

900.4 CORPORATE COMPLIANCE RELATED DEFINITIONS

(Previous Number 901.5)

Abuse

Practices that are inconsistent with sound fiscal, business, or clinical/medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid programs. (42CFR 455.2)

Alleged Violation/Alleged Wrongdoing

Conduct which, at face value, appears to conflict with required law, regulation, contract language, agency policy or Code of Conduct/Ethics or illegal activity. (Also see "Wrongdoing" and "Violation").

Breach

The unauthorized acquisition, access, use, or disclosure of PHI in a manner which compromises the security of privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain the information." (45 CFR 164.408)

Business Associate (BA)

A person or organization that performs a function or activity on behalf of a *covered entity* but is not part of the *covered entity's workforce*. A *business associate* can also be a *covered entity* in its own right. Also see Part II, 45 CFR 160.103.

Complaint

A complaint is any report of suspected or known violation of applicable laws, regulations, contract language, regional and local policies, etc., any suspected wrongdoing, or known or suspected fraud, waste or abuse of public funding.

Complainant

The individual reporting the alleged compliance violation, wrongdoing or improper conduct. A reporting person can be any agency officer, board member, full-time, part-time and temporary employee, volunteer, student, applicant for employment, provider, vendor, (sub)contractor and any other person or entity that may become part of or affiliated with the provider network in the future.

Compliance Investigations

The observation or study of suspected fraud, abuse, waste, or reported violations of laws and regulations for all OnPoint covered services by close examination and systematic inquiry.

Confidentiality of Alcohol and Drug Abuse Participant Records - 42 CFR Part 2

42 CFR Part 2 applies to AOD (Alcohol and Other Drugs) programs that are federally conducted, regulated or assisted in any way, directly or indirectly. Regulations apply to recipients of AOD and their participant identifiable information and prohibit most disclosures of information without participant consent.

<https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol1/CFR-2010-title42-vol1-part2/content-detail.html>

Conflict of Interest - Private interests that create a conflict or give the appearance of a conflict between the private interests and the official financial or professional responsibilities of a person in a position of trust, or a decision or situation based on criteria other than the best interests of

the agency or individuals served, most often creating personal, financial or other benefit to an individual or organization.

Contract Provider (Also referred to as Network Provider)

Any individual, group, or organization that has a provider agreement with OnPoint to provide services and supports to individuals we serve.

Corporate Compliance

The organization's adherence to laws, regulations, contract language, and policies applicable to its operations. Consists of the mechanisms, including the written Compliance Plan and Policies, that are collectively intended to prevent and detect unethical and/or illegal business practices and violations of law.

Corporate Compliance Program

A formal program specifying an organization's policies, procedures, and actions (plan) to help prevent and detect violations of laws, regulations, contractual obligations, standards, and ethical practices. Ultimately, the purpose of a corporate compliance program is to protect the organization. The benefits of a strong program go well beyond regulatory and legal compliance to also include operational benefits. A well-balanced corporate compliance program, along with a continuous quality approach, will help ensure that the agency's organizational structure, people, processes, and technology are working in harmony to manage risks, improve stakeholder satisfaction, optimize the use of limited resources, oversee providers, and achieve strategic and operational goals.

Corporate Compliance Plan

A high-level overview of the Corporate Compliance Program and that outlines OnPoint's commitment to ensuring compliance with applicable federal, state, and regional statutory, regulatory, and contractual requirements. The Compliance Plan provides a formal statement of OnPoint's intent to conduct itself ethically regarding business operations, adherence to applicable regulations, and providing services and care. It includes the fundamental elements of an effective compliance plan, which provides the overall strategy on how the agency will address fraud, waste, and abuse and other potential non-compliance.

Counseling Notes

SUD counseling notes are defined as notes recorded by a substance use disorder (SUD) or mental health professional during counseling sessions. These notes document or analyze the contents of conversations during private, group, joint, or family counseling sessions and are kept separate from the patient's medical record. They can be recorded in any medium, including paper or electronic formats, and requires specific consent for use or disclosure.

Covered Entity

Is defined at CFR 160.103 as one of the following: (1) A health plan; (2) a health care clearinghouse; (3) a health care provider who transmits any health information in electronic form in connection with a transaction covered by part 162 of title 45 of the Code of Federal Regulations (CFR).

Disclosure

The release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

Also see Part II, 45 CFR 164.501.

Fraud (Federal Claims Act)

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some authorized benefit to himself or some other person [or agency/organization]. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act (42CRF 455.2)

Fraud (Per Michigan Statue and Case Law Interpretation)

Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person “should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge.” Errors or mistakes do not constitute “knowing” conduct necessary to establish Medicaid fraud, unless the person’s “course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present.”

FWA

The federal term contained in the Deficit Reduction Act (DRA) refers to any event pertaining to an alleged or actual wrongdoing of Fraud, Waste or Abuse (i.e., generically known as “FWA”).

Health Information

Any information, whether oral or recorded in any form or medium that: (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and that (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

HIPAA Privacy Rule

Establishes national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without participant authorization. The Rule also gives participants’ rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html>

HIPAA Security Rules:

Establishes national standards to protect individuals’ electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html>

HITECH (Health Information Technology for Economic and Clinical Health Act of 2009)

The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper. HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (**HITECH** Act), as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009. The United States Department of Health and Human Services (DHHS) promulgated administrative rules to implement HIPAA and HITECH, which are found at 45 CFR Part 160 and Subpart E of Part 164 (the “Privacy Rule”), 45 CFR Part 162 (the

“Transaction Rule”), 45 CFR Part 160 and Subpart C of Part 164 (the “Security Rule”), 45 CFR Part 160 and Subpart D of Part 164 (the “Breach Notification Rule”) and 45 CFR Part 160, Subpart C (the “Enforcement Rule”). DHHS also issued guidance pursuant to HITECH and intends to issue additional guidance on various aspects of HIPAA and HITECH compliance. Throughout this policy, the term “HIPAA” includes HITECH and all DHHS implementing regulations and guidance. (Contract between Lakeshore LRE and ONPOINT – Medicaid Managed Specialty Supports and Services ..., p. 6)

Individually Identifiable Health Information (IHII) (Also see Protected Health Information (PHI)) Information that is a subset of health information, including demographic information collected from an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identified the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Inquiry

An informal process whereby a person makes the Compliance Office aware of a potential compliance related concern and the Compliance Officer examines the concern to determine if it merits a formal complaint and investigation. If the outcome of the *inquiry* determines that the matter is not FWA related, the Compliance Officer will document the *inquiry* and outcome and take any action necessary to rectify the concern. Conversely, if the outcome of the *inquiry* determines that a formal investigation is warranted, the Compliance Officer will convert the informal *inquiry* into a formal complaint and will conduct a formal investigation in accordance with the policy investigation guidelines.

Knowingly

Defined under the federal False Claims Act (FCA) to include the willful disregard of a regulation imposed upon an organization, the “deliberate ignorance” of the regulation’s propriety, the submission of a claim in “reckless disregard” of the truth, or the falsity of claim. Managerial staff of the provider organization can be held accountable in situations where they refuse to explore a credible concern about the compliance requirements for a particular business or clinical practice, or a submitted bill or claim requiring use of federal funds for its reimbursement. Michigan FCA expands the definition of Knowingly - Errors or mistakes do not constitute “knowing” conduct necessary to establish Medicaid fraud, unless the course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present that result in unnecessary costs to federal/state funding.

Lakeshore Regional Entity (LRE). The LRE is the PIHP (Prepaid Inpatient Health Plan) created to manage specialty carved out Medicaid mental health, intellectual/developmental disability, and substance use disorders services for Medicaid and Health Michigan enrollees in Allegan, Lake, Mason, Oceana, Muskegon, Ottawa, Kent counties. The LRE includes any administrators retained by contract by the LRE.

Marketing

Marketing and advertising practices are defined as those activities used by OnPoint to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers.

Minimum Necessary – HIPAA Privacy Rule Standard (45 CFR 164.502(b), 164.514(d))

A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose (*need to*

know) of the use, disclosure, or request.

Nominal Value

\$25.00 or less per gift; \$300 maximum per year from any one individual/organization/company.

Personnel

For the purposes of the Compliance Program Plan and associated Policies, "Personnel" means OnPoint's employees, Board of Directors, individuals under contract, students, interns, and volunteers.

Protected Health Information (PHI) *(Also see Individually Identifiable Health Information (IIHI))*

Any information, whether oral or recorded in any form or medium, that is created or received by a "Covered Entity" (or a Business Association of a Covered Entity), and relates to the past, present, or future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Provider

Any healthcare organization that furnishes or renders health care services or items within the agency network for which Medicaid or Medicare reimbursement will be sought. A provider includes a person who performs billing, coding, or other reporting services functions. OnPoint often makes a distinction between internal providers (employees) and external providers (subcontract providers).

Psychotherapy Notes

As defined by 45 CFR 164.501 - Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the record. Psychotherapy notes do not include any information about medication prescription and monitoring counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests, nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Qui Tam Provision

The federal False Claims Act (FCA) allows any person with direct knowledge of a false claim to bring a civil suit on behalf of the United States Government, known as a "Qui Tam" action. The individual must first formally notify the Department of Justice of the suspected fraud. The Department of Justice then has the option of either intervening in and prosecuting the action or allowing the individual to proceed on his/her own. If the suit is ultimately successful, the individual who initially brought the suit may be awarded a percentage between 15- 30% of the funds recovered.

Violation

An action that breaks or acts against something, especially a law, agreement, principle, or something that should be treated with respect. An act or omission concerning (a) a violation of any law or regulation; (b) a breach of the Code of Conduct/Ethics of OnPoint; (c) knowing non-compliance with a OnPoint policy; (d) misuse of public funds or assets; (e) mismanagement of a nature sufficiently substantive which would lead one to reasonably believe that such mismanagement would have a potentially harmful impact on OnPoint's work, reputation or operations; or (f) conduct which includes such behaviors as intimidation, harassment and other unethical behavior.

Use of Protected Health Information (PHI)/Individually Identifiable Health Information (IIHI)

The sharing of health/clinical information, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Waste

Over utilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

Whistleblower

A person who tells someone in authority about alleged dishonest or illegal activities (misconduct) occurring in a government department, a public or private organization, or a company. The alleged misconduct may be classified in many ways; for example, a violation of a law, rule, regulation and/or a direct threat to public interest, such as fraud, health/safety violations, and corruption.

Wrongdoing

Illegal or dishonest behavior. Under the federal Deficit Reduction Act (DRA), “wrongdoing” may be either an intentional act or an unintentional act (i.e., omission).