BHS Program Integrity & Compliance Workgroup

September 18, 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.

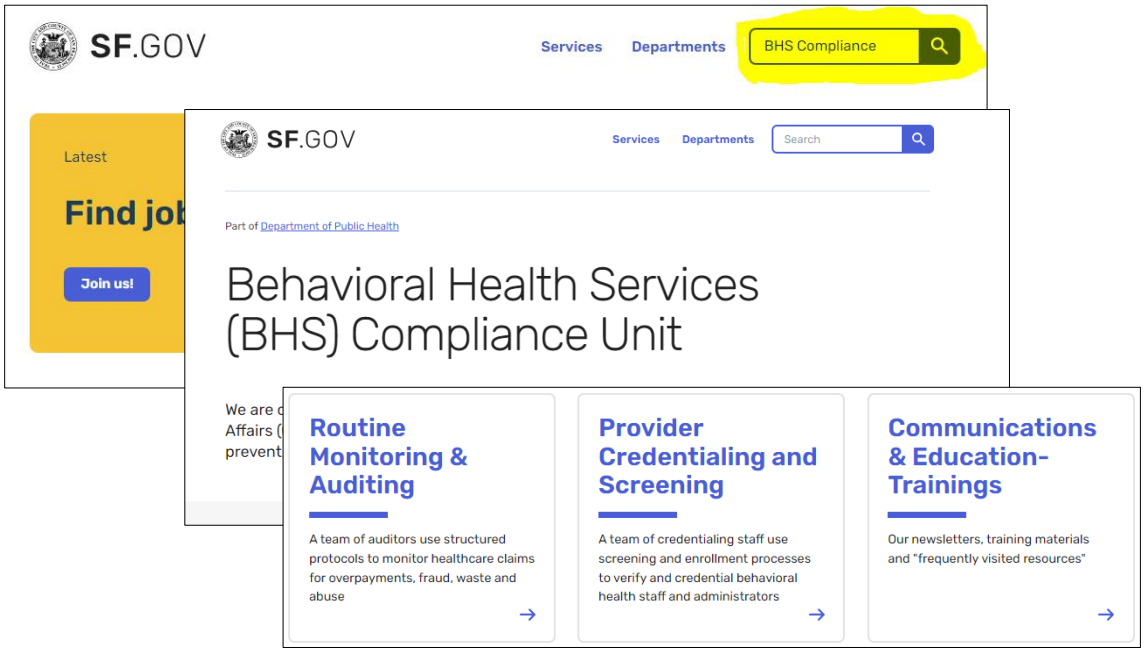
As the Indigenous stewards of this land, and in accordance with their traditions, the Ramaytush Ohlone have never ceded, lost, nor forgotten their responsibilities as the caretakers of this place, as well as for all peoples who reside in their traditional territory.

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:

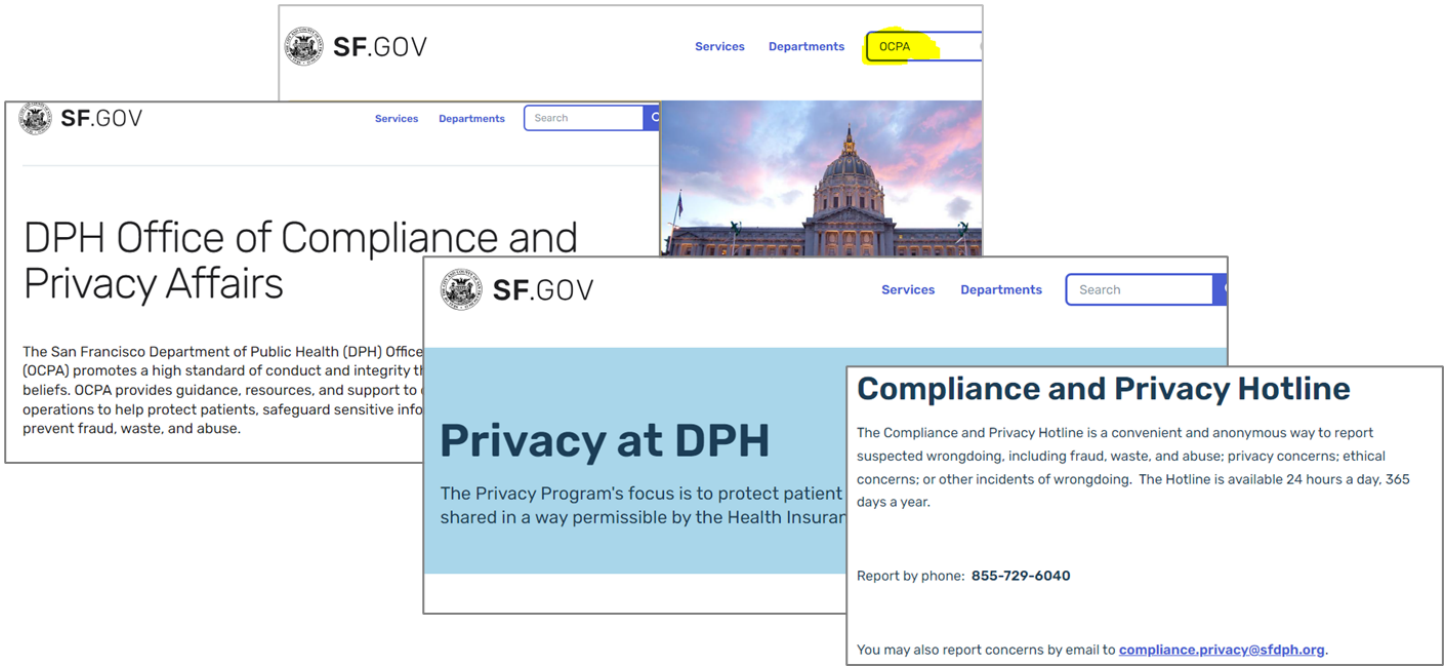
- City & County of San Francisco Health Commission Resolution 21-9
- SFDPH Land Acknowledgement sf.gov page
- Fine Arts Museums of San Francisco Youtube Ohlone Land Acknowledgement Series
- American Indian Cultural District Webpage Ramaytush Ohlone Land Acknowledgment
- The Association of Ramaytush Ohlone

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**	**15mins**
Topic #1: Quick Recap	Let's review our last meeting - - about one month ago - - questions that were identified	15mins
Topic #2: Risk Assessment	Asking for input and thoughts - - ways to identify and understand areas we are not aware of?	15mins
Topic #3: Provider Screening/Credentialing	Asking for input and thoughts - - ways to identify and understand barriers to understanding	15mins
Subgroup	Least defined (waste) to most defined (fraud)	**10mins**

WORKGROUP – Meeting Recap

- **Topics**
  - **Materials posted** to sfgov page
  - **“Main event”** was chart-related information
    - No Direct Contact with the Beneficiary
    - Secondary (“Add On”) Procedure Code
    - TCM Care Planning in SMHS/DMC-ODS
  - **Next steps** - - working with SOC and Managed Care to clarify guidance and technical materials

WORKGROUP – Meeting Recap

- **Questions Posed**

a. Billing and/or IT:
   i. There is a need to see (a) the procedure code selected by the rendering provider; (b) the procedure codes derived/transformed from the initial.
   ii. Within Epic now, every time you submit a psychotherapy code, they are being converted on the back-end to the multiple units of the add-on code. For example, if I bill 90832 for a 30-minute psychotherapy session, it's converted on the back end to two T2021.
   iii. If a service claim audit occurs on a CPT service that originally was 90791 and then converted in Epic system as T2024, you would need clarification as an auditor what code you are auditing.

b. Significant Support Person:
   i. What's the legal definition of significant support person?
   ii. I would love examples of how to indicate the person is a support person and that it is helping to achieve treatment goals. Are there specific words we should use? What billing codes are best to use for that? what would count as plan development without the client/support person?

c. Plan of Care:
   i. Follow up question on the definition of treatment plan/care plan on the previous slide

d. Add On Codes:
   i. When using Interactive Complexity, it sounds like the interventions section is not sufficient for this but instead would need explicit language such as "this services meets criteria for interactive complexity as evidence by ..."
   ii. Add On Codes – the difference between translate and interpretation in language.
   iii. Can you clarify if Add-On for same billing code, or when different billing code. i.e. extended time for family therapy, need to add on Units, should we document, why a longer session then?

e. Client Not Present:
   i. The billing code for evaluating psychiatric documents – can you identify that?
   ii. How do you write a note to justify family therapy when a child does not want to participate? Can you give us the updated audit protocol?

f. New Staff Screening/Enrollment:
   i. MD-App application process for new staff

g. FWA:
   i. How do you define fraud, waste, or abuse?
   ii. Who reports the fraud? The county or the agency?

WORKGROUP – Risk Assessment

- **Final Drafts of Risk Assessment**

  - **Routine process for monitoring systems** - - identifying annual areas of priority:
    - Quality Improvement Assessment and Work Plan
    - Compliance Risk Assessment and Workplan

  - **Known areas** for focus:
    - Managed care changes that relate to overpayments (e.g., units of time changed from minutes to 15-minutes)
    - Program integrity strengthening (e.g., new Epic reports to facilitate claims audits)

  - **“Unknown areas”** to identify:
    - How to identify priority issues - - for the purpose of quickly getting providers and systems onto the same page?

WORKGROUP – Risk Assessment

- **Final Drafts of Risk Assessment**
  - **How to identify?**
    - Domains
    - Situations
    - Populations
  - **How to rally the providers/systems?**
    - Common meetings
    - Common initiatives

WORKGROUP – Screening/Credentialing

- **Improving Our Understanding of Providers Understanding**

  - **Observation** – individuals and organizations struggle – but more “high stakes” than ever:

    - IT access
    - Billing and procedure code nuances
    - Credentialing

  - **Prepping**:
    - DHCS Certified Peers
    - Transitioning local “Mental Health Worker” to standard “Other Qualified Professional”

SUBGROUP – "WASTE"

- **Definitions**

  - 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].

SUBGROUP – “WASTE”

- **Keywords**
  - overutilization (of services)
  - practices (other)
  - directly or indirectly
  - result
  - unnecessary costs
  - criminally negligent actions
  - misuse of resources

SUBGROUP – "WASTE"

- **Thoughts Across Levels:**
  - Staff
  - Supervisor
  - Manager
  - Director
  - Leadership/Governance
  - Agency
  - Other?

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

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].