BARRY COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
POLICY AND PROCEDURE MANUAL

Policy: 9-F Fraud, Waste, and Abuse		Application: BCCMHA Staff and Providers
Approved: Rich Thiemkey Richard Thiemkey, MA Executive Director		
Reviewed 2/26/2025	Revised 11/16/2022	First Effective 10/13/2000

PURPOSE

This policy has been developed to assist with the prevention and detection of fraud, waste and/or abuse. The policy also defines what constitutes fraud, waste and/or abuse and outlines expectations and procedures BCCMHA staff and providers shall follow when fraud, waste and/or abuse is suspected.

POLICY

BCCMHA staff and contracted providers are responsible for adhering to Michigan and Federal laws and regulations regarding Fraud, Waste, and Abuse when submitting claims. BCCMHA staff and providers are responsible for reporting suspected Fraud, Waste and Abuse to BCCMHA's Corporate Compliance Officer, Compliance Hotline

STATE LAWS

1. Michigan Medicaid False Claim Act (MCL 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 for all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period of time and, in some instances, the license to practice their profession may be suspended or revoked.
    a. Some examples are:
        i. Billing for services not rendered.
        ii. Billing without reporting payments received from other sources such as Medicare.
        iii. Billing for a date of service other than the actual date of service.
        iv. Falsifying documentation.
        v. Accepting "kickbacks" as cash payments or gifts in exchange for favorable treatment.
2. Social Welfare Act (MCL 400.111d)
3. Public Health Code (MCL 333.16226)

FEDERAL LAWS

The Office of Inspector General is mandated to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the 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 the Inspector General (OIG). The Office of Investigations (01) 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 to investigate federal cases of potential fraud and abuse:

1. Social Security Act (Section 1909). A conviction resulting in a penalty of up to five years imprisonment and/or a $10,000 fine.
2. 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 the fraudulent claim.
3. Violations of Section 1128A include but are not limited to:
    a. Billing for claims for medical items or services, which were not provided.
    b. Billing codes for services that result in a higher reimbursement than what was actually rendered.
    c. Services rendered by an individual who was not appropriately credentialed.
    d. Coverage not in effect on the date of service.
    e. Billing for services that were not medically necessary.

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

PROCEDURES

BCCMHA STAFF AND PROVIDERS

Any employee who has knowledge of an occurrence of fraud, waste or abuse or has reason to suspect that fraud, waste or abuse has occurred, shall immediately notify their supervisor, Corporate Compliance Officer, or the Anonymous Compliance Hotline (1.800.218.8290), SWMBH Compliance Hotline (1.800.783.0914), or the MDHHS OIG Hotline (855.643.7283) to report. If the employee has reason to believe that the employee's supervisor may be involved, the employee shall immediately notify the Executive Director, Corporate Compliance Officer or Compliance Hotline. BCCMHA staff and contracted providers shall cooperate with any Fraud, Waste, or Abuse investigations per the Compliance Plan, Provider Contract, and/or Employee Handbook. BCCMHA staff shall not discuss the matter with anyone other than their supervisor, Corporate Compliance Officer, the Executive Director, and/or the SWMBH Corporate Compliance Officer.

EXECUTIVE DIRECTOR

Upon notification of the discovery of suspected fraud, the Executive Director shall immediately notify the Corporate Compliance Officer. If the Executive Director has reason to believe that the Corporate Compliance Officer may be involved in the reported wrongdoing, other than investigating the situation, the Executive Director will contact the SWMBH Corporate Compliance Officer within three business days or less if possible.

CORPORATE COMPLIANCE OFFICER

Upon notification of suspected fraud, waste or abuse or if there is a reason to suspect that fraud, waste and/or abuse have occurred, the Corporate Compliance Officer shall immediately notify the Executive Director. If the Corporate Compliance Officer has reason to believe the Executive Director is involved in fraud, waste or abuse, the Corporate Compliance Officer will contact the SWMBH Corporate Compliance Officer within three (3) days or less if possible. Immediate action will be taken to prevent the theft, alteration, or destruction of relevant records. Such actions include, but are not necessarily limited to, removing records and placing them in a secure location, limiting access to the location where the records currently exist, and preventing the individual suspected of committing the fraud from having access to the records.

The Corporate Compliance Officer will report suspected compliance issues within three business days or less to SWMBH Chief Compliance Officer when one or more of the following criteria are met:

1. During an inquiry by the Corporate Compliance Officer (or as reported by a contracted provider staff) that it is determined to be (reasonable person standard) Medicaid or Medicare fraud defined by federal statutes, CMH, HHS, OIG and applicable Michigan statute, regulation or PIHP contract definition and as included in this policy; or
2. Prior to any disclosure to any federal Medicare or State of Michigan Medicaid authority;
3. When, as a result of fraud abuse or waste, BCCMHA makes a material revision to prior reported financial statements to SWMBH;
4. When BCCMHA knows or should have known that action or failure to take action could result in the improper application or improper retention of Medicaid or Medicare funds, or
5. When it is realized that a provider knows or should have known that action or failure to take action could result in the improper receipt or retention of Medicaid or Medicare funds.

BCCMHA's Corporate Compliance Officer will request technical assistance from the SWMBH Corporate Compliance Officer as issues are presented. It is realized that technical assistance does not necessarily consider a "report of compliance issue" by SWMBH.

RECORD SECURITY

A successful audit/investigation can only be performed if the documentation relating to fraud, waste or abuse is available for review in its original form. Therefore, once suspected fraud, waste or abuse is reported, the Executive Director and supervisors shall take immediate action to prevent the theft, alteration, or destruction of relevant records. Such actions include, but are not necessarily limited to, removing the records and placing them in a secure location, limiting access to the location where the records currently exist, and preventing the individual suspected of committing the fraud, waste or abuse from having access to the records. The records must be adequately secured until the Executive Director or Corporate Compliance Officer obtains direction from the SWMBH Corporate Compliance Officer.

CONFIDENTIALITY

All participants in fraud, waste and/or abuse investigations shall keep the details and results of the investigation confidential except as expressly indicated within this policy.

PERSONNEL ACTION

If a suspicion of fraud, waste and/or abuse is substantiated by an investigation from the Corporate Compliance Officer or SWMBH, the BCCMHA Executive Director and Human Resources will be notified in order to assure that disciplinary action is taken in conformance with the BCCMHA Employee Handbook. A false and vindictive allegation of fraud, waste or abuse is a violation of this administrative procedure. All violations of this administrative procedure, including violations of the confidentiality provision, shall result in disciplinary actions up to and including termination.

RETALIATION

It is a violation of this administrative procedure and The Whistleblowers Protection Act for any individual to be discriminated against for reporting fraud, waste or abuse or for cooperating, giving testimony, or participating in an audit investigation, proceeding, or hearing.

At the conclusion of an audit investigation, the Executive Director or Corporate Compliance Officer will document the results, including information received from SWMBH.

If fraud, waste or abuse has resulted in BCCMHA property loss, the Executive Director's designee shall report such loss to the appropriate parties, including but not limited to, Board of Directors, insurance company, etc. Action shall be taken to seek restitution for any property loss as deemed appropriate. Upon completion of the audit investigation and all legal and personnel actions, records will be returned by the Executive Director or Corporate Compliance Officer to the appropriate department if acceptable.

REFERENCES

SWMBH Policy 10.8
BCCMHA
CARF
Michigan Department of Health and Human Services
CMS
Federal False Claims Act MI False Claims Act
Deficit Reduction Act