COUNTY OF IMPERIAL
DEPARTMENT OF BEHAVIORAL HEALTH SERVICES

POLICY AND PROCEDURE MANUAL

SUBJECT: Fraud, Waste, and Abuse Prevention	**POLICY NO:** 01-145
SECTION: Administration	**EFFECTIVE DATE:** 3-17-23
REFERENCE:	**PAGE:** 1 of 7
	SUPERSEDES: 5-17-19
AUTHORITY: Federal Deficit Reduction Act of 2005, Chapter 3 - Eliminating Fraud, Waste and Abuse in Medicaid	**APPROVED BY:** Jeticia Plancarte-Garcia

PURPOSE: To fulfill a mandate identified in the amended Social Security Act (via the Deficit Reduction Act of 2005) that requires entities who receive or make annual Medi-Cal payments of at least $5,000,000 to develop and maintain a written policy to inform ICBHS and contractor employees, including management, of detailed information about the Federal and State versions of the False Claims Act, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse.

SCOPE: The information in this document applies to all ICBHS employees and managers as well as those of its contractors.

NOTES: The False Claims Act (31 USC 3729-3733) is a federal statute used to combat fraud against the United States. Critical elements of the law are: 1) the prosecution only needs to prove that a false claim was knowingly submitted for payment claim; 2) prosecutors do not need to prove specific intent to defraud the government to achieve conviction, and 3) penalties for filing false claims can include repayment of falsely claimed amounts, substantial financial fines and potentially, prison sentences.

Key False Claim Act language holds the claimant responsible for knowing the correct and/or legal method of providing a service or product and preparing a correct and/or legal reimbursement claim. The False Claim Act focuses on personal and/or institutional responsibility to know certain information and to base actions on that information. Additionally, it states that a responsible person or entity cannot act in deliberate ignorance or in reckless disregard of the truth or falsity of information. Applicable provisions from the Federal False Claims Act are included as Attachment I.

The State of California has enacted a False Claims Act under the Government Code Sections 12650-12656. The State language closely parallels the Federal language and holds the claimant responsible for knowing the correct and/or legal method of providing goods and services and completing correct and /or legal requirements. Applicable provisions from the State of California False Claim Act are included as Attachment II.

A submission of a false claim may occur by the commission of an act (i.e., submitting an erroneous paper-based or electronic-based invoice or claim) or by the omission of an act (i.e., failing to report a discovered overpayment).

A false claim occurs when an individual or entity knowingly submits a claim for reimbursement, or false documentation for a claim, to a State or Federal payor source for a service or product despite the quality or quantity of that service or product not fulfilling the requirements associated with those goods or services. Potential false claims include, but are not limited to, the following:

- Double-billing: Submitting more than one claim for the same service
- Lacking a service note: An authorized service for an eligible client provided by an appropriately licensed clinician but lacking a proper service note that documents the service provided and establishes medical necessity.
- Service note lacking a signature and/or date: An authorized service for an eligible client provided by an appropriately licensed clinician but the service note that documents the service and established medical necessity lacks signature or date.
- Out of scope of practice: An authorized service for an eligible client, with all appropriate documentation

being completed, but performed by a clinician lacking the necessary training and license or registration.

- Expired license or registration: Any clinical service that requires a licensed or registered clinician but is provided by a person with an expired, suspended, or revoked license or registration.
- Upcoding: Using an inaccurate diagnosis code or claiming an inaccurate procedure code that has a higher reimbursement rate than is appropriate for the client's condition or the service actually rendered,
- Overcharging: Claiming more minutes (or otherwise applicable reimbursement criteria) that is actually provided.
- Falsified Claim: Claiming for a service that was never provided.

The Federal and State False Claims Act statutes include a section known as the Qui Tam or Whistleblower provision that authorizes private citizens to 1) report false claim violations directly to the government, or (2) file a False Claim Act legal case against an individual or entity. This provision includes non-retaliation protections when exercised in good faith.

There are administrative, civil, and/or criminal remedies available to the government under Federal and State laws including, but not limited to, the following:

- Repayment of falsely claimed amounts.
- Civil remedies may also require the payment of substantial financial penalties (could include treble damages and/or $10,000 per false claim) in addition to the repayment of the actual amount received.
- Criminal remedies may require the repayment of funds received based on the false claim, plus substantial, plus convicted individuals could receive prison sentences.
- Individual or entities convicted of certain civil or criminal violations may be excluded from receiving any payments for services or products from all federally funded health care programs for a specific term.
- The government may choose to settle with the entity rather that pursue a conviction. A settlement often requires the repayment of the falsely claimed amount plus substantial fines. Moreover, such settlements typically require the development of a robust Compliance Program to preclude future false claims.

- Settlement may require an entity to sign a Corporate Integrity Agreement (CIA) to avoid being excluded from federal health care programs.

DEFINITIONS:

Auditing: To methodically review and examine records or accounts to check the accuracy of information.

Abuse: Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Fraud: Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under custody or control of, any health care benefit program (18 USC § 1347).

Monitoring: For the purpose of this policy, monitoring means to systematically test processes on an ongoing basis to document compliance with policies, procedures, laws, or regulations.

Waste: Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

POLICY:

ICBHS will maintain an auditing, monitoring, and reporting program to prevent, detect, and correct fraud, waste and abuse.

All ICBHS employees, contractors and other workforce members have a duty to participate in efforts to prevent fraud, waste and abuse and ensure that public resources are used ethically, prudently and for legally designated purposes.

ICBHS and its contractors shall abide by the federal and state False Claims Act statutes in an effort to prevent fraud, waste, or abuse in the service delivery and billing processes.

All ICBHS employees, contractors, and other workforce members have a duty to report instances of suspected fraud, waste, or abuse. Reports may be made directly to the Compliance Officer through the following means:

Compliance Hotline: 1-866-314-7240

PO Box:
Attn: Compliance Unit
P.O. Box 1766
El Centro, CA 92243

E-Mail: icbhsprivacyofficer@co.imperial.ca.us

Suspected Medi-Cal fraud, waste, or abuse may also be reported directly to:

DHCS Medi-Cal Fraud
(800) 822-6222
Fraud@dhcs.ca.gov

Compliance Program Responsibilities:

- Provide education and information to the ICBHS workforce of the duty to report and the available protections for reporting compliance issues.

- Conduct reviews, audits, and monitoring tasks of ICBHS and contractor operations to detect and correct findings or erroneous service or billing actions that might lead to potential false claim-related problems.

- Implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse that include prompt reporting to the State Department of Health Care Services about the following:

    - Any potential fraud, waste, or abuse;

- All overpayments identified or recovered, specifying the overpayments due to potential fraud.
- Information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including changes in the beneficiary's residence (out-of-county or out-of-state) or the death of a beneficiary.
- Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with ICBHS.

- Promptly refer any potential fraud, waste, or abuse to the Department Medicaid Program Integrity Unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

- Conduct an internal investigation to determine the validity of the issue/complaint received regarding any potential fraud, waste, or abuse and develop and implement corrective action, if needed.

- Suspend payments to a network provider for which there is a credible allegation of fraud.

- Upon determining the report of fraud, waste, or abuse has been substantiated, ensure that a written disclosure is submitted to the Department of Health Care Services Audits and Investigations Unit and/or appropriate local, state and federal agency. Refer to Procedure 01-42 Compliance Investigations, for additional information.

- Investigate any reports of actual or suspected retaliation against good faith reporting of issues. Refer to ICBHS Policy 01-117, Compliance Program - Non-Retaliation.

Management/Supervisors Responsibilities:

- Reduce opportunities for fraud, waste, and abuse by implementing strong internal controls that detect and deter dishonest behavior.

- Ensure that staff are aware of the options available for reporting fraud, waste and abuse and other compliance issues. Refer to ICBHS Policy 01-109, Compliance Hotline and Policy 01-108, Compliance Concern(s) Form.
- Establish an environment free from intimidation and retaliation to encourage open communication. Refer to ICBHS Policy 01-117, Compliance - Non Retaliation, for additional information.

  a. Ensure that employees and other workforce members who report issues are not subject to intimidation, harassment, or other forms of retaliation for reporting issues in good faith.

  b. Immediately address any and all forms of retaliation by co-workers.

  c. Actively discourage conduct that could be perceived as retaliatory.

Individual Responsibilities:

- Perform their clinical and/or administrative functions in a legal, truthful, and complete manner to ensure full compliance with applicable laws and policy requirements.

- Report actual or suspected violations of law, regulations or policy including fraud, waste and abuse to appropriate authorities. Additional information is included in ICBHS Policy 01-109, Compliance Hotline as well as state and federal false claims statutes (Attachment I and II).

- Cooperate with investigations of compliance issues. Refer to Procedure 01-42, Compliance Investigations, for additional information.