VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

Title: Fraud, Abuse and Waste **Number:** I.06.08
Originated: 02/09/10 **Approved By:** Executive Team
Revised: 07/08/14, 09/12/17, 5/29/19, 02/13/25

BACKGROUND:

All services are subject to review for conformity with accepted medical practice and Medicaid, Medicare and third-party payor coverage and limitations. Post and pre-payment review of claims should be performed to ensure services are appropriate, necessary and comply with Medicaid, Medicare and third-party payor laws, rules, or standards. In addition, claims review should also verify that services were billed appropriately and that third party resources were utilized to the fullest extent available.

State Law

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

- Medicaid False Claim Act (MCLA 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 of 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 (MCLA 400.111d)

- Public Health Code (MCLA 333.16226)

  The Office of Civil Rights (OCR) of the United States Department of Health and Human Services (HHS) is an independent law enforcement agency mandated to investigate fraud in Social Security Administration (SSA) programs. The OCR investigates fraud, abuse and violation of HIPAA Privacy and Social Security regulations under federal laws.

  Examples of criminal activity they would investigate are:
  - False statements on claims
  - Concealment of material facts or events affecting eligibility
  - Misuse of benefits by a representative payee

- Buying or selling Social Security cards or SSA information
- SSN misuse involving people with links to terrorist groups or activities ➢ Crimes involving SSA employees

Other violations include:
- Conflict of interest
- Fraud or misuse of grant or contracting funds
- Significant mismanagement and waste of funds
- Standards of conduct violations

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

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 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 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:

- 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 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 who knowingly make payment to a physician as an inducement to reduce or limit services
    - Physicians who accept such payments

- Social Security Act (Section 1909)

  A conviction resulting in a penalty of up to five years imprisonment and/or a $10,000 fine.

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- 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
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POLICY:

All employees of Van Buren Community Mental Health, their delegates or individuals under contractual arrangements will comply with all State and Federal Laws by:

- Ensuring that claims presented for reimbursement are appropriately billed. Do not make assumptions and enter missing data.
- Entering claims for adjudication without alteration. All claims should be entered as billed. Providers may submit corrected claims if needed.
- Never accept gifts in exchange for special treatment.
- Report suspected fraud immediately.

In addition, every effort will be made to identify third party payment resources. Use diligence in reviewing these claims for secondary payment and re-verify other insurance no less than annually. All personnel will receive training regarding the submission of bills and claims including specific information related to the Deficit Reduction Act of 2005, Federal False Claim Act, Michigan False Claim Act and similar laws. See Attachment "Employee Education about

PROCEDURE FOR REPORTING SUSPECTED FRAUD:

The Program Investigation Section of the Michigan Department of Health and Human Services (MDHHS) is responsible for investigating all suspected Medicaid Provider fraud and/or abuse.

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

A. **Telephone Hotline** – Suspected compliance violations can be made to a confidential voice mail by calling Liz Evans, CCO 269-655-3304, the Hot Line 800-292-5419, SWMBH CCO Mila Todd mila.todd@swmbh.org, SWMBH Hot Line 800-783-0914, or the Michigan Office of Inspector General 855-MI-FRAUD (643-7283).

B. **Electronic Mail** – Suspected compliance violations can be sent electronically through intra agency email to the following address: levans@vbcmh.com.

C. **Mail Delivery** – Suspected compliance violations can be mailed to the Compliance Officer at: Van Buren Community Mental Health Authority Compliance Officer, P.O. Box 249, Paw Paw, MI 49079.

D. **In Person** – Suspected compliance violations can be made in person to the Compliance Officer.

DEFINITIONS:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical practices, an 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.

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.

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 systemic or persistent tendency to cause "inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

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.

References:

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