Routine Monitoring & Targeted Auditing for Improper Payments:

BHS Compliance Overpayment Protocol Updates

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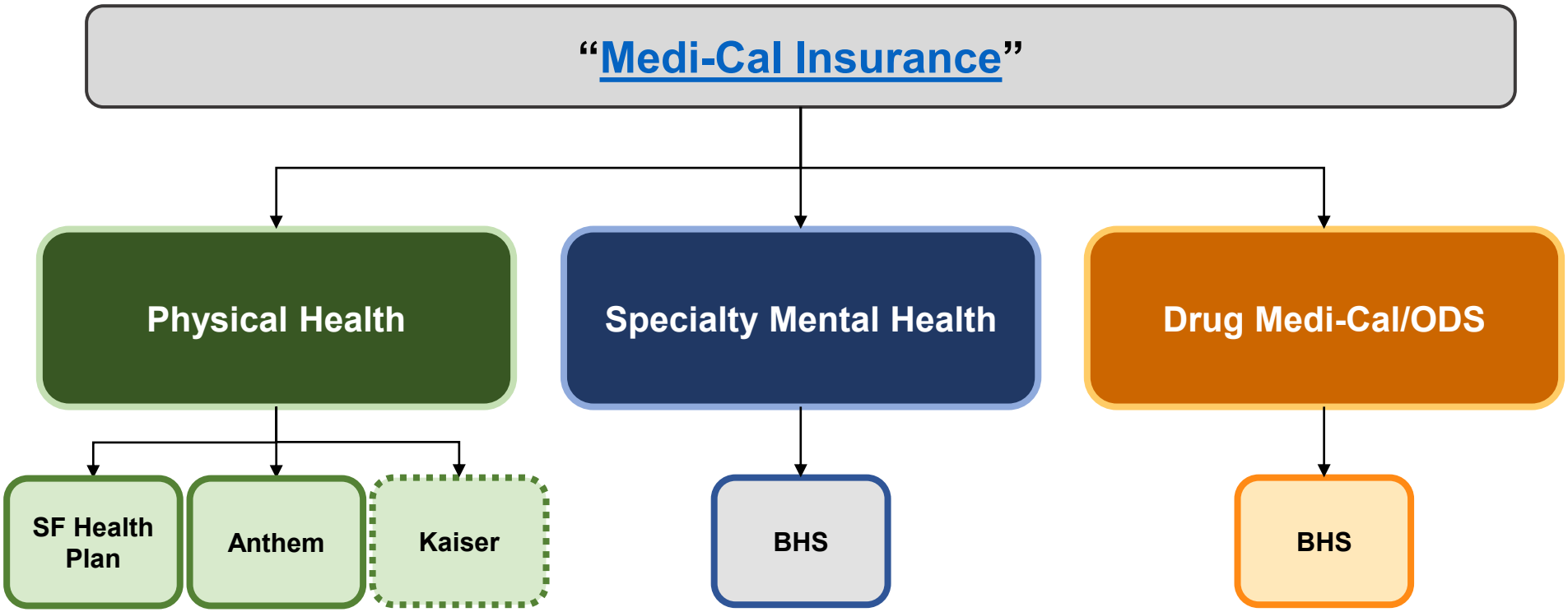
Agenda and Objectives

Item	Objective	Time
Staging & Framing	• Concepts and context for the current landscape	5mins
Protocol	• One protocol for federally funded insurance programs (5 domains, 18 items) • Core obligation is overpayments (mistakes, fraud, waste, abuse)	5mins
Process	• Seven steps for BHS Compliance for FY24-25 • Identifying and prioritizing needs and matching remediation efforts	5mins
CalAIM Lessons Learned	• FY23-24 was identified as “learning year” for CalAIM Payment Reform • Chart documentation must follow program and reimbursement rules	5mins
Standards	• Complexities of SMHS and ODS span many laws, regulations, etc. • Core obligation is overpayments (mistakes, fraud, waste, abuse)	5mins
Compliance Policies	• Five polices that explicate the BHS Compliance Program structure/function • The policies are structured to align to federal managed care regulations	10mins
Enclosures & Questions	• Protocol, Calendar and Example Technical Assistance Tools • Today – collecting questions and clarifying when answers currently exist	15mins

Staging & Framing



- Physical Health & Formulary
- Mild/Moderate MH, SUD SBIRT, ECM & Community Supports
- Medi-Cal Managed Care Boilerplate Contract

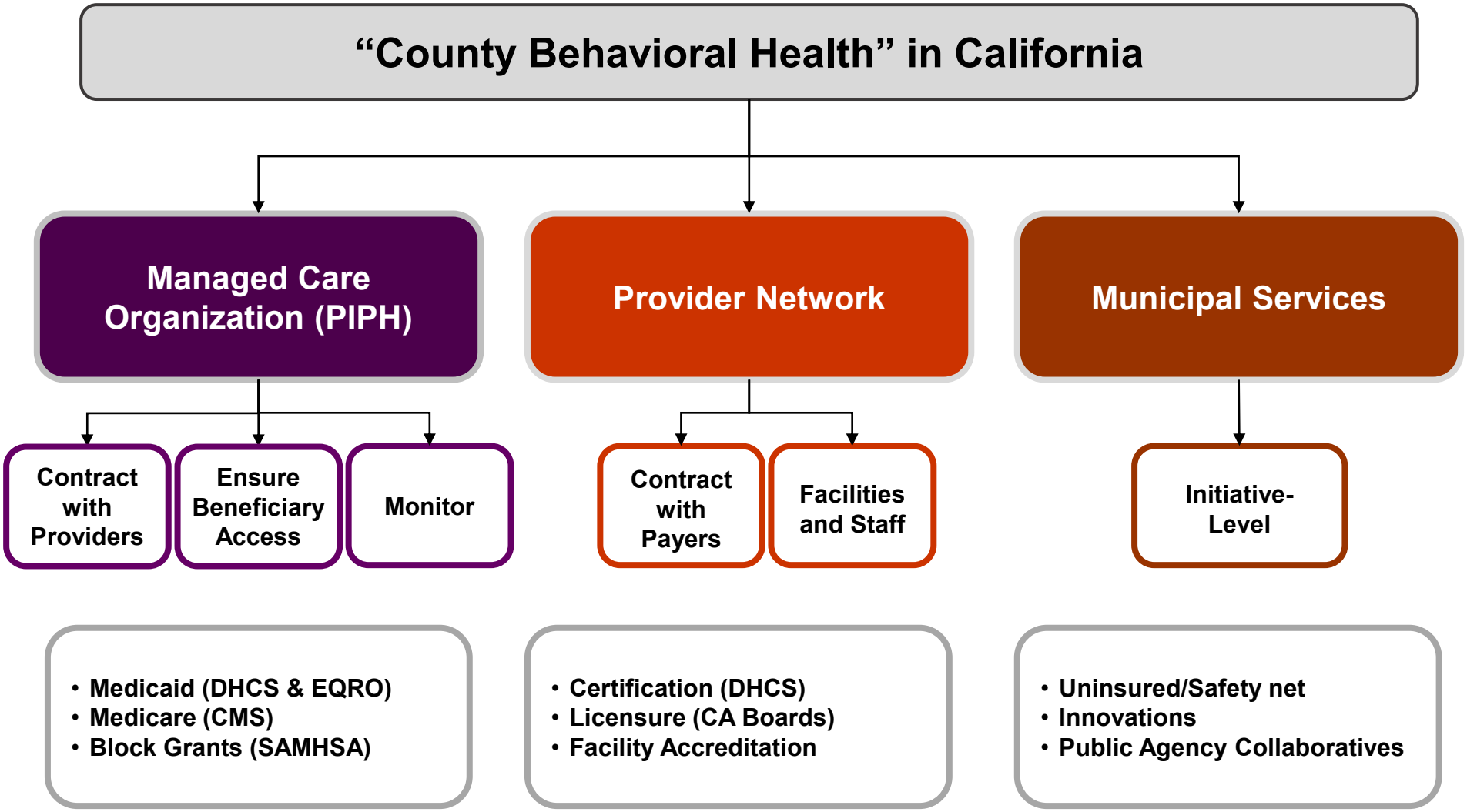
- Moderate-Severe SMHS
- SMHS Boilerplate Contract
- Medicaid State Plan

- DMC-ODS/ODS SUD
- DMC-ODS Intergov. Agreemt.
- Medicaid State Plan

Staging & Framing

- **30 Years of "Minute-by-Minute" and "Service-Travel-Documentation" in SMHS**
  - SMHS Contract Reimbursement Model, 1994 – 2023
    - *Progress notes must contain sufficient information to justify increments of one minute* (including travel/doc justification)
    - *Chart documents are "gatekeepers" to services* (no unplanned services until finalized assessment and client plan)
    - *"Generic" procedure codes for a wide-variety of activities* (HCPCS codes like H2015 and H2017) and staff types (MHRS vs. LMHP)
  - The "worldview" that developed over 30 years needs to be updated - - FY23-24 as a "CalAIM" learning year for BHS!

Staging & Framing

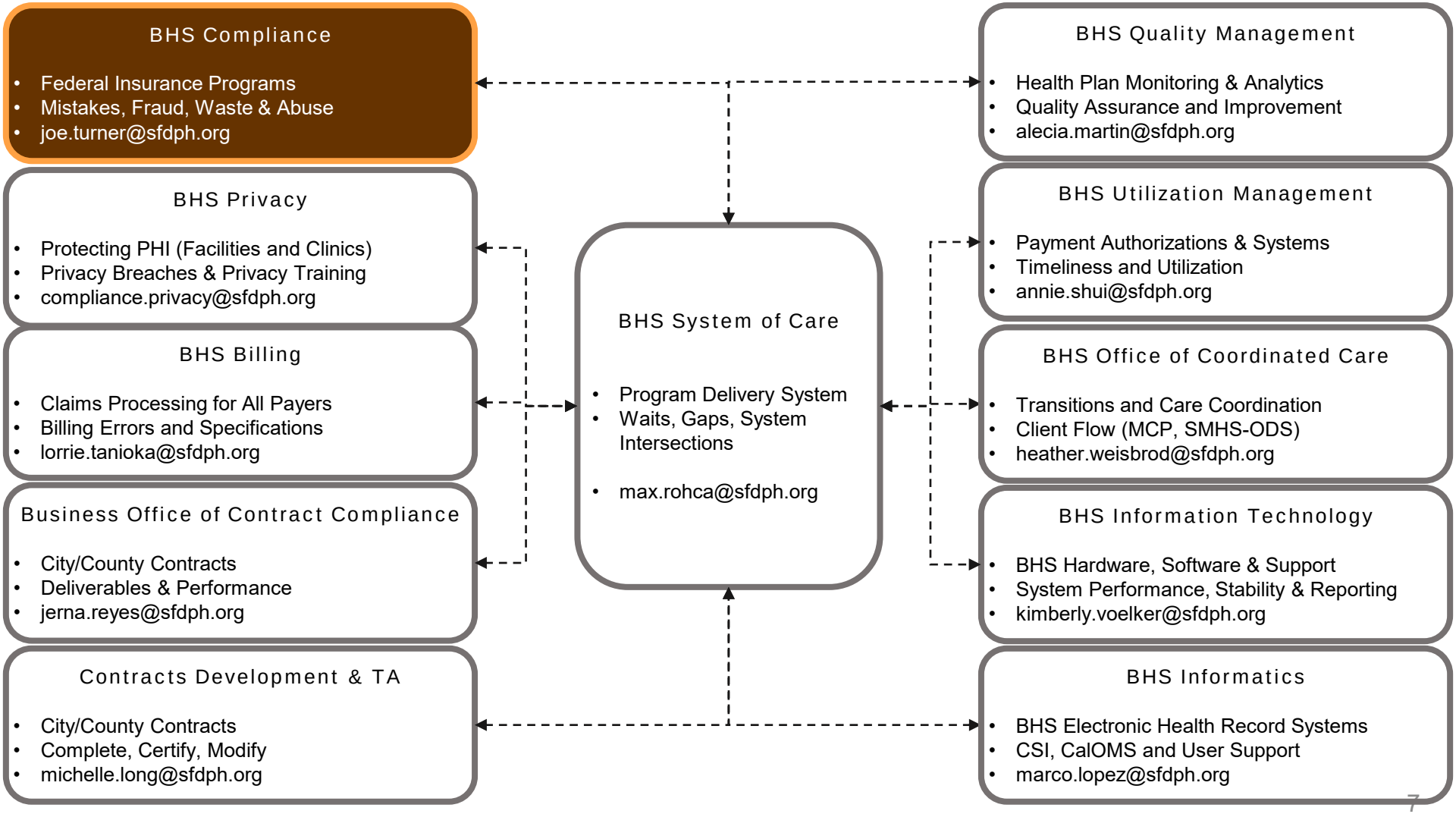


Staging & Framing

- **Compare/Contrast Obligations of Public/Private**
  - ***The health plan***:
    - Contract/reimburse providers
    - Monitor client access/quality/outcomes
    - Federal and state managed care regulations
    - *BOTH SFDPH-BHS and Kaiser Foundation Health Plan*
  - The ***delivery system for services***:
    - Own and operate mental health facilities and directly employ professional and rehab staff
    - *BOTH SFDPH-BHS and Kaiser hospitals and Medical Groups*
  - ***The municipally operated safety net***:
    - California law requires focus for SMI/SED, regardless of insurance
    - Also, innovative services not eligible for reimbursement
    - *ONLY SFDPH-BHS*

Staging & Framing

- **BHS System Monitors & Coordination**



Staging & Framing

- **Our 10 Year Outlook for Managed Care**

  - <u>Now (2022-2027) and Next (2027-2032)</u>

    - *Payment on "Value" vs. Payment on "Cost"*: prospective payments and incentives (e.g., HEDIS performance) that are tied to CPT codes and activities in an integrated "Behavioral Health Plan"

    - *Accessing Services vs. Gatekeeping Services*: access criteria ensures that Managed Care beneficiaries get the service to reduce their problem

    - *Accessing Health Information vs. Barriers to Information:* beneficiaries access health information, appointments, notes, costs, etc. on demand via patient portal

STAGING & FRAMING

- **"Medi-Cal" Benefits**
  - Many benefits - - many plans
  - 30 years of SMHS regulation (disallowance from program and payment failures)

- **Public vs. Private Entities**
  - Both BHS and Kaiser operate as "Payvider"
    - Be the health plan/payer
    - Be the delivery system (facilities and providers)
  - Only BHS operates as "Municipal Safety Net"

- **Monitoring Rationale**
  - Generally, managed care laws require access
  - In CA, beneficiaries have no choice for SMHS/ODS - - County is the only Plan available

Overpayment Protocol Updates

PAST…	PRESENT…
"Chart" is the unit of analysis	Claim (procedure code) is the unit of analysis
Clinical documents are gatekeepers to services	Clinical documents must be complete and present. Some fields and/or elements of clinical and/or administrative forms are required for payment.
Audit protocol built around "charts" and "documents"	Audit protocol built on conditions of payment and proper payments
Reviews at the "Program Code" (Reporting Unit) level	Reviews at the Agency level
Intensity of monitoring and review defined by DHCS	Intensity of monitoring defined by BHS Risk Assessment (inclusive of DHCS, CMS, etc.)
DHCS provided the audit protocol and the "reasons for recoupment" (i.e., reasons that reflected a mix of program & payment non-compliance)	No audit protocol from DHCS and no elaboration-clarification of established "fraud, waste, abuse" laws, regulations, etc.

Overpayment Protocol – 5 Domains

01 PROCEDURE CODE

- *Valid code*
- *Sufficient information in progress note*
- *Staff scope*
- *Direct Patient Care requirement (FTF)*
- *Units of time*
- *Prerequisites, add ons*

02 DIAGNOSIS

- *Documented in medical record*
- *Staff scope*

03 MEDICAL NECESSITY

- *Evidence of client "need"*
- *Evidence of an intervention to reduce client "need"*

04 ACCESS

- *Evidence of functional impairment*
- *Additional circumstances for under 21 years (evidence of SMHS "trauma" and/or SMHS-ODS EPSDT)*
- *Additional circumstances for 21 and over (evidence of SUD diagnosis vis-à-vis incarceration)*

05 THE "SHONS" (TIONs)

- *Admissions*
- *Authorizations*
- *Certifications*
- *Determinations*
- *Directions*
- *Identifications*

Domain 1-Procedure Code on Claim

- **Not An Overpayment When…**

1. Appears in the DHCS and/or BHS manuals
2. Sufficiently described in the narrative progress note
3. Staff scope requirement is met
4. Direct Patient Care (“Face to Face”) requirement is met
5. Units of service requirement is met
6. Prerequisite/add-on requirements are met

Domain 2-Diagnosis on Claim

- **Not An Overpayment When…**

1. Appears in the medical record
2. Staff scope is met
3. LMHP/LPHA-specific diagnostic activities are met (mental status, medication history, relevant conditions/psychosocial factors)

Domain 3-Medical Necessity

- **Not an Overpayment When…**

1. Evidence of client "need" in the medical record
   a. symptom
   b. condition
   c. diagnosis
   d. risk factors
   e. trauma (child)
   f. impairment (distress, disability, or dysfunction)
   g. protect life
   h. prevent significant illness
   i. prevent significant disability
   j. alleviate severe pain
   k. NTP Medical History and Physical Exam

From IN 23-068 – defines "client need" and "impairment"

From 21-073/24-001 – defines "medical necessity"

From 24-001 (p9, footnote 5) – for NTP, satisfies "medical necessity"

2. Evidence the provider delivered an activity to reduce a client "need"

Domain 4-Access

- **Not an Overpayment When …**

1. Evidence of functional impairment due to behavioral health diagnosis within medical record

2. Additional Circumstance SMHS – Under 21 years – evidence of “trauma” (per 21-073) in medical record

3. Additional Circumstance SMHS/ODS – Under 21 years – evidence of EPSDT screening/prevention in medical record

4. Additional Circumstance ODS – 21 years and older – evidence of SUD diagnosis vis-à-vis incarceration

Domain 5-**The "Shons" (TIONs)**

- **Not An Overpayment When Required Staff Involvement, Sufficient Information & Signature/Dates for…**
  - Admiss***ions***
    - Example: the "screening examination" portion of NTP Initial Medical Exam
  - Authorizat***ions***:
    - Example: SMHS and ODS Residential Services
    - Example: Therapeutic Behavioral Services (TBS)
  - Certificat***ions***:
    - Example: SMHS Acute Psych Inpatient Hospital Service
  - Determina***tions***:
    - Example: ODS Level of Care Determination
    - Example: Therapeutic Behavioral Services (TBS) Assessment
  - Direc***tions***:
    - Example: Client Plans in TCM/ICC, NTP, TBS, etc.
    - Example: Medication orders
  - Identifica***tions***:
    - Example: EPSDT screening for early intervention/prevention

OVERPAYMENT PROTOCOL

- **Unit of Analysis is Claimed Procedure Code**
  - "Claims audit" to identify overpayments
  - Five domains to evaluate:
    1. Procedure Code
    2. Diagnosis
    3. Medical Necessity
    4. Access
    5. "The Shons" (Admissions, Authorizations, Certifications, Determinations, Directions, Identifications)
  - About 18 items on the protocol

BHS Compliance Process

Fiscal Year Calendar

- Annual agency audits (same time each year)
- Claims from every program code/RU
- Predictability

Planning Meeting with Agency

- Before we send an audit notification – an invitation
- Plan ahead – tight timelines, tight communication
- Submit electronic medical records

Notifying Agencies of Audit

- We communicate the audit via email (Day 1)
- Agency must confirm receipt of email (Day 2)

Submitting Records

- Agency must submit electronic files (Day 3)
- We communicate and obtain additional records as appropriate

BHS Compliance Process

Auditing

- We communicate preliminary results
- We incorporate additional information as appropriate

Final Report

- Estimated error rate for agency
- Subtotals by funding and modality
- Report sent to SOC, CDTA-BOCC, Billing, etc.

Short Term CAP

- Problems that can be resolved in <30 days
- Void (backout) claims from audit
- Create guidance, train staff, change EHR, etc.

Referral for Long Term CAP

- Problems that cannot be resolved in <30 days
- Self-audit and void claims outside of audit period
- Obtain direction, guidance, TA from BHS-DPH

Audit Planning Meeting with Agency

- **New Frame**
  - Improper Payments (mistakes, fraud, waste, abuse; MFWA)
- **New Timelines**
  - Rapid Communication & Tight Turn Around Times
- **New Medical Records Submission**
  - Electronic Files – By Document Type
- **New Short- and Long-Term Corrective Action**
  - Under 30 days effort – BHS Compliance
  - Above 30 days effort – Referral to BHS/DPH System

Audit Notification Letter to Agency

- **Acknowledgement (within 2 Business Days of Letter)**

- **Submission of documents to BHS Compliance (within 3 Business Days of Letter)**

  - Agency must collate and produce chart information for audit and care purposes (per 23-068)

  - Chart information should contain sufficient information to determine if payment is warranted (e.g., assessments, client plans, notes, problem list, authorization forms, etc.)

Audit Results and Short-Term CAP

- **Agency-Level Error Estimates**
  - SMHS and DMC-ODS sub-totals as well
- **Comparisons to Past Performance**
  - For 23-24, a baseline aggerated from FY20-21, 21-22, 22-23 outcomes
  - For 24-25, both the aggregated and prior year
- **Return Overpayments & CAP (<30 days)**
  - Submit evidence of returning overpayment
  - Submit evidence of CAP (e.g., create/implement policy and review with staff; conduct training with staff)

Referral to SOC and Long-Term CAP

- **Referral for More Complex Problems**
  - SOC (programmatic), Billing/Fiscal (returning overpayment), QM (coordinate agency self-review), etc.

- **Coaching to Agencies (3 Session Model)**
  - Confirm the problem
  - Plan for improvements
  - Report/monitor (internal and external)

- **Inputs to FY24-25 Risk Assessment & Targeted Auditing**
  - BHS Compliance data (outcomes, referrals, CAPs)
  - Pooled data from BHS monitoring systems (BOCC, Billing, QM)

BHS COMPLIANCE PROCESS

- **Annual, Agency-Level Monitoring & Auditing**

  - Transparency for providers
    - We give you the protocol, we show you the standards and the sources of guidance

  - Predictability and consistency for providers
    - One annual agency-level review

  - Standard processes
    - Same processes as DHCS and CMS implement (agency supplies records - - regulator audits and reports)

CalAIM Lessons Learned in BHS Compliance

- **Timeline of <u>Some</u> CalAIM Info Notices**

  - 01/01/2022 = Start of new SMHS medical necessity and access criteria (IN 21-073)
  - 01/01/2022 = Start of new ODS program requirements, 2022-2026 (IN 21-075)
  - 04/15/2022 = Start of new concurrent review utilization management, Inpatient (IN 22-017)
  - 07/01/2022 = Start of new State Plan Contract with CMS-CalAIM (2022-2027)
  - 07/01/2022 = Start of SMHS “no wrong door” (a clarification, actually—IN 22-011)
  - 07/01/2022 = Start of new chart documentation standards (IN 22-019)
  - 01/06/2023 = Update to new ODS program requirements, 2022-2026 (IN 23-001)
  - 07/01/2023 = Start of payment reform (CPT codes, no travel/documentation, IN 23-013)
  - 12/21/2023 = Start of new ODS program requirements, 2022-2006 (IN 24-001)
  - 01/01/2024 = Update to new chart documentation standards (IN 23-068)
  - 07/01/2024 = First fiscal year of services with no published protocol (23-044 published on 09/05/2023)

CalAIM Lessons Learned in BHS Compliance

- **BHS Compliance "CalAIM Lessons Learned"**

  - **Compared to prior years, the current system-level error rate is lower**. Within the DHCS CalAIM guidance, assessments and client plans no longer function as "gatekeepers" to services (i.e., in the past, disallowances if the service was not "planned"). Additionally, in this initial year of CalAIM implementation, our methods were informed by our communications/interaction with DHCS during two separate SMHS Triennial Reviews (Acute Inpatient Psych Hospital in December 2022/January 2023 and the System Review in February/March 2023).

  - **Almost half our reviews (our agencies) have an estimated error rate of 0%** (i.e., the claimed services met the basic conditions of payment/minimum standards for the payment to be considered proper). Note that the estimated error rate is not a metric of clinical quality, clarity, "ease of reading," etc.

  - **Our data and observations suggest there is variation among agencies with respect to their**: (1) understanding and implementation of CalAIM standards and (2) overall performance in process/outcome of our audit. We are tentatively hypothesizing that better readiness and better performance is associated with organizational structures (agency structures) that have formal positions and/or units with established experience with Medicaid/SMHS as well as reimbursement experience with other payers like Kaiser, Medicare, etc.

CalAIM Lessons Learned in BHS Compliance

- **BHS Compliance "CalAIM Lessons Learned"**

  - DHCS' audit protocol provided limited insight
    - *Undefined jargon* (e.g., "important area of life functioning")
    - *Microscopic details* on documents (e.g., SMART objectives)
    - *A process fraught with negative emotions and experiences* (e.g., sense of urgency/risk and expectations for "perfect" documents)

  - DHCS' protocol eclipsed our view and understanding of managed care
    - *DHCS blended programmatic and payment* standards for 30 years because of the reimbursement model
    - *Federal regulations related to managed care and Medicare* focus our attention on conditions that are required for a payment to be proper
    - *Federal-level technical guides and manuals* for health plans and auditors provide details related to the conditions for payment

CalAIM Lessons Learned in BHS Compliance

- **Examples of Deficiencies Observed (FY23-24)**

  - Across All Service Types
    - Note does not contain sufficient information for the procedure code claimed
    - Assessments, client plan forms/notes missing, not complete, late

  - Procedure codes
    - Code requires direct client contact, but client was not present for service
    - Units of time (do not appear; incorrectly calculated)
    - “Add On” codes are not documented correctly (e.g., in a separate progress note or within one note, like G2212)
    - Claiming for SMHS Collateral (not a service)
    - Incorrect procedure code for the service, setting, etc.

  - TCM Care Planning (T1017)
    - TCM Care Planning should be billed as T1017, because it is a TCM service
    - H0032 is the HCPCS Code related to care planning for all services (MHS, TCM, CI)

CalAIM Lessons Learned in BHS Compliance

- **Examples of Deficiencies Observed (FY23-24)**

  - Group Services
    - Total number of participants is not documented
    - Maximum number of group members exceeded

  - ODS Residential Services
    - Daily note was not present - - it must be present and must describe procedure code
    - Daily note must show evidence that beneficiary was present for service

  - ODS Client Plan
    - Client plan not present - - it must be present

  - ODS Requirements Under 21-019 Ending Under 23-068:
    - Continuing Services Justification was required, yet missing during period of 21-019
    - “Narrative Summary” for Diagnosis was required, yet missing during period of 21-019
    - Client signatures on “sign-in sheets” for group were required, yet missing during period of 21-019

LESSONS LEARNED

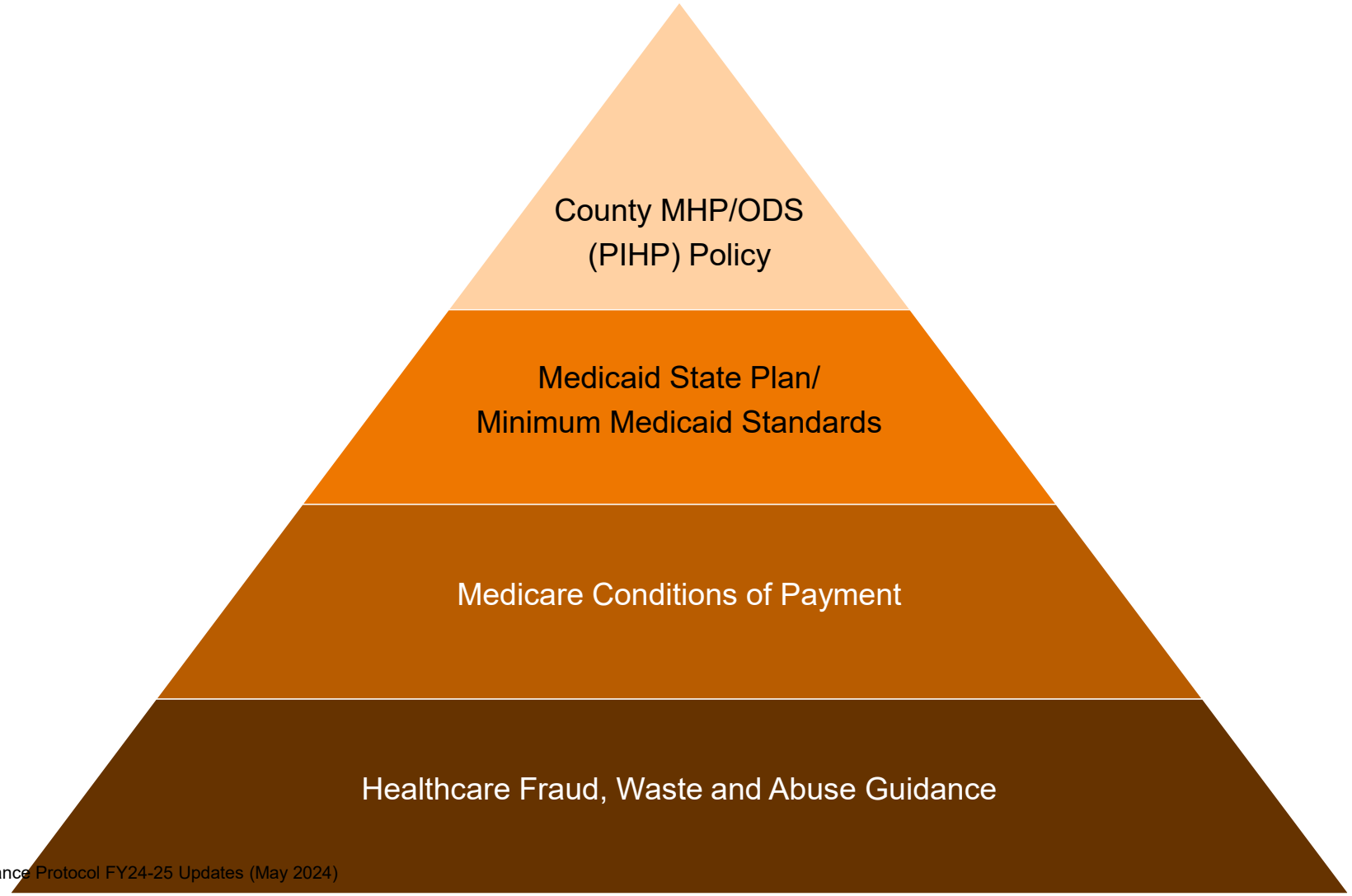
- **Drinking from a Firehose**
  - The amount and pacing of the regulatory changes is staggering - - but FY23-24 has been the year to learn

- **Estimated Error Rate Decreased for BHS**
  - Using the updated guidance, we have observed a decrease in the errors that are associated with financial disallowance

- **Disallowances Limited to Mistakes, Fraud, Waste and Abuse**
  - Patterns of repeated non-compliance after audits, feedback, corrective action and technical assistance could be classified as waste and/or abuse

Standards

- **Standards for Claims Monitoring & Auditing in BHS Compliance**



Standards-Mistakes, Fraud, Waste, Abuse

- **Mistakes, Fraud, Waste, Abuse (MFWA)**

Term	Source and Definition
Improper 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]
Overpayment	"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	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 [MLN Booklet (January 2021) Medicare Fraud & Abuse: Prevent, Detect, Report]
Health Care Fraud	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]

Standards-Mistakes, Fraud, Waste, Abuse

- **MFWA-Continued**

Term	Source and Definition
Health Care 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 [CMS Internet Only Manual #100-16, Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines]
Health Care Abuse	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]

Standards-Participation vs. Payment

- **Conditions of Participation**
  - Requirements that must be met before the legal entity can participate in the insurance program
  - Failure to comply means sanctions, fines and/or exclusion from participation

- **Conditions of Payment**
  - Requirements that must be met before the provider's claim can be reimbursed
  - Failure to comply means the reimbursement must be returned

Standards-Medicare CoPayment

- **Medicare Conditions of Payment (42CFR §424)**

Component	Detail
Service Type, §424.5(a)(1)	Excluded services are not included (e.g., custodial care, services that are not reasonable and necessary
Service Provider, §424.5(a)(2)	At the time the service was furnished, the provider was qualified to have payment made to them
Beneficiary, §424.5(a)(3)	At the time the service was furnished, the client was qualified to have payment made for them
Certification of Need of Services, §424.5(a)(3)	The requirement for a physician certify the necessity of the services and, in some instances, recertify the continued need for those services. No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification.
Claim for Payment, §424.32(a)	A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9
Sufficient Information, §424.5(6)	"…must furnish…sufficient information to determine whether payment is due and the amount of the payment"
Additional Conditions-By Circumstance	Service- and modality-specific payment requirements

Standards-Medical Necessity

- **National Academies (2012) & BHS CDIP Manual (2017)**

Element	Definition
Prudent Provider with Authority	the service/procedure is recommended by an eligible provider acting with practicality, wisdom and judiciousness
Medical-Rehabilitative Purpose	the purpose of the service/procedure is to treat a condition (medical condition; functional condition)
Scope	the type, frequency, extent, site and duration of the service/procedure should be clinically appropriate
Evidence	the service/procedure should be in accordance with generally accepted standards of practice (e.g., scientific evidence, professional standards, expert opinion)
Value	the service/procedure should be cost-effective—that does not mean it must be the "least costly," but rather, not more expensive than other acceptable/effective treatments
Not Primarily for Convenience	the service/procedure should not be primarily for (a) the convenience of the client or provider or (b) the economic benefit of the health plan/purchaser
Individualized	medical necessity must refer to what is medically necessary for a particular client and thus, requires an individual assessment (vs. a general determination of what works in the ordinary case)
Appropriately Signed	a service must have been ordered and provided though a current and appropriately signed treatment plan;
Client Ability to Participate & Benefit	the client must be willing to participate in the treatment. Additionally, the client must have the cognitive ability to benefit from the service
Sufficient Intensity of Treatments	to be medically necessary, there must be an active treatment plan and services are at a sufficient intensity and duration, given generally accepted standards of practice

Standards-Medical Necessity & Access

- **DHCS 21-073 (SMHS) and 24-001 (ODS)**

Age	Medical Necessity	Access
<21 (Child)	• SMHS = EPSDT, USC 42, §1396d(r)(5) • ODS = same	• SMHS = Either "trauma" or impairment o Trauma (Child Welfare, Juvenile Justice, Homeless, Score on a standard measure) o Impairment (traditional "four pathways" including EPSDT) • ODS = EPSDT, §1396d(r)
≥21 (Adult)	• SMHS = to protect life, to prevent significant illness or significant disability, or to alleviate severe pain • ODS = same	• SMHS = Both impairment and disorder o Impairment (either current/significant or maintenance/risk of deterioration) o Disorder (either diagnosed or suspected and not yet diagnosed') • ODS = Only diagnosis (current or incarceration)

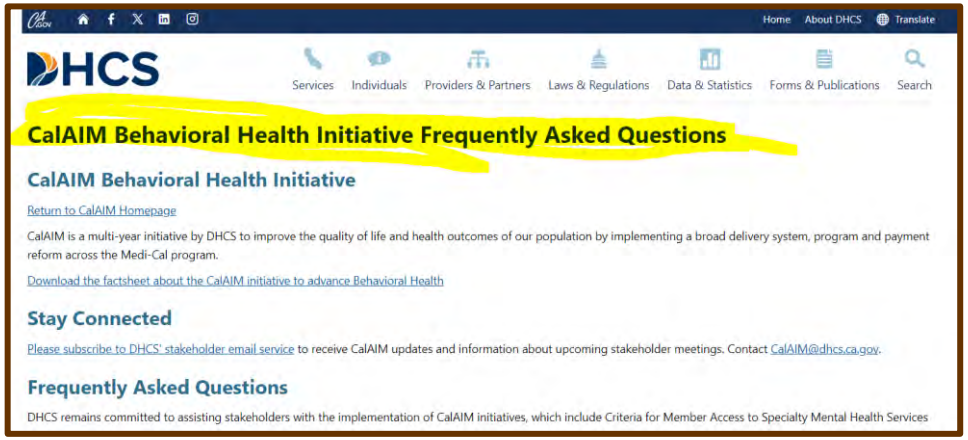
Standards-Evolving DHCS FAQ

- **CalAIM Behavioral Health Initiative – Frequently Asked Questions Webpage**

  - Heads Up - - difficult to discern if/when updates occur

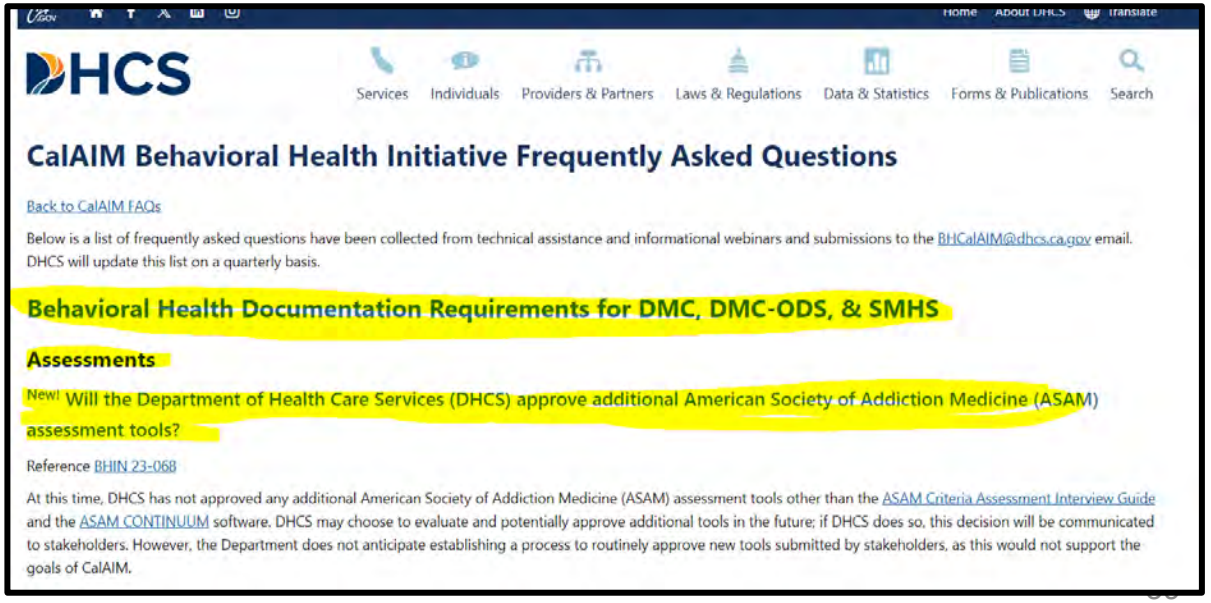
    - Some items are tagged with dates (most recent is July 2023)

    - This page is organized into about 10 domains
      - (1) Access to SMHS, DMC-ODS Policy Improvements, (2) Behavioral Health Documentation Requirements (SMHS, ODS), (3) No Wrong Door/Co-Occurring Treatment, (4) Standardized Screening and Transition Tools, (5) Payment Reform; (6) Administrative Integration, (7) Coding During Assessment, (8) Compliance, (9) Claiming, (10) MOU



Standards-Evolving DHCS FAQ

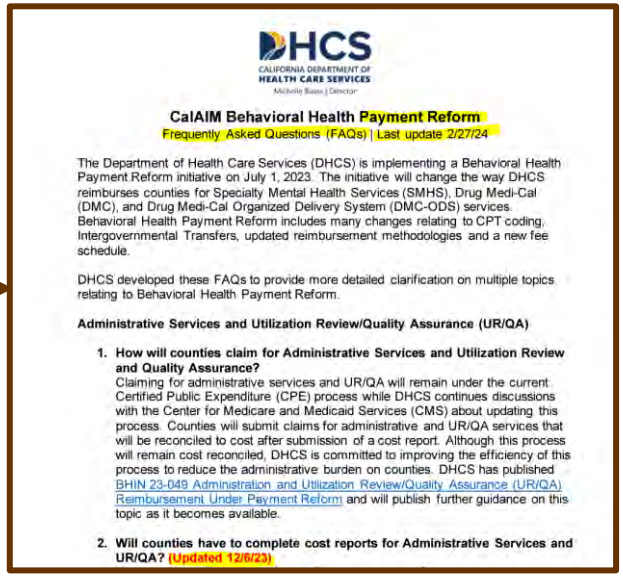
- **Documentation FAQ Subpage**
  - Heads Up - - difficult to discern if/when updates occur
    - Questions were collected by DHCS during webinars and TA events
    - This page is organized into about 5 domains
      - (1) Assessments, (2) Care Plans, (3) Progress Notes, (4) Service, Program, & Facility Requirements, (5) Other



Standards-Evolving DHCS FAQ

- **Payment Reform FAQ Subpage**
  - Heads Up - - difficult to discern if/when updates occur
    - This pdf document is organized into about 14 domains
      - (1) Administrative Services and UR/QA; (2) Acute Psych Inpatient Rates; (3) NTP Rates; (4) SUD Residential Rates; (5) Mobile Crisis Rates; (6) Rates; (7) General Billing and Coding; (8) Graduate/Student Billing; (9) Interpretation Services; (10) Collateral Services; (11) LVN-LPT in SMHS and ODS; (12) Non-Direct Patient Care Time; (13) Multiple Group Services; (14) New Provider Types

- CalAIM Behavioral Health Payment ReformFrequently Asked Questions (FAQs) - Revised 2/28/2024
  - Codes for New Providers



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CalAIM Behavioral Health Payment Reform
Frequently Asked Questions (FAQs) | Last update 2/27/24

The Department of Health Care Services (DHCS) is implementing a Behavioral Health Payment Reform initiative on July 1, 2023. The initiative will change the way DHCS reimburses counties for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Behavioral Health Payment Reform includes many changes relating to CPT coding, Intergovernmental Transfers, updated reimbursement methodologies and a new fee schedule.

DHCS developed these FAQs to provide more detailed clarification on multiple topics relating to Behavioral Health Payment Reform.

Administrative Services and Utilization Review/Quality Assurance (UR/QA)

1. **How will counties claim for Administrative Services and Utilization Review and Quality Assurance?**
   Claiming for administrative services and UR/QA will remain under the current Certified Public Expenditure (CPE) process while DHCS continues discussions with the Center for Medicare and Medicaid Services (CMS) about updating this process. Counties will submit claims for administrative and UR/QA services that will be reconciled to cost after submission of a cost report. Although this process will remain cost reconciled, DHCS is committed to improving the efficiency of this process to reduce the administrative burden on counties. DHCS has published BHIN 23-049 Administration and Utilization Review/Quality Assurance (UR/QA) Reimbursement Under Payment Reform and will publish further guidance on this topic as it becomes available.

2. **Will counties have to complete cost reports for Administrative Services and UR/QA?** (Updated 12/6/23)

STANDARDS

- **How to Think and Where to Look?**

  - In the absence of a published audit protocol from state and federal regulators…

    - Federal and state laws and concepts on Mistakes, Fraud, Waste Abuse
    - Federal and state agency rules for conditions of participation vs. payment
    - Managed care medical necessity concepts and practices
    - State contracts and state policy letters
    - State regulatory “frequently asked questions” websites

BHS Compliance Policies

Policy Name	Summary	Policy Shift and Impact
1. BHS Compliance: The Program, Plan, Committee and Unit	The document describes the compliance program (composed of Compliance Plan, Compliance Committee and Compliance Unit)	• No substantive change from FY23-24
2. Improper Payments (Including Overpayments Due to Mistakes and Health Care Fraud, Waste, Abuse): Definitions, Payment Monitoring/Auditing, Individual Provider Eligibility Screening and Disclosures Monitoring and Overall Reporting for Program Integrity	The document describes the BHS Compliance Unit's role as it relates to improper payments	• Operational definitions for mistakes, fraud, waste, abuse • Formal mechanism to communicate and report improper payments related to provider screening and/or monitoring
3. Routine Monitoring and Targeted Auditing for Improper Payments by BHS Compliance	The document describes the routine monitoring and targeted auditing of medical records for improper payments (including overpayments due to mistakes, fraud, waste and abuse)	• New agency-level model (was program-level) • Corrective Action Plans will be re-instituted (short- vs. long-term)
4. Individual Provider Enrollment, Screening and Credentialing Standards in Federal Insurance Programs	The document describes the standards for individual providers' eligibility and enrollment into DHCS Provider Enrollment (PAVE) and BHS' Prepaid Inpatient Hospital Plan	• Suspending credentialing when staff cannot meet eligibility • Mandated reporting related to fraud/waste/abuse and suspended credentialing
5. Procedure Coding Compliance in Federal Insurance Programs: Standards for Procedure Codes and Related Units of Time	The document describes the standards for individuals and organizations that submit claims for reimbursement in federal insurance programs	• BHS returns overpayments, including those resulting from an incorrect procedure code and/or an incorrect progress note narrative • Individual and organizational providers should have standard workflows that include the use of reports and communications issued by relevant areas of BHS

COMPLIANCE POLICIES

- **Same Concepts Aligned to Federal Language**
  - Terminology like “program integrity” and “provider enrollment” reflects language taken from federal guidance

- **Policies Reflect Practices**
  - Although these policies may not have existed before, these policy documents reflect our practices (e.g., the process for an agency to appeal a finding)

- **BHS’ Policy Committee**
  - BHS Compliance is a member of the BHS Policy Committee, facilitated by Quality Management

ENCLOSURES

- **BHS Compliance Overpayment Monitoring & Auditing Protocol**
- **FY24-25 Calendar**
- **BHS Compliance Memo – New Policies**
- **Example Tools to Support Audit Staff:**
  - Definitions of MFWA
  - Criteria for Medical Necessity and Access (SMHS/ODS)

QUESTIONS

- **Unsure if your question is for BHS Compliance?**
  - Let's clarify (could be SOC, CDTA, BOCC, QM, etc.)

- **Use MS Forms (URL or QR) to Submit Questions!**
  - Links expire Friday, 05/31/2024

https://forms.office.com/g/LFz2dK502n

WRAP UP & REMINDERS

- **BHS Compliance Unit Webpage on sf.gov**

  - We have a webpage on sf.gov!

  - **"Routine Monitoring & Auditing"** section includes these slides and video

  - **"Provider Credentialing & Screening"** includes updated information on who is required to obtain credentialing and also, how to get accounts for the EHRs

  - **"Communications & Education-Training"** will soon include the tools and technical assistance materials we are building!

WRAP UP & REMINDERS

- **BHS Compliance Program**
  - Compliance Officer (Joe Turner, joe.turner@sfdph.org)
  - Compliance Committee Co-Chairs (Joe Turner, Marlo Simmons, Max Rocha)
  - BHS Compliance (on sf.
  - Office of Compliance & Privacy Affairs Website
  - BHS Compliance Website

- **SFDPH Anonymous and Confidential Hotline**
  - 1-855-729-6040
  - compliance.privacy@sfdph.org

- **Always remember that SFDPH has a Non-Retaliation policy**
  - Employee Non-Retaliation Policy (Revised 5/24/23)
  - City/County Controller's Office Whistleblower webpage

THANK YOU TO OUR PARTNERS!

- **SMHS and DMC-ODS Agencies and Staff**
- **BHS Leadership & Management**
- **BHS Enabling Services**
- **Colleagues & Contributors**
  - BHS Compliance Present/Past (Andre Pelote, Carla Love-Washington, Claudia Pinto, Cynthia Chinn, Felicia Davis, Khoi Dang, Rita Wu, Su Mei Ma Teresita Francisco and Elaine Young, Joseph Gorndt, Diana Yee, Lourdes Holt, Matt Flores, Maria Anne Viray, Ei Ei Oliva)
  - OCPA (Maggie Rykowski, Garrett Chatfield, Joseph Gorndt, Catherine Argumendo)
  - BHS CYF (Lisa Hilley, Heather Clendenin LeMoine, Rebecca Matthews)
  - BHS Payment Reform (Wayland Bergman)
  - DPH Business Office of Contract Compliance (Jerna Reyes, Elissa Velez, Nick Hancock)
  - DPH Business Office (Michelle Ruggles)
  - Felton Institute (Jessica Benway, Monique Hamilton, Adrienne Abad Santos)
  - Baker Places Quality Management (Jeremy Tsuchitani-Watson)
  - ZSFGH Psychiatry (Mark Leary, Jessica Ross, Rupinder Kaur) and ZSFGH Care Coordination/Utilization Management (Reanna Mourgos, Jessica Middleton, Christina Fok)

Overview of Overpayment Monitoring & Auditing Protocol (FY24-25)

- BHS Compliance conducts monitoring/auditing activities to identify improper payments - - including overpayments due to mistakes, fraud, waste and abuse (MFWA). The goal is to implement an audit protocol that is tied to published guidance related to payment standards in federal insurance programs (e.g., minimum Medicaid standards, Medicare Conditions of Payment, etc.).

- The FY24-25 protocol evaluates five domains (color coded in the table below):
  - #1 - Procedure Code (six items, blue);
  - #2 - Diagnosis (three items, green);
  - #3 - Medical Necessity (two items, yellow);
  - #4 - Access (one item, gray);
  - #5 - Admissions, Authorizations, Certifications, Determinations, Directions, Identifications (6 items, pink).

Protocol Item	Standard to Meet	If Standard Not Met	Item Included Per
1. Does the procedure code appear in the DHCS-BHS guidance?	Yes – the code appears within the source documents	Reject the Claim and then, Check – does the narrative describe a different service?	Medicare, CFR42 424.5(a)(1) Types of Services
2. For the DHCS-BHS procedure code being claimed, does the narrative progress note contain sufficient information to meet the published DHCS-BHS definition?	Yes – the narrative aligns to definition from DHCS-BHS guidance and tools (service taglines)	Check – other evidence to support the "DHCS rule of thumb" (client had a need – provider in good faith) Otherwise-reject the claim	Medicare, CFR42 424.5(6) Sufficient Information
3. Does the procedure code requirement for staff type-scope have evidence of being met?	Yes – the provider type is listed for the procedure code	Check – staff credentialing label changes like OT (was MHRS), Peer (was MHW) Otherwise-reject the claim	Medicare, CFR42 424.5(a)(2) Source of Services
4. Does the procedure code requirement for a "direct patient care" component have evidence of being met?	Yes – the direct patient care (was "face to face") for the procedure code are correct	Reject the claim	Minimum Medicaid (CalAIM IN 23-068; DHCS Billing Manuals)
5. Does the procedure code requirement for units of time have evidence of being met?	Yes – the units are calculated correctly	Reject the claim and then, check – what is the correct math?	Minimum Medicaid (CalAIM IN 23-068; DHCS Billing Manuals)
6. Does the procedure code requirement for any prerequisite and/or "add on" (e.g., prolonged service procedure code)	If required, then yes – the prerequisite is established	Reject the claim	Minimum Medicaid (CalAIM IN 23-068; DHCS Billing Manuals)

Protocol Item	Standard to Meet	If Standard Not Met	Item Included Per
7. Does the diagnosis on the claim appear in the problem list-diagnosis record-assessment (date specific)	Yes – within the medical record, there is a diagnosis within a reasonable timeframe	Check – the diagnosis could be a "v code" or a traditional diagnosis. Otherwise-reject the claim	Medicare, CFR42 424.32(a) Basic Requirements for All Claims
8. Does the diagnosis on the claim have staff type-scope criteria met (dates matter)?	Yes, for the source used (problem list vs. diagnosis screen vs. assessment form) and the type of diagnosis (e.g., Z code vs. MH), the scope is met	Check – the diagnosis could be a "v code" or a traditional diagnosis. Otherwise-reject the claim	Medicare, CFR42 424.5(a)(2) Source of Services
9. Evidence of diagnosis (a restricted activity) has involvement of LMHP/LPHA	Yes—there should be evidence of LMHP/LPHA involvement for at least one of the following three domains: (1) current mental status, (2) medication history, and (3) assessment of relevant conditions and psychosocial factors	Check – is there evidence that MHRS, Peer, etc. collected psychosocial factors? Otherwise-reject the claim	Minimum Medicaid (CalAIM IN 23-068; California State Plan (Section 3, Attachment 3.1-A to Supplement 3)
10. Does the medical record contain evidence to demonstrate that a Medicaid beneficiary had a "need" per 23-068, 21-073, 24-001	Yes—there should be evidence of at least one of the following: • symptom • condition, • diagnosis, • risk factors • trauma (child) • impairment (distress, disability, dysfunction) • protect life • prevent significant illness • prevent significant disability • alleviate severe pain	Reject the claim	Minimum Medicaid (CalAIM; 23-068, 21-073, 24-001)
11. Does the progress note contain evidence to demonstrate an Medicaid provider delivered an activity that was intended to reduce a "need"	Yes – the narrative aligns to definition from DHCS-BHS guidance and tools (service taglines)	Check – other evidence to support the "DHCS rule of thumb" (client had a need – provider in good faith) Otherwise-reject the claim	Minimum Medicaid (CalAIM; 23-068, 21-073, 24-001)
12. Does the medical record contain evidence of: a. Adult SMHS b. Adult ODS c. Child SMHS d. Child ODS e. Child EPSDT	Yes – evidence for SMHS and EPSDT (23-075) and ODS and EPSDT (24-001)	Check – other evidence to support the "DHCS rule of thumb" (client had a need – provider in good faith) Otherwise-reject the claim	Minimum Medicaid (CalAIM IN 23-068; California State Plan (Section 3, Attachment 3.1-A to Supplement 3)

Protocol Item	Standard to Meet	If Standard Not Met	Item Included Per
13. Admissions: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	Yes—within the record, evidence of the activity should be present	Check and consult with subject matter expert for programmatic vs. reimbursement requirements	Service Specific (e.g., 42CFR, Part 8, §8.12 for NTP)
14. Authorization: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	Yes – the authorization form is present, valid and includes the procedure code and units of time for the claimed procedure code. It's signed by someone who can sign UM	Check – if the form is not present, ask the provider if the authorizing body can provide a copy of the authorization form. Also, check with subject matter experts in this specialized area (e.g., UM)	Service Specific
15. Certifications: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	Yes – the (re)certification statement is signed by required staff	Check – how does the agency capture certification requirements in the medical record? Check and consult with subject matter expert for programmatic vs. reimbursement requirements	Service Specific
16. Determinations: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	Yes – the DMC-ODS LOC document/form is present, signed and dated.	Check – how does the agency capture this in the medical record? Check and consult with subject matter expert for programmatic vs. reimbursement requirements	Service Specific
17. Directions: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	For the given service (TCM, NTP, TBS, Medication) and the timeframe (initial, periodic update), the chart contains evidence.	Check – how does the agency capture this in the medical record? Check and consult with subject matter expert for programmatic vs. reimbursement requirements	Service Specific
18. Identifications: (A) Staff-specific activities; (B) Sufficient information;(C) Signatures and dates	Yes – evidence that screening was conducted as part of early identification and/or prevention	Check – how does the agency capture certification requirements in the medical record? Check and consult with subject matter expert for programmatic vs. reimbursement requirements	Service Specific

BHS Compliance Monitoring and Auditing Program:
Calendar (Expected) for FY24-25 - - Updated 05/15/2024

Overview and Monitoring/Auditing Calendar (Expected) for FY24-25

- BHS Compliance conducts monitoring/auditing activities to identify improper payments - - including overpayments due to mistakes, fraud, waste and abuse (MFWA). Annually, the goal is to audit every BHS-funded agency that submits reimbursement for federal insurance programs (Medicaid, Medicare, CHIP, etc.).

- The expected calendar of for FY24-25 appears below - - BHS Compliance will edit and change this calendar as needed to meet the federal and state obligation to prevent, detect and remediate non-compliance with healthcare laws and regulations related to areas including but not limited to MFWA.

Month and Year of Audit*	Agency Name
July 2024	1. YMCA 2. ZSFGH Acute Inpatient Psych Hospital 3. Swords to Plowshares
August 2024	4. A Better Way (ABS) 5. A Woman's Place 6. Alternative Family Services (AFS) 7. Center on Juvenile & Criminal Justice (CJCJ) 8. Conard House 9. Curry Senior Center
September 2024	10. Episcopal Community Services (ECS) 11. Baker Places 12. Bayview Hunters Point Foundation (BVHPF) 13. Victor Treatment Center
October 2024	14. Community Youth Center (CYC) 15. McAuley/Dignity Health/St. Mary's Medical Center 16. Edgewood Center for Children and Families 17. Epiphany Center San Francisco (Mount St. Joseph/St. Elizabeth)
November 2024	18. Felton Institute 19. Fort Help
December 2024	20. Richmond Area Multi Services (RAMS) 21. Safe and Sound 22. San Francisco AIDS Foundation (SFAF)
January 2025	23. Homeless Children's Network 24. HR 360
February 2025	25. City & County of San Francisco 26. Friendship House Association of American Indians of San Francisco

Month and Year of Audit*	Agency Name
March 2025	27. Horizons Unlimited 28. BHS Private Provider Network (PPN) 29. Progress Foundation
April 2025	30. University of California, San Francisco (UCSF) 31. BAART BayMark Health Services
May 2025	32. Catholic Charities 33. Huckleberry Youth Programs 34. Hyde Street Community Services 35. Instituto Familiar de la Raza (IFR) 36. Mission Council on Alcohol Abuse
June 2025	37. Seneca Family of Agencies 38. The Latino Commission 39. Westside Community Services 40. Jewish Family and Children's Services 41. Occupational Therapy Training Program (OTTP) 42. HomeRise (Community Housing Partnership)

***** *Notes*:

1. Red font = changes/editions made on 05/15/2024 by BHS Compliance
2. Agencies submit medical records to BHS Compliance electronically about one month before the actual audit.

San Francisco Department of Public Health
Behavioral Health Services
1380 Howard Street, San Francisco, CA 94103

San Francisco Department of Public Health
Office of Compliance and Privacy Affairs
Behavioral Health Compliance Unit
1380 Howard St, San Francisco, CA 94103

BHS Compliance Unit Memo

TO	All individuals associated with Behavioral Health Services' (BHS') implementation of federal insurance programs (including but not limited to Medicaid, Medicare, and the Children's Health Insurance Program)
FROM	Joseph A Turner, PhD, BHS Compliance Officer
CC	BHS Executive Team, SFDPH Office of Compliance and Privacy Affairs
DATE	June 2, 2024
RE	Announcing new and/or updated policies published by the BHS Compliance Unit

Purpose:

The purpose of this memo is to announce the publication of new and/or updated policies and related standards. In addition, this memo reminds all individuals of their legal, ethical and professional obligations related to program integrity, improper payments, provider enrollment, and health care mistakes, fraud, waste and abuse.

Background/Context:

Behavioral Health Services functions as both a Prepaid Inpatient Health Plan (PIHP, a type of Medicaid Managed Care Organization) and also as a network of behavioral health care practitioners, clinics and facilities (part of the "San Francisco Health Network," along with county operated health clinics). Within both of these spheres, all individuals associated with the implementation of federal insurance programs must do so with honesty, integrity and fidelity to the Conditions of Participation and Conditions of Payment. The BHS Compliance Unit implements program integrity efforts specific to improper payments, provider enrollment, and health care mistakes, fraud, waste and abuse.

Action Items/Timelines:

The policies attached here effective the date of publication. These policy documents are being posted to the BHS Policy Website.

A summary of the policies is provided below for your convenience—***but within the next 30 days***, you should read the documents with sufficient detail to understand the standard you (your organization) are held to, as well as the implications to you (your organization) for non-compliance with the standards described.

Policy Name	Summary	Policy Shift and Impact
1. BHS Compliance: The Program, Plan, Committee and Unit	The document describes the compliance program (composed of Compliance Plan, Compliance Committee and Compliance Unit)	• This is a new policy • No substantive changes made to the Compliance Plan document (from FY23-24 to FY24-25)
2. Improper Payments (Including Overpayments Due to Mistakes and Health Care Fraud, Waste, Abuse): Definitions, Payment Monitoring/Auditing, Individual Provider Eligibility Screening and Disclosures Monitoring and Overall Reporting for Program Integrity	The document describes the BHS Compliance Unit's role as it relates to improper payments	• This is a new policy • Describes the program integrity requirements for BHS overall • Describes the formal mechanism to communicate and report improper payments related to provider screening and/or monitoring
3. Routine Monitoring and Targeted Auditing for Improper Payments by BHS Compliance	The document describes the routine monitoring and targeted auditing of medical records for improper payments (including overpayments due to mistakes, fraud, waste and abuse)	• This is a new policy • Communicates the standards and processes related to monitoring and auditing
4. Individual Provider Enrollment, Screening and Credentialing Standards in Federal Insurance Programs	The document describes the standards for individual providers' eligibility and enrollment into DHCS Provider Enrollment (PAVE) and BHS' Prepaid Inpatient Hospital Plan	• This is a substantial update to an existing policy (published by BHS on 10/02/23) • BHS Compliance relies on primary source verification that is conducted by state and Federal licensing, certification and/or registration boards
5. Procedure Coding Compliance in Federal Insurance Programs: Standards for Procedure Codes and Related Units of Time	The document describes the standards for individuals and organizations that submit claims for reimbursement in federal insurance programs	• This is a new policy • Communicates the requirement to use the correct procedure code and related units of time for reimbursement

Overview and Tool (Definitions for Mistakes, Fraud, Waste and Abuse)

- BHS Compliance conducts monitoring/auditing activities to identify improper payments - - including overpayments due to mistakes, fraud, waste and abuse (MFWA)'

- Tools have been developed to support staff as they implement the review protocol. In an attempt to continually evaluate "mistakes, fraud, waste and abuse" – the table below provides a snapshot of information and citations.

Terminology	BHS Implementation Definition	Overview of Guidance
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	Any payment that should not have been made…and includes any payment for an ineligible good or service [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	Any funds that a person receives….to which the person…is not entitled [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	Actions that lead to errors (e.g., incorrect coding that is not wide spread) [MLN Booklet (January 2021) Medicare Fraud & Abuse: Prevent, Detect, Report]

Terminology	BHS Implementation Definition	Overview of Guidance
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	An intentional deception (scheme, artifice) or misrepresentation (false statements)… that…could result in some unauthorized benefit [CFR42 §455.2]. …any of the money or property owned by, or under the custody or control of, any health care benefit program [USC18 §1347]. …sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets… 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)]. …it includes any act that constitutes fraud under applicable federal or state law [CA WIC §14043.1]. 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 [CMS Internet Only Manual #100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 1 – General Overview]. Examples can include: (1) Billing for services that were not furnished, like for appointments that the patient failed to keep; (2) Altering claims forms and/or receipts in order to receive a higher payment amount: (3) Duplicating billings to receive payment greater than allowed; (4) 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; (5) falsely representing the nature of the services furnished (like describing a noncovered service in a misleading way that makes it appear as if a covered service was actually furnished); (6) billing a person who has insurance coverage for services provided to another person not eligible for coverage. [CMS Internet Only Manual #100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 1 – General Overview].
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	Misuse of services (overutilization) or other practices that result in unnecessary costs…waste is not seen as *criminal negligence* [CMS Internet Only Manual #100-16, Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines].

Terminology	BHS Implementation Definition	Overview of Guidance
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	Practices that are (1) inconsistent with *sound fiscal/business or medical practices*, and/or (2) result in an unnecessary cost to the insurance program, or (3a) result in in reimbursement for services that are not medically necessary or (3b) that fail to meet *professionally recognized standards* for health care [CFR42 §455.2]. …services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care [CA WIC §14043.1]. … three standards that CMS uses when judging whether abusive acts in billing were committed against the Medicare program: (1) Reasonable and necessary; (2) Conformance to professionally recognized standards; and (3) Provision at a fair price. Examples can include: (1) Charging in excess for services, (2) providing medically unnecessary services, (3) providing services that do not meet professionally recognized standards, (4) billing one insurance based on a higher fee schedule than another; (5) violating the participating physician/supplier agreement. [CMS Internet Only Manual #100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 1 – General Overview].

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Overview of Access & Medical Necessity Grid

- The Overpayment Monitoring/Auditing Protocol evaluates both access and medical necessity domains using guidance from 21-073 (SMHS, published 12/10/2021) and 24-001 (DMC-ODS; published 12/21/2023);
- As seen in the table below, SMHS and ODS have the same criteria for Medical Necessity - - but different criteria for Access.

Age	MEDICAL NECESSITY - - SMHS VS. ODS		ACCESS - - SMHS VS. ODS	
	SMHS	**ODS**	**SMHS**	**ODS**
21 and older (Adult)	• Service is medically necessary/necessity "when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain" (Page 2 of IN# 21-073)	• Service is medically necessary/necessity "when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain" (Pages 5-6 of IN# 24-001)	• Both the "impairment" and "disorder" (Page 3 of IN# 21-073) o Impairment (either current/significant or maintenance/risk of deterioration) ▪ Distress, disability, dysfunction o Disorder ▪ either diagnosed or "suspected and not yet diagnosed"	• For Access, after the assessment, diagnosis is the criteria (Page 7 of IN# 24-001) o Either ▪ Current diagnosis ▪ Per SUD history, a diagnosis prior/during incarceration
Under 21 (Child)	• Section 1396d(r)(5) of Title 42 of the United States Code • provide "all Medicaid-coverable services necessary to correct or ameliorate a mental illness-condition discovered by a screening service" (Pages 2-3 of IN# 21-073	• Section 1396d(r)(5) of Title 42 of the United States Code • provide "all Medicaid-coverable services necessary to correct or ameliorate a mental illness-condition discovered by a screening service" (Page 6 of IN# 24-001)	• Either "high risk for disorder" or four-impairment criteria (Page 4 of IN# 21-073) o High risk for mental health disorder due to trauma (Child Welfare, Juvenile Justice, Homeless, Score on a standard measure) o Impairment (the "four impairment pathways" including EPSDT)	• For access, after the assessment, EPSDT is the criteria (Section 1396d(r)(5) of Title 42 of the United States Code) • provide "all Medicaid-coverable services necessary to correct or ameliorate a mental illness-condition discovered by a screening service" (Page 8 of 24-001)