SUBJECT Corporate Compliance Complaint, Investigation, & Reporting Process		**CHAPTER** 01	**SECTION** 02	**SUBJECT** 05
CHAPTER Administration	**SECTION** Compliance			
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I. APPLICATION:

☒ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It is the policy of Region 10 PIHP to have a Corporate Compliance Program Plan that includes a process for receiving complaints, conducting investigations, and reporting.

This policy is intended to address matters relating to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), as well as any other circumstance in which the potential for or actual occurrence of Medicaid fraud, waste or abuse is involved.

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: That conduct which, on its face, appears to 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

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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: CMHSP and SUD providers, individual or corporation; any CMHSP 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 PIHP Corporate Compliance Program Plan. Personnel may be subject to discipline for failing to participate in compliance efforts.

B. The PIHP shall post Notice regarding access to the PIHP Corporate Compliance Office (including how to report a complaint).

C. The Provider shall post Notice regarding access to the Provider Compliance Office and the PIHP Corporate Compliance Office (including how to report a complaint).

D. It is the responsibility of all regional personnel to report to the Provider Compliance Office and / or the PIHP Compliance Office his or her good faith belief of any violation of the Corporate Compliance Program Plan.

A complainant does not need to disclose his/her identify; he/she may remain anonymous when communicating with the Corporate Compliance Office. Note: anonymity may slow down a prompt and complete investigation. At the request of the personnel reporting the violation, the Provider and / or the PIHP will provide such anonymity to the reporting person as is possible under the circumstances. The Provider and / or the PIHP and its personnel will not retaliate against any individual for good faith reporting of a suspected violation.

The Provider and PIHP Corporate Compliance Officers will respond promptly and thoroughly to reports by personnel, or others that personnel or independent contractor is engaging in activity which may be contrary to the PIHP Corporate Compliance Program Plan.

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E. 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' regarding billing Medicaid or Medicare for services which were not provided, not provided per 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).

   e. The violation of any regulations implementing the Balanced Budget Act of 1997 with respect to regulations which impact on rates, claims and payment issues.

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.

F. Possible Findings: the following is only a sample of findings that could be reportable events:
   - 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

G. Detection of non-compliance may occur through already established reviews, including audit, claims data, record reviews and complaints made by staff, individuals served, subcontract Providers or others. Findings regarding the examples above could result in discipline / corrective action, larger sample of claims review, possible payback of inappropriate payments and reporting to the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) and / or the Medicaid Fraud Unit.

H. The PIHP shall evaluate its own complaints and those of its provider network and report compliance issues to the MDHHS OIG and / or Medicaid Fraud Unit as appropriate. The PIHP will not share the summary reports and / or reports made to the MDHHS OIG and / or Medicaid Fraud Unit with any individual and / or subcontractor (including those involved with complaint origination). The PIHP shall comply with all MDHHS OIG reporting requests (e.g. use of Fraud Referral Form).

I. Each Provider shall evaluate its own complaints and those of its provider network and report corporate compliance complaints to the PIHP monthly (or as needed). Monthly complaint detail shall minimally include:

   a. Date complaint received (by the reporting office);
   b. Affiliate (CMH / SUD Program or subnetwork provider);
   c. Complaint number;
   d. Complaint category (e.g. Medicaid Fraud / Waste / Abuse, Policy Violation, Ethics Violation, Health Insurance Portability and Accountability Act (HIPAA) Violation,

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Other);

e. Findings:
   i. Substantiated (proof or evidence was established that complaint category criteria were met);
   ii. Un-substantiated (proof or evidence was established that complaint category criteria were not met);
f. Outcome (summary information regarding follow up (e.g. reporting, policy / process change, disciplinary action, etc.).

J. The Provider may request for the PIHP to assist in the evaluation. The PIHP reserves the right to investigate possible compliance issues within its provider network agencies.

K. For all complaint analyses, a determination shall be made if the complaint is a reportable event. If a complaint is determined to be a reportable event, further determination shall be made that a complaint is either substantiated or non-substantiated.

L. Plans of correction shall be completed for all substantiated complaints and shall minimally address remediation of the specific allegation and may include a plan for change in Policy or Procedure designed to prevent recurrence of similar findings in the future (e.g. staff notification, error correction, risk minimization, etc.).

M. For all complaints involving alleged Medicaid fraud, waste or abuse:

   a. The PIHP has responsibility and authority to make appropriate referrals.

   b. The Provider shall **not** attempt to thoroughly investigate and / or resolve the complaint. It is expected that the Provider will gather enough information to determine that the allegation appropriately applies to the definitions of fraud, waste or abuse and there appears to be enough evidence to support a more comprehensive investigation. Following this determination, the Provider shall formally notify the PIHP and provide supporting documentation / evidence of the complaint. The Provider shall cooperate with PIHP investigations (e.g. supporting documentation requests, claim detail information, contact information, etc.).

   c. Annually, the Provider shall notify the PIHP of all complaints made to MDHHS separate from those reported to the PIHP. If no complaints were reported to MDHHS, the Provider shall submit an attestation confirming this.

   d. The Provider shall cooperate fully in any investigation by the MDHHS OIG and the PIHP and with any subsequent legal action that may arise from such investigation.

V. <u>PROCEDURES:</u>

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COMPLAINT PROCESS (Providers)

Any Staff/Person/Provider

1. Identifies an alleged act of illegal or improper conduct either by an individual or program.

2. Notifies his/her local "compliance" staff immediately of such conduct by telephone, email or formal complaint (can also notify PIHP Compliance Officer in conjunction with local notification).

3. Identified Compliance Office 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 (Providers)

Compliance Office

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: 14-01, 14-02, 14-03, 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. For allegations related to Medicaid fraud, waste and abuse: Conducts a minimal evaluation, gathers supporting documentation and submits notification to the PIHP.

6. For allegations, unrelated to Medicaid fraud, waste and abuse: Conducts interviews, research and reviews as necessary to investigate the complaint (brings in outside sources as appropriate).

7. Prepares a report within 30 days (unless extenuating circumstances exist) that either substantiates the complaint or does not substantiate the complaint.

8. Recommends action as appropriate for all substantiated complaints.

9. Forwards the report as appropriate (e.g. Chief Executive Officer, Board of Directors, etc.)

10. Distributes complaint information / report findings to the PIHP. Complaint information shall be forwarded when available, but no less than monthly.

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COMPLAINT PROCESS (PIHP Board / PIHP Staff)

Any Staff/Person/Provider

1. Identifies an alleged act of illegal or improper conduct either by an individual or program.

2. Notifies his/her Compliance Officer immediately of such conduct by telephone, email or formal complaint.

3. Identified Compliance Office 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 (PIHP Board / PIHP Staff)

Compliance Office

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: 14-01, 14-02, 14-03, 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. For allegations, related to Medicaid fraud, waste and abuse: Conducts a minimal evaluation, gathers supporting documentation and submits notification to the MDHHS / OIG (following all reporting requirements identified by the MDHHS OIG).

6. For allegations, unrelated to Medicaid fraud, waste and abuse: Conducts interviews, research and reviews as necessary to investigate the complaint (brings in outside sources as appropriate).

7. Prepares a report within 30 days (unless extenuating circumstances exist) that either substantiates the complaint or does not substantiate the complaint.

8. Recommends action as appropriate for all substantiated complaints.

9. Forwards the report as appropriate (e.g. Chief Executive Officer, Board of Directors, etc.).

10. Compiles regional network complaint data and provides annual summary.