SAN BERNARDINO COUNTY
Behavioral Health
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Fraud, Waste and Abuse Policy

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Policy

It is the policy of the Department of Behavioral Health (DBH) to maintain a comprehensive Compliance Program, including implementation of the auditing and monitoring element proactively and responsively. Auditing and monitoring practices will be conducted in an effort to prevent, detect and correct any potential and/or actual fraud, waste or abuse, including false claims within the DBH system of care, including amongst mental health and substance use disorder programs.

All DBH workforce members, including permanent employees, interns, volunteers, contract providers and contractor employees, are required to adhere to all Department policies/procedures, as well as state and federal laws to ensure public resources are utilized appropriately and as legally appropriate. Any potential or actual violations of state or federal law pertaining to fraud/waste/abuse, shall be investigated promptly and reported to the appropriate governing authority(ies).

Purpose

To outline requirements of fraud, waste, abuse prevention, detection and correction implemented DBH, as well as requirements for all DBH workforce members, including contract providers/employees, in accordance with California Government Code §§ 12650-12656 (California False Claims Act), 31 U.S.C. §§ 3729-3733 (Federal False Claims Act), 42 U.S.C. § 1320a-7b(b), 42 U.S.C. § 1395nn, 42 U.S.C. § 1320a-7.

Definition(s)

- **Abuse:** Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. This includes activities that are inconsistent with fiscal, business, or medical best practices, and result in unnecessary cost(s) or in reimbursement for unnecessary medical services or fail to meet standards;
- **Auditing:** Review and systematic examination of records/information to verify accuracy and confirm activities are performed in accordance with applicable standards, policies/procedures, laws and regulations;
- **Best practices:** Generally recognized superior performance by organization in operational and/or financial processes;

Continued on next page

Definition(s), continued

- **Monitoring:** Ongoing observation and/or review of process to assess compliance and identify if a further audit is required;
- **Fraud:** Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or another. It includes any act that constitutes fraud under applicable federal or state law;
- **Waste:** Overutilization/inappropriate utilization of services or misuse of resources.

False Claim

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 payer 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. A partial list of potential behavioral health - related false claims includes the following:

1. **Double billing**: Submitting more than one claim for the same service;
2. **Lacking a case note**: An authorized service for an eligible client provided by an appropriately licensed staff member but lacking a proper case note that documents the service and establishes medical necessity;
3. **Case note lacking a signature and/or date**: Same as # 2 but lacks the clinician's signature and/or date;
4. **Out of scope practice**: An authorized service for an eligible client with all appropriate documentation being completed but performed by a staff member lacking the necessary training or registration/certification/license/waiver;
5. **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;
6. **Up-coding**: Using an inaccurate diagnosis 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;
7. **Overcharging**: Claiming more minutes (or other applicable reimbursement criteria) than actually provided;
8. **False claim**: Claiming for a service that was never provided.

A false claim related legal case could be filed against an individual or entity by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), other Federal or State agency.

Continued on next page

Whistleblower Provision

The State and Federal False Claim Act statutes include a section known as the Qui Tam or Whistleblower provision that authorizes private citizens to report false claim violations directly to the government; and file a False Claims Act legal case against an individual or an entity. The government may join such a legal case, but is not obligated to do so. This provision includes non-retaliation protections when exercised in good faith. Individuals reporting false claims in good faith are protected from retaliation under state and federal law provisions.

Remedies for False Claims

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

1. Repayment of falsely claimed amounts;
2. Civil remedies may also require the payment of substantial financial penalties in addition to the repayment for the actual amount received;
3. Criminal remedies may require the repayment of funds received based on the false claim, plus substantial financial penalty fees, plus convicted individuals could receive prison sentences;
4. Individuals or entities convicted of certain civil or criminal violations may be excluded from receiving any payment for services or products from all federally funded health care programs for a specific term.

In addition to administrative, civil and/or criminal penalties, the Department and contract providers may initiate personnel corrective action for individual employees -- up-to and including termination.

Office of Compliance

The DBH Office of Compliance is responsible for ensuring the DBH workforce and contract providers adhere to applicable Department, County, State and Federal regulations and requirements. This includes implementing guidelines pertaining to billing and coding standards, conflicts of interest, licensing and credentialing requirements, Code of Conduct, and ethical standards as set forth by the appropriate board(s). Additionally, the Office of Compliance conducts investigations in response to complaints and other reports, to prevent/detect/correct fraud/waste abuse. Compliance oversees a comprehensive Compliance Program, which includes the seven elements as follows:

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Office of Compliance, continued

1. Designation of a Compliance Officer and Compliance Committee;
2. Policies and procedures and standards of conduct;
3. Effective training and education for DBH staff and contract agencies, including the duty to report compliance violations and protections when reporting;
4. Maintain an auditing and monitoring program, which includes a *planned* auditing protocol (at least once per year), privacy assessments, and action plans, auditing/monitoring of program activities, contractor monitoring, billing/coding claims reviews and other activities to prevent, detect and correct fraud, waste and abuse;
    - Audits will be ad-hoc (based on reports, complaints, monitoring findings, etc.) as well as planned, and may lead to in-depth investigations to adequate address findings.
    - Compliance will ensure restitution, corrective action and asset recovery actions are completed and properly documented and reported to the state and/or relevant regulatory entity.
    - Compliance will ensure investigations that identify overpayment are paid back to the funding body according to state and federal requirements.
5. Promptly respond to detected, reported and/or actual offenses and violations;
6. Maintain effective lines of communication between the Office of Compliance, Executive Management, DBH employees and contract providers, and
7. Enforce standards through well-publicized disciplinary guidelines.

Workforce Responsibility

All DBH workforce members have a responsibility to follow the standards of conduct as outlined in the Department's Code of Conduct, as well as report any non-compliant behavior. The following responsibilities apply for preventing/detecting/correcting fraud/waste/abuse:

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Workforce Responsibility, continued

Workforce Type	Responsibility
Manager and/or Supervisor	1. Create an environment of honesty and accountability within your area of oversight. This includes providing clear direction on work expectations, appropriate conduct and ethical standards; 2. Reduce opportunities for fraud, waste, and abuse by implementing strong internal controls that detect and deter dishonest behavior; 3. Ensure that employees are aware of the options available for reporting fraud, waste, and abuse and other compliance issues; 4. Establish an environment free from intimidation and retaliation to encourage open communication. This includes encouraging reporting issues without a sense of intimidation, harassment, or other forms of retaliation for reporting.
Individual Employee	1. Perform duties in an ethical and legal manner; 2. Perform duties in a manner that promotes public interest and ensures appropriate use of time and resources; 3. Report actual or suspected violations of the Code, Department policy/procedure and/or state or federal law, fraud/waste/abuse; 4. Cooperate with investigations and/or preliminary research on compliance matters.

Contractor Reporting Responsibility

Contracted providers are required to report to DBH immediately when an overpayment has been received. The overpayment shall be returned to DBH within sixty (60) calendar days after the date on which the overpayment was identified, and notify DBH in writing of the reason for the overpayment. DBH may suspend payments to a contracted provider for which DBH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

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DBH Reporting Responsibility

DBH maintains a Compliance Program responsible for receiving and investigating suspected and/or actual reports of fraud/waste/abuse. For DBH reporting, the anonymous Compliance Hot-line is available (800) 398-9736, an email can be sent to Compliance_Questions@dbh.sbcounty.gov or a call can be placed to (909) 388-0879. Contract providers are responsible for maintaining a compliance program within their agency and developing internal reporting mechanisms per contract terms. They must also report to DBH Compliance and the relevant program contact as specified herein, regarding any potential fraud/waste/abuse or overpayment.

Following investigative findings, suspected/actual fraud/waste/abuse (including Medi-Cal fraud) shall be reported by DBH Compliance to the appropriate governing authority, relevant boards, and Department of Health Care Services (DHCS) Medi-Cal Fraud at (800) 822-6229, or Fraud@dhcs.ca.gov.

Related Policy or Procedure

DBH Standard Practice Manual:

- Compliance Plan Policy (COM0934)
- DBH Compliance Committee Policy (COM0920)
- Compliance Hotline Procedure (COM0919-1)
- Code of Conduct (COM0914)
- Compliance Verification, Monitoring and Auditing Policy (COM0917)
- Conflict of Interest Policy (COM0911)
- Certification of Billed Services Policy (COM0915)
- Ineligible Persons Policy (COM0933)
- Ineligible Persons Procedure (COM0933-1).

Reference(s)

- California Government Code Section 12650-12656 (California False Claims Act)
- Department of Health Care Services All Plan Letter 17-003
- Title 42 of the Code of Federal Regulations (CFR), Section 438.608(d)
- Department of Health Care Services Intergovernmental Agreement for Substance Use Disorders
- 31 United States Code, Section 3729-3733 (Federal False Claims Act)
- 42 United States Code, Section 1320a-7
- 42 United States Code, Section 1320a-7b(b)
- 42 United States Code, Section 1395nn.