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

## I. Purpose

To articulate the policies and procedures that will be used by Southwest Michigan Behavioral Health (SWMBH) regionally in all managed care compliance investigations. To assure complete and proper fulfillment of Prepaid Inpatient Health Plan (PIHP) Compliance Program procedures, processes, and proofs. The SWMBH Chief Compliance Officer (CCO) is responsible for objectively, uniformly, consistently and adequately coordinating and completing the investigation of all suspected fraud, waste and abuse or reported violations of applicable laws and regulations for all covered services throughout the SWMBH region and provider network. The extent of the investigation will vary depending upon the severity of the issue.

## II. Policy

Consistent with SWMBH Procedure 10.8, throughout the entire SWMBH Region and provider network, SWMBH's CCO will coordinate and complete the investigation of all allegations of fraud, waste, or abuse of Medicaid and/or Medicare funds, all other SWMBH-administered funding streams, and other compliance issues pertaining to tasks and functions relating to SWMBH's role and responsibilities as the PIHP. Participant CMHSP staff, and contracted provider staff will report actual and suspected compliance issues to the SWMBH CCO within three (3) business days or less when one or more of the following criteria are met:

A. Circumstances are consistent with the definition of fraud, waste, or abuse as stated in this policy and/or applicable state or federal law;

B. During an inquiry by the participant CMHSP compliance officer or contracted provider staff, there is determined to be (reasonable person standard) Medicaid or Medicare fraud, waste or abuse as defined by federal statute, CMS, HHS OIG, and/or applicable Michigan statute, regulation or PIHP contract definition and as included in this policy; or

C. Prior to any self-disclosure to any federal Medicare or state of Michigan Medicaid authority. In no way is this intended to nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations.

D. When as a result of fraud, abuse or waste the participant CMHSP makes a material revision to prior reported financial statements to the PIHP;
E. When a participant CMHSP knows or should have known that an action or failure to take action in the organization or its contractors could result in the improper application or improper retention of Medicaid or Medicare funds; or
F. When a contracted provider knows or should have known that an action or failure to take action in the organization could result in the improper receipt or retention of Medicaid or Medicare funds.

Participant CMHSP and contracted provider staff are encouraged to request technical assistance discussions with SWMBH's CCO on any compliance issue at any time. Such contacts will not automatically be considered a "report of compliance issue" by SWMBH.

**III. Non-compliance.**

A. Reporting and cooperating in the investigation of compliance issues is mandatory. Failure to do so may result in contract action, up to and including termination, and referral to the appropriate regulatory bodies.

**IV. Standards and Guidelines**

A. Examples of fraud, waste, and abuse activities include, but are not limited to:
    1. Financial
        a. Forgery or alteration of documents related to Medicaid or Medicare services and/or expenditures (checks, contracts, purchase orders, invoices, etc.);
        b. Misrepresentation of information on documents (financial records and medical records);
        c. Theft, unauthorized removal, or willful destruction of Southwest Michigan Behavioral Health records or property;
        d. Misappropriation of Medicaid or Medicare funds or equipment, supplies or other assets purchased with Medicaid funds; and
        e. Embezzlement or theft
    2. Customers
        a. Changing, forging or altering medical records;
        b. Changing referral forms;
        c. Letting someone else use their Medicaid or Medicare card to obtain Southwest Michigan Behavioral Health covered services;
        d. Misrepresentation of eligibility status;
        e. Identity theft;
        f. Prescription diversion and inappropriate use;
        g. Resale of medications on the black market; and
        h. Prescription stockpiling;
    3. Provider
        a. Lying about credentials such as a college degree;
        b. Billing for services that were not provided;
        c. Billing a balance that is not allowed;
        d. Double billing or upcoming;
        e. Misallocation of sub capitated funds provided for services;
        f. Underutilization – not ordering or providing services that are medically necessary;

g. Overutilization – ordering or providing services in excess of what is medically necessary;
h. Falsifying information (not consistent with the customer's condition or medical record) submitted through a prior authorization or other service utilization oversight mechanism in order to justify coverage;
i. Forging a signature on a contract;
j. Pre- or post-dating a contract;
k. Intentionally submitting a false claim;
l. Awarding a contract based solely on friendship or family relationships;
m. Changing, forging or altering medical records;
n. Kickbacks, inducements and/or other illegal remunerations; and
o. Illegal use of drug samples

**V. Definitions**

A. Compliance investigation

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

B. Abuse

Provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid or Medicare programs, 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 or Medicare programs.

C. 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 him 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.

D. 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.

E. 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.

**VI. References**

Applicable guiding laws and regulations include but may not be limited to:

A. State of Michigan PHIP contract provisions;
B. Federal False Claims Act;
C. MI False Claims Act;
D. Deficit Reduction Act of 2005;
E. Social Security Act of 1964 (Medicare and Medicaid);
F. Patient Protection and Affordable Care Act;

G. Michigan Mental Health Code;
H. Privacy and Security requirements of the Health Insurance Portability and Accountability Act of 1996 as well as the expanded HITECH/HIPAA regulations; and
I. Michigan State Licensing requirements as they relate to scope of practice and ability to bill

## VII. Attachments

A. SWMBH Operating Procedure 10.8.1 Compliance Reviews and Investigations for Reporting