BHS Program Integrity & Compliance Workgroup

August 21, 2024

Behavioral Health Services Compliance Unit
San Francisco Department of Public Health
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Webpage: Behavioral Health Services (BHS) Compliance Unit | San Francisco (sf.gov)

Ramaytush Ohlone Land Acknowledgment

The San Francisco Health Commission/San Francisco Department of Public Health staff acknowledges that we are on the unceded ancestral homeland of the Ramaytush Ohlone who are the original inhabitants of the San Francisco Peninsula.

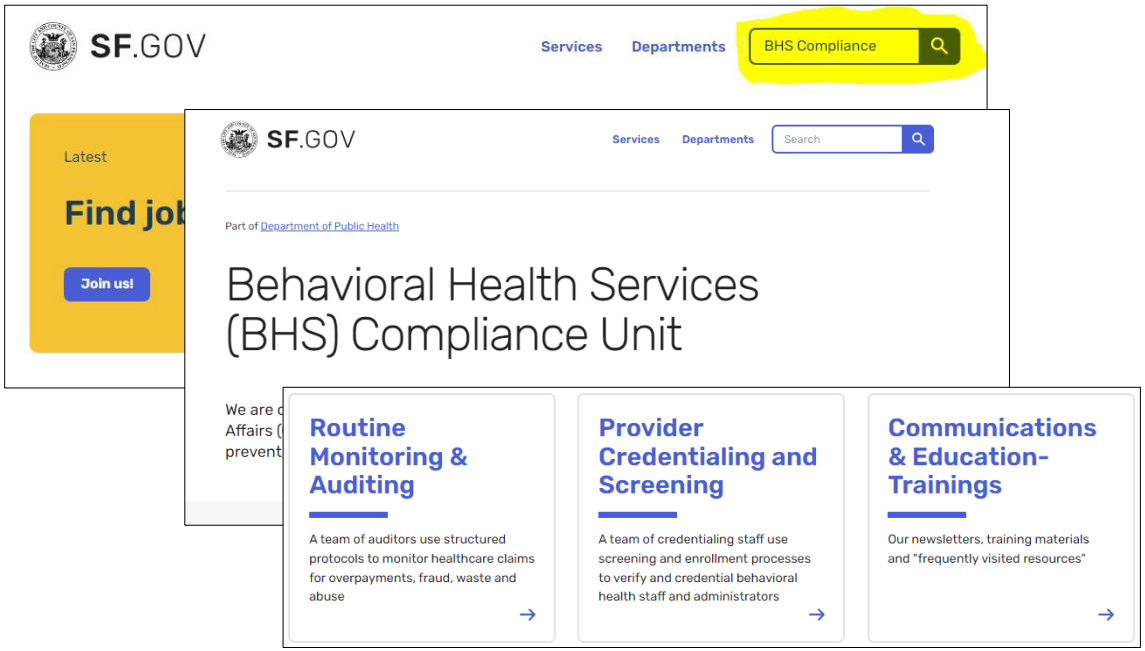
As the Indigenous stewards of this land, and in accordance with their traditions, the Ramaytush Ohlone have never ceded, lost, nor forgotten their responsibilities as the caretakers of this place, as well as for all peoples who reside in their traditional territory.

As guests, we recognize that we benefit from living and working on their traditional homeland. We wish to pay our respects by acknowledging the Ancestors, Elders, and Relatives of the Ramaytush Ohlone community and by affirming their sovereign rights as First Peoples.

Learn more:

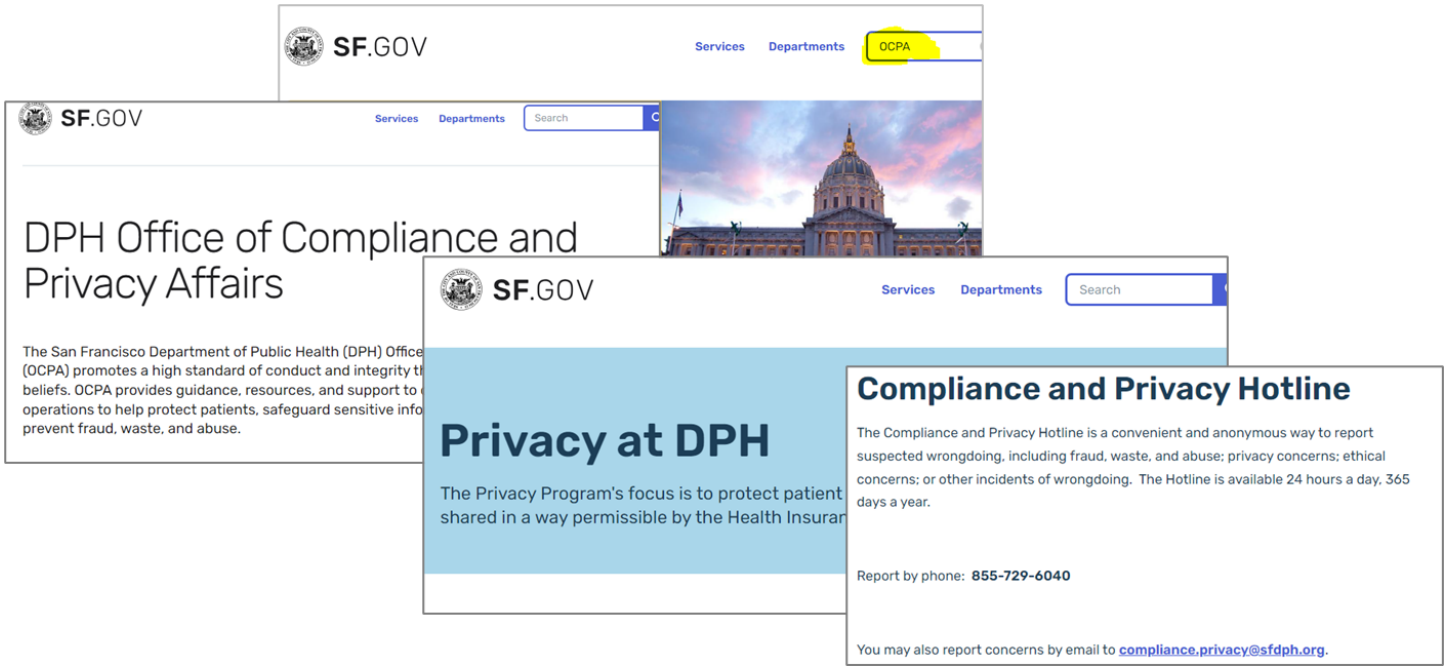
- City & County of San Francisco Health Commission Resolution 21-9
- SFDPH Land Acknowledgement sf.gov page
- Fine Arts Museums of San Francisco Youtube Ohlone Land Acknowledgement Series
- American Indian Cultural District Webpage Ramaytush Ohlone Land Acknowledgment
- The Association of Ramaytush Ohlone

BHS Compliance Unit Webpage (sf.gov)



- **"Routine Monitoring & Auditing"** section includes audit protocol and calendar
- **"Provider Credentialing & Screening"** section includes Avatar & Epic Users
- **"Communications & Education-Training"** section includes Monthly Program Integrity Meeting materials and a sign-up for our distribution list!
- **Staff contact** information

DPH Privacy Unit Webpage (sf.gov)



- **Learn about privacy** and protected health information
- **Get resources related to Data Sharing at DPH**, like Business Associate Agreements
- **Make a request for consultation and/or report a concern** about privacy or compliance via phone (855-729-6040) or email (compliance.privacy@sfdph.org)

Workgroup Objectives

- **Clarify claims audit standards and recoupment**
  - We learned in FY 22-23 CalAIM - - the volume and complexity of regulatory changes is overwhelming
- **Maximize transparency and participation**
  - We learned in FY 22-23 CalAIM - - DHCS no longer publishes the audit protocol or reasons for recoupment
- **Generate and disseminate “wisdom”**
  - We learned in FY 22-23 CalAIM - - our work and decision-making processes are guided by key source documents and implement interim steps (laws, regulations, contracts, professional standards, accreditation, certification, etc.)

Agenda and Objectives

Item	Focus/Objective	Time
Introductions & Check In	**Emphasis on clarity and transparency**	**10mins**
Topic #1: Reason for Disallowances	Reimbursement for provider activity where there is no direct contact with the beneficiary (no direct beneficiary contact)	10mins
Topic #2: Reasons for Disallowances	Reimbursement for provider activity where there is a secondary (“Add On”) procedure code claimed with the primary procedure code	10mins
Topic #3: Reasons for Disallowances	Reimbursement for SMHS and DMC-ODS Targeted Care Management care planning	10mins
Topic #4: Provider Screening	Process Improvement for Requesting Updates and Changes to Provider’s Screening/Enrollment/Credentialing Record	10mins
Workgroup Wrap Up	**Follow Up Items**	**10mins**
Subgroup	Least defined (waste) to most defined (fraud)	30mins

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**

  - **Problem – Unclear Standard**: in circumstances where there is "no direct beneficiary present," can a rendering provider obtain reimbursement for an SMHS/DMC-ODS activity?

  - **Problem – Disallowed Claims in FY23-24**: existing guidance from DHCS and BHS materials emphasize direct beneficiary contact – but also acknowledge alternative scenarios.

  - **Parameters for Recoupment in FY24-25**: **until** clarification is provided by DHCS/BHS, then "direct beneficiary care" **could** include multiple scenarios (see following slides).

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**

  - **<u>Parameters for Recoupment in FY24-25</u>**: BHS Compliance will base disallowance based on the following:

  - **<u>Definition of Direct Patient/Beneficiary Care</u>**: A group of activities defined by DHCS which emphasize time spent directly providing care to the beneficiary – but **when** appropriately delivered and documented, **could** include time spent:

    - (1) With beneficiary's **significant support person**;
    - (2) With beneficiary's **other rendering provider(s)**;
    - (3) **Alone as a rendering provider**, as part of comprehensive assessment/planning process and/or as part of Targeted Case Management/Rehabilitative Referral & Linkage

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**

  - **(1) Significant Support Person: when** appropriately documented, **inclusive of the following** items, the claim will not be disallowed:

    - The medical record **must** contain evidence that the claimed service achieves the beneficiary's care, treatment and client plan;

    - The medical record **should** contain evidence that the individual meets the definition of "significant support person" within 9 CCR § 1810.246.1;

    - In circumstances where a clinical judgement requires that a beneficiary be excluded for a portion of a Family Therapy activity, the medical record **must** state the beneficiary was excluded, the amount of time and the circumstances of the exclusion.

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**

  - **(2) Rendering Provider: when** appropriately documented, **inclusive of the following** items, the claim will not be disallowed:

    - The medical record **must** contain evidence that the claimed service achieves the beneficiary's care, treatment and client plan;

    - **Valid** scenarios with another rendering provider are **limited** to:
      - Creating recommendations for treatment and/or coordinating care with an interdisciplinary team (like a case conference);
      - Making referrals and related activities and/or monitoring service access, use, benefit, and/or linkage referral (like SMHS TCM, ICC, Referral and Linkages);
      - Obtaining consultation (the rendering provider obtains information from an expert, and then uses that information to deliver care to the beneficiary).

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**
  - **(3) Alone: when** appropriately documented, **inclusive of the following** items, the claim will not be disallowed:
    - The medical record **must** contain evidence that the claimed service achieves the beneficiary's care, treatment and client plan;
    - **Valid** scenarios for claiming services alone of are **limited** to:
      - Making referrals and related activities and/or monitoring service access, use, benefit, and/or linkage referral (like SMHS TCM, ICC, Referral and Linkages);
      - Conducting a "psychiatric evaluation of reports, tests, and/or other hospital and psychometric-projective accumulated information" as part of comprehensive assessment and care planning:
        - The medical record must identify the authors/sources and dates of the reports, tests, hospital and accumulated psychometric-projective information.

WORKGROUP-Claims Standards

- **Topic #1: No Direct Contact with the Beneficiary**

  - **BHS Compliance Source Documents & Decision-Making**: we are following the **model established by LA County MHP**– and reviewed the following additional information:

    - *CalAIM Payment Reform* (direct service is time spent with beneficiary and reimbursable activities);
    - *California Medicaid State Plan* (SMHS and DMC-ODS are Rehabilitative Services and they are entitlements to beneficiaries);
    - *CalAIM FAQs* ("Member Not Present," pages 7-8 and 12-13)
    - *County MHPs with Established QA Infrastructure*
      - LA County: Provider Page, QA Page, Procedure Codes (online, pdf)
      - Monterey County: QI Homepage, SMHS Manual,

WORKGROUP-Claims Standards

- **Topic #2: Secondary (“Add On”) Procedure Code**

  - **Problem – Unclear Standard**: in circumstances where an “Add On” (additional) Procedure Code is used, what documentation is needed for SMHS/DMC-ODS reimbursement?

  - **Problem – Disallowed Claims in FY23-24**: DHCS guidance requires that every claimed procedure code be substantiated with a progress note.

WORKGROUP-Claims Standards

- **Topic #2: Secondary ("Add On") Procedure Code**
  - **Parameters for Recoupment in FY24-25**: **until** clarification is provided by BHS, **then** the following apply
  - **Definition of "Add On Procedure Code"**: A rendering professional **is obtaining additional reimbursement** when an additional procedure code is claimed.
    - There are four types of "Add On Procedure Codes":
      - (1) Interactive Complexity
      - (2) ASL/Oral Interpretation
      - (3) Extended Service
      - (4) Psychotherapy Add On to Medical Staff.

WORKGROUP-Claims Standards

- **Topic #2: Secondary ("Add On") Procedure Code**

  - **All "Add On Procedure Codes"**: when appropriately documented, **inclusive of the following items**, the claim will not be disallowed:

    - The rendering provider's progress note **must** identify the use of the Add On Procedure Code (identifying **the name and/or the CPT/HCPCS** code);

    - The rendering provider's progress note **must** also include description of Add On service activity (may be brief – but must **contain sufficient information** to determine if the payment is proper)

  - **Resources**: CMS' site and tools; AACAP's tools

WORKGROUP-Claims Standards

- **Topic #2: Secondary ("Add On") Procedure Code**

  - **BHS Compliance Source Documents & Decision-Making**: we are following the **model established by Monterey County MHP** – but we reviewed the following additional information:

    - DHCS IN 23-068
    - LA County
      - Provider Page, QA Page, Procedure Codes (online, pdf)
    - Monterey County
      - QI Homepage, SMHS Manual

WORKGROUP-Claims Standards

- **Topic #3: TCM Care Planning in SMHS/DMC-ODS**

  - **Problem – Unclear Standard**: what procedure code should be used fora TCM-only care planning activity?

  - **Problem – Disallowed Claims in FY23-24**: if a rendering provider submits a claim for TCM services, then the progress note must describe the TCM service, use the TCM Procedure Code, and then paste the TCM plan into the note.

  - **Parameters for Recoupment in FY24-25**: **until** a policy is provided by BHS, **then** the following apply (see following slides).

WORKGROUP-Claims Standards

- **Topic #3: TCM Care Planning in SMHS/DMC-ODS**

  - **Parameters for Recoupment in FY24-25**: **until** clarification is provided by BHS, **then** the following apply.

  - **Definition of TCM from: 42CFR 440.169**: The assistance that case managers provide in assisting eligible individuals obtain services includes:
    - (1) Comprehensive assessment/reassessment for TCM needs.
    - (2) **Care plan**/periodic updates for TCM goals/actions.
    - (3) Referral and related activities.
    - (4) Monitoring and follow up activities.

WORKGROUP-Claims Standards

- **Topic #3: TCM Care Planning in SMHS/DMC-ODS**

  - **Definition of "TCM-Only Care Planning"**: the rendering provider **exclusively** focused on TCM care planning

    - TCM-Only care planning procedure code (**T1017**).

    - To obtain reimbursement, the progress note **must** describe the care planning activity (e.g., interviewing client to determine needs).

    - To meet the requirements of DHCS IN#23-068, the progress note **must** include the TCM-Only Care Plan (i.e., pasted into the body of the note).

WORKGROUP-Claims Standards

- **Topic #3: TCM Care Planning in SMHS/DMC-ODS**

  - **<u>Observations on Care Planning</u>**:

    - **SMHS Intensive Care Coordination** (child Medicaid benefit) follows the same flow of logic because it is a variation of TCM/T1017.
      - BHS has published guidance (policy page, tip sheet);
      - DHCS has published guidance (IN page; current practice guide)

    - Both SMHS and DMC-ODS have appropriate codes for care planning activities across multiple modalities (e.g., comprehensive care planning that includes rehabilitation, medication, TCM, therapy, etc.)
      - H0032 Mental Health Service Plan Development by Non-Physicians
      - H2021 DMC-ODS

WORKGROUP-Screening-Credentialing

- **Topic #1: Interface of Screening/Credentialing and Other Systems**
  - **BHS Compliance**: Screening, Enrolling, Credentialing
    - sf.gov page
  - **DPH IT-Epic**: Accounts, Active Directory, Training
    - sf.gov page
  - **DPH IT-Avatar**: Accounts, Support
    - sf.gov page

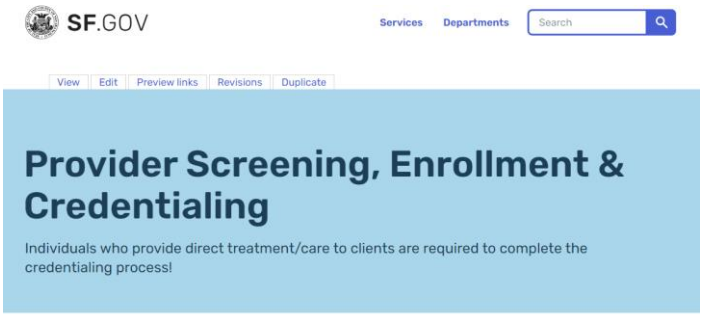
WORKGROUP-Screening-Credentialing

- **Topic #1: Interface of Screening/Credentialing and Other Systems**

  - **Planned Improvement**: requesting an update to Screening/Enrollment/Credentialing Record

    - *Problem*: in the past, we were “fused” with the requests for Avatar accounts – but this changed with Epic (separated processes)

    - *Planned Solution*: users submit a request for updates by using a webform that is located on our sf.gov page



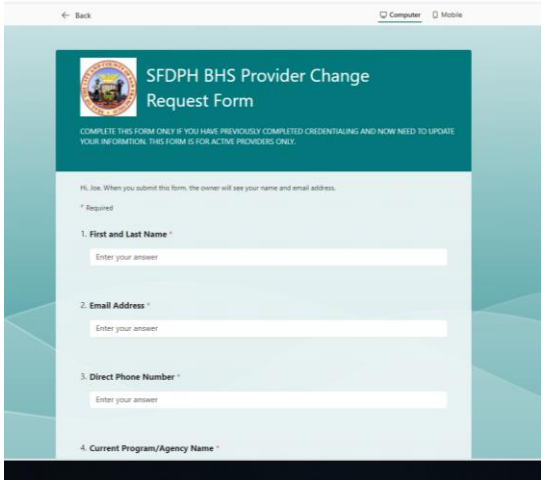
WORKGROUP-Screening-Credentialing

- **Topic #1: Interface of Screening/Credentialing and Other Systems**

  - **Types of Requests**:
    - Name change
    - Reactivate the account after a separation
    - Staff category change (unlicensed-licensed)
    - Program/agency change

  - **Agencies Willing to Pilot**:
    - SMHS and DMC-ODS

  - Future opportunities



WORKGROUP

- **Wrapping-Up and Following-Up**

  - BHS Compliance applies these clarified recoupment standards effective 08/21/2024.
  - BHS Compliance will communicate these clarifications to BHS and request formal guidance updates.
  - BHS Compliance will post these meeting materials to our sf.gov page within 48hrs.
  - For next meeting – thoughts from providers?

SUBGROUP

- **The Conundrum**
  - We are **familiar with the terminology** (fraud, waste and abuse), but we want to be **clear about the definitions**.
    - We need to find examples to help us understand
  - We are **familiar with the obligations** (prevent, detect, remediate), but we want to be **clear about the standards**.
    - We need to know the bodies of guidance in effect

SUBGROUP

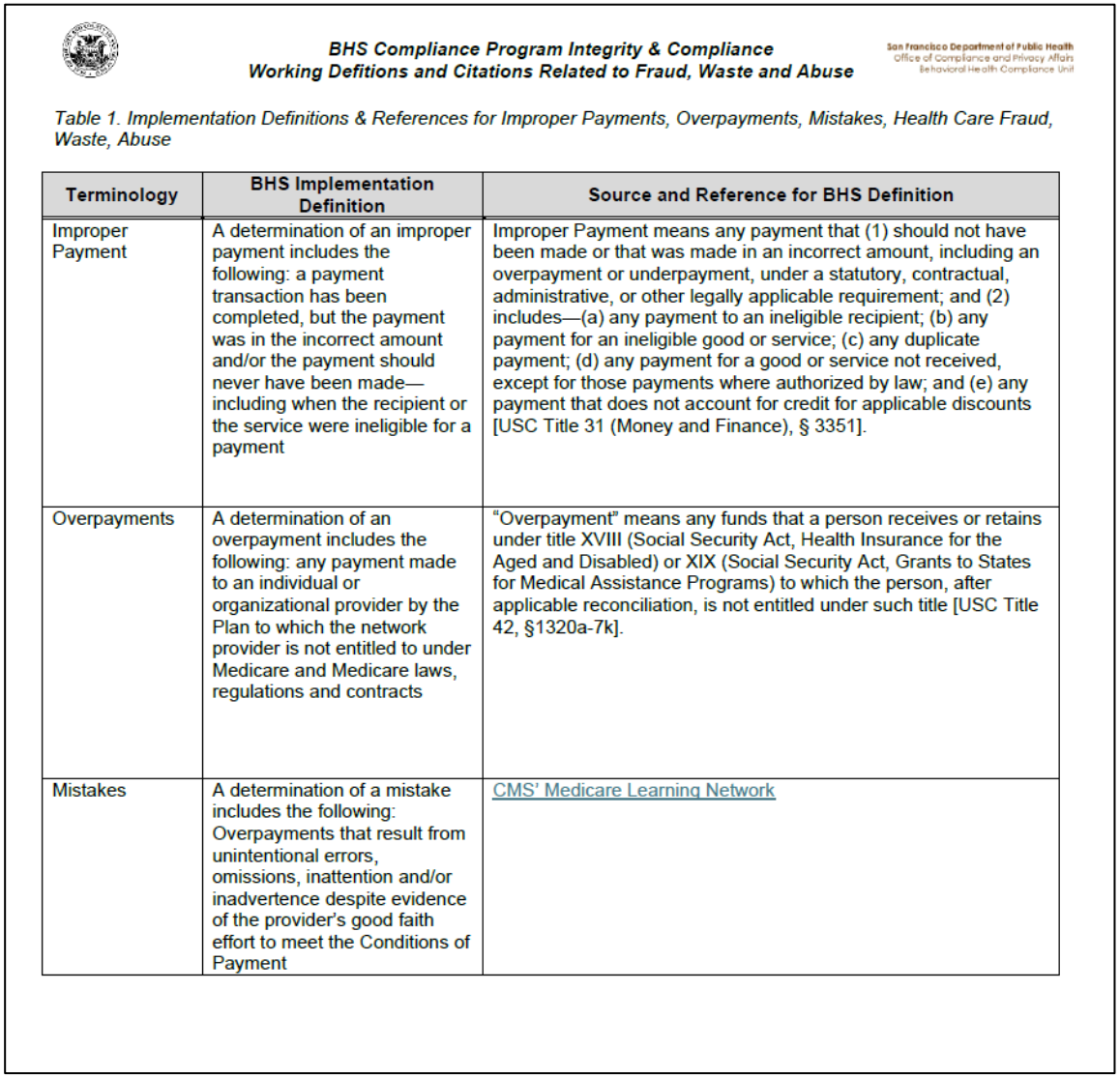
- **The Solution**

  - In instances where we are unclear about the definitions and standards…**we establish and implement interpretive guidance…based on analyses of laws, regulations and court-decisions**.

  - **Levels we seek to understand**:
    - Staff
    - Supervisor
    - Manager
    - Director
    - Leadership/Governance
    - Agency

SUBGROUP

- The Handout



BHS Compliance Program Integrity & Compliance
Working Defitions and Citations Related to Fraud, Waste and Abuse

San Francisco Department of Public Health
Office of Compliance and Privacy Affairs
Behavioral Health Compliance Unit

Table 1. Implementation Definitions & References for Improper Payments, Overpayments, Mistakes, Health Care Fraud, Waste, Abuse

Terminology	BHS Implementation Definition	Source and Reference for BHS Definition
Improper Payment	A determination of an improper payment includes the following: a payment transaction has been completed, but the payment was in the incorrect amount and/or the payment should never have been made—including when the recipient or the service were ineligible for a payment	Improper Payment means any payment that (1) should not have been made or that was made in an incorrect amount, including an overpayment or underpayment, under a statutory, contractual, administrative, or other legally applicable requirement; and (2) includes—(a) any payment to an ineligible recipient; (b) any payment for an ineligible good or service; (c) any duplicate payment; (d) any payment for a good or service not received, except for those payments where authorized by law; and (e) any payment that does not account for credit for applicable discounts [USC Title 31 (Money and Finance), § 3351].
Overpayments	A determination of an overpayment includes the following: any payment made to an individual or organizational provider by the Plan to which the network provider is not entitled to under Medicare and Medicare laws, regulations and contracts	"Overpayment" means any funds that a person receives or retains under title XVIII (Social Security Act, Health Insurance for the Aged and Disabled) or XIX (Social Security Act, Grants to States for Medical Assistance Programs) to which the person, after applicable reconciliation, is not entitled under such title [USC Title 42, §1320a-7k].
Mistakes	A determination of a mistake includes the following: Overpayments that result from unintentional errors, omissions, inattention and/or inadvertence despite evidence of the provider's good faith effort to meet the Conditions of Payment	CMS' Medicare Learning Network

SUBGROUP

- **Wrapping Up/Following Up**
  - We’re starting slow…

Table 1. Implementation Definitions & References for Improper Payments, Overpayments, Mistakes, Health Care Fraud, Waste, Abuse

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Mistakes	A determination of a mistake includes the following: Overpayments that result from unintentional errors, omissions, inattention and/or inadvertence despite evidence of the provider's good faith effort to meet the Conditions of Payment	CMS' Medicare Learning Network

Health Care Fraud	A determination of health care fraud includes the following: intentional actions on the part of an individual involving untruthfulness and obtaining tangible benefits Note that the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors	Health Care fraud means 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. It includes any act that constitutes fraud under applicable Federal or State law [CFR42 §455.2]. Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—(1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned [USC18 §1347]. An allegation of fraud shall be considered credible if it exhibits indicia of reliability as recognized by state or federal courts or by other law sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets. The department shall carefully consider the allegations, facts, data, and evidence with the same thoroughness as a state or federal court would use in approving a warrant for a search or seizure [CA WIC §14107.11(d)]. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law [CA WIC §14043.1]. Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally. Examples of fraud include, but are not limited to, the following: Billing for services that were not furnished and/or supplies not provided (includes billing Medicare for appointments that the patient failed to keep); Altering claims forms and/or receipts in order to receive a higher payment amount; duplicating billings that includes billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed; offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program; falsely representing the nature of the services furnished (encompasses describing a noncovered service in a misleading way that makes it appear as if a covered service was actually furnished); billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage; and using another person's Medicare card to obtain medical care [CMS Internet Only Manual #100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 1 – General Overview].

Terminology	BHS Implementation Definition	Source and Reference for BHS Definition
Health Care Waste	From the Medicare context, a determination of health care waste includes the following: the overuse of practices or routines that lead to costs that are not necessary and actually reflect misuse rather than criminal negligence	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 [CMS Internet Only Manual #100-16, Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines].
Health Care Abuse	A determination of health care abuse includes the following: Practices or routines that are inconsistent with reasonable and logical fiscal, business, or medical practices that lead to either excess unnecessary costs or reimbursements related to activities that (1) were not medically necessary and/or (2) failed to meet professionally recognized standards for health care Note that the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors	Means provider practices 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 that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program [CFR42 §455.2]. “Abuse” means either of the following: (1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state’s Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state; (2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other healthcare programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care [CA WIC §14043.1]. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Following are three standards that CMS uses when judging whether abusive acts in billing were committed against the Medicare program: Reasonable and necessary; Conformance to professionally recognized standards; and Provision at a fair price. Examples of abuse include, but are not limited to, the following: Charging in excess for services or supplies; Providing medically unnecessary services or services that do not meet professionally recognized standards; Billing Medicare based on a higher fee schedule than for non-Medicare patients; Submitting bills to Medicare that are the responsibility of other insurers under the Medicare secondary payer (MSP) regulation; and Violating the participating physician/supplier agreement. [CMS Internet Only Manual #100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 1 – General Overview].