Objectives:

• To gain awareness of the current climate of increased oversight of federal programs, i.e. Medicaid, Medicare

• To learn how to prepare and respond to audits whether internal or external

• To learn ways to minimize risk through a Compliance program and from lessons learned

Consequences of audits

• Reimbursement to the third party payer – "paybacks"

• Potential for external audits by third party payers

• Community and/or national exposure

• Disciplinary actions

Oversight of Federal Programs

• 1991 – Organizations Sentencing Guidelines

• 2004 - OIG Compliance Program Guidelines

• 2005 - Deficit Reduction Act

• 2010 – Affordable Care Act

Federal and State Audits

• ACA provides HHS with new authorities to identify and recover overpayments through

• Recovery Audit Contractors (RACs)

• Zone Program Integrity contractors (Medicare and Medicaid)

• Medicaid Integrity Contractors

• Medicare Administrative Contractors

• Pilot programs with the FBI, Department of Justice, OIG, State Attorney Generals and Medicaid Integrity Programs

• PERMs – Medicare Payment Error Rate Measurement

• Local DHHS –

• Program Integrity

• States and private contractors were mandated to increase their oversight to reduce overpayments, waste, abuse and fraud in the Medicaid and Medicare programs.”

• 2010 – Health care legislation included new laws to further recover and reduce overpayments, reduce or eliminate waste, abuse and fraud and make compliance programs in health care and federal contracts, mandatory as a matter of law.

• 2009 – 2013 - Increased in federal government oversight, regulation and enforcement of the health care industry.

"States and private contractors were mandated to increase their oversight to reduce overpayments, waste, abuse and fraud in the Medicaid and Medicare programs.”
What to Do – Internal Audits

• Establish a systematic and formal audit process
• Use a Peer Review or other format not including self-audits
• Cover all areas of required by the standards
• Do Corrective Action Plans (CAPs)
• Develop a data bank and track your progress and compliance

What to Do – External Audits

• The Compliance Officer must verify the source of the audit request
• Respond to the audit request as quickly as possible by sending all required information
• If the audit is on site, assist the auditors by having available a mock chart, list of staff signatures, and help them navigate the medical record.
• May need to have copier available and offer assistance in gathering any information
• Ask about the process
• Familiarize yourself with the appeal process and penalties

Why a Compliance Program

• ACA requires providers to implement a compliance program as a condition for enrollment in Medicare or Medicaid
• Provides an effective method to –
  • Assess and manage risks
  • Prevent violations
  • Reduce the potential for liability if violations occur
  • Reduce the risk of civil suits

Directors’ Responsibilities or Duty of Care

• Executive Directors have a fiduciary duties to stakeholders applicable to compliance with the law:
  A. Decision-making function – applicable to a particular situation or a specific action
  B. Oversight function – pertains to the general activity of overseeing the day-to-day functions of the business
• The existence of a compliance program that provides relevant information to its leadership to make its decisions fulfills this responsibility.

DRA Requirements

An employer who receives more than $5 million per year in Medicaid must provide the following to their employees:

• Information about the False Claims Act (FCA) and Civil False Claims Act
• Applicable state False Claims Act
• Right to be protected as whistleblowers
• Policies and procedures for detecting and preventing fraud, abuse and waste
• Focus on Medicaid because it is the largest insurance program in the US, jointly funded by the federal government and the states and Medicaid spending like Medicare spending is growing at a very high rate. In 2010, Medicaid spending grew 7.7%
Whistleblower Protection

“An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against, in terms and conditions of employment, because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees” – (Deficit Reduction Act)

Federal Laws that Encourage/Protect Whistleblowers

• Sarbanes-Oxley
• OSHA
• False Claims Act
• ARRA (Recovery/Reinvestment Act)

Terms as defined in the FCA

• “Knowingly” includes a person who-
  • has actual knowledge of the information, or
  • acts in deliberate ignorance of the truth or falsity of the information, or
  • acts in reckless disregard of the truth or falsity of the information
  • No proof of specific intent to defraud is required

• Potential civil liability
  • Between five thousand five hundred ($5,500) and eleven thousand ($11,000) per claim, treble damages, and the costs of any civil action brought to recovery for such penalties or damages

• “Claim”
  • Any request or demand for money or property, if the US Government provides any portion of the money requested or demanded.

The Civil False Claims Act (FCA)

(31 U.S.C. §§3729 et seq.)

Is a statute that imposes civil liability on any person who:

• “knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval, or
• conspires to defraud the government by getting a false or fraudulent claim allowed or paid, or
• uses a false record or statement to avoid or decrease an obligation to pay the Government, and
• other fraudulent acts enumerated in the statute”

“Knows or Should Know”

• Civil Money Penalty law provisions of the SSA
  • Civil sanctions may be imposed against any person who presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency... a claim that the Secretary determines –
    • A. Is for a medical or other item or service that the person knows or should know was not provided as claimed –
    • B. Is for a medical or other item or service and the person knows or should know the claim is false or fraudulent, or
    • C. Is for a pattern of medical or other items or services that a person knows or should know are not “medically necessary”

Abuse

Activity that results in direct or indirect unnecessary costs to the Medicare/Medicaid, i.e.
• Services that do not meet professionally recognized standards of care,
• Medically unnecessary services

Is the over-utilization of services, or other practices that result in unnecessary costs, i.e.
• Inefficiency in health care settings within the delivery of services to the member
• Not following evidence based treatment guidelines for new technologies.

Is knowingly and willfully executing, or attempting to execute, a scheme or artifice to:
• Defraud any health care benefit program, or
• Obtain money or property owned by, or under the custody or control of any health care benefit program

Waste

Is

Fraud
Regulations Related to Fraud and Abuse

- Anti-Kickback Statute - prohibits individuals or companies from offering kickbacks to or accepting kickbacks for referring clients or items paid for by Federal payment sources.
- Center for Medicare and Medicaid Services standards of care and billing requirements (SC DHHS Community Mental Health Manual – Section II, Palmetto GBA-Medicare SC).
- OIG List of Excluded Individuals/Entities – Lists all providers excluded from participation in federal programs, temporarily or permanently.
- Stark Physician Self-Referral - prohibits physicians from referring clients to facilities where they have financial interests or ownership.
- HIPAA Privacy and Security Rules - inappropriate disclosure of medical information.

Leadership Compliance Responsibilities

- Board of Directors
- Executive Director
- DMH Compliance Officer
- DMH Compliance Committee
- All Employees

Elements of a Compliance Program

- Code of Conduct
- Compliance Plan
  - Designates Responsibilities
  - Promotes the development and implementation of training programs
  - "Hotline" to receive compliance complaints
- Audits and monitoring activities to reduce problems
- Investigation and remediation of identified problems

Employees’ Compliance Responsibilities

- Help ensure the agency -
  - Maintains its commitment to ethical behavior
  - Meets its goals
  - Improves the quality of patient care and
  - Operates efficiently while fulfilling its legal obligations

Reporting

“All employees are obligated to make a good faith report of any activity within the agency that appears to violate compliance policies, procedures or statutes to any of the following”:

- Their immediate supervisor
- Their Compliance Officer
- Fraud Hotline toll free

Enforcement

- Compliance must be listed as an essential duty and/or objective in the employees’ performance evaluation.
- Screenings:
  - National Practitioner Data Bank
  - Cumulative Sanction Report
  - OIG List of Excluded Individuals and Entities
- Annual Audits that include compliance with Medicare and Medicaid standards of care.
- Feedback and Consultation
- Corrective Actions and periodic follow-up
Compliance Audit & Monitoring Processes

- Regular audits that include compliance with Medicare and Medicaid standards of care
- Feedback and Consultation
- Corrective Actions and periodic follow-up

Areas of Risk

Medical Necessity and Quality of Care Issues

- “Social Security Act obligates health care providers to assure that services ordered for or provided to Medicaid and Medicare beneficiaries are –
  - Medically necessary
  - Of quality that meets professionally recognized standards of health care
  - Provided economically
  - Supported by evidence in the medical record”

  “Poor documentation of services rendered
  - lack of medical necessity
  - Inappropriate or substandard care
  - unnecessary services
  - denial of claims and potential false claims liability

  • Treatment that is not individualized and appropriate

Identified Areas of Risk

- Physician self-referrals (Stark Law)
- Knowingly and willfully engage in a financial transaction to influence referrals (Anti-kickback Law)
- Relationships with Federal Health Care Beneficiaries
- Inappropriate disclosure of medical information (HIPAA Privacy and Security Rules)

• “Rejection of claims in MH services related to lack of medical necessity are based on –

  - Length of hospitalization
  - Length of psychotherapy sessions
  - Conditions allegedly not appropriate for psychotherapy treatment”
ERRORS LEADING TO RECOUPMENT

• Billing for medically unnecessary services
• Billing for services not rendered
• Billing for undocumented services
• The documentation of a service does not support the service billed
• The documentation of a service does not support the billed time
• Characterizing non-covered services or costs in a way that secures reimbursement

• Billing for a non-billable activity –
  • Transportation
  • Helping clients complete applications
  • Services delivered directly to the family
  • Parenting Skills
  • Employment and vocational supports
  • Recreation and socialization without any valid therapeutic reason

• Not seeking payment from beneficiaries who may have other primary payment sources
• Not billing for legitimate services while billing Medicaid clients, e.g., group therapy
• Errors made in billing due to ignorance of federal and state laws (ignorance of the law is not accepted as a valid defense)

• Delivering and billing for a service beyond what was necessary to treat the client effectively, or
  • Delivering and billing a service that is clearly not helping the client
  • Billing for a clinical service delivered by an “unqualified” provider
  • Assisting a client in falsifying an application for benefits

• Ordering a test or lab work when the documentation in the medical record does not justify the medical need for such a test
• Entering in an agreement with a private facility in the community to refer Center’s clients in change for moneys or other favors
• Referring clients with insurance to the clinician’s private practice (Illegal payment, kickback, bribe or rebate is not allowed)
Successful audits = compliance with standards

General Services Oversight/ Supervision

- Services are rendered under general supervision of the FQHC physician or APRN.
  - Evidenced by signature in the Plan of Care

- The physician or APRN supervises no more than three full-time allied professionals
  - Evidenced by copy of Attestation Statement sent to DHHS

Attestation Statements

- The attestation statements are sent to the Division of Family Services prior to services being rendered and includes the names and credentials of the allied professionals being supervised.
  - Evidenced by copies of the attestation statements sent to DHHS

- Attestation statements are updated within 30 days reflecting any changes.
  - Evidenced by copies of these sent to DHHS

- The physician or APRN is not employed by the allied professional.
  - Evidenced by a Conflict of Interest Form or other required statement

Referrals

- Clients have a referral for behavioral health services from a Medicaid enrolled physician or APRN using a physician's order.
  - Evidence of referral form in the medical record

- The physician’s order includes the following information:
  - Identification of the beneficiary’s current problem area(s)
  - Signature, title and date of a physician or APRN

- A new referral is confirmed and documented annually when services are to be continued
  - Evidenced by the physician’s/APRN order in the client’s medical record
• Reasons for referral are:
  • A psychiatric diagnosis, (excluding irreversible dementias, intellectual/related or developmental D/O unless co-occurring with a psychiatric condition
  • Imminent danger of being removed from the home due to substantiated developmental or behavioral problems
  • The referral form is dated indicating the beginning of the client’s eligibility for behavioral health services
    • Evidenced by the referral form in the medical record
  • Services are furnished after the client was seen by the physician or APRN.
    • Evidenced by an initial service note from the MD or APRN

Medical Necessity Statement (MNS)
  • A Medical Necessity Statement (MNS) is completed and signed by the physician or non-physician practitioner prior to initiation of the service.
  • A new Medical Necessity Statement is documented and confirmed annually (within 365 calendar days) by the physician or non-physician practitioner if services need to be continued.
    • As evidenced by the presence of the MNS in the medical record.

  • The date used for all subsequent renewals and/or annual confirmations of the MNS are based on the signature date of the initial/first MNS that was used to confirm medical necessity.
  • A new MNS was completed when the client did not receive a behavioral health service for 90 consecutive calendar days.
    • As evidenced by its existence in the medical record

  • The MNS used by the FQHC includes the following information on the statement to establish medical necessity:
    • The beneficiary’s name, date of birth and Medicaid number
    • A psychiatric diagnosis from the current edition of the DSM and/or ICD manuals (excluding irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria)
    • The specific behavioral health service(s) recommended including those for integrated treatment of co-occurring disorders

  • Identification of the beneficiary’s problem areas
    • Justification of the recommended behavioral health services and when appropriate, justification for continued treatment upon periodic review of client’s progress toward goals
    • The signature of the physician or non-physician practitioner professional title and date accepting professional responsibility for the information stated in the MNS.
      • Evidenced by the form included in the medical record

Individual Plan Of Care
  • The IPOC was developed prior to the delivery of a behavioral health service and within 60 calendar days of the physician or non-physician practitioner signature date in the MNS.
    • Evidenced by presence of a completed and dated IPOC in the medical record
  • There is evidence of the full participation of the beneficiary and his or her family, if appropriate in the development of the IPOC except in the case of an emergency.
    • Evidenced by documentation in the medical record, goals stated by the client and client/guardian signature in the IPOC
• IPOCs include the following information:
  • Beneficiary Identification
  • Presenting Problem(s)
  • Justification for Treatment
  • Diagnosis with its code and description (Primary DX and all other mental health, substance use, and/or medical diagnoses)

• Goals and Objectives:
  • Goals are short and long term and include input from the beneficiary
  • Objectives are observable, measurable, individualized (specific to the beneficiary’s problems or needs), and realistic.

• Treatment Methods:
  • Specific interventions and/or methods the treatment team will use to meet the stated goals/objectives

• Frequency of Services:
  • Each service is listed by its name or approved abbreviation with a planned frequency

• Criteria for Achievement
  • Target Dates
    • Individualized to the client and the goal and/or objective.
  • Beneficiary Signature:
    • Indicating they were involved in the planning process and were offered a copy of the IPOC.
  • If the client did not sign the plan of care or if it is not considered appropriate for the beneficiary to sign the IPOC, the reason the beneficiary did not sign the IPOC is documented in the medical record.

• Authorized Signature(s):
  • The dated signature of the physician or non-physician practitioner confirming the appropriateness of care.
  • Each page of the IPOC is signed, titled and signature dated by the physician or non-physician practitioner.
    • Evidenced by the inclusion of the IPOC in the client’s medical record

• When changes and updates were made to the original IPOC, an updated copy was provided to the beneficiary within 10 calendar days.
  • Evidenced by a copy of the updated IPOC that was faxed or mailed by certified/return receipt provided to the client
  • Documented evidence that client has granted permission for either of these delivery means in the medical record.
  • Services added or frequencies of services changed in an existing IPOC were signed or initialed and dated by the reviewing physician or non-physician practitioner.
  • All additions to the IPOC are listed in chronological order

• IPOC Addendum
  • The addendum includes the signature and title of the physician or non-physician practitioner who formulated the addendum(s), and the date it was formulated.
  • The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and renewals.
**Progress Summaries**

- Progress Summaries are completed at least every 90 calendar days from the date of the IPOC signature date.
- The Progress Summary notes include a review of the:
  - Client's progress toward the treatment objectives and goals
  - Appropriateness of the services being furnished and their frequency
  - Need for the client’s continued participation in treatment
  - Recommendations for continued services
- The referring physician or non-physician practitioner summarized and documented the Progress Summary in the IPOC.
- A new MNS was completed at the third 90-day review when it was anticipated the client will continue to need services by the anniversary date.

- The IPOC is reviewed annually (12 months or 365 days) and/or prior to termination or expiration of the treatment period by the referring physician or non-physician practitioner.
  - Evidenced by review being documented in the Progress Summary.
- The new IPOC include the signature date when the reformulation was completed, the signature and title of the physician or non-physician practitioner authorizing the services
  - Evidenced by the signature of the physician/non-physician in the new IPOC.
- The IPOC was reviewed based on the client’s progress on each treatment objective (preferably with the client).
  - Evidenced by changes in goals and objectives.
  - If the IPOC was developed prior to the expiration date, the new plan is effective with the anniversary date.

**Clinical Visits**

- There was only one behavioral health encounter code per day.
- There were no more than 12 mental health visits in the fiscal year (July 1st - June 30th) unless an extension was appropriately authorized.
  - Evidenced by documentation sent to DHHS QIO requesting authorization for additional services.
- Requests for additional behavioral health services over the 12 was submitted to DHHS QIO 10 days before the expiration of the 12 pre-authorized services.
- The DHHS Mental Health Form used to request additional services was signed and dated by the client’s physician or non-physician practitioner.
  - Evidenced by a copy of the DHHS MH Form and additional clinical documents substantiating medical necessity for the extension of coverage, i.e. Screening tools, assessment and/or individual care plans.
**Credentialing**

- FQHCs must comply with all applicable state and federal requirements.
- Clinicians provide services within their scope of practice and under the FQHC’s policy for supervision.
- All staff, contractors, volunteers, and other individuals under the authority of the FQHC who have direct ‘contact with beneficiaries are properly qualified, trained, and supervised.

  - Each clinician has a credentialing and training file that includes:
    - A completed employment application form
    - Copies of official college diploma, high school diploma or GED, or transcripts with the official raised seal
    - A copy of all applicable and valid licensure
    - Letters or other documentation of verification of previous employment and/or volunteer work to document experience with the population to be served. (A resume will not serve as the only resource to document experience.)
    - Verification of the staffs’ certifications
    - Documentation of staff credentials

**Medical Records**

- There is a medical record for each Medicaid-eligible beneficiary receiving behavioral health services.
- The medical record contain information that fully describes the extent and course of the treatment provided.
- The FQHC maintains a mock chart or an index showing how the clinical record is organized
  - There is a dated and signed consent to release information.
    - Evidenced by the original consent in the medical record that was signed and dated by the client/parent or guardian and the witness.
  - There is a new consent form signed and dated each time a beneficiary is readmitted to the FQHC system after discharge or when a beneficiary has not received behavioral health services within a 90 calendar day period.
    - Evidenced by the presence of the original new consent form in the medical record.

- Work experience
- Qualifications
- Certifications documentation
- Trainings, to include the outline of the training on the behavioral health manual and evidence that it was successfully completed
- Investigations
- The FQHC maintains a signature sheet that identifies all professionals providing services by name, signature, and initials.

- The FQHC maintains the confidentiality of record information and provide safeguards against loss, destruction, or unauthorized use;
  - Evidenced by written policies and procedures that govern the use and removal of records from the FQHC; and conditions for release of information. Includes HIPAA logs in the medical record.

- There is a written consent dated and signed by the client, parent and/or guardian, or primary caregiver in cases of a minor, or legal representative at the onset of treatment
  - Evidenced by the original consent in the medical record that was signed and dated by the client/parent or guardian and the witness.
Documentation

- All clinical service notes (CSNs) are completed upon the delivery of services or whenever information is obtained that has bearing on the identified beneficiary’s treatment.

- The content of the note corresponds to billing by type of service.

- The note includes the dates of service (with month, day and year).

- The note includes the start and end time(s) for each behavioral service delivered.

- The place of service is clearly stated in the note.
  - The FQHC or center that renders behavioral health services.
  - A skilled nursing facility.
  - The client’s home.

- The CSN is signed, titled and signature dated (month/date/year) by the person responsible for the provision of services.

- The CSN is completed and placed in the clinical record within ten business days from the date of rendering the service.

Error Correction

- Errors are corrected by drawing one line through the error, and write “error,” “ER,” “mistaken entry,” or “ME” to the side of the error in parenthesis.

- The correction is entered, signed or initialed, and dated.

Late Entries

- Late entries are:
  - Document as soon as possible.
  - Identified as a “late entry.”
  - Include the current date and time.
  - Identified or referred to the date and incident for which the late entry is written.

- If the late entry is used to document an omission, validate the source of additional information as much as possible.
Utilization Review

• Client was discharged or transitioned to a different level of care because his/her:
  • Level of functioning improved significantly with respect to the goals outlined in the IPOC
  • Achieved goals as outlined in the IPOC
  • Developed skills and resources needed to transition to a lower level of care
  • Requested discharge (and is not imminently dangerous to self or others)
  • Required a higher level of care (i.e., inpatient hospitalization or PRTF)
  • Evidenced by documentation in the Progress Summary or Clinical Service Note

Final thoughts from “Lessons Learned”

• Know your Manual requirements – “must” = recoupment
• Every standard in the manual has the potential for recoupment
• Paybacks relate to billing errors, lack of medical necessity, insufficient documentation, but also not complying with a standard even if not related to medical necessity
• Check the OIG Annual Plan
• Do periodic checks of the OIG List of Excluded Providers/Entities
• Conduct internal audits
• Establish a Compliance Program
• Educate all staff on Compliance and billing requirements
• Educate all staff on HIPAA/Security requirements

References

... SC Department of Health and Human Services, FQHC Behavioral Health Services Provider Manual, Columbia, SC

... SC Department of Mental Health “Compliance Plan”, Columbia, SC

... The Civil False Claims Act (FCA) (31 U.S.C. §3729 et seq.)

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