SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

NUMBER: DA1005

NAME: CORPORATE COMPLIANCE COMPLAINT, INVESTIGATION, & REPORTING PROCEDURE

INITIAL APPROVAL DATE:	05/04/2016	BY: Administrative Committee
(LAST) REVISION DATE:	11/12/2024	BY: Chief Information Officer
(LAST) REVIEW DATE:	12/12/2024	BY: Policy Committee
DISCONTINUED DATE:	NA	REPLACED BY: NA

I. PURPOSE

To have a process for receiving complaints, conducting investigations, complaint process trainings and reporting under Policy BA032 – Corporate Compliance Program.

II. APPLICATION

Populations: All
Programs: **Direct - All**
Contracted - All

III. DEFINITIONS

Abuse: Means 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 (42 CFR § 455.2).

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

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

Fraud: (Federal False Claims Act): means 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. (42 CFR §455.2)

Fraud: (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that 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." But 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."

Provider: CMH and SUD Providers, individual or corporation; any CMH subcontracted provider/ practitioner, individual or corporation.

Waste: Means 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.

IV. STANDARDS

A. All staff are expected to conduct themselves in a manner that promotes the CMH Board's Mission/Vision and Code of Ethics.

B. A complainant does not need to disclose his/her identify; he/she may remain anonymous when communicating with the Corporate Compliance office. However, please keep in mind that anonymity may slow down a prompt and complete investigation or the success of a later prosecution.

C. The process for reporting complaints of non-compliance will be posted at all sites.

D. Detection of non-compliance will occur through already established reviews, including audit/monitoring activity, claims/encounter data, record reviews and complaints made by staff, individuals served, providers or others.

E. Sanilac CMH shall investigate its own complaints and those of its provider network and report compliance issues to Region 10 monthly (or as needed) and the Office of Inspector General (OIG) when appropriate.

F. Plans of correction (POC) shall address remediation of the specific allegation and may include a plan for change in policy designed to prevent recurrence of similar findings in the future or additional/modified training.

G. Possible Findings: the following is only a sample of findings that could result in fraud, abuse or non-fraudulent activities.
   - Altering a medical record
   - Providing a service, but using the wrong date or time
   - Billing for service that was not medically necessary
   - Billing for non-covered services
   - Double billing (billing for the same service twice)
   - Timesheet falsification
   - Unbundling an all-inclusive service that is resubmitted as separate services
   - Lying about or falsifying credentials
   - Under-billing (not billing for otherwise billable medically necessary services)
   - Unexplained entries and/or altered records
   - Inadequate or missing documentation
   - Delays in producing requested documentation
   - Unauthorized transactions
   - Unusual patterns and trends in contracting and procurement
   - Offers of gifts, money, or other gratuities from contractors, grantees, or other

individuals
- Providing false or misleading information
- Missing signatures and credentials
- Missing files, reports, data and invoices (both electronic and paper)
- Missing, weak, or inadequate internal controls
- Billing for services that were performed by an employee who has been excluded from participation in Federal healthcare programs
- Billing for low-quality services
- Collusion among providers, e.g., providers agreeing on minimum fees they will charge and accept

The above examples could result in discipline/corrective action, larger sample of claims/encounters review, possible payback of inappropriate payments, reporting to MDHHS, the OIG, and/or the Medicaid Fraud Unit.

Following an identified suspicion of Medicaid Fraud, all activities are paused, including financial recoupment, until PIHP/OIG feedback is received related to pursuing financial recoupment.

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

H. Reportable Events:

1. Any incident in which the reporter suspects that an employee, or Board member, is knowingly engaged in activities that violate the legal basis of the Compliance Program centering in the following four statutes:

   A. The Federal False Claims Act (1863): This Act permitting individuals to bring action against parties which have defrauded the government and providing for an award of ½ 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 Michigan Medicaid False Claims Act (1977): An act to prohibit fraud in the obtaining of benefits or payments in connection with the medical assistance program; to prohibit kickbacks or bribes in connection with the program; to prohibit conspiracies in obtaining benefits or payments; to authorize the Attorney General to investigate alleged violations of this act.

   C. The Anti-Kickback Statute: Prohibiting 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 consumer service delivery.

   D. HIPAA (1996): 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 (e.g. sharing passwords).

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

I. Whistleblower Provisions: Whistleblower provisions provide protection to employees who report a violation or suspected violation of state, local, or federal law; it provides protection to employees who participate in hearings, investigations, legislative inquires, or court actions; and prescribes awards, remedies and penalties.

V. PROCEDURE

COMPLAINT PROCESS

Any Staff/Person/Provider

1. Identifies an alleged act of illegal or improper conduct either by an individual or program.
2. Notifies the Corporate Compliance Officer immediately of such conduct by telephone, email or formal complaint.
3. The Corporate Compliance Officer assists the staff person in completing the complaint, if necessary, while maintaining anonymity when requested, if possible. (Note: Recipient Rights complaints should be referred to the Recipient Rights Office. Concurrent investigations can be conducted if appropriate.)

INVESTIGATION PROCESS

Corporate Compliance Officer

1. Determines if an allegation of non-compliance can be identified as a reportable event (consulting with others as necessary).
2. Assigns the complaint a number using a year numbering system: SCCMHA-25-01, SCCMHA-25-02, SCCMHA-25--03, etc.
3. Categorizes the complaint from the type given and description offered.
4. Acknowledges receipt of the complaint to the complainant within five (5) working days.
5. Conducts interviews, research and reviews as necessary to investigate the complaint (brings in outside sources as appropriate.)
6. Prepares a form (Exhibit A) within 30 days (unless extenuating circumstances exist) that either substantiates the complaint or does not substantiate the complaint.
7. Recommends remedial action as appropriate for all substantiated complaints.
8. Forwards the findings to CEO, HR, and appropriate Chief for substantiated complaints.
9. Incorporates findings into a report to Sanilac CMH Board annually and Region10 PIHP monthly.

In cases where the Corporate Compliance Officer's investigation final findings substantiate fraud and/or abuse, the CMH Board's Executive Committee shall meet to review the case and findings.

Following an identified suspicion of Medicaid Fraud, all activities are paused, including financial recoupment, until PIHP/OIG feedback is received related to pursuing financial recoupment.

10. Notification will be sent to the individual(s) whose protected health information (PHI) was breached per policy BA153 HIPAA Breach Notification. The notification will be written in plain language. The notification includes, to the extent possible:

    - A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
    - A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).
    - Any steps enrollees take to protect themselves from potential harm resulting from the breach.
    - A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.
    - Contact procedures for enrollees to ask questions or learn additional information, which shall include a toll-free number, an email address, Web site, or postal address.

11. The written notification will be sent by first-class mail to the individual(s) at the last known address of the enrollee; or, if the enrollee agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.
    - If we know the enrollee is deceased and we have the address of the next of kin or personal representative of the individual (as specified under section 164.502(g) of subpart E), written notification by first class mail to either the next of kin or personal representative of the enrollee. The notification may be provided in one or more mailings as information is available.
    - In the case in which there is insufficient or out of date contact information that precludes written notification to the enrollee under paragraph (d)(1)(i) of this section, a substitute form of notice reasonably calculated to reach the enrollee shall be provided. Substitute notice need not be provided in the case in which there is insufficient or out of date contact information that precludes written notification to the next of kin or personal representative of the enrollee under paragraph (d)(1)(ii).
    - In the case in which there is insufficient or out of date contact information for fewer than 10 enrollees, then such substitute notice may be provided by an alternate form of written notice, telephone or other means.
    - In the case in which there is insufficient or out of date contact information for 10 or more enrollees, then such substitute notice shall be in the form of either a conspicuous posting for a period of 90 days on the home page of the external web site, or conspicuous notice in major print of broadcast media in geographic areas where the enrollees affected by the breach likely reside. The notice will include a toll-free phone number that remains active for at least 90 days where an enrollee can learn whether the enrollee's unsecured protected health information may be included in the breach.

VI. ATTACHMENTS

Non-Compliance Investigative Report

VII. **REFERENCES**

BA032 – Corporate Compliance Program Policy
BA021 – Code of Ethics Policy
BA153 – HIPAA Breach Notification

EXHIBIT A

Sanilac County Community Mental Health Authority

Sanilac CMH Corporate Compliance Complaint Investigation Form

Complaint # SCCMHA- _____ Date & Time Reported _____

Reported By _____ Received By _____

Self-Reported ☐ Yes ☐ No Anonymously Reported ☐ Yes ☐ No

Reported By ☐ Verbal ☐ Hotline ☐ Email ☐ Walk-In ☐ Complaint Form ☐ Other _____

Investigator 1 _____ Investigator 2 _____

Name of Person / Agency Alleged in Non-Compliance _____

Address of Person / Agency Alleged in Non-Compliance
Sanilac CMH

Type of Complaint ☐ Fraud ☐ Waste ☐ Abuse ☐ Policy Violation ☐ Ethical Violation
☐ HIPAA Privacy / Security ☐ Other _____

Names of Individuals Involved and/or interviewed	Organization	Title	Contact Information
	Sanilac CMH		

Complaint Overview:
Investigation Actions (include dates):

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Findings	Disposition
☐ Substantiated	
☐ Not Substantiated	
☐ Suspicious	
☐ Non-Suspicious	

Policy Violations:
Follow Up / Remedial Action / Recommendations:

Litigation (if applicable): ☐ Attorney ☐ Client ☐ Regional or Agency

_____ _____