

VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY POLICIES & PROCEDURES

Title: Compliance Investigations
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Approved By: Executive Team

PURPOSE: To articulate the policies and procedures that will be used by Van Buren Community Mental Health Authority (VBCMHA) in all compliance investigations. To assure complete and proper fulfillment of the Compliance Program procedures, processes, and proofs. The VBCMHA Corporate Compliance Officer (CCO) is responsible for objectively, uniformly, consistently and adequately coordinating and directing the investigation of all suspected fraud, abuse, or waste or reported violations of applicable laws and regulations for all covered services. The extent of the investigation will vary depending upon the severity of the issue.

POLICY: VBCMHA's CCO will coordinate and direct the investigation of all reported fraud, abuse or waste compliance allegations. This policy applies to all fraud, abuse and waste compliance issues, tasks and functions. VBCMHA employees and contracted providers will report suspected compliance issues within three business days or less to the Compliance Officer when one or more of the following criteria are met:

- A. During an inquiry by the 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 applicable Michigan statute, regulation or PIHP contract definition and as included in this policy; or
- B. 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.
- C. When as a result of fraud, abuse or waste the contracted provider or staff makes a material revision prior to a reported financial statement to VBCMHA.
- D. When a staff or contracted provider 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
- E. 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.

PROCEDURES:

I. Purpose of Investigations

Identify those situations in which the laws, rules and standards of Medicaid, Medicare, and other third party payors may not have been followed as related to fraud, abuse and waste. This includes, but is not limited to, the following:

A. Financial

- 1. Forgery or alteration of documents related to Medicaid or Medicare services and/or expenditures (checks, contracts, purchase orders, invoices, etc.).

2. Misrepresentation of information on documents (financial records and medical records);
3. Theft, unauthorized removal, or willful destruction of VBCMHA records or property;
4. Misappropriation of Medicaid or Medicare funds or equipment, supplies or other assets purchased with Medicaid funds; and
5. Embezzlement or theft.

B. Customers

1. Changing, forging or altering medical records;
2. Changing referral forms;
3. Letting someone else use their Medicaid or Medicare card to obtain VBCMHA services;
4. Misrepresentation of eligibility status;
5. Identify theft;
6. Prescription diversion and inappropriate use;
7. Resale of medications on the black market; and
8. Prescription stockpiling.

C. Provider/Staff

1. Lying about credentials such as a college degree;
2. Billing for services that were not provided;
3. Billing a balance that is not allowed;
4. Double billing or up-coding;
5. Misallocation of sub capitated funds provided for services;
6. Underutilization – not ordering or providing services that are medically necessary;
7. Overutilization – ordering or providing services in excess of what is medically necessary/
8. 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;
9. Forging a signature on a contract;
10. Pre- or post-dating a contract;
11. Intentionally submitting a false claim;
12. Awarding a contract based solely on friendship or family relationships;
13. Charging, forging or altering medical records;
14. Kickbacks, inducements and/or other illegal remunerations; and
15. Illegal use of drug samples

II. Initial Investigation

All suspected compliance-related complaints received by VBCMHA's management and Compliance Program staff shall be immediately forwarded to VBCMHA's CCO. Copies of all original data and information will be forwarded to the VBCMHA CCO including emails messages, voice mail message, written documents, etc.

- A.** The CCO will document any suspected compliance issue/inquiry on the Compliance Review/Investigation Case Log (Attachment A). Each issue is:

- Logged into the form on date received
 - Issued a unique case number
 - Given a title based on initial available information
- B.** A protected and segregated unique Compliance Inquiry/Investigation Form (Attachment B) will be created for each suspected compliance issue/inquiry and an Initial Investigation will be completed. In instances where the concerns were previously investigated, the CCO will review the details of the previous investigation and actions taken, if any.
- C.** If the CCO concludes, in consultation and with concurrence of the VBCMHA CEO as applicable and appropriate, based on the Initial Investigation of the issues that no Formal Compliance Review is necessary, the CCO will:
- Respond to the inquiry or question;
 - Document the results on the Compliance Inquiry/Investigation form; and
 - Close the compliance review on the Compliance Review/Investigation Case Log form.
 - Inform VBCMHA CEO and/or representative and VBCMHA Compliance Committee of decision as applicable and appropriate.
- D.** If the CCO concludes, in consultation and with concurrence of the CEO, based on the Initial Investigation, that the conduct reported likely or possibly constitutes noncompliance with any of the following, the matter shall be considered an open compliance investigation and a Formal Compliance Review shall commence:
- Medicaid, Medicare, and other third party payors laws, rules and standards;
 - Policies and procedures of VBCMHA; or
 - Applicable state and/or federal laws.

III. Investigative Process

- A.** VBCMHA's CCO will notify and brief the CEO of the suspected compliance issue(s) and of the commencement of a Formal Compliance Review. The investigation will begin as soon as reasonably possible, but in no event more than 10 business days following the receipt of the report/audit/information/complaint regarding the potential noncompliance issue.

A compliance investigation work plan will be designed prior to the start of the Formal Compliance Review of the compliance issue. (See Attachment C) The investigation may include, but is not limited to, the following processes:

- Review of all documents related to the issue (i.e. policies, communications, audit findings, etc.)
- Review of bills or claims submitted (or to be submitted) to Medicaid, Medicare, and other third party payors. This will aid in determining the nature, scope, frequency, duration, and the potential financial magnitude of the problem.
- Review of all applicable EMR and other care related documents.
- Conduct an interview of the complainant and other persons who may have knowledge of the alleged problem or processes. The purpose of the interview(s)

will be to determine the facts related to the alleged activity, and may include, but shall not be limited to:

- ◆ Full review and documentation of factual findings;
- ◆ Individual understanding of the Medicaid, Medicare, and other third party payors laws, rules, regulations, and standards;
- ◆ Identification of persons with supervisory or managerial responsibility in the process;
- ◆ Training protocols of the individuals performing the functions within the process; and
- ◆ Extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the Medicaid laws, rules or regulations.
- Preparation of a summary report which:
 - ◆ Lists all known facts;
 - ◆ Defines the nature of the problem
 - ◆ Summarizes the investigation process
 - ◆ Identifies any person or process(es) which the investigator believes to have contributed deliberately or with reckless disregard or intentional indifference or otherwise toward the Medicaid, Medicare, and other third party payors laws, rules, policies and standards;
 - ◆ Estimates the nature and extent of the resulting overpayment by the government or third party payor, if any.
- Review the statutes, regulations, policies and standards involved, both internal (VBCMHA) and external (i.e. State, Federal standards, regulations, laws). Consult with internal and external resources as needed.

The VBCMHA CCO may solicit the assistance of staff in conducting any of the specific investigative tasks noted above. The VBCMHA CCO may also solicit the support of internal and external resources with knowledge of the applicable laws and regulations that relate to the specific problem in question. External resources may include legal counsel, consultants and auditors. These internal and/or external persons shall function under the direction of legal counsel and under attorney-client privilege and shall be required to submit relevant evidence, notes, findings and conclusions to legal counsel.

- B.** The CCO may review all investigative findings with the CEO, VBCMHA Compliance Committee and VBCMHA legal counsel prior to developing remediation and repayment plans and closing the case.
- C.** If the Formal Compliance Review results show that the act did not occur as alleged, or that no violation of applicable laws/regulations/policies occurred, the investigation shall be closed subject to VBCMHA COO and VBCMHA Compliance Committee concurrence and a written report filed. Once complete, documentation is to be preserved for a minimum of six (6) years.
- D.** If the Formal Compliance Review results show that a compliance violation exists, all documentation related to the investigation is kept as an “open” case until a remediation plan is completed and any related monitoring is completed and certified.
- E.** VBCMHA will provide general feedback to the source regarding the investigation, provided the issue was not anonymously reported. Sources who report

anonymously may call to receive feedback. Responses should be general in nature and not reveal information of a confidential nature such as an individual's name or corrective action taken.

- F. Unless severely contraindicated or upon advice of VBCMHA Compliance Counsel, the CEO (or designee) will be similarly and timely informed and briefed.
- G. Under no circumstances is retaliation for submitting a compliance issue or inquiry acceptable. This includes, but is not limited to, questions and concerns an employee may discuss with an immediate supervisor, VBCMHA's CCO or CEO, or the VBCMHA Compliance Committee.

IV. Organizational Response

A. Possible Criminal Activity - In the event the Formal Compliance Review uncovers what appears to be criminal activity on the part of any contracted or subcontracted provider, or VBCMHA employee or business unit, VBCMHA shall undertake the following steps:

- In the event that violations substantiate fraud, abuse or waste are found related to Medicaid, Medicare (dual eligibles project), counsel for VBCMHA or the CCO shall notify the PIHP as determined by the VBCMHA CEO. VBCMHA, through compliance counsel or the CCO, shall attempt to negotiate a settlement of the matter with the PIHP.
- VBCMHA shall initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or undertaken with reckless disregard for the Medicaid, Medicare, and other third party payors laws, rules and standards and/or regulations. Appropriate disciplinary action is outlined in VBCMHA's personnel procedures.

B. Other Non-Compliance - In the event the Formal Compliance Review reveals billing or other problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or with reckless disregard for the Medicaid, Medicare, and other third party payors laws, rules and standards, VBCMHA shall nevertheless undertake the following:

- **Improper Payments:** In the event the problem results in duplicate payments by Medicaid, Medicare, and other third party payors or payments for services not rendered or provided other than as claimed, VBCMHA shall:
 - ◆ Define and summarize the defective practice or procedures as quickly as possible;
 - ◆ Calculate and make recommendations regarding repayment to the appropriate governmental entity or third party payor for duplicate payments or improper payments resulting from the act or omission;
 - ◆ Reverse encounter data in all systems which generated data submitted to the State that may have been affected;
 - ◆ Make referral for disciplinary action as appropriate given the facts and circumstances;
 - ◆ Promptly undertake a program of education to prevent future problems; and

- ◆ Convene a business process review team to analyze and remedy process, functional or information system deficits, under the CCO's direction.
- **No Improper Payment:** In the event the problem has or does not result in overpayment by Medicaid, Medicare, and other third party payors, VBCMHA shall:
 - ◆ Define and summarize the defective practice or procedures as quickly as possible;
 - ◆ Reverse encounter data in all systems which generated data submitted to the State that may have been affected;
 - ◆ Make referral for disciplinary action as appropriate given the facts and circumstances;
 - ◆ Promptly undertake a program of education to prevent future problems; and
 - ◆ Convene a business process review team to analyze and remedy process, functional or information system deficits, under the CCO's direction.

VBCMHA Compliance
Investigation Case Log

DATE:		ISSUE #	ISSUE TITLE	STATUS
OPENED:	CLOSED:			

Compliance Investigation Form

Issue Identification #:	
Level of Inquiry (Inquiry, Investigation):	
Problem Type:	
Notification Source:	
Notification Date:	
Notification Method:	

Discussion of Allegation:

Methodology of Review:

Follow-up and Findings:

Conclusions:

Recommendations:

Action Taken:

Date Closed:

Compliance Investigation Work Plan Steps

1. Identification of suspected Compliance Issue.
2. Develop work plan for review of issue:
 - Define schedule and timeframe for review
 - Identify individuals to be interviewed
 - Define sampling methodology/universe to be reviewed (if applicable)
 - Identify/create questions to be asked during interviews
 - Create document request (i.e. policies, communications, medical records, billing data, audit findings, etc.)
3. Review and document findings, including recommendations of legal counsel, if appropriate.