



JEFFERSON
BEHAVIORAL
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Jackson, Josephine, and Klamath Counties

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Fraud & Abuse Policy & Procedure

Board Approved – 01/26/09

State Approved – 03/14/09

JBH POLICY & PROCEDURE

Fraud and Abuse

Approved by JBH Board of Directors: 01/26/09

Approved by State of Oregon – DHS/AMH: 03/14/09

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I. POLICY DESCRIPTION

The purpose of this policy is to ensure that Jefferson Behavioral Health, its Contractors and Subcontractors reduce the potential risk for fraud and abuse, as well as detect and report current acts of fraud and abuse on an ongoing basis in relation to the Oregon Health Plan.

JBH complies with Federal and State fraud and abuse prevention and detection regulations as they relate to the Oregon Health Plan (OHP). This may include operational policies and controls in areas such as claims, prior authorization, utilization management and quality review, grievance resolution, provider credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities. JBH shall review its fraud and abuse policies on an annual basis.

II. APPLICABILITY

For the purposes of this policy, the term Jefferson Behavioral Health (JBH) includes the Jefferson Behavioral Health staff and its authorized representatives. JBH shall follow this policy as it applies to the OHP mental health services governed by the OHP Mental Health Organization Contract between the State of Oregon and JBH. Contractors and subcontractors follow this policy to the extent that it applies to the mental health services that they provide to JBH Members. The responsibilities outlined in this policy shall also include, but not be limited to, the Local Mental Health Authorities (LMHA) in the JBH service area, and any agency delegated with the responsibility for managing non-inpatient mental health services for JBH members in the LMHA's county.

III. DEFINITIONS

The following are key terms that relate to and/or support this procedure:

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to JBH or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. An example of abuse may include submitting claims for services that are not medically necessary. It also includes OHP Member or Recipient practices that result in unnecessary cost for JBH or OHP. (OAR 410-120-0000 (2) and 42 CFR 455.2.

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Conviction or convicted – A judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

Exclusion – Oregon Health Plan will not reimburse a specific Provider who has defrauded or abused OHP for items or services that Provider furnished.

False Claims Act (31 USC 3729-3733) – This law provides for penalties and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims for government funds, such as Medicaid funds. Under this law's *quid tam* provisions, an individual with evidence of fraud, also known as a "whistleblower" is authorized to file a case in federal court and sue, on behalf of the federal government, persons or entities engaged in fraud and to share in any money that the government may recover.

Fraud – 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. Examples of fraud may include billing for services that were not provided, altering claim forms to obtain a higher payment amount, and paying for a referral (offering a kickback).

Oregon Whistleblower Law (ORS 659A.200-224) – It is against the employment practice law for a public employer to prohibit any employee from disclosing, or take or threaten to take disciplinary action against an employee for the disclosure of any information the employee reasonably believes is evidence of a violation of any federal or state law, rule or regulation by the state, agency or political subdivision; or mismanagement, gross waste of funds or abuse of authority or substantial and specific danger to public health and safety resulting from action of the state, agency or political subdivision; or the fact that a person receiving services, benefits or assistance from the state or agency or subdivision is subject to a felony or misdemeanor warrant for arrest. It is also unlawful for a public employer to require any employee to give notice prior to making or disclosure or engaging in any of the items listed in the previous sentence. The same is true for discouraging, restraining, dissuading, coercing, preventing or otherwise interfering with disclosure or discussions related to the employee's belief about a violation.

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Prohibited kickback relationships – Remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 C.F.R. § 1001.951.

Program Fraud Civil Remedies Act (31 USW 3801-3812) – Under this law known as a remedy for false claims and statements, anyone who makes, presents or submits (or causes to be made, presented or submitted) a claim to the federal government, such as for Medicaid funds, that the person knows or has reason to know is false, fictitious or fraudulent, or that omits a material fact, is subject to penalty of up to \$5,000 per claim, plus an assessment of up to twice the amount of each false or fraudulent claim. The US Inspector General investigates violations of this law. Enforcement can begin with a hearing before an administrative law judge. The government can recover penalties by a lawsuit or through an administrative offset against “clean” claims.

Suspension – DMAP will not reimburse a specified Provider who has been convicted of a program-related offense in a federal, state or local court for items or services that Provider furnished.

IV. FRAUD & ABUSE LAWS

JBH adheres to and requires all contractors to adhere to all provisions of the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under sections 3801 through 3812 of Title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

Such Oregon laws shall include the following: ORS 411.670 to 411.690 (submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery); ORS 646.505 to 646.656 (unlawful trade practices); ORS chapter 162 (crimes related to perjury, false swearing and unsworn falsification); ORS chapter 164 (crimes related to theft); ORS chapter 165 (crimes related to fraud or deception), including, but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments); ORS 166.715 to 166.735 (racketeering-civil or criminal); ORS 659A.200 to 659A.224 (whistle blowing); ORS 659A.230 to 659A.233 (whistle blowing);

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OAR 410-120-1395 to 410-120-1510 (program integrity, sanctions, fraud and abuse); and common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses. JBH and its contractors may be subject to additional fraud and abuse laws not listed above.

V. JBH COMPLIANCE PROCEDURES

A. JBH & Contractors Prevention & Detection Activities

1. JBH & Contractors activities to prevent and detect fraud and abuse include, at minimum, the following:
 - a. Written policies, procedures, and standards of conduct that articulate JBH & Contractor's commitment to comply with all applicable Federal and state standards to guard against fraud and abuse. The Fraud & Abuse Prevention, Detection & Monitoring Policy is reviewed and updated by the organization on an annual basis.
 - b. Employee Handbooks are reviewed and updated annually. JBH & Contractor's Employee Handbooks include:
 - 1) a description of the laws referenced in this Policy
 - 2) a description of JBH's Policies and Procedures related to the prevention and detection of fraud and abuse
 - 3) a description of the authority of OHP or any health oversight agency or law enforcement entity to fully exercise its legal authority or to pursue legal recourse to the full extent of the law
 - 4) the rights of employees to be protected as whistleblowers
 - 5) the organization's commitment to guard against fraud and abuse
 - 6) a description of the organization's fraud & abuse program
 - 7) a list of disciplinary guidelines for actions that constitute fraud and abuse

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- 8) clear procedures for reporting fraud and abuse
- 9) an expectation that employees disclose any conflicts of interest relating to the provision and payment of OHP services
- c. JBH & Contractors carefully certify and re-certify provider organizations and each mental health service provider; conduct site reviews of each contracted provider and audits a random sample of treatment records including a review of claims paid data.
- d. JBH & Contractors maintain a quality assurance and review process requirement for each contractor and a process for filing grievances.
- e. JBH contracts with an administrative organization to pay claims and submit encounters for all JBH providers. A part of this contract includes running a series of reports that analyze data to determine whether there are any trends or patterns that might be indicative of fraud or abuse.
- f. JBH and Contractors maintain procedures to promptly repay Medicaid funds paid in error, and to correct the corresponding billing data.
- g. JBH & Contractors each designate a Compliance Officer and a Compliance Committee that are accountable to the senior management to monitor fraud and abuse activities.
- h. JBH & Contractors ensure that effective training and education is provided to the Compliance Officer, Compliance Committee and staff involved in the development and submission of claims.
- i. Effective lines of communication exist between the Compliance Officer, Compliance Committee and the organization's employees;

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- j. Enforcement of standards that guard against fraud and abuse through guidelines included in each Provider's contract. The contractual language states that JBH shall monitor a contracted Provider's delivery of Services and promptly report to DHS or AMH and provider when JBH identifies a major deficiency in a Provider's delivery of a Service or in a contracted Provider's compliance with this Contract. JBH shall promptly take all necessary action to remedy any identified deficiency. JBH shall also monitor the fiscal performance of each Provider and shall take all lawful management and legal action necessary to pursue this responsibility. In the event of a Major deficiency in a contracted Provider's delivery of Services or in a Provider's compliance with any contractual agreement, nothing shall limit or qualify any right or authority of DHS, AMH or JBH under state or federal law to take action directly against a contracted Provider. JBH shall ensure that each contracted Provider conducts an end of the year audit of which a copy is sent to JBH for review.
- k. Provision for internal monitoring and auditing-including appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, eligibility data, and related resources that could be used to facilitate fraud or abuse.
- l. Provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the MHO Agreement.
- m. Services may not be provided by the following persons or their affiliates:
 - 1) Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations

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issues pursuant to Executive Order No. 12549 or under guidelines implementing such order,

- 2) Persons who are currently excluded from Medicaid participation under Section 1128 or Section 1128A of the Act.
 - n. JBH & Contractors shall not refer OHP Members to such persons, as identified in Item m. 1. above, and shall not accept billings for services to OHP Members by such persons.
 - o. JBH & Contractors may not knowingly have a person described in Item m. 1. above as a Director, Officer, Partner, or person with beneficial ownership of more than 5% of organization's equity, or have an employment, consulting, or other agreement with a person for the provision of items and services that are significant and material to the organization's obligations.
 - p. Procedures for JBH & Contractors to report cases of suspected fraud or abuse involving Medicaid funds to the Medicaid Fraud Control Unit or the DHS Fraud Investigation Unit.

B. COMPLIANCE OFFICER AND COMMITTEE

1. Compliance Officer
 - a. JBH and each Contractor designates an individual as the Fraud & Abuse Compliance Officer who is accountable to senior management.
 - b. Responsibilities include, but are not limited to, the following:
 - 1) Receive training on, and maintain current knowledge of, the federal and state laws and regulations regarding fraud and abuse;

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- 2) Establish and implement a clear and accessible process for any individual to bring concerns or evidence of fraud or abuse to the attention of the Compliance Officer or Committee Member;
- 3) Ensure compliance with the organization's program to prevent and detect fraud and abuse, including training staff about the disciplinary process for those involved in fraud or abuse;
- 4) Disseminate written information and provide guidance to employees and contractors about the program;
- 5) Maintain records of cases reported to the organization;
- 6) Submit any required reports to JBH;
- 7) Serve as a point of contact for cases referred to JBH, the MFCU and the DHS Fraud Investigation Unit;
- 8) Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MHO Contract.

2. Fraud and Abuse Compliance Committee

- a. The Committee consists of the Compliance Officer, and others appointed by the organization's director.
- b. The Committee meets a minimum of four times a year to discuss and review cases reported as suspected fraud or abuse to make recommendations about technical assistance, process improvements, and/or corrective actions necessary for JBH and/or Contractors to fully comply with federal and state laws and/or meet their contractual obligations.

C. REPORTING OF FRAUD AND ABUSE

1. JBH & Contractors shall promptly refer all verified cases of fraud and abuse, including fraud by employees and subcontractors to the Medicaid Fraud Control Unit (MFCU). JBH & Contractors may also refer cases of suspected fraud

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and abuse to the MFCU prior to verification. Examples of cases that should be referred:

- a. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records.
 - b. Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the clinical records.
 - c. Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring compliance rating or collecting Medicaid payments not otherwise due.
 - d. Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP Members.
 - e. Providers who intentionally fail to render medically appropriate covered services to OHP Members.
 - f. Providers who knowingly charge OHP Members for services that are covered or intentionally bill a DMAP Member the difference between the service charge and Contractor's payment, in violation of DHS rules.
 - g. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
2. An incident with any of the referral characteristics listed above should be referred to the MFCU. JBH & Contractors may also refer cases of suspected fraud and abuse to the MFCU.

Medicaid Fraud Control Unit
1515 SW 5th Avenue, Suite 410
Portland, OR 97201
Phone: 971-673-1880

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FAX: 971-673-1890

Website:

http://www.doj.state.or.us/divisions/civil_enforcement_index.shtml

3. Incidents of verified or suspected fraud or abuse by an OHP Member should be reported to DHS Fraud Investigation Unit.

DHS Fraud Investigation Unit

P.O. Box 14150,

Salem, Oregon 97309-5027

Phone: 503- 378-6826,

Fax: 503-373-1525

Website:

<http://www.oregon.gov/DHS/aboutdhs/fraud/>

4. JBH & Contractors promptly report all fraud and abuse as required under this section to the MFCU. JBH also notifies AMH of referrals to the MFCU of complaints of fraud and abuse that warrant investigation. Contractors notify JBH of referrals to the MFCU. This notification shall include the following information:
 - a. Provider's name and address
 - b. Involved Oregon Medicaid Number(s)
 - c. Type of Provider
 - d. Source of complaint
 - e. Nature of complaint
 - f. The approximate range of dollars involved
 - g. The disposition of the complaint when known.
5. JBH & Contractors cooperate with the MFCU and the DHS Fraud Unit and allow the MFCU, DHS Fraud Unit and JBH to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse.
6. In the event that JBH or Contractors report suspected fraud, or learn of an MFCU or DHS Fraud Unit investigation, JBH & Contractors shall not notify or

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otherwise advise its subcontractors of the investigation so as not to compromise the investigation.

D. CORRECTIVE ACTION

1. JBH & Contractors may determine that it is necessary for an employee to go through disciplinary action in order to fully comply with laws and rules to prevent and detect fraud and abuse and/or meet contractual responsibilities. Disciplinary or Corrective Actions outlined in the organization's Employee Handbook would be followed accordingly.
2. JBH & Contractors may determine that it is necessary for a Contractor to go through disciplinary or corrective action due to acts of fraud and abuse. The disciplinary or corrective action process described in the JBH Credentialing and Re-Credentialing Policy would be implemented. If the action of the Contractor was such that termination would occur, the process described in the JBH Contract for termination with cause would be implemented.

E. COOPERATION WITH FRAUD AND ABUSE INVESTIGATIONS

JBH & Contractors shall provide access to records and cooperate with activities consistent with the MHO Contract, Exhibit B-Part IV-Relationship of Parties, on record keeping and government access to records. Right of access is provided to Centers for Medicaid & Medicare Services, the Inspector General of the United States, the Oregon Secretary of State, the Oregon Department of Justice Medicaid Fraud Control Unit, DHS and all their duly authorized representatives to facilities, financial records, clinical and personnel records, books, documents, papers, plans and writings of JBH & Contractors related to the fraud and abuse examination and audit. All records and items listed above are kept accessible for a minimum of five years or longer for financial records and seven years for clinical records

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as required by applicable laws, following the final payment and termination of the MHO Agreement between the State of Oregon and JBH, or until the conclusion of any audit, controversy or litigation arising out of or related to the MHO Agreement, whichever date is later. JBH & Contractors provide a suitable work area and copying capabilities to facilitate such a review or audit.