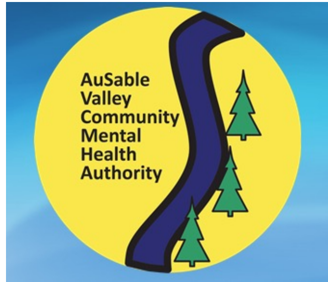
AVCMHA Compliance Training



Corporate Compliance Training

AuSable Valley Community Mental Health Authority

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Why train on Corporate Compliance?

- State and Federal regulations mandate that for any agency reporting over $5 million in services to Medicaid or Medicare all of the following must be trained:
  - Employees
  - Contractors
  - Agents

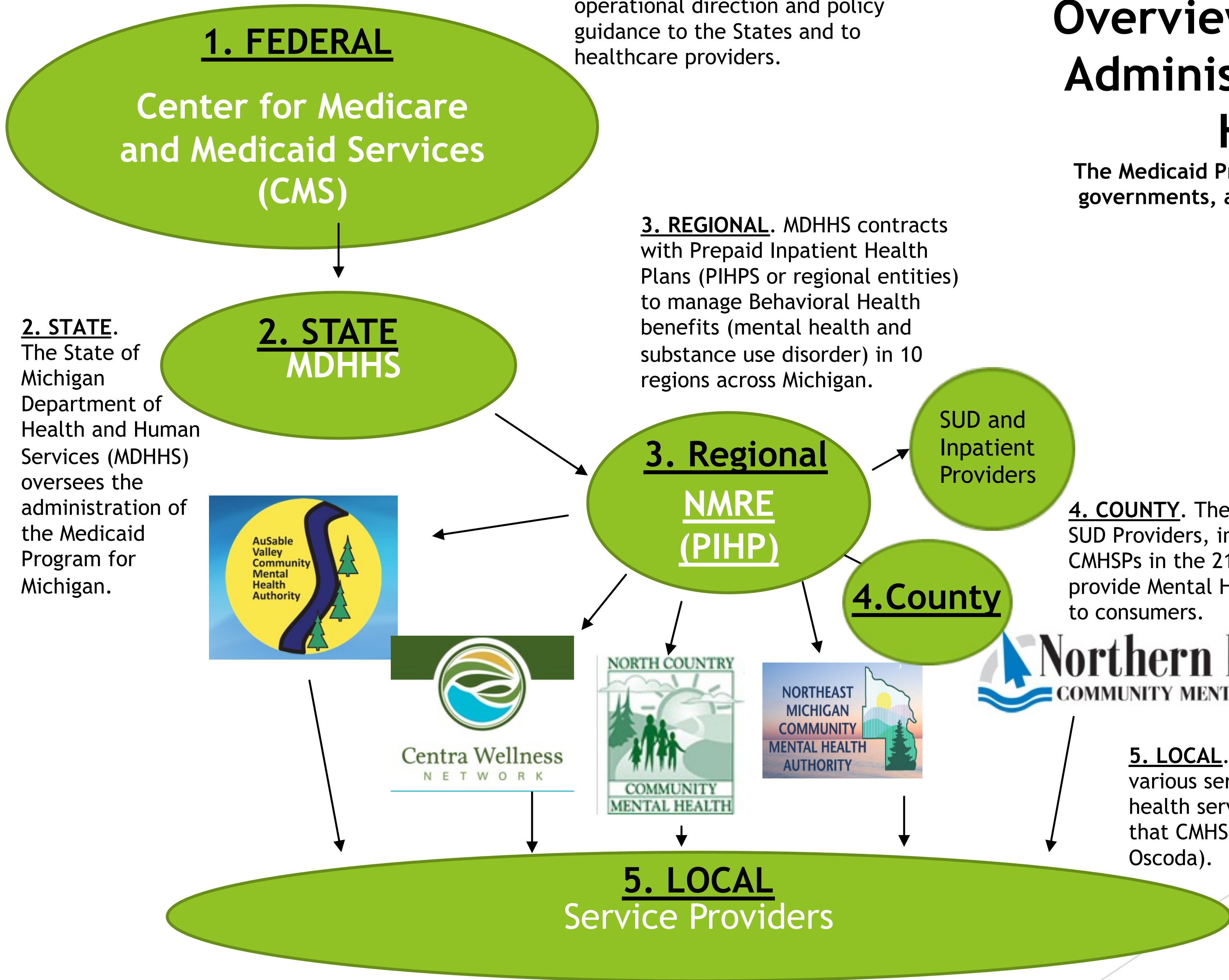
Objectives

Understand, know, and identify the following:

- Overview of Medicaid program
- Compliance and Ethics
- Compliance Program and Plan
- Fraud, Waste, and Abuse and False Claims
- Regulations and Laws
- Code of Conduct
- Enforcement Bodies
- Your responsibility to report

Overview of Medicaid Program Administration for Behavioral Health Services

The Medicaid Program is funded by both the federal and state governments, and is directly administered by the States with approval and oversight by CMS.



1. FEDERAL. CMS provides operational direction and policy guidance to the States and to healthcare providers.

2. STATE. The State of Michigan Department of Health and Human Services (MDHHS) oversees the administration of the Medicaid Program for Michigan.

3. REGIONAL. MDHHS contracts with Prepaid Inpatient Health Plans (PIHPS or regional entities) to manage Behavioral Health benefits (mental health and substance use disorder) in 10 regions across Michigan.

4. COUNTY. The NMRE contracts with SUD Providers, inpatient hospitals and 5 CMHSPs in the 21 County region to provide Mental Health and SUD services to consumers.

5. LOCAL. Each CMHSP contracts with various service providers to provide mental health services to the consumers located in that CMHSP's counties (Iosco, Ogemaw, Oscoda).

Compliance and Ethics – what is it?

Doing the right thing!

- Organizational Responsibility – create a formal program that includes:
  - Policies, procedures, and processes to help prevent and detect violations of laws and regulations.

- Our Responsibility
  - Follow the laws and rules that govern healthcare
  - Prevent, detect, and report all unethical or illegal behavior or actions immediately
  - Prevent, detect, and report all Fraud, Waste, and Abuse (FWA)
  - Document, Audit, Bill, and Monitor to make sure all funds are being used correctly
  - Avoid any improprieties (sexual, financial, physical, etc.)
  - Follow the consumer’s Individual Plan of Service
  - Eliminate conflict of interest
  - Treat everyone with dignity and respect
  - Be honest, responsible, and ethical

Code of Ethics

Ethics

- Carefully read and understand the Code of Ethics associated with your professional license (LMSW, MSW, LLP, LPC, etc. all have a different Code of Ethics).
- Establish and maintain healthy boundaries with consumers, families, and colleagues.
- Avoid using the workplace as a way to promote personal interests or paid endeavors.
- Immediately warn if a consumer discloses intent to harm self or others.
- Ensure continuity of treatment and services (including transfer and discharge responsibilities).
- Ensure treatment is in accordance with the consumer's individual Plan of Service.
- Adequately and accurately document services, billings, progress notes, and communications.

Service Documentation Requirements

From the Michigan Medicaid Provider Manual requirements:

- The clinical record must be **sufficiently detailed** to allow reconstruction of what transpired for each service billed.
- All documentation must be legibly **signed with credentials and dated** by the rendering health care professional **and** signed by the consumer (if applicable).
- For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the **actual begin time and end time** of the particular service.
- Progress notes must include a **Description of Service** that describes:
  - Presenting problems, treatment modality, customer response to treatment
  - Goal(s) and/or Objective(s) of the Plan of Service addressed
  - Progress/lack thereof toward desired outcomes
  - Current status of the consumer/future treatment recommendations
  - Specific clinician/staff interventions offered during the service contact

Medicaid Services Verification

Verify:

- Service Code is approved under the contract.
- Eligibility of the beneficiary (consumer) on the date of service.
- Service is included in the consumer's individual Plan of Service.
- Date and time of service is listed on the progress note.
- Service is provided by a qualified practitioner and falls within the scope of the code billed and paid.
- The amount billed **or** paid does not exceed the payer's (PIHP or CMHSP) contracted amount.
- Any additional elements are included to support the PIHP (regional entity) quality improvement efforts with claims or encounters data, including consumer signatures on Plans of Service.

Compliance Program

- Defines Fraud, Waste, and Abuse
- Addresses matters related to regulations and laws:
  - The Deficit Reduction Act
  - The Federal False Claims Act
  - The Michigan Medicaid False Claims Act
  - The Anti-Kickback Statute
  - The Health Insurance Portability & Accountability Act
  - Whistleblower’s Act
- Outlines the 7 elements of the Compliance Plan

Fraud, Waste, and Abuse

Definitions

- Fraud – knowingly deceiving in such a manner that an unauthorized benefit could be gained (services, billings, etc.).
- Waste - overutilization of services, or other practices that result in unnecessary costs.
- Abuse – practices that do not follow medical, financial, or business standards that could result in reimbursement for services that are not medically necessary or that are billed without following billing guidelines.
- * Abuse can turn into Fraud – if the individual knowingly and willingly conducted the abusive practices.

Fraud, Waste, and Abuse Examples

- Fraud – An intentional deception or misrepresentation by a person with the knowledge the deception could result in a benefit to him or some other person. Examples:
    - Billing for services not performed
    - Altering documentation to obtain higher payment (upcoding)
    - Deliberate duplicate billing
  - Scenario:
    - Dr. Smith's consumer arrived for an hour long appointment but became visibly distraught in the waiting room and was transported to the hospital via ambulance. While waiting for the ambulance, Dr. Smith spoke to the consumer for 5 minutes in the waiting room.
    - Dr. Smith submitted a claim for the total scheduled appointment time of 60 minutes. The claim was paid out of Medicaid.
    - During an audit, documentation for the claim was requested from Dr. Smith. He instructed his receptionist to create a Progress Note for the hour, which she did, he then signed and dated it the day the consumer went to the hospital. He furnished it to the auditors.
- **FRAUD** – Dr. Smith's submission of a claim for a service not rendered, and creation of a fake progress note to support that claim. The receptionist is also guilty of Fraud.

Fraud, Waste, and Abuse Examples

- Waste – overutilization of services, or other practices resulting in unnecessary costs. Examples:
    - Redundant testing or appointments
    - Healthcare spending that can be reduced without impacting quality of care
  - Scenario:
    - Consumer received an Assessment from a Provider last month. There has been no significant change in the Consumer's condition, nor any change in the treatment being delivered. The Provider performs another Assessment and submits a claim for payment to Medicaid.
- **Waste** – The second Assessment, a month after the first one, was redundant and not based on any consumer change. Submission of the claim constitutes waste.

Fraud, Waste, and Abuse Examples

- Abuse – Practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the payor. Examples:
    - Submitting claims that do not comply with billing guidelines
    - Providing services that are not medically necessary or do not meet professionally recognized standards
    - Submitting bills to Medicare/Medicaid instead of the primary insurer.
  - Scenario:
    - A Provider has multiple sites with clinicians at each site. The Provider determined it made billing easier if all claims were submitted listing a single location of service with the clinician associated to that site, rather than having the claims reflect the actual site and clinician who performed the services.
- ABUSE – The Provider did not accurately reflect where the services were performed or by the actual clinician who performed the service. These claims do not comply with billing guidelines.

Regulations and Laws

- Federal (and Michigan) False Claims Act – statutes establishing civil liability for any fraud against a federally funded program like Medicaid for:
  - **Knowingly -**
    - Submitting fraudulent claims
    - Conspiring to defraud by getting a false claim paid
    - Making or using a false record or statement to avoid an obligation to pay money to the Government.
  - Knowingly means:
    - Actual knowledge (or should be aware of the knowledge)
    - Acting in deliberate ignorance or reckless disregard of the truth
  - Examples: up-coding services, overlapping services, billing for services not rendered or not necessary, not having the proper credentials for the service rendered, services rendered by an excluded (barred) provider as stated in the Exclusion Authorities (attestations are signed and excluded provider checks are conducted).
- Penalties –
  - $5,500 to $11,000 for each claim, 3X the damages incurred, exclusion from state and federal programs, and potential federal charges.
  - Health care fraud is punishable by imprisonment of up to 10 years, and fines of up to $250,000 as stated in the Criminal Health Care Fraud Statute.
  - Exclusion from participation in State and Federal programs (barred)

Regulations and Laws continued

- Deficit Reduction Act – increased education and training to prevent, identify and report fraud, waste, and abuse in the Federal health care programs.
- Anti-kickback Act – prohibits health care providers from monetary gains in exchange for referrals, extra business, or services covered by Medicaid.
- Health Insurance Portability and Accountability Act – protects, and keeps confidential, personal health information.
- Whistleblower's Act – protects employees who report FWA in good faith. Whistleblower can file a lawsuit on behalf of the Government and share in recovery, and employers cannot discriminate or retaliate against whistleblower.

7 elements of the Compliance Plan

1. Outlining Standards of Conduct, Policies and Procedures
   - Code of Conduct, Employee Handbook
2. Describing Compliance Administration
   - Compliance Officers, NMRE Compliance Committee
3. Providing effective training, education and communication
   - New hire and annual refresher training, anonymous reporting, Whistleblower's protection
4. Ensuring providers are compliant and not excluded from participating
   - Attestations and excluded or barred provider checks
5. Conducting internal monitoring and auditing
   - Periodic audits, regional reviews, internal auditor checks
6. Enforcing standards through well-publicized disciplinary guidelines
   - Regulations and Laws, Code of Conduct, Employee Handbook, Compliance Plan
7. Responding promptly to detected offenses and undertaking corrective action

Standards of Conduct

Code of Conduct

- Follow HIPAA and Confidentiality to protect the personal information of those we serve.
- Contribute to an alcohol and drug free environment.
- Ensure workplace is free of harassment of any kind.
- Avoid any conflict of interest.
- Do not solicit or accept gifts.
- Make this a safe, respectful work environment where all employees and consumers are treated with dignity and respect.
- Do not engage in any political contributions or campaigns with agency funds or resources.
- Report any suspected or actual unethical or illegal behavior and all Fraud, Waste, and Abuse.

Enforcement Bodies

- Center for Medicare and Medicaid Services (CMS)
  - Federal Agency with the US Department of Health and Human Services (HHS) that administers the Medicare program and partners with state governments to administer Medicaid programs.
- Office of the Inspector General (OIG)
  - Enforcement division of both the Federal Health and Human Services (HHS) agency and the Michigan Department of Health and Human Services.
  - In charge of investigating Fraud, Waste, and Abuse in the Medicaid/Medicare Programs, and pursuing civil judgments under the Civil Monetary Penalties Law.
- Office for Civil Rights (OCR)
  - In charge of enforcing HIPAA Privacy and Security Rules. Levies huge civil penalties against entities that violate HIPAA.
  - Implements and monitors Corporate Integrity Agreements.

Enforcement Bodies continued

- Department of Justice (DOJ)
  - Federal enforcement agency in charge of criminally prosecuting individuals/entities under applicable Federal laws.
  - Works collaboratively with the OIG.
- Michigan Attorney General
  - Health Care Fraud Division in charge of investigating Fraud, Waste, and Abuse in the Michigan Medicaid/Medicare Programs.
  - Can prosecute individuals/entities criminally under applicable State laws.

Your Reporting Responsibility

Report any actual or suspected Compliance violation to:

NMRE Compliance Reporting	**AVCMHA Compliance Reporting**
Compliance Hotline: 866-789-5774 **In-person, by telephone, or via email to:** Compliance Officer 1999 Walden Dr. Gaylord, MI 49735 www.nmre.org/Resources/Non Compliance form 231.383.6522	**Compliance Hotline**: 989-747-3003 **In-person or by telephone to:** Chief Quality Officer 1199 W. Harris Ave. P.O. Box 310 Tawas City, MI 48764 989.362.8636

You may not be intimidated, threatened, coerced, discriminated against, or subjected to other retaliatory action for making a good faith report of an actual or suspected violation (Whistleblower's Act).