LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 07/20/2006
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CHAPTER Administrative	**CHAPTER** 01	**SECTION** 002	**SUBJECT** 05
SECTION Operations	**DESCRIPTION** Corporate Compliance Complaint Investigation and Reporting		
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APPLICATION:

☒CMH Staff	☒Board Members	☒Provider Network	☒Employment Services Providers
☒Employment Services Provider Agencies	☒Independent Contractors	☒Students	☒Interns
☒Volunteers	☒Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) promotes honesty, integrity and high ethical standards in the work environment and complies with all applicable federal and state statutes, regulations and other legal and ethical obligations.

STANDARDS:

A. All persons in the Applications section of this policy are expected to conduct themselves in a manner promoting the agency and the Region 10 PIHP's Mission, Vision, Values, Code of Ethics and Code of Conduct.

B. The LCCMH Corporate Compliance Program includes a process for receiving complaints, conducting investigations, and reporting complaints to legal authorities.

C. Detection of non-compliance will occur through already established reviews, including audits, claims data, and record reviews, as well as by complaints made

by staff, persons served, providers or others. The process for reporting complaints of non-compliance is posted at all sites.

D. Reportable events include:

1. Any incident in which the reporter suspects a person affiliated with LCCMH is knowingly engaged in activities violating the legal basis of the Compliance Program which centers on the following four Federal statutes:

    a. The False Claims Act (1863): This Act permits individuals to bring action against parties which have defrauded the government and provides for an award of one-half of the amount recovered. The Act provides a broad definition of 'knowingly' with regard to billing Medicaid or Medicare for services which were not provided, not provided according to requirements for receiving payment, or were unnecessary.

    b. The Anti-Kickback Statute prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the federal government or for any good or service paid for in connection with service delivery for persons served.

    c. Self-Referral Prohibitions (Stark Laws), which prohibit referral by physicians to entities in which the physician or immediate family has a financial interest.

    d. HIPAA (1996) which expands the definition of 'knowing and willful conduct' to include instances of 'deliberate ignorance' such as failure to understand and correctly apply billing codes, or failing to give privacy notice, and/or not following security measures.

2. Violation of any regulations implementing the Balanced Budget Act of 1996 with respect to regulations which impact rates, claims and payment issues.

3. Violations of Agency Policies, or Code of Ethics.

E. Complaints are investigated as outlined in the Procedures Section of this policy.

F. Possible findings include:

1. False claims, falsification of documents

2. Abuse: Routine claims verification review indicating over fifteen percent of claims are inappropriate

3. Waste: Inappropriately paid claims or overpayment

4. Intentional fraudulent action for the purpose of personal financial gain

5. Debarred Provider of services

G. The findings of the investigation may result in disciplinary / corrective action, larger sample of claims review, possible payback of inappropriate payments, reporting to MDHHS, Office of Attorney General, and/or Medicaid Fraud Unit.

a. With respect to all areas of risk, the magnitude of the risk and changes in the risk from previous periods, recommendations for remediating the risk are made.

b. Plans of correction will address remediation of the specific allegation and may include policy changes designed to prevent recurrence of similar findings in the future.

H. A written report of local compliance issues will be compiled and reported to the Standards Committee (designated as the Compliance Committee) and to the PIHP at least quarterly.

PROCEDURES:

A. COMPLAINT PROCESS:

Who:	**Does What:**
Any CMH Staff, Board Member, Employment Service Provider or Agency, Provider Network, Independent Contractor, Student, Intern, Volunteer persons served or others	1. Identifies an alleged act of illegal or improper conduct by either an individual or program.
	2. Notifies the compliance liaison immediately of such conduct by telephone, e-mail or formal written complaint.
Compliance Liaison	3. Completes a complaint form. Anonymity will be maintained if possible. The complaint will be categorized and a complaint number will be assigned. *Note: Recipient Rights complaints are referred to the Recipient Rights Office. Concurrent investigations are conducted when appropriate.*

B. INVESTIGATION PROCESS:

Who:	**Does What:**
Compliance Liaison	1. Determines if an allegation of non-compliance can be identified as a reportable event (consults with

Region 10 PIHP Compliance Officer or others as necessary).

2. Conducts interviews, research and reviews as necessary to investigate the complaint, bringing in outside sources as appropriate.

3. Within 30 days, prepares a report identifying the complaint as either Suspicious or Non- Suspicious of Fraud, Waste or Abuse. The compliance officer will also Substantiate or Not-Substantiate the complaint of ethical, policy or HIPAA violations when applicable. HIPAA violations are addressed according to the agency HIPAA Breach Policy. If extenuating circumstances exist, the investigation period may be extended.

    a. Recommends remedial action for substantiated complaints. Complaints suspicious of Fraud, Waste or Abuse are reported to the Region 10 PIHP Corporate Compliance Officer and the Office of Inspector General when applicable.
    b. When overpayment involving waste or abuse is identified prior to identification by MDHHS-OIG, LCCMH must void or correct applicable encounters, recover the overpayment and must report the overpayment on the OIG Quarterly Report.

4. Forwards the report to the Chief Executive Officer.

Chief Executive Officer

5. Reviews the complaint and report within ten (10) business days.

6. Agrees or disagrees with the findings and

recommendations, and provides final direction within five (5) working days.

7. Distributes final report to legal counsel or others as needed.

8. Reports to law enforcement or others as necessary.

C. RECORD KEEPING PROCESS:

Who:	**Does What:**
Compliance Liaison	1. Maintains a log of all complaints and follow-up. 2. Reports quarterly to the Standards Committee and the PIHP.

DEFINITIONS:

Abuse: For purposes of this policy, a pattern of behavior resulting in the submission of inappropriate, unfounded, or illegal claims, with a frequency greater than what could be reasonably considered a mistake. Abuse includes any practice not consistent with the goal of providing persons served with medically necessary services, meet professionally recognized standards, and are fairly priced.

Alleged Illegal Conduct: Conduct which, on its face, appears to be in conflict with conduct required by law.

Alleged Improper Conduct: Conduct which includes such behaviors as intimidation, harassment and other unethical behavior.

Debarred Provider: Any provider who is providing any service while they are debarred, excluded, suspended, or otherwise ineligible for participation in any governmental health care program, including without limitation, Medicaid and Medicare.

Fraud (Federal False Claims Act): Intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to

themselves 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 (42 CFR 455.2). Knowingly and willfully executing or attempting to execute a scheme or artifice, making a false (claim) statement for payment of benefit, twisting or bending the facts to obtain payment or other benefits.

1. To defraud any health care benefit program; or
2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of any health care benefit program, in connection with the delivery of or payment for health care benefits, items or services.

Fraud (per Michigan statute and case law): Under Michigan Law, a finding of Medicaid Fraud can be based upon evidence 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".

Suspicious: Considered to exist whenever one of the following circumstances is present:

1. When the allegation arises as a result of regular review of claims, case review, or other routine monitoring and detection activities, and the number of improprieties exceeds the level a reasonable person would categorize as a mistake.
2. When the allegation arises as a result of routine detection and monitoring activities and the same impropriety continues after a warning has been issued.
3. Whenever a specific allegation of improper or illegal activity has been brought to the Compliance Liaison, the Chief Executive Officer by a credible person.

Kickbacks: An offer, gift, solicitation, or receipt of payments or gratuities, in cash or in kind, intended to induce the referral of individuals to the Agency, PIHP or any health care provider.

Self-Referral: Conduct which may violate state or federal self-referral statutes and regulations. In general, these laws prohibit medical practices and physicians from referring patients to certain health care providers for the delivery of certain health care services.

REFERENCES:

Region 10 PIHP Policy: Corporate Compliance Program
Region 10 PIHP Compliance Program Annual Plan

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This policy supersedes
#07/06044 dated 07/20/2006.
