

Superintendent's Regulation- 8600-R MEDICAID

COMPLIANCE AND INTEGRITY PROGRAM

BV
Approved Upon Superintendent's Initials

3/26/13
Date

I. Overview

- A. New York State has agreed to implement a Compliance and Integrity Program to prevent fraud, abuse and false billing to Medicaid in its School and Pre-school Supportive Health Services Program (SSHSP). The Program shall be maintained so as to ensure that the New York State Medicaid program, the New York State Education Department (NYSED), local school districts, and its relevant employees are in compliance with all laws and regulations applicable to this program and with the terms of the agreement. The Rochester City School District (the "District") implemented a compliance program that will prevent and detect fraud, waste and abuse.
- B. The goal of the District's Compliance Program is to ensure that the District has the structure in place to minimize the risk of inaccurate Medicaid billings. Although the District's Medicaid Compliance Officer ("MCO") oversees the Compliance Program, it is the responsibility of all District employees and service providers to comply with all Federal and State laws, the District's Board Policies and Superintendent's Regulations.

II. Compliance Expectations

- A. It is the District's expectations that all employees and service providers report any instances of wrongdoing of Medicaid billings: wrongdoing includes any violation of Federal or State law. In addition to a violation of Federal or State law, wrongdoing includes violation and impermissible billing practices such as:
- Billing for services not performed at all or not performed as described;
 - Submission of claims for unnecessary or undocumented services, equipment, or supplies;
 - Double billing;
 - False cost reports;
 - Billing for services by an unlicensed or excluded provider: paying or accepting money, gifts, or favors in return for referrals.

B. The District's Medicaid Compliance and Reimbursement Department is responsible for the oversight and facilitation of all areas pertaining to the monetary reimbursement for the delivery of health-related services provided by the District. This includes:

- Review and audit of all potential claims to be submitted for reimbursement in accordance with State and Federal guidelines, regulations and laws;
- Submission of audit defensible claims for monetary reimbursement;
- Ongoing training of all relevant District staff, contracted employees and agencies;
- Maintenance of documentation for the support of all claims;
- Maximization of potential reimbursement for services provided;
- Reconciliation of reimbursements received;
- Determining that the service providers are licensed at the time of providing services and submitting the claim and ensuring that the service provider is not on the Center for Medicare and Medicaid Services excluded list.

III. Medicaid Compliance Officer

The District has designated an MCO. The MCO will report directly to the Superintendent or designee. The Superintendent will provide periodic reports to the Board of Education on the activity of the MCO. The MCO will provide oversight and monitoring to ensure that the District's Medicaid Department is complying with the operating procedures.

A. The MCO will communicate regularly with the Superintendent or designee on the Compliance Plan implementation including:

1. Compliance work plan for the year
2. Bi- monthly status reports;
3. Compliance issues;
4. Corrective actions;
5. Billing irregularities;
6. Audits;
7. Disciplinary actions for noncompliance;
8. Status of compliance training; and
9. Remain current on the regulatory environment.

- B. The MCO provides guidance to the District's Medicaid Department regarding Medicaid procedures and governmental laws and regulations.
- C. The MCO monitors compliance with required mandatory reporting, credentialing, monitoring and auditing of internal data and confirms that any adverse events are properly reported and addressed.
- D. The MCO investigates all compliance-related issues and complaints.
- E. The MCO reviews risk assessment results and makes recommendations and/or takes appropriate corrective action.
- F. The MCO determines the effectiveness of any corrective action that has been taken.
- G. The MCO ensures and documents the effectiveness of the compliance plan, and also makes assessment based on results of audits and investigations. The MCO will retain results of audits and investigations.
- H. The MCO coordinates ongoing internal and external audits.
- I. The MCO is responsible for investigating every report of non-compliance in a timely manner. All District employees must cooperate with these investigations. Upon completion of the investigation, the MCO will prepare a report to the Superintendent or designee. This report will include the MCO's recommendations in collaboration with the District's Human Capital Initiatives for any disciplinary action.
- J. The MCO in conjunction with the District's Medicaid Department shall develop, implement, oversee and/or provide training on Medicaid billing and documentation requirements. Training will include compliance plan overview and contents, department specific risk areas, summary of fraud and abuse laws and the topics of security and confidentiality.

IV. Duty to Report Wrongdoing; Whistleblower Protection

- A. Any person who has knowledge of or, in good faith, suspects any wrongdoing in the documentation, coding, or billing for services, equipment, or supplies, in either practice or those of our students or students' parent or guardian, should report it internally to the District's MCO or anonymously at 585-262-8282 so that an investigation can be conducted and appropriate action taken. Failure of a District employee or service provider to report a suspected problem with Medicaid claims will result in disciplinary action up to and including termination.

- B. The District will not retaliate or intimidate against any employee who reports in good faith an act or suspected act of non-compliance. Retaliation or reprisal in any form against anyone who makes a report of wrongdoing, cooperates in an investigation, or participates in the compliance program is strictly prohibited. If an employee or service provider believes that an adverse action in the form of intimidation or retaliation has been taken against him or her as the result of making a report or cooperating in an investigation pursuant to this Regulation, he or she should report it to the District's MCO immediately.
- C. Upon a report of wrongdoing, the MCO will conduct an investigation into the allegations to determine the nature, scope, and duration of wrongdoing, if any, and shall remedy the situation. Remedies may include contacting appropriate State or Federal officials when the allegation is confirmed.
- D. The MCO shall maintain a confidential log in a secure place of all reports of compliance concerns and shall update the Superintendent or designee as often as necessary.
- E. Anyone who makes a report of wrongdoing maliciously, frivolously, or in bad faith will be subject to disciplinary action up to and including termination.

V. Billing and Coding Standards

The District has set forth the standards that are applicable to reimbursement for medical services, supplies and equipment in order to comply with Federal and State Law, Board Policies and Superintendent's Regulation.

Each employee or service provider involved with providing or obtaining reimbursement for medical services, supplies, or equipment from, or on behalf of our students is responsible for submitting honest and accurate bills to Medicaid, Medicare, and other Federal and State health care programs. All employees or service providers are expected to comply with Federal and State laws and administrative remedies designed to prevent fraud, abuse, and waste in Federal and State health care programs.

- A. Completeness and Accuracy in Medical Records and Billing
 - 1. All services, equipment and supplies billed for will be reasonable and fully documented.
 - 2. All bills will be for services provided by providers who are properly credentialed and licensed and provide services within their scope of practice.
 - 3. Documentation will be in sufficient detail so that an accurate bill can be submitted for each treatment or procedure performed.
 - 4. Provider numbers will be accurate and will not be shared.

5. Services performed by therapists who require supervision will be billed only in compliance with Federal and State laws and regulations including the presence of a Supervising Licensed professional.
6. Bills submitted for service performed shall describe the services in sufficient detail, based on proper documentation, be accurate, be based on the correct provider number, and be in compliance with Federal and State law.
7. Billing and Coding staff will comply with the Center for Medicaid Services and State program instructions and policies.

B. Impermissible Billing Practice

The following practices are not permitted:

1. Billing for services that were not performed at all or not performed as described.
2. Submitting claims for medical equipment, supplies, or services that were not necessary.
3. Double billing.
4. Assigning a code that secures a higher reimbursement, rather than the code that matches the services performed.
5. Knowingly misusing provider numbers.
6. Failing to use coding modifiers accurately or appropriately.
7. Preparing or submitting false cost reports.
8. Billing for services performed by an unlicensed provider or one who has been excluded from a Federal health care program.

C. Compliance with Federal Law

1. All District employees and service providers will comply with Federal and State law and regulations concerning fraud and abuse in Federal health care programs, especially the Federal False Claims Act and administrative remedies associated with their enforcement.
2. No employee and/or service provider is permitted to give cash, gifts, favors, payment, services, entertainment, tips or any other items of value to anyone in exchange for their signing a contract or reporting services to be billed to Medicaid, Medicare or any other government or private health care program.

D. Government Reporting

1. All reports required to be submitted to State or Federal health care programs must be truthful and accurate. No District employee or service provider shall attest to the accuracy of a submitted report unless he or she has been able to satisfy that the data submitted or the representations made be truthful and accurate.
2. If it is determined that a claim has been overpaid by a government program or third party payer the District will promptly adjust the payment in the future billing to the proper party to return the overpayment.
3. All cost report data, schedules and worksheets must be truthful, accurate, and complete.
4. No District employee or service provider will attempt to improperly influence the actions or decisions made by government bodies, officials, employees, or contractors.
5. The District will cooperate and be truthful in responding to government inquiries, requests, and investigations, including audits, and certification reviews.

VI. Training

- A. Initial Training** – The New York State Training Plan requires that relevant employees of the District, including contractors that bill Medicaid either directly or indirectly under SSHSP receive at least one (1) hour of initial training.
1. New employees, new appointees, new associates, new executives, and new Board of Education members will receive Medicaid compliance training at the time of orientation or within 30 days of hire.
 2. The District must provide a list of relevant employees to the State Education Department.
 3. Relevant employees include those that provide SSHSP services to students, those that prepare or submit claims, the Superintendent, the Special Education Department Director and Board members.
 3. The employees will be required to certify in writing that they have participated in the training. Certification must be maintained for three (3) years from the date of training.
- B. Annual Training** – Relevant employees are required to receive at least one (1) hour of additional training each year.

- C. The District's Medicaid Department will provide training for all District employees involved in Medicaid Billing.

VI. Audits and Reviews

- A. The MCO is responsible for the coordination of all Medicaid audits.
- B. The MCO will conduct internal audits of the District's Medicaid Department's claiming process.

The District will follow all applicable compliance requirements of the current School Supportive Health Services Program/Preschool Supportive Health Services Program (SSHSP/PSHSP) per the *New York State Medicaid in Education Handbook* available at <http://www.oms.nysed.gov/medicaid/>