Part 438, Subpart H and specifically in Section 438.608.

Code of Conduct

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

- **Upon hire**, each staff member will be required to sign an acknowledgement that he/she has received and read a copy of the Code of Conduct. Each staff member is expected to be familiar with the detailed policies applicable to their activities and is required to adhere to such policies. This acknowledgement will be maintained in each employee's file, held by the Human Resources Department with a copy electronically held by the Quality Assurance Manager.
- A copy of the Code of Conduct will be given to each NCBH staff Annually and the acknowledgement form will be re-signed on an annual basis after reviewing the NCBH Code of Conduct.

NCBH Compliance Plan

The NCBH Compliance Plan will be monitored in accordance with this document and the NCBH Code of Conduct prepared by the NCBH Compliance Committee. In addition, the Committee will review key issue areas. The key issue areas will be determined by the Management Team, in collaboration with the Committee.

NCBH Compliance Committee

The NCBH Compliance Committee will be appointed by the NCBH Quality Assurance Manager and may include:

- Director of Behavioral Health
- Alcohol and Drug Program Manager
- Compliance Officer
- Adult Program Manager
- Children's Program Manager
- NCBH Supervisors
- Other Staff

Statement of Policy on Ethical Practices

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

Each NCBH 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 NCBH Code of Conduct. Employees who act in violation of the Compliance Plan or who otherwise ignore or disregard the standards of Nevada County may be subjected to progressive disciplinary action, up to and including termination.

NCBH will adhere to all applicable federal, state and local laws and regulations in the performance of its day-to-day activities. In addition, NCBH will inform its providers and/or organizational service providers of this intention. Where uncertainty regarding federal, state, and local law and regulations exists, each employee will seek guidance from a knowledgeable supervisor. Supervisors may contact Nevada County's Compliance Officer or Deputy Directors as the situation warrants.

NCBH, as part of its Compliance Plan, has developed and implemented detailed policies setting forth standards of conduct specifically applicable to the services. These policies will be communicated to all department employees, and contracted organizational service providers, as appropriate. NCBH 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: Maintaining Program Integrity

Overview

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

Monitoring Staff and Providers – License and Status Checks; Disclosures

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

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

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

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

3. California Licensing Boards
   https://www.breeze.ca.gov
   - Monthly, verify that provider's license has not expired and that there are no current limitations on the license.

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

5. Social Security Administration's Death Master File
   https://www.ssdmf.com/
   - During hiring or certification/recertification, verify that the individual is NOT on the list.

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

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. Currently, peer mentors are not verified, as they do not have access to the EHR.

Frequency of Verification Checks

Verification will occur as follows:

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

NCBH is responsible for verifying individual and organizational/entity contract providers, NCBH staff, and NCBH applicants. Organizational providers are required to verify that their own employees and applicants are not on the Exclusion Lists.

Adverse Findings

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

- For involved staff, mitigation and disciplinary action follow the Nevada County Memorandum of Understanding (MOU) and the Nevada County General Unit Union guidelines, as warranted (refer to Component VII in this document).
- For contract providers, contracts may be immediately terminated, as warranted.
- An applicant who is identified as an excluded provider will not be hired. NCBH will not enter into contracts with individual or organizational providers that are identified as excluded.
- Organizational providers must report immediately to the NCBH Director any adverse findings related to their employees.

B. In order to ensure professionalism and ethical conduct, NCBH complies with state regulation in collecting disclosures of ownership, control, and relationship information from its managing staff and providers, and its providers' managing employees, regardless of for-profit or non-profit status.
    - When an individual (provider or staff member) has an interest of 5% or more of any mortgage, deed of trust, note, or other obligation secured by an NCBH contract provider, and that interest equals at least 5% of the contract provider's property or assets, the provider is required to disclose this information to NCBH.
    - Disclosure information is collected at the time of hire or contract execution between the provider and NCBH, and upon renewal of each contract (annually or otherwise).
    - In the event that in the future, any individual obtains an interest of 5% or more of any mortgage, deed of trust, note, or other obligation secured by the staff member or provider, and that interest equals at least 5% of the provider's property or assets, the staff member or provider must disclose this updated information to NCBH.

Billing Auditing and Monitoring 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) Billing Chart Review: NCBH conducts a monthly random review of ten charts to compare billing with chart documentation. A chart review consisting of a minimum of 5 charts for each organizational provider is conducted on an annual basis or as needed. The network providers charts are also randomly audited yearly. This review seeks to confirm that:
    a. Bills are accurately coded and reflect the services provided (as documented in the client's chart);
    b. Documentation is being completed correctly and in a timely manner (per Mental Health Plan contract requirements);
    c. Services provided meet medical necessity criteria; and
    d. Incentives for unnecessary billing do not exist.

2) Standards and Procedures Review: Policies and procedures are reviewed and evaluated as needed by 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. All new Policy and Procedures are vetted by the Compliance Committee and the Management Team.

3) System Level Monitoring: The Compliance Committee reviews monthly data on staff productivity and service data (i.e., service codes used, timeliness of entry, etc.)

4) Medi-Cal Denial Reports: To help to identify any potential compliance issues, the denials are reviewed and resolved on an ongoing basis as the EOB's (835) are made available by the California Department of Health Care Services (DHCS) on their Information Technology Web Services (ITWS) website. The Anasazi Denial/Pending Report is also reviewed on a monthly basis. Noncompliance issues such as, incorrect Client Index Number (CIN#), Other Health Insurance, etc. are resolved by the Fiscal Department during the initial and ongoing monthly eligibility process. Potential compliance issues are reported to the Quality Assurance (QA) Manager. 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
    - Billing Suspense Report
    - No Final/Approved Progress Note for Service
    - Missing/Not Final Approved Progress Note
    - Staff Credentials verified/confirmed. National Provider Identifier (NPI) numbers are entered.

5) Timeliness of Chart Documentation: Timeliness of progress note documentation is monitored on a monthly basis via Anasazi. Any issues are reported to the Behavioral Health Supervisors, the Adult and Children Program Manager, and the Quality Assurance Manager.

6) Claims Submission Process:
    - 1st week: Monthly MEDS Extract File (MMEF) is loaded into the system. (MEDS is the Medi-Cal Eligibility Data System.)

- Weekly: Audit reports are run and any issues are reported to the staff member and the Behavioral Health Supervisor, or designee, for correction, as applicable. Audit error reports are run bi-weekly, immediately following each pay period, to compare staff reported time and billing. A discrepancy list is created and distributed for correction.
- Ongoing during the month: Client Payments are entered. Audit reports are re-run and updated. Providers'/Staff's NPI numbers are verified upon initial staff setup via the National Plan and Provider Enumeration System (NPPES) website.
- Approximately the 17th of each month, the Billing Process begins: Run Audit Reports. Verify Client payments batches are closed/posted. Verify client adjustment batches are closed/posted. Verify 3rd party payments are posted. Verify server credentials (License numbers and expiration date). Verify Staff NPI numbers are in the system. Verify Pay Source priority. Check Financial Reviews for expiration, start date. Check duplicate services. 3rd party suspense report; no F/A note or missing Progress Note, valid diagnosis, Payor source. 3rd party coverage; services going to self-pay, M/Cal-HF overlapping, verify CIN# is entered correctly, check effective dates. Share of cost report; check if any have been met. Post HIPAA 5010 837P claim reports for Medi-Cal and Medicare. Insurance: post HIPAA 837P report. Preview client self-pay statements. Preview and post Uniform Method of Determining Ability to Pay (UMDAP). Check unapplied payments report. Print, review for accuracy and mail Centers for Medicare and Medicaid Services (CMS) 1500 insurance claim forms. Print Client statements; review for accuracy and mail Client statements. The claim totals are then forward to the software support vendor for review and the edit reports are generated again to confirm all errors have been cleared and the totals match. The 1982 claim forms are then prepared and routed for signatures. Once, the signatures have been obtained the 1982 claim forms are faxed to the software support vendor and the 837 claim files are submitted to ITWS and Medicare.

7) Timeliness of Chart Documentation: Timeliness of chart documentation is monitored in through utilization review activities, and in monthly chart reviews. This activity is also monitored through a monthly report that is provided to the QA Manager and the direct supervisor of the staff member. This review may be documented in the UR Log via the Chart Review record.

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

Component II: Implementing Compliance and Practice Standards

As a component of the broader Compliance Program, NCBH has designed processes for combating fraud and unethical conduct through the development of this NCBH 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 as needed by the Compliance Committee to determine their continued viability and relevance.

The Compliance policies and procedures are as follows:

- Medi-Cal Service Verification
- Verification of Contract Providers, Staff and Applicants-Exclusion and Status Lists
- Ownership Disclosure of Management Staff and Contract Providers
- Compliance Program Standards
- Compliance Auditing and Monitoring Activities
- Risk Areas and Potential Violations
- Oversight of the Compliance Program
- Compliance Training
- Non-Compliance Investigation and Corrective Action
- Reporting Suspected Fraudulent Activity
- Disciplinary Guidelines
- Physical Accessibility Compliance and Monitoring Activities
- Compliance Program Documentation

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 mental 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 NCBH than the code that is applicable to the service actually provided;

2. *Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary.* A claim for health equipment, medical supplies, and/or mental health services that is not reasonable and medically necessary. These claims are not warranted by a client's documented condition. This includes services which are not warranted by the client's current and documented mental health condition (medical necessity).
   - Medi-Cal: NCBH operates under a State waiver implementing the managed mental health services as construed in Chapter 11, Title 9, CCR, Sections 1830.205 and 1830.210, which specify the medical necessity requirements. All persons served in mental health must meet the state guidelines for medical necessity.

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 NCBH. Although duplicate billing can occur due to simple error, the knowing submission of duplicate claims, which may be evidenced by systematic or repeated double billing, can create liability under criminal, civil, and/or administrative law.

4. *Billing for non-covered services as if covered.* Submitting a claim using a covered service code when the actual service was a non-covered service. "Necessary" does not always constitute "covered."

5. *Knowing misuse of provider identification numbers, which results in improper billing.* A provider has not yet been issued a provider number, so he/she uses another provider's number. Staff need to bill using the correct provider number, even if that means delaying billing until the provider receives the correct provider number.

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

7. *Failure to properly use coding modifiers.* A modifier, as defined by the federal Current Procedural Terminology, 4th Edition (CPT-4) manual and/or Client and Services Information system (CSI) coding manual, provides the means by which a provider can indicate a service or procedure that has been performed.

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

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

10. *Claim from an Excluded Provider. a* claim for a mental health service or other item or service furnished during a period that the provider who furnished the services was excluded from the program under which the claim was made.

B. Medically Necessary Services

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

C. Service Documentation

Timely, accurate, and complete documentation is important to clinical client care and an important component of compliance. All progress notes should be completed and final approved on the same date of service. If unavoidable circumstances necessitate documentation of a service after the date of service delivery, the note is entered with a documentation date, and completed and final approved no later than ten (10) working days after the date of service.

This documentation serves a second function when a bill is submitted for payment, namely, as verification that the bill is accurate as submitted. Therefore, one of the most important practices is the appropriate documentation of diagnosis and treatment. Documentation demonstrates medical necessity and the appropriate mental health treatment for the client and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

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

Documentation ensures that the:

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

- ***Alcohol and Drug Client Plans*** are completed within thirty (30) calendar days from the admission date. The provider submits the signed Client Plan to the physician for review. The physician shall review, approve, and sign the Client Plan within fifteen (15) calendar days. The provider reviews and documents the client's progress every thirty (30) days after signing the initial Client Plan, and an updated Client Plan will be completed every ninety (90) calendar days.

Signature Requirements
Signatures/electronic are required to provide a minimum level of assurance that the provider is qualified to deliver the level of service being billed. CMS accepts a signature other than the provider's personal signature (e.g., electronic equivalent), if proper safeguards are established.

Such safeguards may include the following:

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

Supervisory Review of Clinical Documentation
Each clinical supervisor may select 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 a NCBH employee's private practice;
- Financial arrangements with outside entities to whom the practice may refer federal mental health business;
- Joint ventures with entities supplying goods or services to the provider or its clients (for example, medical equipment referrals);
- Consulting contracts or medical directorships;
- Office and equipment leases with entities to which the provider refers;
- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit;
- Waiving co-insurance or deductible amounts without a good faith determination that the client is in financial need or failing to make reasonable efforts to collect the cost-sharing amount;
- Inappropriate crisis care;
- "Gain sharing" arrangements;

- Physician third-party billing;
- Non-participating physician billing limitations;
- "Professional courtesy" billing;
- Rental of physician office space to suppliers; and
- Others.

E. Record Retention

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

- The length of time that NCBH or a provider's mental health records are to be retained.
- Management of the mental health record including protecting it against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and/or damage.
- The destruction of the mental health records after the period of retention has expired.
- The disposition of the mental health 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 abuse treatment. Patient-identifying information is information that reveals that a person is receiving, has received, or has applied for substance abuse treatment. What the regulations protect is not the individual's identity per se, but rather his or her identity as a participant in, or applicant for, substance abuse treatment.

Compliance Program Documentation

To ensure successful implementation of the compliance standards, to track compliance violations, and to document the department's commitment to compliance, NCBH 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 may be reviewed with the Quality Improvement Committee (QIC) and Compliance Committee. Suggestions, feedback, and changes to the system from the QIC and Compliance Committee are also documented in the Compliance Log. The Compliance Log contains the following materials:

- The date or general time period in which suspected fraudulent action occurred;
- Name of the reporting party and/or source of the allegation (via compliance hotline, direct contact with Compliance Officer, routine audit, monitoring activities, etc.);
- Name of the provider(s) involved;
- Name of the client(s) or chart number(s) involved; (although materials protected by attorney-client privilege will be filed separately)
- Specific information regarding the investigation, including copies of interview notes, supporting reference materials, etc.;
- Name of the person responsible for providing feedback to the staff person, if appropriate; and
- The corrective action taken, as applicable.

Compliance Program Binder

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

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

The Compliance Committee Minutes Binder

The Minutes binder contains the following materials:

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

Compliance Hotline

NCBH has developed an employee Compliance Hotline to report possible compliance violations. The Compliance Officer will track complaints from this reporting mechanism.

Component III: Oversight of Compliance Program

The successful implementation and maintenance of the NCBH Compliance Program depends on the efforts and support of all NCBH staff and administrators. To guide these efforts and perform day-to-day operations, NCBH 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. The Compliance Committee works in coordination with the Management Team, as well as 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 has the responsibility of developing a corrective action plan and providing oversight to NCBH'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 Management Team provides oversight to the Compliance Officer and ensures implementation of all compliance activities. 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 payers, 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 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.

Management Team

The Management Team is responsible for the supervision of the compliance efforts of Nevada County Behavioral Health. The Management Team, with assistance from the Compliance Committee, will oversee all of NCBH's compliance efforts.

Compliance Committee

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

- Receives reports on compliance violations and corrective actions from the Compliance Officer;
- Advises the Compliance Officer on matters of compliance violations and corrective actions;
- Advises the NCBH Director on compliance matters;
- Advises NCBH staff on compliance matters;
- Develops and maintains the Compliance Plan;
- Ensures that an appropriate record-keeping system for compliance files is developed and maintained;
- Ensures that compliance training programs are developed and made available to employees and that such training is documented;
- Ensures that a departmental review and audit system is developed and implemented to ensure the accuracy of the claims documentation and submission process to all payers, which will include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action; and
- Meets as needed, but no less than twice per year.

Utilization Review Team

Utilization Review Activities ensure successful compliance. The Utilization Review (UR) Team is responsible for performing the following activities related to compliance and practice standards:

- Annually reviews a minimum annual sample of 10% of the charts for documentation practices using a Clinical Chart Review 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 UR minutes and on a UR checklist that is maintained by the QA Manager.
- Submits a copy of the Clinical Chart Review checklist to the supervisor and staff member for the deficiencies of the chart that is reviewed.
- The staff Supervisor reviews charts with deficiencies to determine if all deficiencies have been corrected and/or addressed. A report of the corrections is submitted to the QA Manager.
- Reviews additional charts of those clinicians who have repeated problems.
- For charts with problems still outstanding by the second review, the QIC Coordinator will discuss the documentation issues with the clinician's supervisor.
- Monitors the types of charting and compliance issues found during chart reviews and provide system level training to address any systemic problems
- As needed reviews policies and procedures and compliance standards to ensure that these standards are relevant and up-to-date.

Quality Improvement Committee

The Quality Improvement Committee provides oversight and monitoring of compliance as a component of the Nevada County Behavioral Health Program. The QIC reviews access to services, improvements to service delivery, and enhancements to quality of care. This activity is

accomplished by following a planned and systematic process of collecting data, setting objectives, and monitoring progress. The QIC monitors quality improvement and compliance activities, as well as addressing consumer rights issues.

Component IV: Conducting Appropriate Training and Education

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

Compliance training has two goals:

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

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

Training Timelines

New employees are trained as soon as possible after their start date and employees receive refresher training on an annual basis, or as appropriate. Training(s) will be scheduled periodically to maintain and enhance all employees' understanding of the Compliance Plan.

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 NCBH *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.

Coding and Billing Training

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

- Coding requirements;
- 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 QA Manager or designee 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, NCBH has implemented the following communication mechanisms:

- All Compliance policies and procedures are posted on the shared drive accessible to staff.
- Scheduled periodic Compliance trainings.

Training for the Compliance Officer

NCBH will dedicate resources to provide ongoing training for the Compliance Officer and senior management, in addition to the training and education described above. Trainings may include but are not limited to attendance at topically relevant training conferences, organizational meetings regarding compliance, and/or webinars.

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, the employee Compliance Hotline, 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
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations
- State chart disallowances
- Any other sources of information that become available

The investigation may include staff interviews, review of relevant compliance documents, and regulations and/or the assistance of external experts, auditors, etc.

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;
- Suspension of payments to any provider for which there is a credible allegation of fraud;
- Reporting of the incident to DHCS and any other appropriate state or federal agency;
- Referral to law enforcement authorities if appropriate; 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, or the magnitude of the non-compliance issue cannot be remedied through a plan of correction, 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

NCBH 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 NCBH to successfully implement and monitor the Compliance Plan.

To ensure this communication standard, NCBH 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. Suspense billing reports in the electronic health record are used to identify possible erroneous claims, and prevent them from being submitted. The erroneous claims are voided before the monthly billing cycle.
- A confidential process that maintains the anonymity of the persons involved in the reported possible erroneous or fraudulent behavior and the person reporting the concern. However, there may be certain occasions when a person's identity may become known or may need to be revealed to aid the investigation or corrective action process.
- Standards that outline that there will be no retribution for reporting behavior that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.
- Policies and procedures that implement these standards in detail.

Feedback to Staff

It is part of NCBH's responsibility to advise staff of their audit findings and inform them of the corrective actions needed. The Compliance Officer, in coordination with the supervisors and/or Quality Assurance Manager, 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 $11,000 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 will be suspended from participation in the Medi-Cal/Medicare programs.

Component VII: Enforcing Disciplinary Standards

The Compliance Plan clearly outlines consistent and appropriate sanctions for compliance violations while, at the same time, is flexible enough to account for mitigating or aggravating circumstances. The ranges of disciplinary actions that may be taken closely follow the Nevada County Memorandum of Understanding and the Nevada County General Unit Union guidelines.

The NCBH corrective action plan for compliance issues is outlined below:

A. The range of disciplinary activities taken follow the Nevada County MOU and the Nevada County General Unit Union guidelines:

"Disciplinary Action" means dismissal (except dismissal for medical reasons), demotion, reduction in pay, or suspension without pay, written warning, and verbal warnings.

Each of the following constitutes cause for discipline of an employee:

- Incompetence
- Inefficiency
- Inexcusable neglect of duty
- Willfully disobeying a reasonable order or refusal to perform the job as required
- In possession of/or under the influence of, or trafficking in habit forming drugs and/or narcotics while at work or on County property
- Unauthorized absence without leave
- Conviction of a felony or conviction of a misdemeanor related to the performance of duties of the job. A plea or verdict of guilty or a conviction following a plea of nolo contendere to a charge of a felony or any offense involving moral turpitude is deemed to be conviction within the meaning of this section.
- Discourteous treatment of the public or other employees
- Improper political activity as defined in the Government Code
- Misuse of County property or damage to public or private property resulting from misuse or negligence
- Violation of the Code of Conduct (Conflict of Interest Code)
- Abuse or misuse of sick leave, vacation, or other employee benefits
- Gambling on County premises
- Failure to properly report absenteeism
- Excessive tardiness
- Refusal to take and subscribe any oath or affirmation which is required by law in connection with employment
- Other conduct either during or outside of duty hours which is of such a nature that it causes discredit to the department or to the County
- Violation of any State law or County ordinance requiring confidentiality of records or information
- Inability to perform the duties of the position as a result of the removal of "deputy" status by an appropriate elected official
- Inability to perform the deputies of the position due to loss or inability to obtain required licenses

B. Job duty statements include 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, and all staff on an annual basis, are required to sign a signature page stating their understanding of the documentation and professional conduct expectations outlined above.

D. NCBH follows a "Chain of Command" system regarding the MOU that outlines progressive stages of feedback to address any issues of noncompliance. These stages may include:
    - Verbal Warning
    - Written Warning
    - Written in Annual Evaluation or during Probationary Period
    - Written in the Departmental Personnel File
    - Reduction in pay
    - Suspension without pay
    - Demotion
    - Dismissal

E. The following Nevada County Health Services committees and/or departments will monitor and manage Compliance issues:
    - Compliance Committee
    - Management Team
    - Quality Improvement Committee
    - Utilization Review (QIC) Team