



## DBH/CBH Compliance Policies

*Under the HealthChoices Behavioral Health Program, DBH/CBH receives state and federal Medicaid funding for payment of services for eligible Medicaid clients. DBH/CBH has the responsibility to insure that Medicaid funding is spent according to federal and state rules. Both DBH/CBH and the providers have the responsibility to have systems in place to prevent fraud and abuse of these funds.*

### Definitions

**FRAUD**, as defined by the Center for Medicare and Medicaid Programs (CMS), “**Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting.**”

**ABUSE**, as defined by CMS, “**Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the MA program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Provider Agreement, and the requirements of the state or federal regulations) for health care in a managed care setting.**”

Statute Title 42, Section 1320 Medicare/Medicaid Fraud is specifically designed to control and prevent fraud in connection with claims under the Medicare or Medicaid programs. Providers found to be non-compliant could face hefty fines (e.g. up to \$10,000 for each claim plus treble damages), temporary and permanent exclusions from the Medicare and Medicaid programs, and criminal prosecution and imprisonment. Penalties will apply not only to those who knowingly engage in improper practices but also to those who deliberately ignore or recklessly disregard their legal obligations.

### Examples of Specifically Prohibited Activities

- ▶ billings for services not rendered
- ▶ misrepresenting the services rendered
- ▶ falsely certifying that services met medical necessary criteria
- ▶ submitting a claim for physician services by an unlicensed individual
- ▶ making false statements or representations related to an institution’s compliance with its Conditions of Participation
- ▶ retaining Medicare or Medicaid funds that were improperly paid
- ▶ billing multiple funding streams for the same services

## Provider's Responsibility

### PROVIDER COMPLIANCE PLAN

Providers are required to have a corporate compliance program that is designed to minimize an organization's risk of violating federal and state statutes and regulations related to the Medicare and Medicaid programs. The Office of the Inspector General (OIG) of the United States has published guidance for various types of healthcare providers in developing compliance programs. In addition the U.S. Sentencing Commission has published the areas which should be included in a comprehensive corporate compliance program. The seven areas are as follows:

- 1 written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards
- 2 designation of a compliance officer and compliance committee accountable to senior management
- 3 effective training and education for compliance officer and organization's employees
- 4 effective lines of communication between compliance officer and organization's employees
- 5 enforcement of standards through well publicized disciplinary guidelines
- 6 provision for internal monitoring and auditing
- 7 provisions for prompt response to detected offenses and the development of corrective action initiatives

### PROVIDERS, AS PARTICIPANTS IN THE MEDICAL ASSISTANCE (MA) PROGRAM, MUST:

- ▶ Follow all state MA regulations and ensure that all services for which they have received payment follow all of the appropriate rules.
- ▶ Have a system to ensure that employees know, understand, and comply with the legal requirements that apply to the business. These include rules and regulations for clinical documentation, physical plant requirements and those related to claims submission.
- ▶ Be able to prove that they have provided all the services for which they have submitted a claim.
- ▶ Have documentation to support that the services billed were covered by DBH/CBH.
- ▶ Have mechanisms to identify, investigate and take corrective action for suspected or substantiated fraud and abuse activities.
- ▶ Notify the DBH/CBH Compliance Department of suspected program or client fraud and abuse within 24 hours of discovery.
- ▶ Participate in announced and unannounced Compliance audits.
- ▶ Display the DBH/CBH Compliance Hotline posting in all clinical areas.

## Monitoring of Fraud and Abuse by DBH/CBH

The Compliance Department of DBH/CBH has been charged with the responsibility to:

- ▶ monitor compliance with Medicaid regulations
- ▶ perform routine and special audits of providers
- ▶ report activities to the Compliance Committee, the CBH Board of Directors and the other components of DBH
- ▶ provide education and training for employees and providers
- ▶ develop and monitor corrective actions taken by providers as a result of audit activities
- ▶ maintain a fraud and abuse hotline
- ▶ maintain a cooperative relationship with governmental oversight agencies and fully cooperate in any investigation of suspected fraud and abuse

In addition, special features have been and continue to be incorporated into the Claims Payment System at CBH to automatically scan and prevent payment of services that may potentially constitute fraud or abuse. These features or “edits,” as they are called, include, but are not limited to, the prevention of payments for services that have:

- ▶ not been authorized
- ▶ been previously paid
- ▶ been provided to persons who were ineligible for treatment

Reports have been and continue to be developed in the Claims Payment System to monitor provider activity relating to services billed, including both payment and rejections, for purposes of identifying potential fraud and abuse.

DPW’s Medichex List is also reviewed on a monthly basis to determine if any DBH/CBH providers are on the list.