

CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	1.16
Title:	Compliance	Page:	1 of 13
		Date Effective: November 1, 2005	
Subject:	Fraud and Abuse Compliance Plan	Date Revised: February 16, 2011	
		Authorizing Signature:	

**POLICY STATEMENT:**

The CDRSN/PIHP is committed to the prevention of Medicaid fraud and Medicaid abuse. The CDRSN/PIHP actively guards against Medicaid fraud and Medicaid abuse, and it compels its senior management, staff, contracted providers and practitioners to guard against such abuse as well. The CDRSN/PIHP and its contractors comply with the following:

1. Comply with all reporting and other anti-fraud and anti-abuse requirements;
2. Cooperate with the Washington State Attorney General’s Medicaid Fraud Control Unit relevant to any investigation of alleged fraud or abuse;
3. Maintain prudent fiscal and record keeping policies, procedures, and/or practices;
4. Have administrative and management procedures in place that are designed to guard against fraud and abuse;
5. Follow ethical standards dictated by their respective professional organization(s).
6. Acknowledge by signature having read and understood the CD RSN/PIHP Code of Business Conduct

**APPLIES TO:**

CD RSN/PIHP and its contracted providers and practitioners.

**DEFINITIONS:**

**Medicaid Abuse:**

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary cost to the CD RSN/PIHP.

**Medicaid Managed Care Abuse:**

Practices in a capitated CDRSN/PIHP or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards to contractual obligations for health care. The abuse can be committed by the CDRSN/PIHP, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated RSN/PIHP, or other managed care setting that results in unnecessary cost to the Medicaid program, or the CDRSN/PIHP, contractor, subcontractor or provider.

**Medicaid Fraud:**

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Fraud includes any act that constitutes fraud under applicable Federal or State law.

**Medicaid Managed Care Fraud:**

Any type of intentional deception or misrepresentation made by an entity or person in a capitated RSN/PIHP, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself or some other person. A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (the CD RSN/PIHP, contractor, or subcontractor).

**Medicaid Recipient:**

An individual who is currently eligible for the Medicaid program, as shown on the medical identification card.

**Provider:**

Any individual or entity that receives Medicaid funds in exchange for providing a service (CD RSN/PIHP, contractor or subcontractor). It should be noted that Medicaid funds paid to an RSN, then passed to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

**Fraud and Abuse (includes but is not limited to):**

- “Phantom Patients”
- Enrolling deceased patients
- Billing for services not performed
- Double billing
- Intentional improper billing
- Unnecessary services
- Kickbacks
- Up coding
- Unbundling
- Falsification of health care provider credentials
- Falsification of provider financial solvency
- Related party contracting

- Incentives that limit services or referral
- Embezzlement and theft
- Billing Medicaid enrollees for RSN covered services

**PROCEDURE:**

- I. The CDRSN/PIHP has designated the Database Manger I position as the Compliance Officer. The Compliance Officer, also called the Program Integrity Officer (PIO) under the Medicaid Program, is responsible for overseeing the Compliance Plan and coordinating monitoring activities. The Compliance Officer is supported by a Compliance Committee. The Compliance Committee includes the CDRSN Administrator, CDRSN Clinical Director, and the CDRSN Contracts Manager. The Compliance Committee meets quarterly. The Compliance Committee duties include the following:
  - A. To oversee and monitor CDRSN/PIHP compliance activities.
  - B. To oversee and monitor compliance with the internal policies and procedures relating to the prevention of Medicaid/Managed Care Fraud and abuse within their sphere of responsibility.
  - C. To report on a periodic basis to the Administrator on the progress of the implementation of the plan.
  - D. To create an annual report on fraud and abuse committee activities and any investigations that has taken place. This report is forwarded to the governing bodies overseeing the RSN/PIHP, including the Mental Health Advisory Board and the CDRSN Board of Commissioners.
  - E. To assist the RSN Administrator in establishing methods to reduce CDRSN vulnerability to fraud and abuse.
  - F. To periodically review the Plan and recommend revisions as necessary.
  - G. To coordinate internal auditing and monitoring activities within the CDRSN and to establish procedures for periodic audits of the operations of providers.
  - H. To receive and investigate reports of possible violations of the Plan.
  - I. To develop corrective action plans to correct violations and prevent future incidents of noncompliance.
  - J. To develop policies and programs that encourage employees and contractors to report suspected violations of the Plan without fear of retaliation.
  - K. To identify areas where corrective actions are needed and, in consultation with the Compliance Officer and the Director, develop strategies to improve compliance.

- L. As part of the ongoing monitoring and auditing of the Plan, the Compliance Officer, in cooperation with the Compliance Committee, establishes mechanisms to notify employees and contractors of changes in laws, regulations or policies, as necessary, to assure continued compliance.
- II. **Monitoring:** The CDRSN compliance committee pursues the detection and prevention of fraud and abuse through the following activities:
- A. The compliance committee develops a risk assessment tool which is re-evaluated annually, guides compliance monitoring activities and guides the assessment and identification of weaknesses and risks in CDRSN operations
  - B. CDRSN conducted Provider Site Reviews
  - C. Review of Provider Quarterly Financial Information
  - D. Review of Provider monthly data service reports
  - E. Review of CDRSN MIS data service reports
  - F. Review of subcontractors Revenue and Expense Report submissions
  - G. Review of subcontractors annual independent financial audits and management letter
  - H. Review of community inpatient claims
  - I. Review of Ombudsman complaints and grievances
  - J. Review of Grievances filed at the RSN level
  - K. Utilization Management Operations
  - L. Review of MHD Provider Licensing reports
  - M. Annual Contract Compliance reviews

The results of these reviews, site visits and the operational findings are to be reviewed by the compliance committee at scheduled meetings. The compliance committee representative with oversight for the area under review presents the results of the review. Any activities detected in the reviews that do not appear to comply with the code of business conduct or established procedures is subject to an investigation by the compliance committee.

### III. **Provider Relations and Contracts**

- A. The CDRSN/PIHP does not enter into contracts or other arrangements with providers which, directly or indirectly, pay or offer to pay anything of value, be it money, gifts, space, equipment or services, in return for the referral of consumers to the CDRSN/PIHP for services paid by the Medicaid program or by any other federal health care program. Further, CDRSN may, by written notice to an Agency, terminate the right of the Agency to proceed under contract with CDRSN for actions, policies, practices or omissions which constitute conflict of interest within the meaning of RCW chapter 42.18. This includes, but is not limited to prohibitions against offering CDRSN or DSHS employees, directly or indirectly, anything of economic value from an Agency or a potential contractor (and from subcontractors) in exchange for any official act or forbearance to act.
- B. State and CDRSN employees are not permitted to receive, accept, take, seek, or solicit, directly or indirectly, anything of economic value from any person, entity, corporation, partnership, or similar organization which has or is seeking to obtain a contractual, financial or other business relationship with the CDRSN or DSHS. This prohibition includes action by employees designed to benefit other persons in addition to or instead of the employee directly. In the conduct of state or CDRSN business, DSHS and CDRSN employees are expected to compose themselves in a method and manner which avoids even the appearance of favoritism, special favors, or other conflicts of interest with contractors and potential contractors.
- C. Providers are prohibited from utilizing funds, materials, supplies or property provided directly or indirectly by CDRSN contracts for any political activity or to further the election or defeat of any candidate for public office. Further, contracting agencies are required to certify that no federal funds payable under CDRSN contract or on behalf of the Agency will be paid for influencing or attempting to influence an officer or employee of any agency, Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of a federal contract, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- D. The CDRSN/PIHP does not approve nor cause claims to be submitted to the Medicaid program or any other federal health care program:
  - 1. For services provided as a result of payments made in violation of (A) above.
  - 2. For services that are not reasonable or necessary.
  - 3. For services which cannot be supported by the documentation in the medical record.

4. CDRSN/PIHP does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with the Medicaid program or any other federal health care benefit program.
5. CDRSN/PIHP does not provide incentives to providers to reduce or limit medically necessary mental health services to Medicaid beneficiaries or recipients of other federal health care programs.
6. CDRSN/PIHP conducts all business with providers at arm's length and pursuant to written contract.
7. No CDRSN/PIHP employee or person associated with CDRSN/PIHP prevents or delays the communication of information or records related to violation of the Plan to the Compliance Officer.
8. All CDRSN employees and all provider agencies are screened monthly to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for program participation, as required by current federal and state laws. The latter is verified through the United States Health and Human Services website at <http://exclusions.oig.hhs.gov>.
9. Agencies or individuals listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by current federal and state laws, or found to have a conviction or sanction related to health care will be excluded from providing CDRSN funded services.

#### **IV. Provider Responsibilities**

- A. Providers are required to develop internal compliance programs, and to appoint internal compliance officers and committees.
- B. Providers implement procedures to screen employees and subcontractors monthly to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation as verified through the United States Health and Human Services website at <http://exclusions.oig.hhs.gov>. Employees or subcontractors found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with, CDRSN funded services.
- C. Providers are required to report all incidents of abuse and fraudulent activities related to CDRSN funded services to the CDRSN Compliance Officer.

- D. Providers are required to maintain books, records and reports and other evidence of documents, accounting procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature expended in performance of their contracts. Providers are required to allow CDRSN the right to monitor and audit the fiscal components of their agency to ensure that the actual expenditures remain consistent with the terms of their contracts.
- E. Providers are required to retain all books, documents and other material relevant to their contracts for a period of six years after expiration of a contract, and to provide the CDRSN full access to and right to examine any of said materials at all reasonable times during this period.
- F. Providers are required to adhere to OMB Circular A-133 “Audits of State, Local Governments and Non-Profit Organizations” (if applicable) which establishes single audit requirements and federal responsibilities for implementing and monitoring audit requirements for non-profit and governmental organizations receiving federal financial assistance, and to provide access to financial records by independent auditors.
- G. Providers are required to submit a copy of the audit, management letter, and corrective action plans (if applicable). Submission of the report shall be the earlier of 30 days after the Agency’s receipt of the auditor’s report or nine months after the end of the audit period. The audit must be accompanied by documentation indicating that the Agency’s Board of Directors has reviewed the audit and management letter.
- H. Provider agencies are required to maintain program records and reports including statistical information and to make such records and reports available for inspection by the CDRSN in order for the CDRSN to be assured that program services remain consistent with the terms of contract agreements. Agencies are further required to provide such information as requested by CDRSN for monitoring and evaluating within time limitations established by CDRSN.
- I. The CDRSN/PIHP and its contracting agencies ensure that mental health professionals, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:
  - 1. The enrollee's mental health status, or mental health treatment options, including any alternative treatment, in a culturally competent manner;
  - 2. Any information the enrollee needs in order to decide among all relevant mental health treatment options;
  - 3. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment);

4. The enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse treatment, and to express preferences about future treatment decisions;
5. The enrollees right to be treated with respect and with due consideration for his or her dignity and privacy;
6. The enrollee's right to be free from any sort of restraint or seclusion used as a mean of coercion, discipline, convenience or retaliation;
7. The enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;
8. The enrollee's right to be free to exercise his or her rights, and to do so does not adversely affect the way the CDRSN/PIHP, contacting agency or individual care provider treats the enrollee.

## V. **Education and Training**

- A. Contractors are made aware of their obligation to report to CDRSN/PIHP their good faith belief of any possible instances of non-compliance through terms identified in the CDRSN/PIHP Statement of Work.
- B. The Plan and reporting requirements are referenced in CDRSN/PIHP contracts. CDRSN/PIHP will notify subcontractors of applicable fraud and abuse training opportunities available through CMS, the State Mental Health Division or the RSN.
- C. The compliance Committee will seek out qualified trainers to conduct annual, mandatory, compliance training for CDRSN/PIHP staff and contractors, including general and specific training pertinent to staff's responsibilities. The content of the training will be evaluated annually by the compliance committee to determine that subject content is appropriate and sufficient to cover the range of issues currently confronting its employees. Participation in the training will be verified using training completion forms kept in the employees personnel file. Employees who do not attend the mandatory training are required to watch (and document having viewed) a video tape of the annual training session. The personnel file of an employee who has not participated in the annual training will not be considered complete unless documentation of their participation in the training is included.
- D. The compliance officer is afforded annual training opportunities in order to remain abreast of laws, regulations and applicable guidelines for Federal and State programs.
- E. Changes in Federal health care program requirements are communicated to organizational personnel through e-mail.

- F. All CDRSN/PIHP directors, officers, managers, employees, contractors and medical/clinical staff receive a copy of the CDRSN/PIHP Fraud and Abuse Compliance Plan and the CDRSN/PIHP Code of Conduct annually. The Compliance Plan and the Code of Conduct are distributed in January of each year.
  
- G. All CDRSN/PIHP directors, officers, managers, employees, contractors and medical/clinical staff receive training provided by the CDRSN Compliance Officer on their responsibilities to report non-compliance. Training addresses the following:
  - 1. CDRSN/PIHP commitment to compliance with all laws, regulations and guidelines of Federal and state programs.
  - 2. The elements of the Plan.
  - 3. An overview of what constitutes fraud and abuse in a Medicaid Managed Care environment.
  - 4. A review of the specific state contract requirements applicable to CDRSN/PIHP business.
  - 5. Access to Care standards and Medical Necessity
  - 6. Only submitting encounters performed
  - 7. Duty to report misconduct
  - 8. The consequences of failing to comply with applicable laws.

### **Developing Effective Lines of Communication**

- A. The Compliance Officer has direct access to the Administrator, all senior management and legal counsel for the purpose of monitoring, preventing or investigating fraud and abuse.
  
- B. The Compliance Officer makes regular reports to the RSN/PIHP Governing Body in an annual written report within 30 days of the end of each calendar year.
  
- C. An open line of communication between the Compliance Officer and employees or others associated with the CDRSN/PIHP is critical to the successful implementation and operation of the Plan.
  - 1. The CDRSN/PIHP utilizes the CDRSN web site to communicate to staff and the public. The web site is located at [www.cdrrsn.org](http://www.cdrrsn.org). The web site includes a link that connects the user to contact information

for the compliance officer and to an anonymous Fraud and Abuse reporting hotline.

2. All employees and persons associated with the CDRSN/PIHP have a duty to report all incidents of abuse and fraudulent activities to the Compliance Officer.
3. A report is made in any of the following ways:
  - a. In person, to the Compliance Officer
  - b. By faxing the Compliance Officer at (509) 886-6320
  - c. By calling the Compliance Officer at (509) 886-6318 ext. 1205 or 1-877-563-3678
  - d. Through the CDRSN/PIHP website by clicking on the "Report Fraud and Abuse" link on the homepage.
  - e. By anonymous call to the toll free Fraud and Abuse Prevention Hotline. This Hotline number is published in the public areas of provider facilities, in public areas within the CDRSN/PIHP, in brochures distributed by the providers and in printed materials discussing the Ombuds service. The toll free Fraud and Abuse Prevention number is 1-877-563-3678.
  - f. By mailing a written concern to:  
Compliance Officer  
CDRSN  
636 Valley Mall Parkway, Suite 200  
East Wenatchee, WA 98802
3. In addition, any person may seek guidance with respect to the Code or the Compliance Plan at any time by following the same reporting mechanisms outlined above.
4. A log of the number and types of calls, letters or reports on suspected Fraud and Abuse is kept by the compliance officer in the Compliance Committee folder at the CDRSN/PIHP. The log is updated each time a report, call or letter is received.

D. All alleged instances of fraud and abuse are investigated. The process for an investigation of a report is as follows: Upon notification of all suspected instances of non-compliance, the Compliance Officer will conduct an initial investigation. The results of that investigation, and all follow up actions, are logged in an official record of fraud and abuse investigation activities. The results of the investigation are also included in the report to the CDRSN Governing Board and reported at meetings of the Compliance Committee. If it appears that there are genuine compliance concerns, the Compliance Officer

informs the Compliance Committee, the CDRSN Administrator and the State Division of Behavioral Health and Recovery. The committee, after consideration and any modification, forwards the corrective action to the Administrator. Upon approval, the Compliance Officer and Compliance Committee develop a strategy for implementation of the corrective action plan, with the advice and guidance of legal counsel. The corrective action plan is designed to ensure that the specific violation is addressed and, to the extent possible, that a similar problem does not occur in other departments or areas; appropriate education activities are included. Periodic reviews of problem areas are conducted to verify that corrective action was implemented successfully.

1. If the investigation reveals possible criminal activity, the corrective action plan includes:
  - a. immediate cessation of the activity until the corrective action is in place.
  - b. initiation of appropriate disciplinary action against the person or persons involved in the activity.
  - c. notification to such law enforcement and regulatory authorities as legal counsel advises, which at a minimum includes, for Medicaid fraud, notification to the Medicaid Fraud Unit of the Washington Attorney General's office and the Director of the Managed Care Contracting Division of the Department of Health Care Policy and Financing.
  - d. Appropriate education of employees and those associated with the CDRSN/PIHP to prevent future similar problems.
  - e. Initiation of any necessary action to ensure that no consumers are placed at clinical risk.
2. If the review results in conclusions or findings that the activity is not a violation of the Plan or that the activity did not occur as alleged, the investigation is closed.
3. Any threat of reprisal against a person who makes a good faith report under the Plan is against CDRSN/PIHP policy. Reprisal, if found to be substantiated, are subject to appropriate discipline, up to and including termination.
4. When a detected deficiency results in an identified need for re-payment, re-payment is promptly reported and arranged.
5. Any attempt to harm or slander another through false accusations, malicious rumors or other irresponsible actions is a violation of CDRSN policy. Such attempts, if substantiated, shall be subject to discipline up to and including termination.

6. CDRSN/PIHP, at the request of a reporting person, shall provide such anonymity to the reporting person as is possible under the circumstances in the judgment of the Compliance Officer, consistent with CDRSN/PIHP's obligation to investigate concerns and take necessary corrective action. If the identity of the complainant is known, the Compliance Officer provides a written report to the reporting individual that an investigation has been completed and, if appropriate, the corrective action that has been taken.

E. Following a CDRSN investigation, instances of suspected Medicaid Fraud wherein there is sufficient evidence to warrant escalation of the report are referred to the Medicaid Fraud Control Unit (MFCU). All reports to the MFCU include the minimum criteria for a referral as indicated in the "CMS-MIG Performance Standard for Referrals of Suspected Fraud from A Single State Agency to a Medicaid Fraud Control Unit." The address, telephone and fax numbers for the MFCU is as follows: Office of the Attorney General Medicaid Fraud Control Unit, 1019 Pacific Avenue, Third Floor, P.O. Box 2317, Tacoma, WA 98401. Phone (253) 593-2154 or (253) 593-2155. Fax (253) 593-5135.

## **VII. Enforcement Through Disciplinary Measures**

### **A. Employee Discipline**

1. Disciplinary standards for CDRSN employees are available to all CDRSN personnel. These standards are outlined in the CDRSN (Douglas County) Employee Handbook, and are enforced across the organization. Enforcement of disciplinary standards is documented through the mechanisms outlined in the Employee Handbook.
2. CDRSN/PIHP will initiate appropriate disciplinary action against the person(s) whose conduct appears to have been intentional, willfully indifferent or with reckless disregard of state and federal laws.

### **B. Contractor Discipline/Termination**

9. CDRSN/PIHP contracts include provisions which require compliance with the Plan and clearly state that breach of these provisions will be events for corrective action or termination of the contract after failure to cure.

**REFERENCE:**

Citation: BBA Protocol Attachment “B”: Subpart C-42CFR 438.100 Enrollee Rights and Protections, in total; and,

42 CFR 438.608

State MHD Quality Strategy Doc Sec X, with references in Sec IV;

CMS-MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit