SWMBH Operating Policy 10.11

Subject: Fraud and Abuse	**Accountability:** Compliance	**Effective Date:** 01/01/2014	Pages: 3
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** _____ **NCQA/URAC Standard** _____ **Other** _____		Last Reviewed Date: 10/4/18	Past Reviewed Dates: 1/1/14 5/17/17
LINE OF BUSINESS: ☒ Specialty Waiver (B/C) ☒ 1115 Waiver ☒ Healthy Michigan ☒ SUD Medicaid ☒ SUD Block Grant ☒ MI Health Link ☐ OTHER:_____	**APPLICATION:** ☒ SWMBH Staff and Ops ☒ Participant CMHSPs ☒ SUD Providers ☒ MH / DD providers ☒ Other: MHL Providers	Last Revised Date: 10/4/18	Past Revised Dates: 1/1/14 5/13/16 5/17/17
Approved: Nila C. Todd Date: 10-11-18		Required Reviewer: Chief Compliance & Privacy Officer	

I. Purpose

All lines of business services are subject to review for conformity with accepted clinical practice and plan coverage limitations. Post and pre-payment review of claims should be performed to ensure services are appropriate, necessary and comply with plan/policy. In addition, claims review should also verify that services were billed appropriately and that third party resources were utilized to the fullest extent available.

II. Policy

All employees of Southwest Michigan Behavioral Health (SWMBH), their delegates, Participants or individuals under contractual arrangements will comply with all State and Federal Laws.

III. Standards and Guidelines

A. State Law

The Michigan Department of Attorney General uses the following State laws for investigating Medicaid provider fraud and abuse:

1. Medicaid False Claim Act (MCL 400.601 et. seq.)

An individual, whether a provider, an employee, or an accomplice, convicted of submitting false claims is subject to a fine of up to $50,000 and a prison sentence of four to ten years for each count, as well as full restitution to the Medicaid Program for all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

Some examples are:

- Billing for services not rendered.
- Billing without reporting payments received from other sources such as Medicare.
- Billing for a brand name drug when a generic substitute was dispensed.

- Misrepresenting the patient's diagnosis in order to bill for unnecessary tests and procedures.
- Billing a date of service other than the actual date services were rendered.
- Accepting "kickbacks" as cash payments or gifts in exchange for favorable treatment.
- Fraudulent Cost Reports.
- Social Welfare Act (MCL 400.111d)
- Public Health Code (MCL 333.16226)

B. Federal Law

The Office of Inspector General is mandated to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components. There are six offices within the U. S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG). The Office of Investigations (OI) is responsible for conducting and coordinating investigative activities related to fraud, waste and abuse in more than 300 HHS programs.

The following federal laws are primarily used to investigate federal cases of potential fraud and abuse:

- Social Security Act (Section 1909). A conviction resulting in a penalty of up to five years imprisonment and/or a $10,000 fine.
- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than $2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.
- Violations of Section 1128A include but are not limited to:
  - Billing for claims for medical items or services, which were not provided.
  - Billing codes for services that result in a higher reimbursement than what was actually rendered.
  - Services rendered by an individual who was not a licensed physician.
  - Coverage not in effect on the date of service.
  - Billing for services that were not medically necessary.
  - Hospitals that knowingly make payment to a physician as an inducement to reduce or limit services.
  - Physicians who accept such payments.

Allegations of identity theft will be referred by the Office of Inspector General (OIG) to the Federal Trade Commission.

C. Reporting Suspected Fraud

If you suspect claims fraud, report it to the Compliance Officer through one of the following mechanisms:

- Telephone Hotline: 1-800-783-0914

- Electronic Mail: mila.todd@swmbh.org
- In Person or Mail Delivery to the following address:

  Mila C. Todd, Esq., CHC
  Chief Compliance & Privacy Officer
  Southwest Michigan Behavioral Health
  5250 Lovers Lane, Suite 200
  Portage, MI 49002

IV. Definition

A. Abuse

Provider practices that are inconsistent with sound fiscal, business, or clinical 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 program.

B. Fraud (per CMS)

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act.

C. Fraud (per Michigan Court of Appeals)

Michigan law permits a finding of Medicaid fraud based upon "constructive knowledge." This means that if the course of conduct reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

D. Waste

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

V. References

A. Michigan Medicaid False Claims Act, MCL 400.601 et. Seq.
B. Federal False Claims Act, 31 U.S.C. §§3729-3733
C. Civil Monetary Penalties Law, 42 U.S.C. §§ 1320a-7a, 42 CFR pt. 1003

VI. Attachments

None