



**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SYSTEMS OF CARE COMPLIANCE PROGRAM**

Compliance Plan

UPDATE 2021

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PLACER COUNTY SYSTEM OF CARE COMPLIANCE PROGRAM

INTRODUCTION:

What is Compliance and why do we have to be concerned?

Compliance refers to adherence to federal health care program requirements. The two programs of prime interest are Medicare and Medicaid. Medicaid is referred to as Medi-Cal in the State of California.

Medicare is a health insurance program for 1) people 65 years of age and older; 2) people with severe disabilities under the age of 65; and 3) people of any age with End-Stage Renal Disease. Standard Medicare covers outpatient, inpatient and partial hospitalization benefits for mental health care. Medicare will pay for mental health services provided by certain licensed specialty providers, including psychiatrists, clinical psychologists, and clinical social workers.

Medicaid, known as Medi-Cal in California, is a health insurance program that provides medical and medically related services to the most vulnerable populations. In general, Medicaid provides three types of health services: 1) health insurance for low-income families and individuals with disabilities; 2) long-term institutional and or community-based care for older Americans and individuals with disabilities; and 3) supplemental co-payments coverage for low-income Medicare beneficiaries. Medicaid is a joint Federal and State program. The Medicaid benefit package is determined by each state based on broad Federal guidelines. In general, each state must cover 15 categories of "mandatory services" identified in statute, such as inpatient and outpatient services, laboratory and X-ray services, nursing facility services, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under the age of 21. In addition, states have the option to cover one or more of up to 28 "optional services" under Medicaid, such as case management, personal care services, inpatient psychiatric services for individuals under age 21, prescribed drugs, and a variety of professional services. Placer County receives payments from both programs and therefore is required by law to have a Compliance Program to prevent fraud, waste, and abuse in our behavioral health care programs. The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs outlined above. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

Who monitors fraud and abuse?

1. California Department of Health Care Service (DHCS), Audits and Investigations Division
2. U.S. Department of Health and Human Services, Office of Inspector General (OIG)
3. US Department of Justice (DOJ), Federal Bureau of Investigation (FBI)
4. State Medicaid Fraud Control Units (MFCUs)
5. US Centers for Medicaid and Medicare Services (CMS)
6. Internal Revenue Service (IRS)
7. Other entities

Systems of Care Compliance Program:

In support of our goal of full compliance, Placer County Systems of Care (PCSOC) has adopted this Compliance Plan and implemented a Compliance Program. It is based on the guidance and standards established by the Office of Inspector General (OIG), Federal Department of Health and Human Services (HHS), and the Department of Health Care Services for Medi-Cal (DHCS), Drug Medi-Cal, CMS regulations, and the Medicare Managed Care Manual. This document addresses the fundamental elements of a compliance plan and program, and establishes the principles, standards, and policies regarding compliance with applicable federal laws and regulations. This plan is periodically updated. The most recent significant update occurred in 2018 as a result of Placer County's implementation of the Drug Medi-Cal Organized Delivery System.

PCSOC, including the Placer/Sierra Mental Health Plan (MHP) and the Placer Drug Medi-Cal Organized Delivery System (DMC-ODS) is committed to providing high quality health care services in compliance with all applicable federal, state, and local laws and regulations including those pertaining to Medi-Cal, Drug Medi-Cal, and Medicare. Our commitment extends from internal business operations to oversight and monitoring responsibilities related to county operated programs, a contractor's employees, private providers, and agencies that enable to fully implement all aspects of Medi-Cal, Drug Medi-Cal, and Medicare benefits. Unless otherwise stated, the term "All Employees" applies to all PCSOC employees, temporary employees, interns, trainees, and contractors working in county owned or operated sites.

PCSOC strive to maximize all federal, state, and other revenues/sources necessary to promote, provide and maintain Placer County's comprehensive integrated services systems. In order to ensure Placer County maximizes all federal revenues that fund Systems of Care, the Placer/Sierra County(s) Mental Health Plan (MHP) along with Placer's DMC-ODS shall require all mental health and substance use services employees and providers comply with all appropriate federal and state laws and regulations, and to promote and enforce adherence to this policy. One of the means both the MHP and DMC-ODS will use to promote and gain adherence to this policy is the development and maintenance of a Compliance Program.

BACKGROUND:

The genesis of the Compliance Program originated with the federal government's increased emphasis on compliance relative to private mental health/managed care provider practices. The Placer/Sierra MHP and Placer's DMC-ODS are recognized as a mental health and substance use treatment services managed care systems and they as well as other public mental health/managed care systems, are required to establish a Compliance Program.

OVERVIEW:

The Compliance Program is designed, implemented, and enforced in order to promote MHP's and DMC-ODS understanding of and adherence to state and federal statutes and regulations that are applicable to MHP and DMC-ODS business, as well as to detect, respond to, and prevent violations of those requirements.

The Compliance Plan addresses the following issues:

1. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. Conducting internal monitoring

and auditing of SOC programs through the performance of periodic audits to ensure adherence to all applicable state and federal laws and regulations.

2. Implementing compliance and practice standards for Systems of Care (SOC) programs through the development of written policies, procedure and standards of conduct that articulate SOC's commitment to comply with all applicable Federal and State requirements.
3. Oversight of the Compliance Program, which includes designating a SOC Compliance Officer to monitor compliance efforts, establishment of a SOC Compliance Committee, management and supervisory responsibilities, and individual responsibilities.
4. Conducting appropriate training and education for HHS SOC working within identified programs, including the Compliance Officer and Senior Management to perform their jobs in compliance with the standards of the Compliance Plan and all applicable laws, regulations, and policies.
5. Establishing mechanisms to correct SOC program non-compliance and respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.
6. Developing open lines of communication, including discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct; internal memos; informational notices; e-mail; ongoing trainings; other reasonable methods to keep SOC employees updated on compliance activities, and providing clear and ethical business guidelines for behavioral health employees to follow.
7. Enforcing disciplinary standards through well-publicized guidelines; and
8. Prompt response to compliance issues as they arise, investigation of potential compliance problems as identified during self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements.

Compliance Program Authority

Executive Oversight – Health and Human Services Policy Team: The Agency Oversight Committee, with general oversight responsibility for the MHP, will provide strategic direction to the Compliance Program, as well as be responsible for approving the Compliance Program. The Compliance Officer

will communicate status and progress to the Oversight Committee during its regular meetings. Compliance Officer: **Twylla Abrahamson, Ph.D.**, Email: TAbraham@placer.ca.gov: The **MHP/DMC-ODS Compliance Officer** is delegated authority for development and day-to-day operation of the Compliance Program. The Compliance Officer shall report directly to the ASOC Director (designated as the MHP Director and the AOD Administrator) and will have a working relationship with County Counsel. The Compliance Officer will update the Oversight Committee on status and progress of the Compliance Program during its regular meetings.

Compliance Committee: The Compliance Committee will assist the Compliance Officer in the development, implementation, and ongoing refinement of the Compliance Program.

County Counsel: The Compliance Officer will collaborate with the County Counsel, in the development and implementation of the Compliance Program. The County Counsel shall be responsible for:

- ❑ Providing legal counsel and support to the Compliance Officer.
- ❑ Actively participating in the training and educational sessions regarding legal elements of the Compliance Program; and,
- ❑ As requested, investigating complaints and issues that are raised during the monitoring of compliance activities.

Why Compliance Now?

- ❑ To provide a higher quality of care through more thorough and precise clinical documentation
- ❑ To promote compliance with new federal managed care regulations
- ❑ To avoid fraud and abuse

What Is Clinical Documentation And Why Is It Important?

- ❑ Clinical record documentation is required to record pertinent facts, findings, and observations about an individual's health including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

What Is Casework Documentation And Why Is It Important?

*Centers for Medicare and Medicaid Services (CMS),
Department of Health and Human Services*

On April 25, 2016, CMS put on display at the Federal Register the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. See the related blog co-authored by the CMS Administrator and CMCS Director, Medicaid Moving Forward. For questions regarding Managed care, please email ManagedCareRule@cms.hhs.gov. Current federal requirements for Program Integrity Safeguards including a Compliance Program to detect fraud, waste and abuse are included in the final rule at Title 42, Code of Federal Regulations (CFR), Part 438, Subpart H and specifically in Section 438.608.

Casework record documentation is required to record pertinent facts, findings, and observations about an individual's social and family situation including past and present events, assessments, interventions, treatments, and outcomes. The casework record chronologically documents the care of the client and is an important element contributing to high quality care.

Medical Records Federal Guidelines - 1997

An appropriately documented medical record provides the basis for claims processing and may serve as a legal document to verify the care provided, if necessary.

Special Note: In 2017, the record retention period for managed care programs, including both the MHP and the DMC-ODS, was increased to 10 years.

Clinical Documentation Facilitates:

- ❑ The ability of professionals to evaluate and plan the client's immediate treatment and to monitor his/her health and care over time
- ❑ Communication and continuity of care among professionals involved in the client's care
- ❑ Accurate and timely claims review and payment
- ❑ Appropriate utilization review and quality of care evaluations
- ❑ Collection of data that may be useful for research and education

What Is Fraud?

Intentional deception or misrepresentations made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person.

What Is Abuse?

Provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the Federal government, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Ethical staff makes billing mistakes and errors through inadvertence or negligence. Innocent billing errors are a significant drain on the Federal Health care programs and must be corrected.

Expectations of the Federal Government-October 2000

All health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate. The Office of Inspector General (OIG) expects providers to minimize errors and prevent potential penalties for improper billings before they occur. The Compliance Plan provides a means to accomplish this.

Key Placer SOC Compliance Issue

- ❑ The distinction between Medicare and Medi-Cal documentation standards
- ❑ The distinction between DMC-ODS and MHP documentation Standards
- ❑ Service billings not supported by clinical documentation in the client file including assessment, treatment plan, diagnosis, and progress notes

File Review

- ❑ The file review is a major component of the internal monitoring to establish those areas creating risk of fraudulent billing practices
- ❑ Supervisors will be doing an additional file review to assist in further risk assessment
- ❑ The results of reviews may lead to additional reviews, increased training, corrective action, and discipline if necessary

Employee Expectations

- ❑ Provide high quality consumer care
- ❑ Follow the letter and spirit of the HHS SOC Code of Conduct (Appendix)
- ❑ Make a good faith effort to detect and prevent any wrongdoing in your day-to-day activities before it happens
- ❑ Raise questions to supervisors and managers
- ❑ Use the resources available, such as the Compliance Hotline (530) 886-3622, to report any inappropriate activity
- ❑ Participate in all required training programs
- ❑ Understand Medicare/Medi-Cal billing and documentation requirements

Training

- ❑ Staff will be required to attend scheduled trainings that will respond to areas of risk.

Quality of Care And Services

- ❑ We are committed to providing high quality care that is consistent, and to offering skilled, compassionate, reliable service to our constituents, clients, and community.

Quality Of Care And Services Are Achieved By:

- ❑ Treating all clients with dignity, respect, and courtesy
- ❑ Providing appropriate services
- ❑ Employing professionals with proper credentials and experience
- ❑ Accurately and completely documenting all encounters in the medical record
- ❑ Providing clients with the information they need to make informed decisions about their treatment
- ❑ Providing culturally appropriate services
- ❑ Participating in activities that promote quality improvement and bring deficiencies or errors in the quality of care and services to patients, constituents, and clients to the attention of those who can properly assess and resolve the problem
- ❑ Striving to do our jobs so that no harm is caused to our clients, the community, co-workers, or ourselves
- ❑ Promoting a positive image for PCSOC, its employees and its services

Workplace Conduct

- ❑ We recognize that our greatest strength lies in the talent of our workforce who foster our success and reputation. We treat our colleagues with respect, dignity, and courtesy.

- ❑ We maintain a working environment free from all forms of harassment
- ❑ We afford equal employment and advancement opportunities
- ❑ We conform to the Codes of Ethics and standards of our respective professions and exercise sound judgment in the performance of duties
- ❑ We comply with work and safety policies
- ❑ We provide our employees clear direction about what is expected of them

Adhere To Laws And Regulations: Employees are expected to:

- ❑ Follow the letter and spirit of applicable laws and regulations and conduct our business in an ethical and honest manner that enhances PCSOC's standing in the community
- ❑ Comply with all applicable laws, rules, regulations, and standards
- ❑ Not engage in any practice that involves unethical or illegal activity
- ❑ Take reasonable precaution to ensure that billing and/or coding of claims are prepared and submitted accurately, timely and consistently with regulations
- ❑ Ensure that no false, fraudulent, inaccurate, or fictitious claims for payment or reimbursement of any kind are submitted
- ❑ Bill only for eligible services actually rendered and fully documented.
- ❑ Act promptly to investigate and correct problems if errors in claims or billings are discovered
- ❑ Voluntarily disclose to third party law enforcement or regulatory agencies violations of law, regulations, or standards where appropriate and legally required

Conflicts Of Interest: Employees are expected to:

- ❑ Avoid conflicts of interest or the appearance of conflicts of interest between our own personal interests and the best interests of the County
- ❑ Avoid commitments that interfere with our ability to properly perform duties or any activity that may conflict with the known interests of PCSOC, its clients or constituents
- ❑ Report any potential conflicts of interest
- ❑ Not accept or provide benefits that create conflict between personal interests and PCSOC interests

Protecting Assets: Employees are expected to:

- ❑ Protect the County's property and assets
- ❑ Obtain appropriate authorization prior to committing or spending PCSOC funds
- ❑ Use work hours in a productive and professional manner
- ❑ Use computer systems, networks, and software consistent with county policies

Work Relationships: Employees are expected to:

- ❑ Be committed to establishing and maintaining ethical work relationships
- ❑ Seek positive and cooperative relationships
- ❑ Be honest and forthright in providing information to clients, payers, or other employees
- ❑ Bring to the attention of supervisors and managers information related to non-compliance of these standards and expectations

- ❑ Cooperate in accomplishing PCSOC's commitment to maintaining a work culture that promotes the prevention, detection and resolution of conduct that do not conform to these standards and expectations

Records Maintenance: Employees are expected to:

- ❑ Maintain complete, accurate and thorough records
- ❑ Comply with all laws governing the confidentiality of information
- ❑ Ensure that timesheets and other cost records and reports are complete and reflect accurate information

Responsibilities of Employees

- ❑ PCSOC Compliance Program can succeed only through the efforts of dedicated employees who conduct themselves with honesty and integrity, and in compliance with the letter and the spirit of all applicable laws and regulations. Although everyone is ultimately responsible for his or her own conduct, PCSOC is committed to maintaining a work environment that promotes these ideals and encourages our employees to demonstrate the highest ethical standards in performing their daily tasks.
- ❑ PCSOC requires the active participation of all employees including executive, administrative and supervisory in:
 - Reading, acknowledging, and retaining a copy of the Code of Conduct
 - Complying with the Code of Conduct, policies, procedures, laws, and regulations. (Failure to comply may subject an employee to civil and criminal liability, sanctions, penalties, or disciplinary action.)
 - Helping to create a culture within PCSOC that promotes the highest standards of ethics and compliance
- ❑ Employees and contract providers are obligated to report violations of the Code of Conduct, agency policies and procedures or laws and regulations. (Depending on the circumstances, failure to report a known or suspected violation could subject an employee to disciplinary action.)
- ❑ Employees cannot exempt themselves from the consequences of their own misconduct by self-reporting, although self-reporting may be considered in determining the appropriate course of action.
- ❑ Supervisors are responsible to:
 - Ensure that those on their team have sufficient information to comply with these policies
 - Provide appropriate and necessary training
 - Respond in an appropriate and timely manner to issues or concerns brought to their attention by employees
 - Monitor staff to ensure that those on their team are in adherence with the Compliance Program.

Disclosure Program

PCSOC disclosure program is designed to promote and provide the mechanisms for the disclosure of any issues or questions associated with PCSOC policies, practices, or procedures with response to a Federal health care program viewed by the individual to be inappropriate

If you become aware of actual fraud or abuse, or have questions about PCSOC's policies, practices, or procedures (related to Federal health care programs) it is your duty to disclose your concerns to the Compliance Officer.

No disciplinary action or retaliation will be taken against an employee for reporting in good faith a perceived compliance issue, problem, concern, or violation. The phrase "in good faith" means that the employee honestly or truthfully believes or perceives the information reported to be true.

Confidential Disclosure Program:

PCSOC is a learning organization that has put a Compliance Program in place so that errors and processes that might cause less than accurate billing, will be addressed quickly and corrected through a system of regular and routine monitoring. In addition, this system is designed to discover, eliminate, and correct any fraudulent billing.

SOC employees and contract providers have an obligation to report in good faith known or suspected violations of any statute, regulation, or guideline applicable to the federal healthcare programs, any law or regulation, the Code of Conduct or policies and procedures to their supervisor, manager, other management staff or contractor within their chain-of-command. Employees may also report their concerns to SOC, HHS Human Resources or the United States Health and Human Services.

If an employee or contract provider is uncomfortable reporting a suspected violation to any of the above-referenced resources or if they believe that the issue has not been handled appropriately, he or she is encouraged to contact **Twylla Abrahamson, Ph.D., Compliance Officer** by telephone at (530) 886-5440, by email at TAbraham@placer.ca.gov, by fax (530) 886-6735 or by letter to **Twylla Abrahamson, Ph.D., Compliance Officer**, 11716 Enterprise Drive, Auburn, CA. 95603; or by contacting the Compliance Telephone Hotline at (530) 886-3622. The Compliance Telephone Hotline provides a confidential means to report compliance related concerns or violations. All calls will be treated as confidentially as practicable or allowed by law. Employees are not required to identify themselves when reporting a concern. Callers who wish to remain anonymous will be assigned a private code that can be used for follow-up communication so that they may be advised on the process of investigating and resolving the reported concern. Calls received by the Compliance Telephone Hotline will be referred to **Twylla Abrahamson, Ph.D., Compliance Officer, Office of Compliance** for internal investigation and resolution.

Committing or condoning retaliation for good faith reporting of a perceived or suspected Code of Conduct violation(s), or for participation in an investigation of an alleged violation, will not be tolerated. Any employee who commits or condones any form of retaliation may be subject to discipline up to, and including, termination.

Considerations for Reporting

- Do I have all the facts?
- What is the action that I perceive violates standards as outlined in the Code of Conduct?
- What is the action that I perceive violates any known rule, policy, law, or regulation?
- What opportunity has been given to my supervisor or manager to make them aware of and to address the issue (if appropriate)?

System of Care Code Of Conduct

- ❑ PCSOC provides guidance to covered individuals and off-site contract providers to carry out daily activities within appropriate ethical standards and applicable laws and regulations
- ❑ Covered Individuals: All PCSOC employees, contractors, and individuals with responsibility pertaining to the ordering, provision, and documentation of billed services
- ❑ Off-site Contractor Providers: Individuals who contract with PCSOC, or who are employed by or subcontracted with a person or entity who contracts with PCSOC
- ❑ All covered individuals are required to receive, understand, sign, and adhere to the PCSOC Code of Conduct

Intent of the Code of Conduct

- ❑ To communicate County and SOC expectations of ethical behavior
- ❑ To communicate the commitment of SOC to its employees and contract providers and to compliance with laws, regulations, contractual obligations, and standards of care consistent with community standards
- ❑ To familiarize all staff with the basic legal principles and ethical standards of behavior expected throughout SOC

COMPLIANCE TEAM CHARTER

PURPOSE:

To lead, direct and perform tasks and projects necessary to comply with applicable regulations governing Systems of Care (SOC) activities. These include California Department of Mental Health regulations, California Department of Social Services regulations and those associated with other government authorities. To serve as a vehicle through which the SOC Quality Management (QM) fulfills its charge to ensure compliance. To assure that knowledge of regulations is held by a number of staff, rather than by just one or two individuals. To promote compliance in a manner that is not restrictively categorical in nature, which promotes Family-Centered work consistent with our SOC approach to working with clients and families.

FUNCTION:

To continuously develop, implement and support processes and procedures relative to compliance with regulatory requirements. These include, but are not limited to, issues of documentation standards, access to services, performance standards, outcomes, and problem resolution processes.

MEMBERSHIP:

The core team is composed of SOC Quality Management (QM) program staff. Additionally, SOC QM and others representing program areas throughout SOC; including ASOC, CSOC, Adult Intake Services (AIS), Family and Children Services (FACS), and administrative clerks; may participate for periods of time to address program-specific issues as appropriate. Members will be actively involved on QM committees and SOC workgroups to provide technical assistance and to promote consistency with a Family-Centered approach throughout SOC.

Terms of service for specific individuals will vary as their assignment on the Team is associated with their role (for example, SOC QM staff). As possible, changes in Team membership will be staggered to promote team stability and consistency. The SOC Quality Improvement Coordinator serves as the team chair. The specific members of the Compliance Team are noted in Chapter 2 of the Compliance Plan.

ROLES:

Team Chair: To lead the Committee at each meeting to assure orderly, collaborative, sequential, and timely accomplishment of the Committee's work.

Team Member: To take responsibility for staying current on Team business, including the activities missed due to absences from meetings, and following-through on action items.

When unable to attend a meeting, Members should advise the Team chair in advance.

DECISION MAKING:

Decisions on actions and recommendations are to be made by consensus among those in attendance. When unable to reach consensus on a matter, the Team shall determine the appropriate processes for handling disagreements on a *case-by-case* basis. Possible resolutions, for example, might include a 2/3 vote or a majority vote.

CONSTRAINTS:

Members are to represent the Team's decisions and recommendations.

RESOURCES:

Team Members will utilize Placer County System of Care resources for preparatory and follow-on work to assure the timely and complete accomplishment of the Committee's goals. Other System of Care staff may be consulted for technical information and assistance as available and appropriate.

If the Team determines that occasional County office support is needed, reasonable requests will be made for assistance, utilizing established supervisory and/or management approval methods.

MEETING SCHEDULE:

The HHS Compliance meeting will occur on a quarterly basis. The Committee Chair will prepare meeting agendas and action tracking materials in advance and will provide sufficient copies at the beginning of the meeting. If documents are to be discussed, the Committee member with access to the document will be responsible for providing sufficient copies. A review of and corrections to the written meeting materials will be included on each meeting's agenda.

Implementing Standards, Policies, Procedures and Practice Guidelines

Overview

The Plan is designed to establish a culture within the SOC that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law and ethical and business policies. The Plan is organized around key topics seen as essential to the foundation and operation of a Program and the development and on-going implementation of the Plan. Because they are considered essential, each key topic is the subject of a separate policy and procedure.

While serving as foundational and operational, these policies and procedures also help to formulate the seven required elements of a Plan. The required elements are:

- Standards and procedures.
- High level of oversight and delegation of authority.
- Employee training.
- Communication.
- Auditing and monitoring.
- Enforcement and discipline; and,
- Corrective actions and prevention.

The first four of these policies and procedures are foundational in nature and provide the infrastructure for Plan development, oversight, and monitoring adherence to the Plan. These policies and procedures outline the:

- Compliance Program.
- Compliance Committee.
- Compliance Officer; and,
- Compliance Program Communication Plan.

The final five policies and procedures are operational in nature and provide the mechanisms for Plan implementation. These policies and procedures include:

- Auditing and Monitoring.
- Corrective Actions.
- Compliance Hotline.
- Code of Conduct; and,
- Maintenance of Records.

Achieving SOC’s ongoing adherence to these policies and procedures is the primary responsibility of the Compliance Officer and the Compliance Committee, with the assistance of legal, administrative, and analytic staff, as needed.

Additional policies within the County and the SOC also address compliance and program integrity. A full list of policies and where to locate the policies are listed in the table below:

Systems of Care Policies and Procedures

Policy Number	Title	Location
EA200	Residential Services Reimbursement	T:\HHS\Special - Restricted\SOC Policies and Procedures\Eligibility and Authorizations
EA220	Medi-Cal Reimbursement for Adoption	

EA230	Medi-Cal reimbursable Services and Lock Out for clients in placement	
EA411	Definition of Medical Necessity (SMHS)	
EA420	Authorization for Medi-Cal Specialty Mental Health Services	
EA535	DMC-ODS Treatment Authorization and Timely Access	
EA540	Inpatient Concurrent Review and Authorization	
EA 550	Ambulance Billing Authorization	
GO100	Mission and Vision Statement ASOC	T:\HHS\Special - Restricted\SOC Policies and Procedures\General Operations
GO200	Mission and Vision Statement CSOC	
LG100	Leadership and Supervision	
LG200	Review of DHCS/CDSS Information Notices	
PS100	Professional License Presentation	T:\HHS\Special - Restricted\SOC Policies and Procedures\Professional Standards
PS104	Disclosure of Education by Health Care Provider	
PS110	Medical Board License Notification	
PS300	Clinical Supervision	
PS310	Psychiatric Mental Health Nurse Practitioner Standardized Practices	T:\HHS\Special - Restricted\SOC Policies and Procedures\Professional
PS400	Scope of Practice and Documentation	T:\HHS\Special - Restricted\SOC Policies and Procedures\Professional
PS500	Training ASOC	
PS505	AOD Staff Training	
QM101	Quarterly Report Submission to DHCS Forms #1008, #1009, #1010, and #1011	T:\HHS\Special - Restricted\SOC Policies and Procedures\Quality Management
QM300	Certification of Network and Organizational Providers	
QM310	Network Provider Selection (SMHS)	
QM311	Uniform Registration and Credentialling, and recredentialing for Placer MHP and DMC-ODS	
QM312	DMC-ODS Network Provider Selection	
QM315	DMC-ODS Medical Director Monitoring	
QM504	Compliance Program	
QM505	Compliance and Program Integrity	
QM506	Compliance Program Communication Plan	
QM507	Compliance Officer Purpose, Qualifications and Duties	
QM508	Compliance Committee	
QM509		

QM510	Corrective Action Plans	
QM511	Compliance Hotline-Re: Federal Healthcare, Social Services Programs	
QM512	SOC Code of Conduct	
QM513	Maintenance of Compliance Records	
QM514	Compliance Training	
QM520	Network/Organizational Mental Health Provider Chart Auditing	
QM525	Electronic Health Record Monitoring	
SP1270	Electronic Signature and Electronically Signed Records.	T:\HHS\Special - Restricted\SOC Policies and Procedures\Services and Practices
SP1809	SUS Site Review Procedures	
SP 1864	DMC-ODS Provider Training	
P1010	Moonlighting	T:\HHS\Special - Restricted\SOC Policies and Procedures\Personnel
P1020	Moonlighting Consumer Navigators within ASOC	T:\HHS\Special - Restricted\SOC Policies and Procedures\Personnel

Placer County Administrative Manual (PAM) available on Website.
General Government and Administration

Board of Supervisors' Procedures
 Fraud Reporting/Whistleblower Program Policy
 Placer County Charter
 Records Management Policy
 Use of Internal Service Providers Policy
 Finance and Accounting

[Accounting Manual for Cash](#)
[Accounting Policies & Procedures Manual](#)
[Accounting Procedures Documents](#)
[Budget & Financial Policy](#)
[Budget - Final](#)
[Budget - Proposed](#)
[Capital Assets -Policies & Procedures Guide](#)
[Charge-Out Rate Policy](#)
[Debt Management Policy](#)
[Procurement Card Program Manual](#)
[Procurement Policy](#)
[Procurement Procedures](#)

Information Technology

[Electronic and Digital Signature Policy](#) (Updated!)
[Enterprise Network Access Standards Policy](#)
[Information Security Program Charter](#)
[Information Security Policies](#)

[Information Technology Acceptable Use Policy](#) (New!)
[Information Technology Strategic Plan](#)
[Mobile Communication Device Policy & Procedures](#) (Updated!)
[Use of Private Devices and Accounts for County Business and the Public Records Act Policy](#)

Human Resources

[Personnell Rules & Regulations: See County Code -Chapter 3](#)
[Background Check Policy](#)

Foundational Components

Compliance Program, Compliance Committee, Compliance Officer and Compliance Program Communication Plan

Introduction

This section addresses the foundational components of the Plan. These components provide the infrastructure for Plan development, oversight, and monitoring of adherence to the Plan. There are four policies and procedures that specifically detail the foundational components of the Plan. Full versions of these policies can be located on the SOC Policies and Procedures folder on the Placer shared electronic drive. These policies and procedures include the Compliance Program, Compliance Committee, Compliance Officer, and the Compliance Program Communication Plan.

Compliance Program

It is the policy of SOC to maximize all federal, state, and other revenues/sources necessary to promote, provide and maintain Placer County's comprehensive integrated services systems. In order to ensure Placer County maximizes all federal revenues that fund SOC, the MHP and DMC-ODS shall require all mental health staff and providers comply with all appropriate federal and state laws and regulations, and to promote and enforce adherence to this policy. One of the means the MHP and DMC-ODS will use to promote and gain adherence to this policy is the development and maintenance of a Compliance Program.

The Compliance Program Policy and Procedure describes the design of the Compliance Program and, more importantly, formally commits the MHP and DMC-ODS to achieving and maintaining a compliant organization.

The Compliance Program is designed, and will be implemented and enforced, in order to promote MHP's and DMC-ODS's understanding of and adherence to state and federal statutes and regulations that are applicable to MHP business, as well as to detect, respond to, and prevent violations of those requirements. Care has been taken to prevent the perception that the Compliance Program represents one more heavy-handed process that will increase the burden and challenge of providing care to clients. Rather, an attempt has been made to communicate that the Compliance Program is a mechanism for guarding against external investigation, and for promoting the MHP's and DMC-ODS's mission.

While one of the most important objectives of a Compliance Program is to ensure that all MHP staff and providers observe and abide by pertinent laws and regulations, another parallel important objective is to establish explicit ethical standards that become well understood and serve as practical guidelines for making decisions with ethical implications.

Compliance Committee

A SOC Compliance Committee has been created to advise the Compliance Officer and assist in the implementation of the Compliance Program. The Compliance Committee consists of management representatives from all appropriate units throughout Health and Human Services and will report to the Compliance Officer.

The purpose of the Compliance Committee is to provide organizational support, create agency-wide awareness of the Compliance Program, and advise the MHP/DMC-ODS Compliance Officer, Director and Oversight Committee on the development and implementation of the Compliance Program.

The Compliance Committee Policy and Procedure establishes Committee membership, as well as its roles and responsibilities.

Membership on the Compliance Committee is based on the premise that directors of functional areas and physician and clinical leaders are good candidates for participation on the Compliance Committee by virtue of their positions. They bring with them management responsibility for development of and adherence to compliance standards applicable to their areas of responsibility and are generally well positioned to guide compliance efforts.

Further, since the majority of operational compliance pursuits, such as auditing and monitoring, interface in some way with patient care, very few if any standards and procedures will be completely independent of medical and clinical expertise. While physicians and clinicians are often constrained resources, compliance efforts may miss the mark or interfere with the patient care process if medical and clinical views are not integral to compliance efforts.

In addition, the Privacy Officer is a natural member of the Compliance Committee; his or her participation can help assure that HIPPA and other privacy issues are appropriately integrated within the comprehensive compliance effort.

Members* of the Compliance Committee are as follows:

- Compliance Officer.
- Privacy Officer.
- IT Security Officer
- Medical Director/Chief Psychiatrist
- Systems of Care Quality Management, Program Manager, Quality Improvement.
- HHS Manager, Finance & Accounting; and,
- Behavioral Health Clinical Director, Sierra County.
- HHS Deputy Director, Children's System of Care, or designee
- HHS Deputy Director, Adult System of Care, or designee
- County Counsel.

- HHS Risk Management.

*Compliance Committee members may assign a designee to attend on their behalf.

Staff supporting the Compliance Committee includes:

- Designated MH Manager, ASOC
- Designated SUS Manager, ASOC
- Designated MH Manager, CSOC
- Designated SUS Manager, CSOC
- Training Supervisor, ASOC; and,
- Training Supervisor, CSOC.
- QA staff as requested.

In order to demonstrate that pursuit of program fidelity is both explicit and evidence based, written records of Committee meetings will be routinely maintained, with agendas and meeting minutes documented and retained. Documentation will demonstrate the following:

- Review of auditing and monitoring results, Hotline reports, etc.
- Confirmation of compliance and/or, including individuals responsible.
- Monitoring of follow-up and corrective action; and,
- Closure of corrective actions when compliant performance has been achieved.

Compliance Officer

The MHP/DMC-ODS Compliance Officer is the delegated authority for the development, operation, and oversight of the Compliance Program. The Compliance Officer reports directly to the MHP/DMC-ODS Director and has a working relationship with the Office of County Counsel. The Compliance Officer regularly reports to the Oversight Committee the status of implementation and on-going operations of the Compliance Program for advice and guidance.

The Compliance Officer contributes to the fulfillment of MHP's and DMC-ODS's compliance commitment by planning, designing, implementing, and refining the Compliance Program. This involves developing standards, coordinating compliance training and education, conducting, or arranging internal audits, identifying compliance issues and trends, investigating, and resolving compliance complaints and promoting an awareness and understanding of the positive ethical and moral practices consistent with the mission and values of MHP and DMC-ODS and those required by state and federal law.

The Compliance Officer Policy establishes the Compliance Officer role, delegates the position's authority, and delineates its qualifications and responsibilities.

The Placer County SOC Compliance Officer is a management level staff person who is not the identified Behavioral Health Director. This reflects the commitment of Placer County SOC to this role, gives the Plan credibility and provides direct access to top management. It also assures sufficient independence and freedom from conflicts of interest and the sway of other operational duties to effectively perform the duties required of a Compliance Officer. In coordination with the Quality Improvement Coordinator, the Compliance Officer duties include, but may not be limited to:

- Designing and implementing the Compliance Program.

- Advising the SOC Directors and Oversight Committee regarding compliance issues including regulatory, fiscal, and operational policies.
- Serving as a member of the SOC Senior Management Team to participate in establishing MHP/DMC-ODS policy and operational oversight.
- Developing and chairing the Compliance Committee.
- Maintaining a document control system for all reports and operations of the Compliance Committee including minutes of meetings, audit and monitoring reports, corrective actions, disciplinary actions, investigations, disclosures, government inspections, training, and education activities.
- Facilitating development of compliance Standards of Conduct and Practice, as well as policies and procedures for each operational and administrative component of MHP and DMC-ODS.
- Monitoring and keeping current with laws, regulations, standards, and organizational guidelines.
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the Compliance Program and seeks to ensure that all appropriate employees, affiliated professionals, and contractors are knowledgeable of, and comply with, pertinent state and federal standards.
- Assessing the need for additional training and education.
- Developing structure that enables employees to report violations to compliance team and to the Compliance Officer, including effective use of a “hot line” without fear of retaliation.
- Ensure that the system is adequately publicized and that allegations of non-compliance are investigated and responded to promptly.
- Arranging and coordinating internal audits for the purpose of monitoring and detecting non-compliance with applicable laws and Compliance Program requirements.
- Enforcing the standards and fully investigating possible violations.
- If any non-compliance is detected, ensuring that it is investigated, a corrective action is developed and carried out, and that compliance is achieved and sustained.
- Working with Human Resources to ensure a workforce with high ethical standards, including the establishment of minimum standards for conducting appropriate background/reference checks on both potential and existing employees.
- Imposing or recommending consequences for violation of standards.
- Monitoring the effectiveness of the compliance program on a regular basis, including a comprehensive review conducted at least annually.
- Improving the Compliance Program on a continual basis and implement changes on an ongoing basis to improve the prevention/detection of any non-compliance, as well as changes in both MHP’s needs and state and federal laws.
- Making recommendations relative to the annual budget for compliance activities, (taking MHP’s resources into consideration); and, making recommendations regarding compliance operational plans based upon budget projections; and,
- Preparing compliance reports to the Oversight Committee to assure they remain generally informed of compliance issues and developments.

The Compliance Officer will report any areas of concern directly to the Adult System of Care Director who is the designated MHP and DMC-ODS Director, as well as the Compliance Committee.

Compliance Program Communication Plan

The Compliance Program Communication Plan is designed to provide a prompt, consistent and system-wide method of communication regarding SOC Compliance Program implementation, operations, risk assessment, monitoring, procedures, and information notices. In addition, the Communication Plan demonstrates the MHP's and DMC-ODS's commitment to communication, one of the seven key elements of a Compliance Program.

Operational Components

Auditing and Monitoring, Corrective Actions, Compliance Hotline, Code of Conduct and Maintenance of Records

Introduction

This section addresses the operational components of the Plan. These components provide the mechanisms for Plan implementation. There are five policies and procedures that specifically detail the operational components of the Plan. These policies and procedures include Auditing and Monitoring, Corrective Actions, Compliance Hotline, Code of Conduct and Maintenance of Records.

Auditing and Monitoring

Auditing and monitoring are a key pursuit in developing evidence of compliant performance, or identifying cases of non-compliance, in order to prevent non-compliant activities from going undetected and uncorrected for a significant duration. To ensure the SOC Compliance Program is effective and the MHP's and DMC-ODS's performance is compliant, SOC Compliance Program will monitor the SOC QM activities that are subject to regulatory requirements for both the MHP and DMC-ODS and routinely report findings to the Compliance Officer and members of the Compliance Committee. The Compliance Program will perform audits to investigate indications of non-compliance revealed by monitoring activities, the Hotline and other detection means. Routine audits will also be performed based on findings from the various monitoring processes. These audits will focus on both the County's programs and its contracted providers. Collectively, these evaluations, conducted with the support of management, will also help assure compliance with SOC policies and procedures.

SOC QM will also conduct annual reviews to determine whether the program's compliance elements have been satisfactorily addressed. This process will verify actual conformity with the compliance program by all departments. When this monitoring identifies deviations that had not otherwise been detected, appropriate program modifications will be implemented.

The Auditing and Monitoring Policy and Procedure commits the MHP and DMC-ODS to conduct routine auditing and monitoring in known risk areas, acknowledging the importance of confirming compliance or detecting (and correcting) non-compliance. Adhering to this commitment demonstrates the MHP's and DMC-ODS's dedication to the identification of cases of noncompliance. This Policy and Procedure establishes a general Policy and Procedure and specific Auditing and Monitoring Policies and Procedures in the areas of Billing and Coding, Medical Records Review, Medi-Cal / Medicare Denial Reports, Error Correction Reports, Compliance Hotline, Compliance Education, Exclusion List – Individuals, Exclusion List - Provider Network, Exclusion List – Procurement, Site Certification, Staff Licenses Review and Outpatient and Hospital Committees.

Written standards, policies and procedures are a central component of the Plan. The standards, policies and procedures address identified risk areas and establish internal controls to reduce the

possibility of erroneous claims and fraudulent activities; and they include practice standards for client care, personnel matters, and compliance with federal and state law.

The areas in this Plan for which auditing, and monitoring policies and procedures have been developed, were identified through an initial risk assessment as high-risk areas.

In general, primary risk areas include:

- **Abuse:** The term *abuse* describes incidents or practices of providers that are inconsistent with accepted sound medical, business, or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Although these types of practices may initially be categorized as abusive, under certain circumstances they may constitute fraud.
- **Fraud:** Fraud is an intentional deception or misrepresentation that the individual makes, knowing it to be false and that could result in some unauthorized benefit. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare/Medi-Cal program. The violator may be a provider, a supplier of durable medical equipment, a beneficiary, or some other person or business entity.

An ongoing evaluation process is the cornerstone of the Plan. It determines if the Plan is working and whether individuals are carrying out their responsibilities and claims are submitted appropriately.

Ongoing monitoring and auditing of billing practices, referral practices and use of proper provider numbers helps pinpoint weaknesses and identify additional training needs. Employee interviews may be used to monitor everyday operations, e.g., paper flow, billing practices and accounting procedures. Interviews may help identify problems that are not reflected in documents or records and can be useful tools for discovering unethical or illegal activity.

Monitoring and auditing are different concepts. Monitoring uses systems to direct and correct day-to-day operations. Monitoring systems are real-time and broad in scope to facilitate appropriate management action. Auditing consists of retrospectively testing the established monitoring systems to ensure they are functioning as prescribed.

Billing and Coding

The Compliance Program will provide for review of analysis of billing code accuracy. Billing codes consist of “procedure” codes and diagnosis codes. The AVATAR billing system translates service codes to service function codes for billing Medi-Cal. A limited number of service codes are likewise translated in the billing system to CPT codes for purposes of billing Medicare and private insurance. The Medical Record Review will provide for review individual service documentation: legibility, completeness, medical necessity, diagnosis, and accuracy of the procedure code billed. In the event compliance issues are found, the Compliance Program will ensure that the issues are investigated; corrective actions are identified, communicated to staff, and implemented.

The purpose of billing and coding review is to provide a mechanism to identify noncompliant performance and pursue corrective actions. The performance in question will be investigated to determine whether a violation of the SOC Code of Conduct or state, federal or local law and regulations has occurred.

One of the most important risks to manage in any health care delivery setting is reimbursement. Both the MHP and DMC-ODS should have a mechanism in place to ensure that the translation of services into billing codes (procedure/service codes and diagnosis codes) is accurate. Incorrect coding resulting in overpayment by Medi-Cal or Medicare is essentially fraudulent, – especially when it is either undetected because there is no detection process or detected and ignored. Auditing billed services for coding accuracy is invaluable to both identify systemic problems requiring corrective actions, as well as demonstrating a commitment to prevention of fraudulent billing.

SOC Monitoring Processes: Claims Submission Process

Internal Providers: For services provided and billed by SOC staff, billing information is entered directly into the electronic health record with the final note is submitted by the provider.

External Individual Providers: For assessment services provided and billed by individual network mental health private providers, SOC utilizes an ongoing process to ensure that each assessment service billed has been authorized by SOC staff and that there is corresponding documentation of the assessment. Individual private providers submit copies of the completed assessments with their claims, and an Administrative Clerk matches claims submitted by individual private providers to the service authorization record and the corresponding documentation. This ensures that claims are paid only for assessment services that have been authorized and that there is documentation of the service. This is completed on 100% of the claims for assessment services.

For services other than assessment services, SOC utilizes an ongoing process to ensure that SOC staff has authorized each service claimed by individual Network Mental Health Private Providers and for specific organizational providers.

Organizational Providers: Contracted Organizational providers will submit billings in compliance with their contract.

SOC Monitoring Processes: Systems Level Monitoring

The SOC Quality Improvement Committee (QIC) is comprised of stakeholders in SOC services. Members include the Adult System of Care (ASOC) Director (the Placer County Mental Health Director and the Placer County Alcohol and Drug Administrator), the Children's System of Care (CSOC) Director, the Health and Human Services (HHS) Medical Director; the SOC Chief Psychiatrist, the SOC Quality Improvement (QI) Coordinator, the SOC Patients' Rights Advocate, the Consumer Liaison/Representative; the SOC Family Advocate (consumer representative), MH Service Providers, SUS Service Provider and a Placer County Mental Health, Alcohol and Drug Board Representative.

The QIC meets monthly and reviews QI activities described in the Annual QI Work Plan. The SOC Leadership Team is responsible for implementing needed changes in policies and procedures. The agenda for the QIC meeting regularly includes compliance-related items. This includes review of data on service utilization and costs.

The Deputy Directors, Assistant Directors, Program Managers, and Supervisors also periodically (at least quarterly) review data on staff productivity for their respective divisions (ASOC and CSOC).

Medical Records Review

SOC will maintain medical records that meet established documentation and billing standards and requirements. To accomplish this, SOC Quality Management Staff will facilitate a monthly peer review of adult and children's mental health charts to check for compliance with documentation requirements. At a minimum, 5% of the mental health charts will be reviewed annually. These records will be comprised of records from the SOC, individual network providers and contracted organizational providers.

A random sample of Substance Use Services charts will be reviewed during each SUS site visit. The review will include a process for ensuring that, when possible, identified deficiencies are corrected. The review will include a process for ensuring that identified billing errors are reported to accounting in order to adjust claims against payers and avoid improper billing.

Documented results from the chart review process will be shared with the Compliance Officer and Compliance Committee. Further, the Compliance Committee will monitor follow-ups on identified issues.

SOC Audit Processes

SOC Compliance Team staff facilitates a monthly peer review of client charts to ensure compliance with documentation and billing requirements. This process is used to determine if bills are accurately coded and accurately reflect the services provided as documented in the medical records; and if documentation is being completed correctly per Medicare/Medi-Cal regulations and SOC policies and procedures. Charting is evaluated to determine if the medical necessity for the services provided is documented. Staff meets as a group to review randomly selected charts using the most recent QM sanctioned utilization review (UR) tool. Annually, 5% of the SOC mental health charts are audited in this way.

Peer review findings are reported to direct service staff, supervisors, and managers. The reports are cumulative and updated monthly to reflect the latest findings. The reports track the completion of needed corrections. Reviews of the chart reviews are provided to the direct service staff along with the findings report so that needed corrections to documentation can be made.

The SOC standard for making corrections is 30 days. Supervisors verify that corrections are made and report this verification to Compliance Team staff so that the completion of corrections is reflected in the reports. Managers monitor this usage of information provided in the findings report and follow-up with supervisors when corrections are not made in a timely fashion.

Billing errors are reported to the SOC Accounting Manager and claims reports are corrected. These include corrections for double billings and billings for which there is no supporting documentation.

In addition to the monthly peer review audit process conducted by SOC Compliance Team staff, Supervisors annually audit 5% of the mental health cases to evaluate the appropriateness, efficiency, effectiveness, and the medical necessity of the services provided. This process is documented and is completed for each case.

The QIC and SOC Leadership Team review data developed from the chart audit process to evaluate the effectiveness of the process and respond to identified problems. Responses include providing training on documentation requirements or to follow-up on specific documentation errors to ensure that they are corrected. The QIC and SOC Leadership Team also evaluate the data from the chart

audit process for trends or patterns that indicates that incentives for unnecessary billing exist. In the event that there are indications of incentives for unnecessary billing, the SOC Leadership Team develops and implements appropriate corrective actions.

Clinical Documentation

The Plan provides for monitoring and auditing to ensure timely, accurate and complete clinical documentation. One of the most important compliance issues is appropriate documentation of diagnosis and treatment. The medical record may be used to validate a) the site of the service; b) the appropriateness of the services provided; c) the accuracy of the billing; and d) the identity of the service provider.

Documentation ensures that the:

- Medical record is complete and legible.
- Documentation includes all necessary components including date, service code, duration of service, location, and signature with title.
- Diagnostic codes used for claims submission are supported by documentation and the medical review.
- Service plans are written within time guidelines and meet documentation standards including measurable objectives.
- Documentation for each encounter includes the reason for the encounter, any relevant history; assessment of clinical impression or diagnosis; plan of care; and date and legible identity of the provider; and,
- Appropriate health risk factors are identified. The client's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis are documented.

Medi-Cal and Medicare Denial Reports

The Compliance Program will provide for review of analysis of denied services for indication of suspected noncompliance with billing standards. In the event compliance issues are found, the Compliance Program will ensure that the issues are investigated; corrective actions are identified, communicated to staff, and implemented.

The purpose of the Medi-Cal and Medicare Denial Report review is to provide a mechanism to identify noncompliant performance and pursue corrective actions. The performance in question will be investigated to determine whether a violation of the SOC Code of Conduct or state, federal or local law and regulations has occurred. Denials are not necessarily indicative of noncompliant performance; however, review of ongoing and timely denial analysis is needed to ensure that denials are being actively monitored and remedied by SOC claiming staff.

Denial of payment by Medi-Cal or Medicare may indicate problematic claiming that is linked to noncompliant performance. While many denials will likely prove to be without compliance issues, investigating them will provide assurance that there are no such problems.

Error Correction Reports

The Compliance Program will provide for review of analysis of suspended services for indication of suspected noncompliance with billing standards. In the event compliance issues are found, the

Compliance Program will ensure that the issues are investigated; corrective actions are identified, communicated to staff, and implemented.

The purpose of the Medi-Cal Error Correction Report review is to provide a mechanism to identify noncompliant performance and pursue corrective actions. The performance in question will be investigated to determine whether a violation of the SOC Code of Conduct or state, federal or local law and regulations has occurred. Suspended claims are not necessarily indicative of noncompliant performance; however, review of ongoing and timely suspended claim analysis is needed to ensure that such claims are being actively monitored and remedied by SOC claiming staff.

Compliance Hotline

The Hotline directly addresses effective lines of communication between the Compliance Officer and the organization's employees. To evidence the effectiveness of this function, once it is up and running, the individual supervising the Hotline function should prepare for the Compliance Officer and Committee monthly reports of Hotline activity (while maintaining each caller's anonymity).

The Hotline is one mechanism for providing effective lines of communication between the Compliance Officer and SOC's employees. The Hotline will be supported by routine auditing and monitoring. To evidence the effectiveness of the Hotline, the Compliance Officer will prepare quarterly reports of Hotline activity for the Compliance Committee. The Compliance Officer will maintain each caller's anonymity, at the caller's request.

The Compliance Officer will review Hotline activity, including Hotline Logs and Compliance Issue Worksheets, to prepare reports for the Compliance Committee. These reports will be submitted to the Compliance Committee for guidance on follow-ups as well as for general oversight.

Compliance Education

The goal of Compliance Education is to provide effective training and education for SOC's employees. The SOC QM team will track compliance-related education in order to evidence that it is taking place as required, as well as to identify when it is not for the purpose of remedying the problem.

The Compliance Officer will have responsibility for tracking compliance-related education provided to all staff, while functional managers will be responsible for tracking function specific compliance training (i.e. medical record documentation or coding) and reporting activity to the Compliance Officer.

SOC compliance training has two goals:

- 1) All employees will receive training on how to perform their jobs in compliance with the standards of practice and any applicable laws and regulations; and,
- 2) Each employee will understand that compliance is a condition of continued employment.

Education to be tracked will generally fall into two categories:

- 1) General compliance education for all employees; and,
- 2) Function or job specific compliance education.

SOC communicates the Plan's policies and procedures clearly to all physicians and staff, as well as to independent contractors whose services are billed under the County's provider number; and alerts all appropriate parties to changes in standards of practice, policies or procedures, laws, or regulations.

Training in how to follow the law is ongoing and tailored to the needs of the clinical staff and physicians, case management providers, and support staff. Training programs take a variety of forms, such as seminars and video presentations.

New employees are trained as soon as possible after their start date and employees receive refresher training on an annual basis or as appropriate.

SOC maintains a log of all training activities. This log provides information on the date of the training, the staff's name attending, type of training, location of the training, trainer's name(s), duration of the training, and number of CEUs earned.

Training topics include, but are not necessarily limited to:

- Coding requirements.
- Claim development and submission.
- Signing a form for a physician without the physician's authorization.
- Proper documentation of services rendered.
- Proper billing standards and procedures and submission of accurate bills for services or items rendered to Federal health care program beneficiaries.
- The legal sanctions which will result from submitting deliberately false or reckless billings.
- Ongoing training for staff on changes in standards of practice, policies or procedures, laws, or regulations.
- As appropriate, unit-meeting agendas include discussions of compliance activities and QIC system level issues.
- New staff orientation training includes specific discussion and training on compliance issues.
- Code of Conduct.
- Hotline.
- Confidentiality; and,
- Prevention of Inducements.

Medicaid and Medicare Exclusion List – Individuals

According to the OIG:

“The effect of an exclusion (not being able to participate) is: No program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.”

Since Medi-Cal and Medicare will not reimburse services provided by debarred individuals, including services associated with support or administration by debarred individuals; and since debarred individuals may neither be employed nor contracted to an MHP and DMC-ODS, the Health and

Human Services Office of Personnel Services will assume auditing and monitoring responsibility to ensure that individuals are not debarred from billing for services to Medi-Cal or Medicare.

Medicaid and Medicare Exclusion List - Private Providers

Since it is essential that Private Providers be eligible to bill for services to Medi-Cal or Medicare; and since SOC Quality Management Program staff credential providers to become a part of the SOC Private Provider Network, SOC QM staff will assume auditing and monitoring responsibility to ensure that Private Providers used in the Placer County Private Provider Network are not debarred from billing for services to Medi-Cal or Medicare.

Medicaid and Medicare Exclusion List - Procurement

Since neither debarred providers or suppliers may be contracted, Health and Human Services Administration – Contracts will assume auditing and monitoring responsibility to ensure that Placer County Managed Care does not contract with providers or other suppliers who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations.

The Medicaid and Medicare Exclusion List Policy and Procedure for Procurement will assist in ensuring that Placer County Managed Care does not contract with providers or other suppliers who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations

Site Certification

SOC QM will maintain and monitor certified Mental Health providers and monitor SUS provider sites as required by the California Department of Health Care Services. In addition, SOC will ensure that the private organizational providers of Medi-Cal specialty mental health services with which it contracts maintain certified provider sites as required by the California Department of Health Care Services.

This category of auditing and monitoring is intended to centralize the monitoring of all required operating licenses and certifications. This allows the MHP/DMC-ODS designated Director to know at a glance the status of all approvals, a valuable capability as external inquiries into status of these will usually be initiated through the Director's office. This also ensures that licenses or certificates are not inadvertently allowed to lapse.

Staff Professional Licensure

A significant challenge for any clinical program is assuring the current, active licensure of all licensed staff; this is particularly important when services performed by these individuals are claimed as having been performed by a licensed individual.

SOC Administration requires that staff with professional licenses/internships provide a current copy of their license/registration for quality assurance/compliance; and SOC Administration will track the staff who must be licensed, those whose licensure will expire in coming months, status of those renewals, and staff whose licenses have expired without confirmation of renewal.

Outpatient and Hospital Physician Committees

It is the policy of SOC to ensure physician compliance with medical and clinical standards relative to medication prescribing and outpatient and inpatient treatment; to monitor specific physician compliance with medical and clinical standards; and to provide continuous review and monitoring of in-patient activities in order to assess and take corrective action when necessary and to provide improved services.

The two primary areas of review are:

- 1) Outpatient Medication Review to ensure quality of medication prescribing and use; and,
- 2) Inpatient Continuous Quality Improvement Review.

Professional and Paraprofessional Staff

It is the policy of SOC to ensure that individuals providing direct services to either the MHP or DMC-ODS beneficiaries do so in a manner that is consistent to their scope of practice as either a license, registered or certified provider or a paraprofessional. The SOC QM team is responsible to credential each direct service provider and to monitor all professional licenses on a monthly basis to ensure that professional staff remain in good standing with their respective boards.

Corrective Actions

Upon report or reasonable indication of suspected noncompliance, the SOC Compliance Officer or designee will promptly investigate the conduct in question to determine whether a material violation of applicable law, rule or program instruction or the requirements of the Compliance Program has occurred.

Detected but uncorrected misconduct can seriously endanger the mission, reputation, funding, and legal status of SOC. The Compliance Program will ensure that detected misconduct is promptly investigated and corrective action is carried out responsively and responsibly.

Corrective actions can be quite varied, and may include correction of a one-time error, elaborate process improvement, or even refunding of payments associated with the noncompliant performance.

Clearly, it is not enough to audit and monitor performance; identified cases of noncompliance must be responsibly addressed. Failure to notify authorities of an overpayment within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the government, thereby establishing an independent basis for a criminal violation with respect to the MHP or DMC-ODS, as well as any individuals who may have been involved.

Upon receipt of a report or reasonable indications of suspected noncompliance, the Compliance Officer investigates the allegations to determine whether a significant violation of applicable law or the requirements of the Plan has occurred, and if so, takes decisive steps to correct the problem. As appropriate, such steps may involve a corrective action plan, the return of any overpayments, a report to the government, and/or a referral to law enforcement authorities.

The program also provides for an internal investigation of all reported violations. When problems are detected, the SOC Leadership Team determines whether a flaw in the Plan failed to anticipate the problem or whether the program's self-policing procedures failed to prevent the violation. This investigative process may result in changes in policy to prevent reoccurrence of the

problem/violation.

To assist in identifying noncompliance, the Plan utilizes a set of monitors or warning indicators. These include the number and/or types of claim rejections, challenges to medical necessity, and/or high volumes of unusual charge or payment adjustment transactions.

SOC requires that detected misconduct be corrected promptly. In most cases, “promptly” means that the misconduct will be corrected within 90 days of detection.

SOC informs providers that:

- According to Section 1128J (d) and 1128J (d)(2) of the Social Security Act a provider can be prosecuted for his or her failure to disclose a known overpayment to the Medicare carrier even if the payment was not fraudulently obtained.
- Overpayments or errors that are not believed to be fraudulent are to be reported directly SOC.
- Fraudulent claims that have occurred in a provider's own organization can be disclosed to the OIG through its Provider Self-Disclosure Protocol; and,
- Instructions on how to submit a voluntary disclosure under this protocol can be downloaded from the OIG's Web Site at [www.hhs.gov/oig/oig/oigreg/selfdisclosure.pdf].

SOC Enforcement of Standards and Procedures

SOC enforcement and disciplinary mechanisms ensure that violations of compliance policies result in consistent and appropriate sanctions, including the possibility of termination, while being flexible enough to account for mitigating or aggravating circumstances.

It is made clear that individuals who fail to detect or report violations of the Plan may also be subject to discipline; and that disciplinary actions could include warnings, reprimands, probation, demotion, temporary suspension, discharge, restitution, and referral for criminal or civil prosecution.

SOC conducts checks to make sure all potential practice employees are not listed on the OIG or GSA lists of individuals excluded from participation in federal health care or government procurement programs.

SOC advises providers of any audit findings and informs providers of corrective actions that are needed. SOC provides feedback to providers. Providers who have been informed of non-covered services or practices, but continue to bill for them, or providers whose claims must consistently be reviewed because of repeated over-utilization or other abuse practices, will be subject to administrative actions.

SOC notifies providers that these actions may include suspension from participation in the Medicare/Medi-Cal programs and assessment of a civil monetary penalty; and that this penalty could be an amount up to \$10,000 for each false or improper item or service claimed and an additional assessment of up to three times the amount falsely claimed.

SOC conducts subsequent audits to determine if corrective action has been taken. If the subsequent audit indicates that corrective action was not taken, the case may be sent to the Office of the Inspector General to be reviewed for possible civil and criminal action.

SOC notifies employees of the fact that, those who participate in fraudulent activities or fail to detect or report violations may be subject to disciplinary action; and that the range of disciplinary actions taken may include warnings, reprimands, probation, demotion, temporary suspension, discharge, restitution, and referral for criminal or civil prosecution. SOC documents all disciplinary actions.

This policy and procedure commit the MHP and DMC-ODS to prompt response to potential cases of non-compliance. It also helps create a system to facilitate effective, efficient, and consistent responses to these cases, as failure to do so can seriously endanger the mission, reputation, and legal status of the MHP/DMC-ODS.

Policies and Procedures for MHP and DMC-ODS monitoring will assist in ensuring that detected misconduct is promptly investigated and corrective action is carried out responsively and responsibly.

Compliance Hotline

SOC 'Open Communication' Activities

- SOC adheres to a system for employees to report potential wrongdoing/misconduct directly to the Compliance Officer, without having to go through the chain of command.
- The Compliance Officer has an open-door policy for reporting possible misconduct.
- SOC clearly communicates its commitment to the process of reporting potential wrongdoing/misconduct and ensures staff that those in charge want them to come forward and will not penalize them for doing so.
- The Compliance Officer maintains a compliance bulletin board where everyone involved in the PCSOC MH and SUS can receive up-to-date compliance information.
- The Quality Management program supports the Compliance Officer in maintaining all policies and procedures, in an electronic format.
- SOC provides training, as appropriate, to ensure that staff receives the most recent information.
- SOC encourages staff to seek guidance if they are unsure about whether they are following policies and procedures correctly or if they need additional training; and,
- The Compliance Program provides a Compliance Hotline.
- Compliance Hotline numbers will be posted in each contract community-based organization site.

Every SOC employee is expected to report any activity he or she reasonably believes is in violation of the law, regulation, SOC Code of Conduct, ethical standards, or County policies. The employee need not be certain that the violation has occurred in order to report it. Reporting enables the Compliance Officer to investigate potential problems quickly and to take prompt action to resolve them.

Reports of violations may be made without fear of retribution and will be handled in a manner that protects the privacy of the caller. The confidentiality and other rights of all personnel involved, including anyone who is the subject of a compliance investigation, are protected to the extent permissible by law.

All reports will be evaluated promptly, thoroughly, and fairly by persons having a sufficient level of expertise and knowledge with regard to the issue presented by the caller. Investigations of reported cases will normally be completed within 21 days.

The Compliance Hotline provides a mechanism for employees to report information about known or suspected non-compliance when the employee is uncomfortable using his or her chain-of-command.

The purpose of the Compliance Hotline is to provide a mechanism for employees to report any activity that may violate SOC Code of Conduct or state, federal or local law and regulations. The goal of the Hotline is to present opportunities for the identification, investigation, correction, and prevention of inappropriate activities.

The Hotline ensures both confidentiality and protection from retaliation. The Hotline is available 24 hours a day; seven days a week to ensure all staff have equal access to reporting.

The Compliance Hotline Policy and Procedure establishes the mechanism for employees to report information about known or suspected non-compliance when the employee is uncomfortable using his or her chain-of-command.

Code of Conduct

The SOC is firmly committed to full compliance with all federal and state laws, regulations, rules, and guidelines that apply to SOC's operations and services. At the core of this commitment are the employees of the MHP and DMC-ODS, and the manner in which they conduct themselves. To assure that its employees share SOC's commitment, SOC has established a Compliance Program Code of Conduct. Employees are expected to read, understand, and certify their commitment to act in complete compliance with the Code of Conduct.

The Code of Conduct specifically addresses conduct prescribed by the Compliance Program and is maintained in addition to other standard codes of conduct already in effect. The Code of Conduct accomplishes the important objective of establishing compliant standards of employee and contractor conduct.

All employees and contractors will receive copies of the Code of Conduct and will receive training regarding the Code of Conduct.

The Code of Conduct and the Code of Conduct Policy and Procedure provides for the important objective of establishing compliant standards of employee and contractor conduct.

Maintenance of Compliance Records

SOC will document its efforts to comply with applicable statutes, regulations, and program requirements. The SOC Compliance Officer will maintain and dispose of compliance related records in accordance with applicable statutes and regulations.



**PLACER COUNTY DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SYSTEMS OF CARE**

**CODE OF CONDUCT
2021 UPDATE**

Special Note:

It is the expectation that all HHS Systems of Care (SOC) employees and contracted employees working at county worksites will adhere to the HHS Code of Ethics and this Systems of Care Code of Conduct. In addition, some programs under the SOC may be required to have their own Code of Conduct. When this occurs, the program code of conducts will be added as an attachment.

Our Vision

Placer County's Health and Human Services is a multi-division department focused on the health and social services fields. Our services are available throughout the county. We provide a unified system of quality services to safeguard the health and well-being of the people in our communities. To realize our mission, we strive to keep all children, adults, and families:

Healthy
Safe
At home
In school or at work
Out of trouble
Self-sufficient
Culturally Supported

Our Mission

The SOC shall ensure that all public programs for adults, children and families will provide services in a comprehensive and integrated manner, regardless of the agency door by which families enter. In addition, we will effectively collaborate with individuals, families, and their supports, as well as community partners, to promote self-determination and to achieve optimal quality of life.

Our Guiding Principles

We commit to:

- Being guided by the highest professional standards.
- Sharing ownership and responsibility for the organization.
- Inviting staff, consumers, youth, and families to participate or have voice in organizational problem solving.
- Supporting excellence in professional development.
- Building a strong work ethic and sound business principles.
- Creating a collaborative climate.
- Supporting innovation and promising program practices.
- Being respectful, responsive, and attentive.
- Being an organization that is appreciative of cultural differences.
- Promoting and providing services which are outcome-focused, strength-based, family-centered, comprehensive, and integrated to the extent possible by a single services plan which encourages and directs families to use their own resources to resolve problems.
- Identifying, developing, and maintaining services systems consistent with public/private, community-based, school-linked, and family partnerships, which can intervene early or prevent problems with at-risk children and families and/or adults.
- Providing services to adults, children, youth, and families in the least restrictive and intrusive setting appropriate to meet the identified needs.
- Identifying, developing, and monitoring coordinated policies, procedures, and resources for the benefit of at-risk children and families and/or adults; and to hold member agencies and their staffs accountable in these efforts.
- Adopting confidentiality standards consistent with and authorized by WIC Section 18986.46, WIC Section 108500.00, Local Rule 50.19 of Placer County Superior Court, or other general provisions of the law which promote a comprehensive, integrated, family-centered approach.
- Promoting and maintaining quality services which are cost effective and appropriate through the use of a unified service record, universal intake, service authorization /reauthorization, utilization review and outcomes evaluation.
- Providing on-going support and direction to each member agency and their staff in providing services and resources for at-risk children and families and/or adults consistent with the vision mission and principles; and
- Promoting reinvestment of any fiscal savings into identified gaps in services, early intervention, and prevention programs.

Our Goals

Are to:

- Promote self-sufficiency.
- Promote healthy lifestyles.
- Promote and ensure a healthful environment.
- Prevent disease and disability.
- Assure easy access to quality health care services.
- Reduce environmental threats to health; and
- Recommend and implement health policy and services based upon assessment of community health needs.

Business Strategies

Include:

- Encouraging excellence by ensuring a healthy work environment that values employees; and
- Supporting the workforce through the effective use of technological and other resources.

Introduction to The Code of Conduct Expectations

As part of the Systems of Care (SOC) ongoing commitment to providing service with a focus on quality and creating a working environment that encourages excellence, this Code of Conduct was developed with participation of staff from all organizational levels throughout SOC. The Code of Conduct is intended to:

- Communicate County and SOC expectations of ethical behavior.
- Communicate the commitment of SOC to its employees and contract providers and to compliance with laws, regulations, contractual obligations, and standards of care consistent with community standards; and
- Familiarize all staff with the basic legal principles and ethical standards of behavior expected throughout SOC.

The Code of Conduct is intended to complement, not replace, department policies and procedures. Policies and procedures utilized by Placer County Department of Health and Human Services include those issued by the Placer County Executive Officer and the Board of Supervisors.

All regular and extra-help employees (including executive, administrative, and supervisory management), contract employees, contract providers, volunteers and other designated individuals engaged in our work environment or acting on behalf of SOC are expected to follow the Code of Conduct standards, as well as all applicable statutes, regulations, contractual obligations and SOC and County policies and procedures. If there is not an existing SOC or County policy on a particular subject matter, the general principles of this Code of Conduct shall be used as a guideline.

When seeking guidance and direction concerning a workplace issue or concern, employees are encouraged to refer to SOC's administrative, division or program policies and procedures or to contact their supervisor, manager, or other management staff within their chain-of-command.

County employees may also contact Human Resources at (530) 889-4060 or issues can also be reported confidentially and anonymously to the Compliance Telephone Hotline at (530) 886-3622. County employees may also choose to report to the County Wide Compliance Hotline at 1-800-461-9330 or visit <https://myplacer/informus/Pages/default.aspx> to file a report.

The Code of Conduct is a "living document" which will be updated periodically to keep pace with changes. At minimum, the Code of Conduct will be reviewed and, if necessary, revised on an annual basis.

Questions regarding the Code of Conduct should be directed to **Twylla Abrahamson, Ph.D., Compliance Officer** by telephone at (530) 886-6700, by email at TAbraham@placer.ca.gov, by fax (530) 886-6735 or by letter to **Twylla Abrahamson, Ph.D., Compliance Officer**, 11716 Enterprise Drive, Auburn, CA 95603.

Quality of Care and Services

We are committed to providing consistent high-quality care and to offering skilled, compassionate, reliable service to our consumers, youth, families, and community by:

- Treating all consumers, youth and families with dignity, respect, and courtesy.
- Providing appropriate care and service and, whenever possible, individualize that service to address unmet consumer, youth, family, and community needs.
- Employing professionals with proper credentials and ensuring that all members of the care team have experience and expertise in the area(s) in which they provide service.
- Providing all services in accordance with applicable federal, state, and local government laws and regulations, and the standards of practice in the community.
- Accurately and completely documenting all encounters in the SOC record.
- Providing consumers, youth, and families with the information they need to make fully informed decisions. We recognize and honor that our consumers, youth, and families have a right to receive information about SOC services and its policies, procedures, and charges.
- Treating consumers, youth, and families in a manner appropriate to their background, culture, religion, and heritage.
- Participating in activities that promote quality improvement and bring deficiencies or errors in the quality of care and services to consumers, youth, and families to the attention of those who can properly assess and resolve the problem.
- Striving to do our jobs so that no harm is caused to our consumers, youth, families, the community, co-workers or ourselves; and
- Promoting a positive image for SOC, its employees and its services.

Workplace Conduct

We recognize that our greatest strength lies in the talent of our workforce who foster our success and reputation. We treat our colleagues with respect, dignity, and courtesy. We:

- Maintain a working environment free from all forms of harassment or intimidation, sexual or otherwise, showing respect and consideration for each other. Discriminatory treatment, abuse, violence, or intimidation is not tolerated.
- Afford equal employment and advancement opportunities to all applicants and employees pursuant to SOC and County policies.
- Conform to the codes of ethics and standards of our respective professions and exercise sound judgment in the performance of duties.
- Comply with work and safety policies in accordance with County and SOC policies and procedures, including, but not limited to, the Non-Smoking Ordinance in County, and the County of Placer drug and alcohol policy prohibiting the use of alcohol or drugs in the workplace.
- Provide our employees with clear direction about what is expected of them; and
- Violations of the Code of Conduct may be considered violations of the County's Policies and Procedures pertaining to Personnel Practices and may be considered for disciplinary action.

Adhering to Laws and Regulations

We follow the letter and spirit of applicable laws and regulations and conduct our business in an ethical and honest manner that enhances SOC's standing in the community. We:

- Comply with all applicable laws, rules, regulations, standards, and other applicable requirements made necessary by federal, state and county governments. We comply with all requirements of federal healthcare program statutes, regulations, and guidelines.
- Do not engage in any practice that involves unethical or illegal activity.
- Take reasonable precaution to ensure that billing and/or coding of claims are prepared and submitted accurately, timely, and are consistent with federal, state and county laws and regulations and SOC's policies and procedures and/or agreements with third party payers. This includes federal healthcare program regulations and procedures, or instructions otherwise communicated by regulatory agencies (e.g., the Centers for Medicare and Medicaid Services) or their agents.
- Ensure that no false, fraudulent, inaccurate, or fictitious claims for payment or reimbursement of any kind are submitted.
- Bill only for eligible services actually rendered and fully documented. When the services must be coded, only billing codes that accurately describe the services provided will be used.
- Act promptly to investigate and correct problems if errors in claims or billings are discovered; and
- Voluntarily disclose to third party law enforcement or regulatory agencies violations of law, regulations, or standards where appropriate and legally required.

Conflicts of Interest

We avoid conflicts of interest or the appearance of conflicts of interest between our own personal interests and the best interests of the County. We:

- Avoid commitments that interfere with our ability to properly perform duties for SOC or any activity that may conflict with the known interests of SOC, its consumers, youth, or families. Examples include but are not limited to 1) the solicitation of future employment with a company doing business with the County over which the employee has some control or influence in his/her official capacity; 2) the use of County time, facilities, equipment, badge or uniform for private gain or advantage, or the private gain or advantage of another.
- Conduct ourselves in a manner appropriate to our standing as representatives of local government, representing the best interests of the County's citizens.
- Report any potential conflicts of interest to SOC in accordance with the SOC Conflict of Interest policy. Concerns or questions regarding potential conflicts of interest are brought to the attention of a supervisor, manager, Human Resources, the Compliance Officer, or the County Wide Compliance line; and
- Do not accept or provide benefits that create conflict between personal interests and SOC's interests. These benefits include, but are not limited to, accepting meals, gifts, refreshments, transportation, entertainment, or any item of monetary value provided or received in connection with assigned duties as set forth for designated employees in the County's Gift Ban Ordinance, enacted by the Placer County Board of Supervisors.

Protecting Assets

We protect the County's property and assets. We:

- Are responsible and accountable for the proper expenditure of County funds and for the proper use of County assets and property. We perform cash handling and receipting duties in accordance with County policies and procedures.
- Obtain appropriate authorization prior to committing or spending SOC funds.

- Use work hours in a productive and professional manner.
- Dispose of surplus, obsolete, or junked property in accordance with County's procedures. Unauthorized disposal, including scrapping, selling, or transferring of property without appropriate approval, is a misuse of assets.
- Safely store, secure, document and inventory supplies and report missing supplies promptly to appropriate supervisors in accordance with County policy.
- Dispose of medical and/or county waste or other hazardous materials properly and lawfully.
- Use computer systems, networks, and software consistent with license(s) and/or rights, and store equipment, data files and software in a secure manner in accordance with SOC policies and procedures.
- Use electronic health record systems for minimal need and not for personal gain or the gain of others; and
- Are responsible for reporting any observed misuse of SOC property or funds to an appropriate supervisor or manager, Human Resources, the Compliance Officer, or the confidential Compliance Hotline. No disciplinary action or retaliation will be taken against an employee for reporting in good faith a perceived issue, problem, concern, or violation.

Work Relationships:

We:

- Are committed to establishing and maintaining ethical work relationships.
- Seek positive and cooperative relationships within SOC as well as with other government programs, vendors, contractors, community groups and industry to enhance services and resources available to the public.
- Are honest and forthright in providing information to consumers, youth, families, vendors, payers, other employees or agents, and the community.
- Bring to the attention of supervisors or managers, Human Resources, the Compliance Officer, or the confidential Compliance Hotline information related to non-compliance or adherence to agency policies and procedures as well as required federal, state, or local regulations.
- Cooperate in accomplishing SOC's commitment to maintaining a work culture that promotes the prevention, detection, and resolution of instances of conduct that do not conform to ethical standards or the Code of Conduct.
- Ensure that no employee is required to compromise his or her appropriate professional integrity, standards, judgment or objectivity in the performance of his or her duties.
- Ensure that all reports or other information provided to any internal or external entities including federal, state, or local government agencies, are accurate and submitted in a timely manner; and
- Perform duties in a way that promotes the public trust and encourages participation and access to county programs and resources.

Records Maintenance

We are committed to maintaining accurate and appropriate records in accordance with all federal, state and county laws and regulations and SOC policies and procedures. We:

- Maintain complete, accurate and thorough records.
- Ensure that all records in any medium are maintained, in accordance with guidelines established by the Placer County Board of Supervisors and applicable government and civil codes, in an accurate and confidential manner in order to protect privacy and to provide factual information.
- Maintain guidelines for clinical documentation according to the legal requirements for the records.
- Comply with all laws governing the confidentiality of information.
- Ensure that timesheets and other cost records and reports are complete and reflect accurate information; and

- Are committed to accessing records, only on a “need to know” basis and in line of duty for the work we perform.

Questions regarding record maintenance guidelines may be referred to each division’s Custodian of Records. For Adult System of Care, **Nancy Washman, Administrative Supervisor**, by telephone (916) 787-8830, by email at NWashman@placer.ca.gov, or by letter to **Nancy Washman, Custodian of Records**, 101 Cirby Hills Drive, Roseville, CA 95678. For Children’s System of Care, **Norma Ibarra Mancilla, Administrative Supervisor**, by telephone (530) 889-6704, by email at Nlbarra@placer.ca.gov, or by letter to **Norma Ibarra Mancilla, Administrative Supervisor**, 11716 Enterprise Drive, Auburn, CA 95603.

Statement of Non-Retaliation

No disciplinary action or retaliation will be taken against an employee for reporting in good faith a perceived compliance issue, problem, concern, or violation. The phrase "in good faith" means that the employee honestly or truthfully believes or perceives the information reported to be true. All SOC staff shall respect the value and dignity of each person and the right as an employee to be treated fairly and with respect.

SOC Compliance Officer

SOC has appointed a Compliance Officer who is responsible for the daily oversight of the Compliance Program. The primary responsibilities of the Compliance Officer include:

- Receiving, investigating, and following up on concerns, questions, and issues raised by employees or others related to the Compliance Program, including potential violations of the Code of Conduct, policies and procedures, laws, and regulations.
- Maintaining, auditing, and monitoring mechanisms to ensure compliance.
- Ensuring an ongoing compliance education program for all employees and other designated individuals.
- Monitoring the operation of the Compliance Hotline; and
- Maintaining the Code of Conduct and compliance policies and procedures.

Responsibilities of Employees

SOC Compliance Program can succeed only through the efforts of dedicated employees who conduct themselves with honesty and integrity, and in compliance with the letter and the spirit of all applicable laws and regulations. Although each individual is ultimately responsible for his or her own conduct, SOC is committed to maintaining a work environment that promotes these ideals and encourages employees to demonstrate the highest ethical standards in performing their daily tasks.

With these goals in mind, SOC requires the active participation of all employees (including executive, administrative, and supervisory management) and contract providers in the SOC Compliance Program. Highlights of employee responsibilities are as follows:

- Employees and contract providers are responsible for reading, acknowledging and retaining a copy of the Code of Conduct.
- Employees and contract providers are expected to comply with the Code of Conduct, SOC policies and procedures, and contractual obligations, as well as laws and regulations. This includes statutes, regulations and guidelines applicable to state, county, and federal healthcare programs. Failure to comply with the above may potentially subject an employee to civil and criminal liability, sanctions, penalties or disciplinary action.
- All employees and contract providers are responsible for helping to create a culture within SOC that promotes the highest standards of ethics and compliance.

- Supervisors, managers, and contractors are responsible and accountable for: 1) ensuring that those on their team have sufficient information to comply with law, regulation, and policy, 2) providing appropriate and necessary training and, 3) for responding in an appropriate and timely manner to issues or concerns brought to their attention by employees; and
- Employees and contract providers are obligated to report a violation of the Code of Conduct, agency policies and procedures or laws and regulations. Depending on the circumstances, failure to comply in reporting a known or suspected violation could subject an employee to disciplinary action.

Employees cannot exempt themselves from the consequences of their own misconduct by self-reporting, although self-reporting may be taken into account in determining the appropriate course of action.

When considering reporting what you believe to be a violation, employees or contract provider should ask themselves:

- Do I have all the facts?
- What is the action that I perceive violates standards as outlined in the Code of Conduct?
- What is the action that I perceive violates any known law, rule, regulation, or policy and procedure?
- What opportunity has been given to my supervisor or manager to make them aware of and to address the issue (if appropriate)?

Confidential Disclosure Program

Placer County SOC is a learning organization that has implemented a Compliance Program so that errors and processes that might cause less than accurate billing, will be addressed quickly and corrected through a system of regular and routine monitoring. In addition, this system will uncover, eliminate, and correct any fraudulent billing.

SOC employees and contract providers have an obligation to report in good faith known or suspected violations of any statute, regulation, or guideline applicable to the federal healthcare programs, any law or regulation, the Code of Conduct or policies and procedures to their supervisor, manager, other management staff or contractor within their chain of command. Employees may also report their concerns to Human Resources.

If an employee or contract provider is uncomfortable reporting a suspected violation to any of the above-referenced resources or if they believe that the issue has not been handled appropriately, he or she is encouraged to contact **Twylla Abrahamson, Ph.D., Compliance Officer** by telephone at (530) 886-6700, by email at TAbraham@placer.ca.gov, by fax (530) 886-6735 or by letter to **Twylla Abrahamson, Ph.D., Compliance Officer**, 11716 Enterprise Drive, Auburn, CA. 95603 or by contacting the Compliance Telephone Hotline at (530) 886-3622. The Compliance Telephone Hotline provides a confidential means to report compliance-related concerns or violations. All calls will be treated as confidentially as practicable or allowed by law. Employees are not required to identify themselves when reporting a concern. Callers who wish to remain anonymous will be assigned a private code that may be used for follow-up communication so that they may be advised on the process of investigating and resolving the reported concern. County employees may also choose to report to the County Wide Compliance Hotline at 1-800-461-9330 or visit <https://myplacer/informus/Pages/default.aspx> to file a report.

Calls received by the Compliance Telephone Hotline will be referred to Twylla Abrahamson, Ph.D., Compliance Officer, for internal investigation and resolution.

Committing or condoning retaliation for good faith reporting of a perceived or suspected Code of Conduct violation(s), or for participation in an investigation of an alleged violation, will not be tolerated. Any employee who commits or condones any form of retaliation may be subject to discipline up to, and including, termination.

Electronic Employee Affirmation

Employees will be required to complete an electronic affirmation confirming they have read and understand the Systems of Care (SOC) Compliance Program Code of Conduct. Non-electronic affirmations will require a signature affirmation following the template below. Review of the Code of Conduct and completion of the employee affirmation is required within 30 days of hire and annually thereafter.

Employee Affirmation

I affirm that I have read and understand the Systems of Care (SOC) Compliance Program Code of Conduct.

I certify my intention to act in complete compliance with the SOC Compliance Program Code of Conduct. I understand that, when necessary, I may seek advice from the appropriate supervisor, and the Compliance Officer, concerning appropriate actions that I may need to take in order to comply with the Code of Conduct.

Date

Title or Capacity

Signature

Department/Clinic

Name (Printed)



Placer County HHS Substance Use Disorder Services Code of Conduct

The SUDS Code of Conduct is a living document. The SUDS Code of Conduct reflects compliance under the:

**PLACER COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES SYSTEMS OF CARE
CODE OF CONDUCT (2012)**

Placer County Substance Use Disorder Services addresses the following:

Use of Alcohol and/or other drugs on the premises and when off the premises.

- We comply with work and safety policies in accordance with County and Systems of Care (SOC) policies and procedures, including but not limited to, the mandated Non-Smoking Ordinance in County buildings and vehicles, and the County of Placer drug and alcohol policy prohibiting the use of alcohol or drugs in the workplace.

Personal relationships with participants:

- We avoid conflicts of interest or the appearance of conflicts of interest between our own personal interests and the best interests of the County including, but not limited to social/business relationships with clients and/or their family members. We conduct ourselves in a manner appropriate to our standing as representatives of local government, representing the best interests of the County's citizens. We Report any potential conflicts of interest to SOC in accordance with the SOC Conflict of Interest policy and refrain from any political activities.

Prohibition of sexual contact with participants:

- We will refrain from sexual contact with patients and clients.

Verbal, physical, and sexual harassment:

- We maintain a working environment free from all forms of harassment or intimidation, sexual or otherwise, showing respect and consideration for each other. Discriminatory treatment, abuse, violence, or intimidation is not tolerated.

Unlawful discrimination:

- There will be no discrimination based on race, religion, sex, ethnicity, age, disability, sexual preference or personal beliefs. We uphold participant rights to expect non-discrimination on the part of SUDS staff and in return, the participant is expected to do the same.

Conflict of interest:

- We avoid commitments that interfere with our ability to properly perform duties for SOC or any activity that may conflict with the known interests of SOC, its patients, clients, or constituents.

Scope of practice:

- Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statues. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. At no time shall anyone provide services beyond their scope of practice.

Confidentiality:

- We adhere to guidelines under HIPAA (Health Information Portability and Accountability Act) and 42 CFR (whichever is more protective of client confidentiality) while working with participants and interacting with agencies providing services.

Complaint investigations:

- We adhere to the guidelines of beneficiary protections and participants' right to file grievances regarding their SUD services. We will be made available to cooperate with any form of investigation regarding grievances and compliance.



SUDS Compliance Program

Code of Conduct

Employee Affirmation

I affirm that I have read and understand the SUDS code of conduct in addition to the SOC Compliance Program Code of Conduct.

I certify my intention to act in complete compliance with the SOC Compliance Program Code of Conduct and the SUDS Code of Conduct. I understand that when necessary, I may seek advice from the appropriate supervisor and the Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct.

Date

Signature

Name (Printed)

Title or Capacity

Agency/Department/Clinic