Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Financial Fraud and Abuse***
Committee/Department: Regional Finance Committee	**Local Policy Number (if used)**
Implementation Date 07/08/2022	**Regional Approval Date** 06/24/2022

Reviewed by:	**Recommendation Date:**
ROC	05/02/2022
CMH Board:	**Approval Date:**
Lenawee	05/26/2022
Livingston	05/31/2022
Monroe	05/18/2022
Washtenaw	06/24/2022

I. PURPOSE

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

II. REVISION HISTORY

DATE	MODIFICATION
03/16/2015	Revised to reflect the new regional entity effective January 1, 2014
06/24/2022	3-year review by Regional Finance

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. DEFINITIONS

Abuse: Describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing consumers with services that are medically necessary, meet professionally recognized standards, and priced fairly.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Exploitation: Any action by an employee, contract employee, or volunteer that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual

or individuals other than the recipient.

Financial Fraud: Intentional or unintentional failure to comply with any professional standards for health care, standards for medical necessity, or standards for billing/business operations that could result in potential false claims/overpayment. 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.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

V. POLICY

It is the policy of the CMHPSM to report and document suspected financial fraud and financial abuse to the proper state and federal authorities, to maintain a database of all alleged fraud instances, and to provide to MDHHS an aggregated report of all cases reported.

VI. STANDARDS

A. All entities shall ensure that staff receives training about fraud, abuse and reporting requirements.

B. All staff, students and volunteers shall report possible financial fraud or financial abuse to the CMHSP designee or CMHPSM Finance Director or Chief Financial Officer; and submit an incident report to the Office of Recipient Rights if it is a consumer-related matter, such as exploitation.

C. The CMHSP or CMHPSM as appropriate shall gather preliminary information regarding the suspected fraud and/or abuse situation. Preliminary information shall include Who, What, Where, and When.

D. The CMHSP shall notify the CMHPSM of suspected fraud and/or abuse within 48 hours of gathering the preliminary information.

E. The CMHPSM shall ensure that the Office of the Inspector General (OIG) is notified of suspected fraud and/or abuse cases at the onset of the investigation process as applicable.

F. When there is suspected financial fraud and/or abuse, the CMHSP and the CMHPSM shall ensure that a thorough audit is conducted and shall determine whether it will be conducted by the local CMHSP/CMHPSM Finance Director or Chief Financial Officer or designee.

G. The financial audit shall include the following:
   1. A review of the provider's documentation and operational controls in accordance with the Service Verification Policy.
   2. When the suspected abuse occurred, including:

a. Dates of reported service whether actually provided or only reported to have been provided.
b. 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.

H. Finance Director, Chief Financial Officer or Designee is responsible for the following:
   1. Review documentation compiled from the internal financial audit.
   2. Consults with CMHPSM Managing Director and/or, CMHPSM Compliance Officer, CMHPSM Director of Operations, and the Director of Recipient Rights and provides them with regular status updates.
   3. Determines if independent audit is warranted. If warranted, obtains services of an 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:
      a. Number of complaints of financial fraud and financial abuse made to agency
      b. Source of complaint
      c. Type of Provider Nature of complaint
      d. Approximate range of dollars involved
      e. Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred

I. The CMHPSM Chief Executive Officer determines if and when local, state and/or federal authorities should be notified. If warranted, the Chief Executive Officer files Medicaid Fraud Complaint Form with the Health Services Office of the Inspector General.

J. The CMHPSM Chief Operation Officer notifies the CMHSP Provider Network Manager of the need to notify the provider of its placement on Provisional Status until outcome of investigation is reached.

K. The CMHSP or CMHPSM will terminate the contract with cause if full investigation results in affirmation of fraudulent act(s).

L. The local ORR officer shall follow relevant ORR policies relating to consumer rights and protections around the financial fraud investigation,

VII. EXHIBITS

None

VIII. REFERENCE

None