Behavioral Health Compliance Office
Compliance Corner

Department of Public Health
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COMPLIANCE

The ABC's of OIG Exclusion List Monitoring

Featured, OIG February 26, 2018 by Michael Rosen, Esq.
Article from: **https://www.providertrust.com/blog/the-abc-s-of-oig-exclusion-monitoring/**

Understanding the HHS Office of Inspector General (OIG) exclusion list is essential to your path towards 100% compliance and better employee monitoring for healthcare Human Resource professionals. Since federal tax dollars are used to reimburse healthcare providers for services, the Department of Health and Human Services (HHS), as well as the Department of Justice (DOJ), have oversight on how those dollars are spent.

What is an OIG Exclusion and Why Should You Care?

An OIG exclusion is an administrative action taken against an individual or entity (such as a provider or vendor) by the Dept. of Health and Human Services (HHS), Office of Inspector General (OIG). The DHHS OIG is in charge of enforcing exclusions against individuals or entities.
***The OIG mandates that healthcare organizations do not hire or do business with "excluded or sanctioned" individuals or entities. If an individual or entity is excluded, he/she/it is prohibited from participating in reimbursements for or from federally funded healthcare programs (CMS.gov – Centers for Medicare & Medicaid Services*).**
Once an individual or entity is excluded, he/she/it is considered excluded in all states, not just the one excluded in. In other words, under the Affordable Care Act, an individual or entity excluded in one state is not permitted to participate in federal healthcare funds in all other states. A person or entity can be excluded by a federal agency (OIG) or by a state Medicaid agency.

What are the Penalties for Allowing Services to be Performed by and Billed to Medicare and Medicaid by an Excluded Individual or Entity?
Civil fines and monetary penalties can be assessed by the OIG. Fines and penalties include the following:

1. $10,000 per each item claimed or services provided
2. Treble (3 times the amounts claimed to CMS for reimbursement) damages
3. Possible program exclusion of the company
4. Possible loss of the right to bill CMS for services rendered
5. Possible additional fines for filing false claims under the False Claims Act (Penalties up to $11,000 per claim, and possible placement in a Corporate Integrity Agreement with the OIG).
6. Possible criminal fines and/or jail time.

Where did Healthcare Exclusions Come From?
Since the early 1970's, the Department of Health and Human Services (HHS), Office of the Inspector General (OIG) has the authority and responsibility "to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries". The OIG is acting in the people's best interest to regulate and enforce violations of healthcare fraud, waste, and abuse.
The OIG was created in 1976 and oversees more than 300 other HHS programs. The most common and well known are Medicare, Medicaid, TriCare, and CHIPs. Others include the Centers for Disease Control and Prevention, National Institutes of Health, and the Food and Drug Administration. The OIG for HHS is the largest Inspector General's office in the federal government, with approximately 1,600 employees. The current **Inspector General for HHS is Daniel Levinson**.

What Does the OIG Govern?
There are 11 departments in the HHS OIG organization: They revolve around auditing, investigating, enforcement, evaluating, and policy making. For the purpose of this blog, we'll be addressing the enforcement function of the OIG.
There are three departments that focus on the enforcement of health care fraud, waste, and abuse.

1. **Office of Investigations** (OI) which conducts criminal, civil and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries.
2. **Office of Audit Services** (OAS) which conducts independent audits of HHS programs, grantees, and contractors to examine the performance of HHS programs and responsibilities, as well as provide assessments.
3. **Office of Evaluation and Inspections** (OEI) which conducts national evaluations of HHS programs and issue recommendations focused on preventing fraud, waste, and abuse.

The ABC's of OIG Exclusion List cont. from page 1

What is an OIG Exclusion List?

A person or entity becomes excluded or sanctioned and placed on an exclusion list maintained by the OIG called the **List of Excluded Individuals or Entities (LEIE)**. According to OIG, there are two types of exclusions – mandatory and permissive.

Mandatory Exclusions

- Felony conviction for substance abuse or alcohol
- Felony conviction for patient abuse
- Felony conviction for fraud and abuse
- Felony conviction for sexual assault
- License revocation due to any of the above

Permissive Exclusions

- Misdemeanor convictions for substance abuse or alcohol
- Misdemeanor convictions for patient abuse
- Misdemeanor convictions fraud and abuse
- Misdemeanor convictions sexual assault
- License revocation due to any of the above
- Default on a federal student loan

Federal reimbursement, whether direct or indirect, for goods provided or services rendered by an excluded individual or entity, is prohibited. This includes reimbursement for salaries, benefits or items claimed/billed by licensed healthcare providers or administrative personnel. Also, a healthcare organization cannot purchase goods or services from an entity or vendor that is excluded.

A ***mandatory exclusion*** is for a minimum of 5 years and has been imposed for up to 50 years, in certain cases (it can be indefinite if the facts warrant). Once the exclusion period ends, **the individual or entity MUST apply for reinstatement** at the federal and state level. It is not automatic.

A ***permissive exclusion*** can be up to 5 years (typically 1-3 years). At the conclusion of the exclusion period, the individual or entity MUST apply for reinstatement at the federal and state level. It is NOT automatic.

Federal Datasets of Excluded Individuals and Entities for Healthcare

There are 2 main Federal exclusion lists and 42 available state Medicaid exclusion list. All of these exclusion lists need to be individually cross-checked and monitored on a monthly basis in order to remain compliant.

List of Excluded Individuals and Entities (LEIE) - These are individuals and/or entities that are currently excluded from healthcare participation likely due to an offense related to fraud and/or abuse. This list is maintained by the OIG.

General Services Administration -Excluded Parties List System (GSA-EPLS)-An individual or entity can be debarred or sanctioned at the GSA-EPLS. This is the Federal entity that excludes companies and individuals from receiving Federal contracts. GSA-EPLS administers all procurement databases through the System for Award Management (SAM).

System for Award Management (SAM) - The purpose of SAM is to prevent companies from doing business with an individual or entity that has been debarred, sanctioned, or excluded by a Federal Agency. SAM houses the GSA-EPLS list, which contains debarment actions taken by various Federal Agencies, including exclusion actions taken by the OIG.

State Medicaid Fraud Control Units (MFCU) - This is the State Medicaid Exclusion List. Individual States maintain a MEDICAID Exclusion List. Employers need to search these in addition to the OIG LEIE and the SAM.gov. Currently, there are 42 states that have a Medicaid exclusion list. Each year, more state Medicaid exclusion lists are added and made publicly available.

How Often are Records Updated at the Primary Source?

Federal Exclusion Datasets: The OIG-LEIE list is updated once a month, typically between the 10th and 15th. Each week, the SAM.gov database is updated from multiple sources. There is no designated time in which exclusion data is uploaded into SAM.gov.

State Medicaid Exclusion Lists: Each state updates at different intervals. Some update once a month, others once a quarter, and others update periodically.

How Often Should an Employer Monitor for Exclusions?

Monthly Monitoring is Best Practice

Daniel Levinson, HHS OIG Inspector General has stated: "The OIG updates our list monthly and we recommend that employers search and monitor prior to hire and on a monthly basis thereafter."

The Affordable Care Act (ACA), expanded the types of actions that can result in an exclusion and the U.S. Congress tasked the Centers for Medicare and Medicaid Services (CMS) to issue guidance to employers, that employers search the OIG LEIE and GSA-EPLS prior to hire and monthly thereafter, including MFCU, Licensing Boards, DEA, NPPES, National Practitioner Data Bank, Social Security Death Master List, etc. CMS issued letters to each State Medicaid Director in 2009 reminding them to advise employers to do monthly monitoring.

Many states have issued state Medicaid bulletins that require prior to hire and monthly monitoring of the OIG LEIE, SAM, Licensing, DEA, MFCU, NPPES, National Practitioner Data Bank, Social Security Death Master List, etc. Healthcare providers must monitor their staff, contractors, and vendors for exclusion each month. The OIG is serious about enforcing, penalties, and sanctions for violations.

SUBSTANCE USE

SFDPH BHCO DMC ODS Reasons for Recoupment

Written by: Joseph Gorndt, DPH OCPA Assistant Auditor. March 2019.

As our providers who also work in Specialty Mental Health probably know, DHCS issues an annual breakdown of the reasons that they will recoup payments when they review a program, and we here in the Behavioral Health Compliance Office base our audits on the same criteria. Unfortunately, the state does not issue an equivalent list for Substance Use Disorder providers who are enrolled in the Organized Delivery System. Therefore, the BHCO has decided to issue this list in order to provide clarity and guidance to our providers. These standards are based on the QA-C training provided by the California Institute of Behavioral Health Services, which the Training Unit will be hosting on April 24, 2019. Our focus will be on the documentation of medical necessity for the client's services.

The following deficiencies will result in a recovery.

1) **Diagnosis:**
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(10)
   a) The client does not have a diagnosis for a DSM-5 substance use disorder or equivalent.
   b) There is no narrative summary describing the basis for the diagnosis written by a LPHA.
   c) The written summary does not demonstrate that the LPHA has evaluated the client's assessment information and had a face-to-face consultation with the person who assessed the client, if the LPHA him- or herself did not conduct the assessment.
   d) The diagnosis was not made by a LPHA working within his or her scope of practice.
   e) The diagnosis is not supported by evidence in a valid assessment.
2) **ASAM Level of Care placement:**
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(B)(2)(ii)(b)
   a) The indicated ASAM level of care is not sufficiently justified by the dimensional severity ratings on the Substance Use Disorder Level of Care Recommendation Form.
   b) The dimensional severity ratings are not sufficiently justified by documentation in the Level of Care Recommendation Form.
   c) The ASAM level of care placement was not made by a LPHA.
3) **Continuing Services Justification:**
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(B)(2)(v)
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(15)
   a) The continuing services justification was not based on an updated Substance Use Disorder Level of Care Recommendation Form.
   b) The continuing services justification was not made by an LPHA working within his or her scope of practice.
4) **Treatment Plan:**
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(12)
   a) The treatment plan was not properly executed by the counselor, client, and LPHA.
   b) The services planned are not appropriate to the client's level of care placement.
5) **Service Evidence:**
   Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(14)
   a) The progress note does not support the type of service claimed.
   b) In the case of group counseling, the service was not substantiated by a valid sign-in sheet.
      Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(13)
   c) Services other than crisis were not provided in accordance with a valid treatment plan or during the period before the initial treatment plan is due.
      Intergovernmental Agreement, Exhibit A, Attachment I A2 (III)(PP)(12)(i)(a)(i)(5)
   d) Services provided are not within the scope of practice of the individual providing services.
   e) The progress note documents a non-billable service, such as scheduling, leaving a telephone message, or set-up for a service.
   f) Services were not provided within six months of either admission of the client or finalization of a continuing services justification. (**NTP- Narcotics Treatment Program HAS A DIFFERENT REQUIREMENT**)
      Intergovernmental Agreement, Exhibit A, Attachment I A2 (II)(PP)(15)

As required by the San Francisco ODS Intergovernmental Agreement, these requirements apply to all providers of ODS services. Some modalities have additional requirements with which they must comply to avoid recoupment, such as Title 9, California Code of Regulations for NTPs, and pre-authorization, for residential programs.

SUBSTANCE USE

Checklist to Prevent Deficiencies Resulting in Recoupment

Diagnosis

- Is there a diagnosis for a DSM-5 SUD or equivalent?
  - Is the narrative summary completed by LPHA?
    - Is the diagnosis made by LPHA within scope of practice?
  - Was there a face-to-face consultation with LPHA?
    - Is the diagnosis supported by valid assessment?

ASAM LOC Placement

ASAM Criteria Severity Rating

0	1	2	3	4
Indicates that this dimension is a **non-issue** for the client	Indicates that the client has either a mildly difficult issue in the dimension, or that there are presently only **minor signs** of problems or symptoms	Indicates that the client has **moderate difficulty** in functioning in this dimension	Indicates that the client has a **serious issue or difficulty coping** with this dimension of his or her life. This client is likely to suffer harm due to this dimension if he or she does not begin treatment, but that harm is not likely to be as immediate or as serious as a person who rates a four in that dimension	Indicates that a client will be **likely to suffer serious harm** in the next few hours or days due to problems in this dimension **unless** he or she **immediately begins treatment** in an appropriate institution
non-issue	mild	moderate	severe	immediate danger

- Is the ASAM level justified?
- Is the ASAM placement made by LPHA?

Continuing Services Justification

- Is the Continuing Services Justification (CSJ) made by LPHA?
  - Is the CSJ based on the updated SUD LOC Recommendation form?

Treatment Plan

- Is treatment plan properly executed by the counselor, client, and LPHA?
  - Are the services planned appropriate to the client's level of care placement?

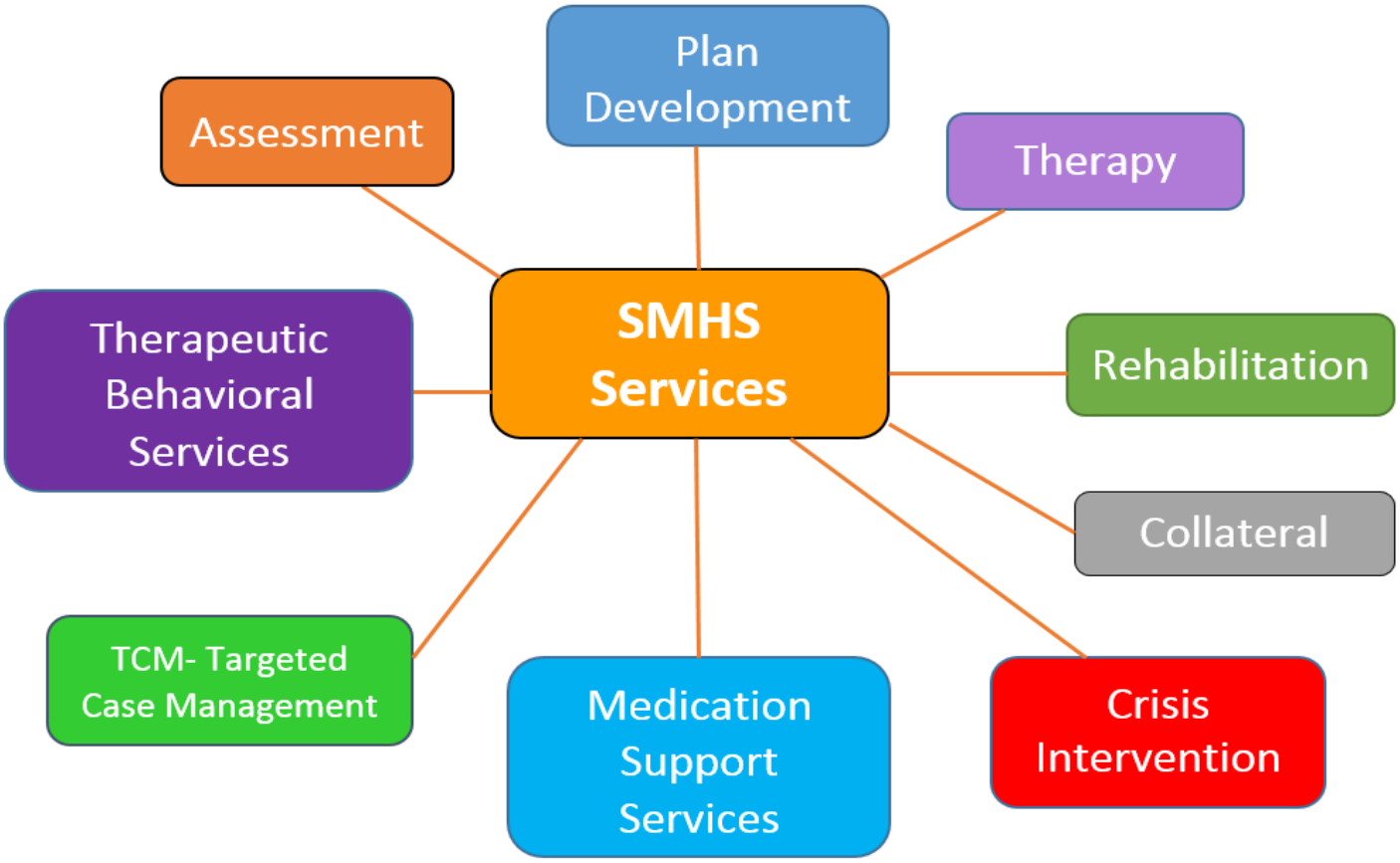
Service Evidence

- Does the progress note support the type of service claimed?
  - Do the services have a valid treatment plan? And are not prepared before the initial treatment plan is due?
    - Does the progress note document a billable service? (No-shows, leaving a message, and scheduling are non-billable services.)
  - Do the group counseling sessions have a completed valid sign-in sheet?
    - Are services provided within the scope of practice of the individual?
      - Are services provided within six months of either admission or finalization of CSJ?

MENTAL HEALTH

WHAT ARE THE DIFFERENT TYPES OF SERVICES?

Created by Joseph A Turner, PhD, PSY22453 Former Clinical Documentation Specialist, BHS-QM. Oct 2018.



In the prior issue (Feb 2019) newsletter, we talked about the Golden Standard of documentation. In continuation, here are nine different services definitions from CCR Title 9, Division 1, Chapter 11.

§1810.204. **"Assessment"** means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

§1810.232. **"Plan Development"** means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.

§1810.250. **"Therapy"** means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

§1810.243. **"Rehabilitation"** means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

§1810.206. **"Collateral"** means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

What are the different types of Services? cont.

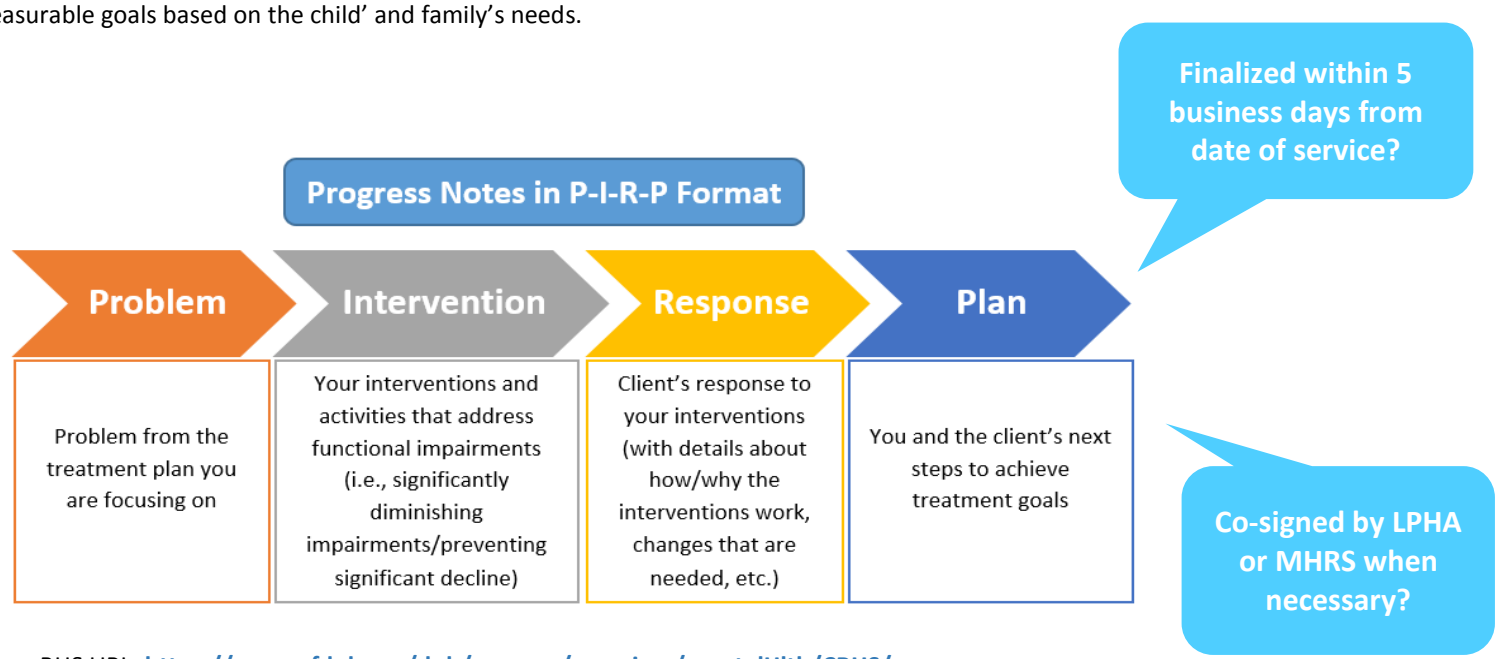
§1810.209. **"Crisis Intervention"** means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

§1810.225. **"Medication Support Services"** means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.

§1810.249. **"Targeted Case Management"** means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

"Therapeutic Behavioral Services" (TBS) are supplemental specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. §1810.215 states "EPSDT supplemental specialty mental health services" means those services defined in Title 22, [CCR] Section 51184, that are "provided to correct or ameliorate the diagnoses listed in §1830.205, and that are not otherwise covered by this chapter."

TBS is an intensive, individualized, one-to-one behavioral mental health service available to child/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs.



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