BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 13	**Corporate Compliance**		
Section: 2	**Administrative & Operational Practices**		
Topic: 16	**False Claims**		
Page: 1 of 12	**Supersedes Date:** **Pol: 10-19-06** **Proc: 6-5-17, 11-25-13, 10-19-06**	**Approval Date:** **Pol: 9-21-17** **Proc: 9-21-2021**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay Arenac Behavioral Health Authority (BABHA) that employees and contracted service providers will not present, or cause to be presented, a false or fraudulent claim for payment or approval, for services funded by federal and state health care programs.

Purpose

To ensure all BABH employees and contracted service providers comply with the federal False Claims and Deficit Reduction Acts, and with the state Medicaid False Claims Act.

Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ Other:

Definitions

Abuse: Per 42 CFR 455.2, provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medical necessary or that fail to meet professionally recognized standards for healthcare.

Claim: Means any request or demand, whether under a contract or otherwise, for money or property that is presented to BABHA or the state or federal government, is made to a contractor or other recipient, if the money or property is to be spent or used for state/federal health care programs, and if BABHA provides or has provided any portion of the money or property requested or demanded or will reimburse such contractor or other recipient; includes any attempt to cause the Michigan Department of Community Health to pay out sums of money under the social welfare act.

Credible Allegation of Fraud: Per 42 CFR 455.2, an allegation of fraud which has indicia of reliability and is based upon a careful and judicious review of the allegation and the facts on a case-by-case basis.

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Fraud: Per 42 CFR 455.2, 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.

Knowing and Knowingly: Meaning that a person with respect to information, has actual knowledge of the information; that the facts under which he or she is aware, or should be aware of the nature of his or her conduct, and that his or her conduct is substantially certain to cause the payment of a Medicaid benefit; and acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard or deliberate ignorance of the truth or falsity of the information; and requires no proof of specific intent to defraud.

Medicaid Benefit: A benefit paid or payable under a program for medical assistance for medically indigent in accordance with the social welfare act.

Money or Property: Refers to state or federal health care program funds or property purchased with such funds.

Overpayment: Per 42 CFR 401.303, any Medicare funds that a person has received or retained to which the person, after applicable reconciliation, is not entitled; per section 1128J(d) of the Affordable Care Act, the requirement is applicable to Medicaid also.

Social Welfare Act: Means the social welfare act, 1939 PA 280, MCH 400.1 to 400.119b.

Procedure

1) Under the federal False Claims Act, employees and contracted service providers of BABHA are not permitted to:
    a) Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval.
    b) Knowingly make, use or cause to made or used, a false record or statement material to a false or fraudulent claim.
    c) Conspire to commit a violation of this policy and procedure.
    d) Have possession, custody, or control of property or money used, or to be used, by BABHA, and knowingly deliver or cause to be delivered, less than all of that money or property.
    e) If authorized to make or deliver a document certifying receipt of property used, or to be used by BABHA, and intending to defraud state or federal healthcare programs, make or deliver the receipt without completely knowing in the information on the receipt is true;

f) Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of BABHA, who lawfully may not sell or pledge property; or

g) Knowingly make, use, or cause to made or used, a false record or statement material to an obligation to pay or transmit money or property to BABHA, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money to the government.

2) Under the state False Claims Act, employees and contracted service providers are not permitted to:

a) Knowingly make or cause to be made a false statement or false representation of a material fact in an application for Medicaid benefits.

b) Knowingly make or cause to be made a false statement or false representation of a material fact for use in determining rights to a Medicaid benefit.

c) Conceal or fail to disclose an event affecting the right of a person to receive a Medicaid benefit or the initial or continued right of any other person on whose behalf he has applied for or is receiving a benefit with an intent to obtain a benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.

d) Enter into an agreement or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false claim.

e) Make or present or cause to be made or presented a claim that he or she knows falsely represents that the goods or services for which the claim is made were medically necessary in accordance with professionally accepted standards.

f) Make, use or cause to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state pertaining to a claim.

3) Severity of Violations

a) The following examples of errors, and potential abuse and fraud are listed in order of severity and will be used by BABHA for purposes of determining the severity of mitigating and remedial actions to be taken. This is not an exhaustive list and is not intended to reflect criteria that may be used by the state or federal government for adverse actions:

b) Poor Quality:

i.) Inconsistent documentation – required information spread across multiple forms, forms not filled out uniformly, etc.

ii.) Lack of specificity– documentation which is unclear or does not adequately describe the service rendered.

c) Low Level Errors: When it is credible the service was medically necessary and delivered as billed by a qualified provider:

i.) Qualifications

1. Licensure, certification or registration is active, but proofs are not up-to-date or are missing.

ii.) Medical Necessity/Authorization

1. Continuing to provide services when assessments, diagnoses, physician's orders or test results which document medical necessity have expired.

iii.) Service Documentation/Claims

1. Errors in documentation, or, partially completed or missing documentation, including the following (but excluding service up-coding and rounding-up service times or units):
    a. Dates and/or start/stop times (including a.m./p.m.)
    b. Name of person receiving service
    c. Service codes and/or modifiers
    d. Description of the service delivered (i.e, narratives)
    e. Signature of service provider, title and date of signature
    f. Gaps in shift notes for per diem billed services
2. Unintentional duplicate claims.

iv.) Insurance/Funding

1. Errors in documentation or partially completed or missing documentation for ability to pay assessments and insurance records.

d) Moderate Level Errors: Direct/indirect acts that result in unnecessary services and costs (when it ***is*** credible that service was delivered):

i.) Qualifications

1. Failing to maintain continuous license, certification or registration.

ii.) Medical Necessity/Authorization

1. Providing services (including prescribing medications) that are medically unnecessary, including ordering/authorizing more service than needed.
2. Providing a different covered service than the covered service authorized or in the plan of service (excluding upcoding).
3. Providing two services at the same time (with limited exceptions).

iii.) Service Documentation/Claims

1. Missing documentation for a billed service, when the service was provided.
2. Documentation is present, but the content does not match the state or BABHA definition/ description of the service.
3. Adding time/units for consumer transportation or staff travel time when not allowed by Medicaid billing rules.
4. Rounding up time, units or mileage.
5. Billing of services in a bundle and billing separately.

iv.) Insurance/Funding

1. Billing a service that is the financial responsibility of another healthcare program or insurance (not coordinating benefits)
2. Not charging a consumer a required fee or co-pay.

e) High Level - Intentional acts; credible potential fraud and/or abuse:

i.) Qualifications

1. Billing services provided in whole or in part by an individual, entity, co-owner or others who are excluded/debarred.

2. Falsification of licensure, certification, registration or other required qualification.
3. Deliberately providing/billing services with a suspended license, certification or registration.

ii.) Medical Necessity/Authorization

1. Falsifying a diagnosis or test results to meet service or billing criteria.
2. Prescribing medicines or ordering equipment for use by people other than the consumer.
3. Intentionally billing for a costlier service than performed (up-coding).

iii.) Service Documentation/Claims

1. Falsifying the conditions of service delivery (i.e., if face-to-face, date, location, etc.) to meet criteria for Medicaid/Medicare services .
2. Falsifying documentation or billing when no service was provided (i.e., creating documentation for a service that did not occur, including progress notes, assessments, plans of service, prescriptions, timesheets and travel vouchers).
3. Backdating of signatures or dates of occurrence.
4. Intentionally billing multiple times for the same service.

iv.) Insurance/Funding

1. Accepting kickbacks for referrals.

4) Consequences of Violations

a) Employees

i.) Employees who violate this policy and procedure are subject to disciplinary action in accordance with BABHA Human Resources standards of conduct and policies/ procedures, depending on severity. The range of disciplinary actions applicable to false claims includes verbal/written warnings, remedial training, performance improvement plans, probationary status, suspension, and termination of employment for more severe violations. During investigations of false claims,

BABHA Human Resources policies and procedures allow for the suspension of employees with or without pay.

ii.) Discipline may also be applied to employees and supervisors who facilitated or ignored fraud or abuse by others

b) Contracted service providers

i.) Contracted service providers who violate this policy and procedure are subject to adverse contract action in accordance with BABHA Provider Services Boilerplate contract language.

ii.) +In accordance with 42 CFR Part 455 BABHA may temporarily suspend payment for services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud unless good cause exists for not suspending payments. Good cause may include the potential impact on persons served, a lack of alternative service providers, or otherwise not in the best interest of the Medicaid program.

iii.) Any funds paid to a contracted service provider based upon false claims will be considered an overpayment by BABHA and are subject to reclamation/repayment (see BABHA policy and procedure C08-S03-T13 Third Party Revenue Collection and Repayments and BABHA Provider Services Boilerplate contract language).

c) Employees and contracted service providers who are found guilty by the State of Michigan of violating the Michigan Medicaid False Claims Act are subject to imprisonment and fines, as follows:

i.) If the violation involved Medicaid benefits, are guilty of a felony punishable by imprisonment of not more than 4 years or a fine of not more than $50,000 or both.

ii.) If the violation involved obtaining payment or allowing a false claim, are guilty are guilty of a felony punishable by imprisonment of not more than 10 years or a fine of not more than $50,000 or both.

iii.) If the violation involved making or presenting a false claim, record or statement, are guilty of a felony punishable by imprisonment of not more than 4 years or a fine of not more than $50,000 or both.

d) Employees and contracted service providers who violate the federal False Claims Acts are liable to the federal government. Remedies include:

i.) Civil penalties of not less than $5,000 and not more than $10,000, as adjusted by federal laws.

ii.) Three times the amount of damages which the government sustains because of the employees' or providers' action, unless reduced damages are found to be warranted.

iii.) Exclusion or debarment from participation in state and federal health care programs, and federal procurement.

iv.) Potential criminal prosecution and if found guilty, imprisonment of not more than five years and a fine, as defined in federal crimes and criminal procedure.

e) Under the federal civil monetary penalties' statute, any individuals and organizations, may be subject to the following, in addition to any other penalties that may be prescribed by law:

i.) A civil money penalty of not more than $10,000-$50,000 for each item or service, depending upon the nature of the occurrence(s).

ii.) An assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or the State of Michigan because of such claim (or, the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose, or the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact).

iii.) In addition, the federal government may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs and to direct the State of Michigan to exclude the person from participation in any State health care program.

5) Reporting Violations and Associated Protections

a) Employees and contracted service providers are required to report suspected fraud, waste and abuse of federal and state health care funds. (See BABHA policy and procedure C13:S02:T01 Internal Reporting of Fraud, Waste and Abuse)

b) Provisions in federal law permit individuals to file suit on behalf of the federal government to recover damages incurred by the federal government as a result of fraud

or other false claims. If the federal government proceeds with legal action in response to the suit, individuals are entitled to receive at least 15% but not more than 25% of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution by the federal government. Other provisions in federal law also apply.

c) Employees and contracted service providers who report suspected fraud, waste and abuse are entitled to relief if retaliated against by BABHA, its employees or contracted service providers because of lawful acts done by the employee or contracted service provider in furtherance of action under the state and federal False Claims Acts, and the false claims provisions of the Deficit Reduction Act. (See BABHA policy and procedure C13:S02:T02 Non-Retaliation/Non-Retribution)

6) Education Process

a) Employees

i.) In accordance with False Claims Act requirements, the BABHA employee handbook will describe the employee's rights to be protected as a Whistleblower and will refer to the Corporate Compliance Plan regarding the BABHA process for detecting fraud, waste and abuse.

ii.) Education for BABHA employees will be provided at the time of new employee orientation and annually during the Staff Development Day process.

iii.) All employees of BABHA will be provided with:

1. Educational materials regarding the False Claims Acts, federal administrative remedies for false claims and statements, and state laws pertaining to civil or criminal penalties for false claims, whistleblower protections under such laws, and examples of false claims.
2. Methods that BABHA has for detecting and preventing fraud, waste and abuse (e.g., auditing and monitoring).
3. The BABH employee's handbook.
4. A signature page for acknowledgement of receipt, with a name of BABHA personnel to contact for question or concerns or for more educational materials.

b) Contracted service providers

i.) Individual practitioners will be trained by BABHA regarding the federal and state False Claims Acts, and whistleblower protections. Proof of training will be maintained in BABHA contract administration or training center records.

ii.) Service provider organizations

1. Provider agencies shall implement written policies, procedures and/or standards of conduct, appropriate to the type and scale of the Provider agency, that articulate the organization's commitment to program integrity and the Provider's expectations for its personnel, as outlined in the contract boilerplate.
2. Service provider organizations will be provided with:
    a. Educational materials regarding the false claims acts, federal administrative remedies for false claims and statements, and state laws pertaining to civil or criminal penalties for false claims, whistleblower protections under such laws, and examples of false claims;
    b. Methods that BABHA has for detecting and preventing fraud, waste and abuse (e.g., auditing and monitoring);
3. Service provider organizations will be monitored for compliance with this policy and procedure during site reviews.

7) Detecting and Preventing False Claims

a) As outlined in the Corporate Compliance Plan, policies and procedures, BABHA will:

i.) Perform exclusion and debarment checks of employees, contracted service providers and others (see BABHA policy and procedure: C13:S02:T11 Prohibited Affiliations and/or Exclusion or Conviction).

ii.) Verify registration, certification and/or licensure of employees and licensed independent practitioners (see BABHA policy and procedures: C07:S01:T01 Staff Credentials and T13 Credentialing and Privileging of Licensed Independent Practitioners).

iii.) Use an electronic service documentation and billing system which contains automated business rules, data logic error edits and other validations to reduce the risk of inappropriate service coding and reporting.

iv.) Complete clinical record compliance reviews (see BABHA policy and procedure: C04:S10:T01 Clinical Documentation).

v.) Perform regular assessments and/or environmental scans to determine risk areas for false claims.

vi.) Verify Medicaid and Medicare claims (see BABHA policy and procedure: C13:S02:T20 Service Event Verification and Restitution).

vii.) Review the Centers for Medicaid and Medicare Services' Office of Inspector General annual work plan for priority areas to be reviewed or monitored.

viii.) Approve a data monitoring plan that encompasses risk/concern areas for BABHA that include responsibility and regular reporting to the Corporate Compliance Committee.

ix.) Conduct site reviews of contracted service providers (see BABHA policy and procedure: C02:S03:T01 Site Reviews).

Attachments

N/A

Related Forms

N/A

Related Materials

- BABH Contract Boilerplate
- BABH Human Resources policies and procedures
- MDHHS/PIHP Master Agreement

References/Legal Authority

- 18 USC 287 False, Fictitious or Fraudulent Claims (i.e., criminal 'False Claims Act')
- 18 USC 1347 Health Care Fraud Statute
- 31 USC 3729-3733 False Claims Act (i.e., 'civil False Claims Act')
- 42 USC 1320a-7a Civil Monetary Penalties
- 42 CFR 455 Medicaid Program Integrity
- 42 USC 1320a-7 Medicare and Medicaid Program Integrity Provisions
- Deficit Reduction Act of 2005, PL 109-171 (Section 6032)

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- Michigan Medicaid False Claims Act (Act 72 of 1977)
- CMS Medicare/Medicaid Fraud and Abuse Prevention 2014 National Training Program Workbook

SUBMISSION FORM				
AUTHOR/ REVIEWER	APPROVING BODY/ COMMITTEE/ SUPERVISOR	APPROVAL/ REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION If replacement, list policy to be replaced
M. Wolber	M. Bartlett	8/20/2009	Revision	Reviewed and format updated
J. Pinter	J. Pinter	11/25/13	Revision	Reviewed and updated to current practices – added new employee orientation to training
J. Pinter; Corp Comp Committee	Strategic Leadership Team	08/01/17	Revisions	Add guidelines for severity, additional consequences of fraud/abuse
J. Pinter	Corporate Compliance Committee	09/21/21	Revisions	Update for current practices; aligned with contract language; added severity scale; verified cited laws.