Health Care Agency Behavioral Health Services Policies and Procedures	Section Name: Sub Section: Section Number: Policy Status:	Administration Billing & Reimbursement 04.02.08 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	7/1/2020

SUBJECT:	Billing Compliance, Recoveries and Reporting of Overpayments

PURPOSE:

To ensure that overpayments and recoveries for services provided by Behavioral Health Services (BHS) staff in the Orange Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) are identified promptly and reported to the Department of Health Care Services (DHCS) as required.

POLICY:

BHS shall comply with Health Care Agency (HCA), Behavioral Health Services Policies and Procedures, Code of Conduct and all Federal and State laws and regulations to ensure that services are provided in a compliant manner and any overpayments and recoveries are promptly reported to DHCS.

SCOPE:

This policy and procedure applies to all BHS County and County Contracted providers and BHS staff responsible for financial and reimbursement.

REFERENCES:

MHSUDS Information Notice 19-022 Certification of Document and Data Submissions for Drug Medi-Cal Organized Delivery (DMC-ODS) System Pilot Counties

MHSUDS Information Notice 19-034 Overpayments Recovery and Reporting Procedures

Title 42, Code of Federal Regulations, Sections 438.604 and 438.606

HCA P&P VIII 4.05 Employee Compliance Hotline Operation

HCA P&P VIII 5.06 Compliance Issue Reporting

BHS P&P 07.01.01 Fraud and Abuse

BHS P&P 07.01.02 Billing Compliance

Exhibit A, Attachment I of the Intergovernmental Agreement (IA) for the provision of Drug Medi-Cal Organized Delivery Services

DEFINITIONS:

Overpayment - any payment made to a network provider by the Plan to which the network provider is not entitled to under Title XIX of the Act or any payment to the Plan by the State to which the MHP or DMC-ODS under Title XIX of the Act.

PROCEDURE:

I. All BHS staff are responsible for accurate and complete processing of documentation related to billing.

   A. Providers shall take reasonable precaution to ensure that the coding of health care claims, billings and/or invoices are prepared and submitted in an accurate and timely manner and are consistent with federal, state and county laws and regulations. This includes compliance with federal and state health care program regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or their agents.

   B. No submission shall be made of any false, fraudulent, inaccurate and/or fictitious claims for payment or reimbursement of any kind.

   C. Providers shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, provider shall use proper billing codes which accurately describes the services provided and must ensure compliance with all billing and documentation requirements.

   D. Providers shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified.

II. All County Contracted network providers are bound by the requirements above and the language contained in the Compliance section; Medical, Billing, Coding and Documentation Compliance Standards of their Contract Agreement with HCA.

   A. Contractor shall promptly return any overpayment within the timeframe indicated in the contract after the overpayment is verified by the Administrator, but no later than (60) days.

III. All staff are required to take action should they have any concerns that services are not being accurately and appropriately coded and billed. The options for action are detailed in the HCA P&P VIII 4.05 Employee Compliance Hotline Operation, HCA P&P VIII 5.06 Compliance Issue Reporting, BHS P&P 07.01.01 Fraud and Abuse and BHS P&P 07.01.02 Billing Compliance.

IV. Reports of potential fraud, waste or abuse made to the HCA Office of Compliance (OOC) will be investigated and followed up by OOC with the assistance of Authority and Quality Improvement Services (AQIS), if applicable.

A. When applicable, potential fraud, waste and abuse identified by HCA will be promptly referred to the Department of Medicaid Program Integrity Unit and potential fraud directly referred to the State Medicaid Fraud Control Unit.

V. Issues that are identified through routine reviews or reports made to AQIS can be opened for a formal compliance investigation.

A. Issues referred formally from the OOC are always opened as an AQIS BHS Compliance Issue.

B. Issues that are identified through routine reviews by AQIS are opened for a formal compliance investigation and are referred to as “AQIS BHS Compliance Issue.” A AQIS BHS Compliance Issue Initial Report and/or AQIS BHS Investigation Report is created for all formal compliance investigations

C. Issues referred from other sources to AQIS are opened as an AQIS BHS Compliance Issue at the discretion of an AQIS Administrative Manager. AQIS Administrative Manager determines whether the issue should also be referred to the OOC.

1. If determined to be an appropriate referral to the OOC due to potential fraud, waste of abuse, the issue is referred to OOC and an OOC Compliance Issue Number is obtained, if appropriate after consultation.

2. Issues referred to AQIS that involve errors resulting in inappropriate billing or overpayment or identified through routine clinical records reviews are processed by AQIS to ensure corrections and repayments are made promptly.

D. The AQIS BHS Compliance Issue Initial Report and the AQIS BHS Compliance Issue Investigation Report (if applicable depending on the issue) is formulated and sent to all involved parties by the AQIS Administrative Manager or Designee upon conducting the necessary investigation and determining appropriate AQIS Directive(s) and recommendation(s) based on the investigation findings.

E. Required actions are to be completed and reported to AQIS with proof of completion within 30 days from the date the AQIS BHS Compliance Issue or the AQIS BHS Investigation Report is issued.

1. If the compliance issue is related to overpayment, the provider shall credit all services identified by the AQIS Team and provide written notification of all services being credited back and replaced with Non-compliant service codes.

F. An AQIS BHS Compliance Issue Final Report is formulated and sent to all involved parties by AQIS Administrative Manager or Designee upon confirming that AQIS Directive(s) have been completed and the issue has been resolved.

VI. Additional AQIS Responsibilities

A. Additional DHCS Reporting to the Normal Claim Voiding Process

1. Following the close of every state fiscal Year (FY) and per the requirements of 42 CFR, section 438.608(d}, annually the Orange MHP and DMC-ODS must create a void report using the supplied DHCS template, listing all voided claims in a Microsoft Excel spreadsheet format and send the spreadsheet to MedCCC@dhcs.ca.gov with the following headers:

a) Payer Claim Control Number

b) Client Index Number

c) Health Care Provider National Provider Identifier

d) Payment Amount

e) Federal Financial Participation Amount

f) Recovery Type Classification:

i. 42 CFR, section 438.608(d) or;

ii. All other Medi-Cal

2. The MHP and DMC-ODS must also submit a signed certification in accordance with 42 CFR, section 438.606 using the certification template form provided by DHCS to comply with MHSUDS IN # 19-034.

3. For DMC-ODS, Annual report of overpayment recoveries certification statements shall be completed and signed on county letterhead are sent to ODSSubmissions@dhcs.ca.gov with the void reports spreadsheet supplied by DHCS, in accordance with DHCS MHSUDS IN # 19-022.

VII. No disciplinary action or retaliation shall be taken against an employee for reporting in good faith a perceived issue, problem, concern, or violation regarding billing compliance to a supervisor, manager, Human Resources, the Office of Compliance, the Compliance Hotline, or regulatory agency. "In good faith" simply means that the employee actually believes or perceives the information reported to be true. The value and dignity of each person and the right as an employee to be treated fairly and with respect shall be recognized by all HCA staff.