

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i>	
Department Finance	# of Pages: 7		
Policy Name FINANCIAL FRAUD AND ABUSE REPORTING	Type of Policy: Finance [] WCHO [X] Regional [] Network		
Policy Number	Effective Date	Revision Date	Approval Date 9/19/06
Administrative/Board of Directors Sign Off			
Administrative Signature:		Date:	
Board of Directors Signature:		Date:	

I. PURPOSE

To establish a procedure to investigate, document and report alleged financial fraud and abuse.

II. APPLICATION

This policy applies to all agencies receiving any funding, either directly or through a subcontract agreement, from the WCHO/PIHP, its Comprehensive Specialty Services Network Providers (CSSNs/CSSN-Look-Alikes), and Coordinating Agencies (CAs).

III. DEFINITIONS

Financial Fraud - Intentional submission of a false or fraudulent claim(s) for payment. These include claims for services not delivered, for services delivered that are not in accordance with the service code definitions included in the CPT (Current Procedural Terminology) manual and the Healthcare Common Procedure Coding System (HCPCS) manual, both issued by the American Medical Association.

Financial Abuse - To unlawfully take money or property, regardless of its value, from a consumer.

IV. POLICY

It is the policy of the WCHO to report and document suspected financial fraud and financial abuse to the Michigan State Attorney' Office and to the Michigan Department of Community Health's Program Investigations Section, to maintain a database of all

alleged fraud instances, and to provide the State Department of Mental Health an aggregated report of all cases reported.

All staff will be trained on the Fraud Act and shall report suspected fraud to the PIHP.

V. EXHIBITS

- A. Medicaid Fraud Complaint Form
- B. Financial Fraud Investigation and Reporting Flow Chart

VI. REFERENCES

- A. The Deficit Reduction Act of 2005
- B. Balance Budget Act: 438.608; 447.46
- C. False Claims Act
- D. Whistleblowers Act
- E. Title 42—Public Health; Part 455—Program Integrity; Subpart A—Medicaid Fraud Detection and Investigation Program [cite: 42CFR455.17]
- F. Current Procedural Terminology (CPT) manual issued by the American Medical Association
- G. Healthcare Common Procedure Coding System (HCPCS) issued by the American Medical Association
- H. Claims Submission Policy
- I. Rights Violation Policy
- J. Contract Termination Policy
- K. Organizational Credentialing Policy

VII. PROCEDURES

<u>WHO</u>	<u>DOES WHAT</u>
Professional Development Committee	1. Includes training about fraud in its curriculum.
Anyone suspecting a possible financial fraud or financial abuse situation	1. Reports possible financial fraud or financial abuse situation to the CSSN or PIHP Finance Department; <u>and</u> 2. Submit an Incident Report to the Office of Recipient Rights
CSSN/CA	1. Gathers preliminary information regarding suspected financial fraud situation, including <ul style="list-style-type: none">a. Whob. Whatc. Whered. When 2. Notifies PIHP of suspected fraud.

WHO

DOES WHAT

Finance Site Reviewer

1. Conducts a Financial Review of Provider's documentation and operational controls in accordance with the Service Verification Policy.
2. Gathers and documents the following information:
 - a. When the suspected abuse occurred.
 1. Dates of reported service whether actually provided or only reported to have been provided.
 2. Dates of suspected financial abuse. Include summary of details; e.g., nature of financial abuse, amount in question, etc.
 3. Where the service took place; or where it was claimed to have been provided.
 4. Who reported the service
 - a. The provider agency name and address
 - b. The staff person who reported providing the service.
 5. What services were reported.
 - a. Actual service provided.
 - b. Services billed.
 - c. Non-authorized services billed.
 6. Obtain copies of any backup documentation
 - a. Obtain copies of the Provider's backup whether or not thought to be falsified
 - b. Document the lack of evidence supporting the claims/invoice.
 - c. Obtain copies of documentation that contradict Provider backup; e.g., hospital stay documentation for a date billed by Provider.

PIHP Finance Director or Designee

1. Reviews documentation compiled by the Financial Site Reviewer.
2. Consults with CEO of PIHP and/or CSSN, Compliance Officer, Network Management Administrator, and Recipient Rights Manager and provides them with regular status updates.
3. Determines if Independent Audit is warranted. If warranted, obtains services of Independent Audit firm to conduct special audit of provider.
4. Consults with Independent Auditor regarding any special audit prepared.
5. Maintains Fraud Incidents Database.
6. Submits annual report to the Department of Community Health that includes the following aggregate data:

WHO

DOES WHAT

- a. Number of complaints of financial fraud and financial abuse made to agency
- b. Source of complaint
- c. Type of Provider
- d. Nature of complaint
- e. Approximate range of dollars involved
- f. Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

CEO

- 1. Determines if and when Local, State and/or Federal Authorities should be notified. If warranted, files Medicaid Fraud Complaint Form with the Michigan Department of Community Health's Program Investigation Section. That division will determine whether or not to file with the Michigan Department of Attorney General.

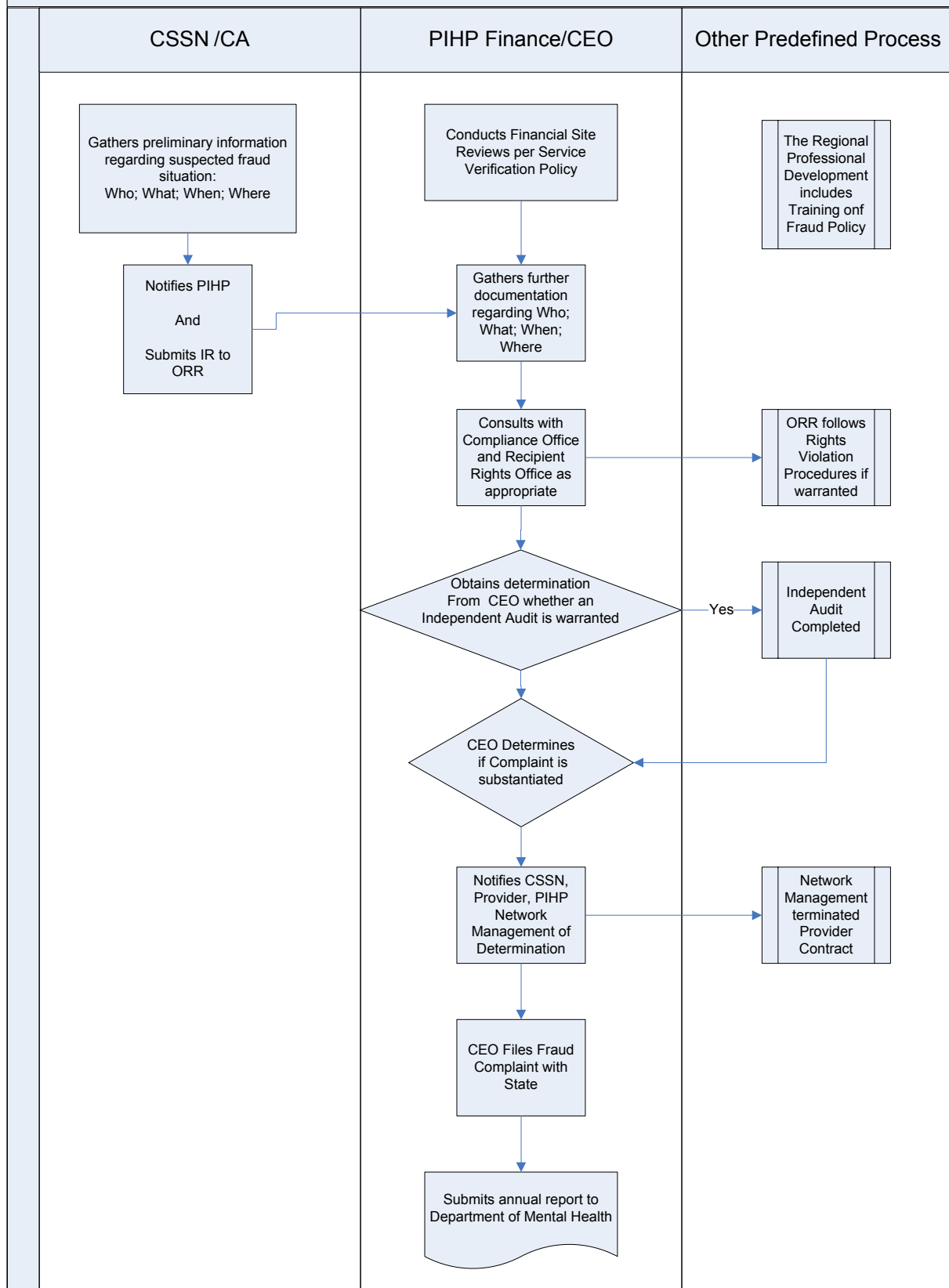
Network Management

- 1. Notifies Provider of Provisional Status until outcome of investigation is reached.
- 2. Terminates contract with cause if full investigation results in affirmation of fraudulent act(s).

Office of Recipient Rights

- 1. Follows ORR policies relating to consumer rights and protections.

FINANCIAL FRAUD: Informatin Gathering and Reporting



MEDICAID FRAUD COMPLAINT FORM

COMPLAINANT INFORMATION:

Confidentiality Required: Yes _____ No _____

Agency's Medicaid ID Number: 4455653 **Case #** _____

Agency Name: WASHTENAW COMMUNITY HEALTH ORGANIZATION

Address: 555 Towner, P.O. Box 915, Ypsilanti Michigan 48197

Name of Person filing Complain on behalf of Agency:

_____ **Phone Number** _____

FRAUD INFORMATION:

Suspect Name: _____ **Social Security No.** _____

AND/OR

Agency Name: _____

Federal ID Number: _____

Address: _____

Telephone: _____

Description of Alleged Fraud: _____

Submitted by: _____
[Signature]

Date

Submit to:

**Michigan Department of Community Health
Program Investigation Section
Capitol Commons Center Building
400 S. Pine, 6th Floor
Lansing MI 48909**