

# BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY POLICIES AND PROCEDURES MANUAL

<b>Chapter: 13</b>	<b>Corporate Compliance</b>		
<b>Section: 2</b>	<b>Administrative and Operational Practices</b>		
<b>Topic: 22</b>	<b>Complaint Investigations</b>		
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	<b>Pol:</b>	<b>Pol: 2-20-14</b>	<i>Board Chairperson Signature</i>
	<b>Proc:8-1-17, 2-20-14</b>	<b>Proc:9-21-2021</b>	<i>Chief Executive Officer Signature</i>
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## **Policy**

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to conduct corporate compliance investigations when a complaint is received and/or there is reasonable cause to suspect there may have been an unintentional or intentional violation of law relative to fraud and abuse of Federal and State health care funds or privacy and security violations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

## **Purpose**

This policy and procedure is established to define the procedures for the investigation of corporate compliance complaints and serves as a companion policy and procedure to C13-S02-T01 – Internal Reporting (HOT-LINE) and Response for Suspected Fraud, Waste and Abuse.

## **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

## **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.

**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.

**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.

## **Procedure**

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- 1) Identification of Violations
  - a) BABHA will identify priority risk areas, perform routine monitoring and conduct audits to identify compliance related issues including but not limited to documentation and billing errors, excluded/debarred individuals and entities, privacy and security violations (including security breaches), and other violations of regulatory requirements (see the BABHA Compliance Plan). Routine monitoring and self-review will be performed by clinical leadership, finance leadership and staff, and quality/compliance leadership and staff. Consistent with federal compliance program guidelines, quality/compliance and finance staff will perform audits independent of, but in collaboration with, the clinical service delivery system within BABHA.
  - b) Other sources of complaints or potential violations include, but are not limited to: compliance hotline calls, other phone calls, emails, or written complaints to the CCO (Corporate Compliance Officer) or Privacy and Security Officers from staff, people served or contracted service providers; site review audits; Medicaid Event Verification audits; or referrals from the Recipient Rights Department (see BABHA policy and procedure C13:S02:T01 Internal Reporting (Hot-Line)).
- 2) Preliminary Investigation of Potential Violations
  - a) The CCO will take action to initiate a preliminary investigation to determine whether a complaint or identified issue could potentially constitute fraud/abuse within 15 business days of receipt, as required by the MDHHS PIHP Master Agreement. The Privacy/Security officers will do the same for a potential privacy/security violation, under the oversight of the CCO. Complaints and identified issues warranting further review will be logged on the Corporate Compliance Log.
  - b) If a complaint is received from an identifiable source, the CCO or Privacy/ Security Officer will provide a written acknowledgement of receipt to the source within five business days.
  - c) If an issue is routine in nature or if further review is not warranted due to a lack of potential violation of regulatory, legal, contractual or other requirements, the issue will be closed. The individual reporting the concern will be informed of the disposition of the issue as appropriate.
  - d) Any process changes or other improvements that should be initiated to address the concern will be referred to the appropriate party within BABH or the Pre-Paid Inpatient

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Health Plan (PIHP). The CCO will document any actions taken and the final resolution on the Log.

3) Further Investigation

- a) MI Department of Health and Human Services (MDHHS) contractual requirements preclude BABHA from investigating or resolving potential fraud and/or abuse. If a complaint or identified issue is determined to be a credible allegation of fraud (i.e., involves more than documentation errors or other unintentional acts):
  - i) BABHA will act to mitigate the immediate effect on the consumer, to remediate individual and system failures to prevent further fraud and abuse, and secure the situation as indicated in this procedure.
  - ii) BABHA will report issues to the PIHP, and state authorities as required for potential investigation.
  - iii) PIHP policies and plans require BABHA to complete an investigation within 90 days from the date of initial report. If state authorities do not investigate in a timely manner, BABHA will complete an investigation to comply with the 90-day requirement of the PIHP.
- b) Staff and supervisors will not independently investigate or mitigate compliance issues and should only gather information to the extent necessary to confirm the presence of potential fraud/abuse or privacy/security violations for purposes of reporting.
- c) Contracted service providers should adhere to reporting timelines and coordinate review of fraud/abuse and privacy/security issues with the BABH CCO or Privacy/Security Officers.
- d) If further review by BABHA is warranted, the CCO (or Privacy/Security Officers under the oversight of the CCO) will:
  - i) Coordinate the review with the Chief Financial Officer, Director of Human Resources and the relevant Director of Integrated Healthcare as appropriate (assuming there is no conflict of interest).
  - ii) Ensure suspected privacy violations are reported to the Recipient Rights Office in accord with recipient rights policies and procedures for potential investigation as confidentiality violations.

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- iii) In consultation with the CFO, CEO or Clinical Director(s) as appropriate, act to ensure involved consumers are protected and their services are not disrupted, clinical records and other documentation are secured, and access by involved staff and/or contracted service providers is restricted as appropriate.
  - iv) BABHA employees and/or contracted service providers may be placed on temporary suspension of their employment or contractual agreement if warranted, per personnel policies and contractual boilerplate language.
- 4) Integrity of Reviews/Investigations
- a) The work of the CCO will be performed under sanction by the CEO.
  - b) In the event the CEO has a conflict of interest or is the subject of a corporate compliance review, the CCO will substitute the Chair of the BABHA Board of Directors for the CEO in performing all duties as outlined in this procedure.
  - c) If the CCO has a conflict of interest or is themselves a potential subject of a corporate compliance review, the CCO will recuse themselves and hand the review off to the BABHA Chief Financial Officer. In such instances, the CFO or CEO may contact the Corporate Compliance Officer of the PIHP for assistance with the review.
  - d) The CCO or CFO, in consultation with the CEO or Chair of the Board of Directors, will seek legal counsel as necessary during the review.
  - e) BABHA staff and contracted service providers will cooperate with compliance reviews.
  - f) An in-depth review will, at a minimum, review the following:
    - i) Date the incident happened or started, if known, and the date the incident was discovered
    - ii) Date of notification to parties who are required to be notified
    - iii) Location(s) of the incident or issue
    - iv) Any interviews with the complainant or others who can provide relevant information
    - v) Review of records, when applicable, and any other pertinent documentation
    - vi) Review of applicable BABHA policies and procedures and citations for relevant provisions of the Michigan Mental Health Code, Administrative Guidelines, etc.

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- vii) Other details pertinent to the incident, including whether the incident was unintentional or intentional, any contributing factors such as human error, age/type of equipment, any uncontrollable factors, etc.
  - viii) Recommendations for mitigation, remediation and prevention, and resolution of the investigation, including any actions taken by law enforcement officials
  - ix) Date of resolution
- 5) Mitigation and Remediation
- a) In the event the review results in evidence of a potential HIPAA breach, the procedures found in BABHA Policy and Procedure, C13-S01-T13 – HITECH Breach, will be followed.
  - b) In the event the review substantiates a false claim, the procedures found in BABHA Policy and Procedure C13-S02-T16 False Claims will be followed.
  - c) If a review was initiated elsewhere, i.e., by a contracted service provider, the Human Resources Department or the Recipient Rights Office, the CCO may accept the results of the investigation and respond accordingly. The RR Office will report their findings and recommendations to the Privacy Officer for investigations involving privacy violations.
  - d) Reviews will be documented on a Corporate Compliance Fraud-Abuse or Privacy Record by the CCO (or Privacy/Security Officers as designated) and maintained in secure Corporate Compliance office records in accordance with BABH retention procedures.
  - e) BABHA will use a reasonable time frame to formulate and summarize a response using the date of the filing of the complaint, or date of suspected violation, but no later than 90 days from either date.
- 6) Internal Monitoring and Reporting
- a) The Privacy/Security Officers will report the results of their reviews to the CCO. The CCO, in consultation with the CEO and other members of senior management as warranted and appropriate, will determine whether the fraud/abuse or privacy/security issue was substantiated and if external reporting is required.
  - b) As appropriate, the CCO will inform the complainant about the results of a review, including steps taken to rectify any harm done and steps taken to prevent possible future harm.

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- c) The CCO or Privacy/Security Officer will follow-up on and monitor any actions taken to remediate the incident.
  - d) The BABHA Corporate Compliance Committee will receive regular updates from the CCO, Privacy and Security Officers regarding incidents. The Officers, in conjunction with the Committee, will determine if root cause analysis is warranted. Root cause will be performed as outlined in BABH policies and procedures governing Adverse Events. Results of the root cause analysis will be reported to the Committee for actioning.
- 7) External Reporting
- a) The CEO, CCO, or CFO, will report suspected Medicaid fraud or abuse to the designated official at the PIHP, MDHHS, and the Michigan Office of Health Services Inspector General (MIOHSIG), as required by BABH’s contractual agreements. BABHA will report suspected fraud and abuse to the PIHP within ten business days per PIHP policy. BABH will cooperate fully with any investigation by relevant authorities.
  - b) The CCO or CEO will report summary level information regarding substantiated fraud and abuse to the BABH Board of Directors Corporate Compliance Committee.
  - c) Semi-annually BABH will report information about the number of Medicaid fraud and abuse related complaints that warranted preliminary investigation to the PIHP in compliance with contractual requirements.
  - d) The BABH CEO will inform, in writing, the PIHP Chief Executive Officer (CEO) of any notice to, inquiry from, investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory, prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization that directly relates to the rights, safety, or care of a recipient of Medicaid services. The CMHSP Participant CEO/ED shall inform, in writing, the PIHP CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
  - e) The BABHA CEO will notify the PIHP and MDHHS when information is received about changes in a BABHA network provider’s circumstances that may affect their eligibility to participate in the Medicaid managed care program.
- 8) Disciplinary Action for Substantiated Violations by BABHA Employees

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- a) BABHA may take disciplinary action against staff in response to substantiated fraud/abuse or privacy/security violations in accordance with human resource policies and procedures. The level of discipline depends upon the level of severity.
  - b) The range of disciplinary actions includes verbal/written warnings, remedial training, performance improvement plans, probationary status, suspension, and termination of employment for more severe violations.
  - c) During investigations, employees may be suspended with or without pay.
  - d) Discipline may also be applied to employees and supervisors who facilitated or ignored privacy/security violations by others
- 9) Contract Action for Substantiated Violations by Contracted Service Providers
- a) Substantiated fraud/abuse is subject to adverse contract action including suspension of payment depending upon the severity of the violation (See BABHA policy and procedure C13-S02-T16 False Claims for more information).
    - i) 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).
  - b) Security breaches and failure to maintain an adequate system to comply with applicable confidentiality privacy and security regulations as specified in the contractual agreement with BABHA are subject to adverse contract action, including requiring a plan of correction, additional oversight by BABHA, and potential contract termination.
  - c) Payments and additional referrals and/or service authorizations may be suspended during a pending investigation.
- 10) Civil, Criminal and Licensure Actions
- a) The federal Office of Civil Rights can impose civil penalties and the US Department of Justice investigates and prosecutes criminal violations of HIPAA.
  - b) Federal and state False Claims Acts establish liability for submitting false or fraudulent claims to the government, including Medicaid and Medicare, including criminal and civil action by state and federal authorities. Individuals and organizations have liability for false claims if they knew or should have known their claim was false or fraudulent.

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- c) BABH must report licensed professionals to MI Licensing and Regulatory Affairs for suspected fraud/abuse or privacy/security violations, which may result in adverse action against professional or organizational licensure by the State of Michigan.
- 11) Examples of Fraud and Abuse Violations by Level of Severity
- a) See BABHA policy and procedure C13-S02-T16 False Claims for examples of fraud and abuse violations by level of severity.
- 12) Examples of Privacy and Security Violations by Level of Severity
- a) The determination of the severity of privacy and security violations for purposes of action by BABHA depends upon:
    - i) The scope and potential impact of the violation on the person served
    - ii) Whether reasonably within assigned responsibilities and scope of work
    - iii) The presence or absence of intent to violate privacy or breach security
  - b) The following guideline for the severity of confidentiality, privacy and security violations of protected health information (PHI) will be followed by BABHA. The guideline is not an exhaustive list and is not intended to reflect criteria that may be used by the federal government for adverse actions:

<b>Level of Severity</b>	<b>Examples of Privacy and Security Violations</b>
Level I	<ul style="list-style-type: none"> <li>▪ Misdirected faxes, e-mails &amp; mail that <i>are</i> recovered or assurance of destruction by the recipient obtained.</li> <li>▪ Email or other electronic transmission of PHI using an unsecured method.</li> <li>▪ Failing to log-off a computer with PHI displayed.</li> <li>▪ Exposing PHI in a public location (including public areas of BABHA or provider network buildings – i.e., lobby, hallway, cafeteria, elevator) <i>without</i> knowledge of observation of the documents by someone without a need-to-know</li> <li>▪ Sharing PHI with a BABHA staff or contracted service provider who does not have a need-to-know</li> <li>▪ Dictating or discussing PHI in a public location (including public areas of BABHA or provider network buildings – i.e., lobby, hallway, cafeteria, elevator)</li> </ul>



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Level of Severity	Examples of Privacy and Security Violations
	<ul style="list-style-type: none"> <li>▪ Failing to redact or de-identify PHI for operational/business uses.</li> <li>▪ Improper disposal of PHI.</li> </ul>
Level II	<ul style="list-style-type: none"> <li>▪ Leaving PHI on an answering machine without consumer permission</li> <li>▪ Sending US mail containing PHI to an address without consumer permission.</li> <li>▪ Misdirected faxes, e-mails &amp; mail that that <b>are not</b> recovered nor assurance of destruction by the recipient obtained.</li> <li>▪ Exposing PHI in a public location (including public areas of BABHA or provider network buildings – i.e., lobby, hallway, cafeteria, elevator) with observation by someone without a need-to-know and/or <b>without</b> loss of documents</li> <li>▪ Sharing PHI with another health care or community human service provider or educational facility who does not have a need-to-know</li> <li>▪ Directly accessing the PHI of someone who is <b>not</b> a family member, friend, neighbor or co-worker, on an isolated basis, without the need-to-know for current job duties; this includes PHI which can be accessed without “breaking-the-glass” (i.e., without going outside of role-based security parameters)</li> <li>▪ Inappropriate sharing of ID/password with another coworker or encouraging coworker to share ID/password.</li> <li>▪ Failure to secure data on mobile devices through password/encryption.</li> </ul>
Level III	<ul style="list-style-type: none"> <li>▪ Exposing PHI in a public location (including public areas of BABHA or provider network buildings – i.e., lobby, hallway, cafeteria, elevator) with loss of documents</li> <li>▪ Sharing PHI with a business or other non-health care or human service-related organization who does not have a need-to-know</li> <li>▪ Directly accessing the PHI of someone who is <b>not</b> a family member, friend, neighbor or co-worker on a repeated basis without the need-to-know for current job duties; this includes PHI which can be accessed without “breaking-the-glass” (i.e., without going outside of role-based security parameters).</li> <li>▪ Directly accessing PHI for a family member, friend, neighbor or co-worker, regardless of the frequency of occurrence; this includes PHI which can be</li> </ul>

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<b>Level of Severity</b>	<b>Examples of Privacy and Security Violations</b>
	<p>accessed without “breaking-the-glass” (i.e., without going outside of role-based security parameters).</p> <ul style="list-style-type: none"> <li>▪ Asking another individual to access PHI without a need-to-know based on their current job duties.</li> <li>▪ Giving another individual access to your electronic signature.</li> <li>▪ Posting PHI to a social media website.</li> <li>▪ Releasing or using aggregate data containing PHI without BABHA approval for work related research, studies, publications, etc.</li> </ul>
Level IV	<ul style="list-style-type: none"> <li>▪ Releasing or using aggregate data containing PHI without BABHA approval for non-work-related research, studies, publications, etc.</li> <li>▪ Use of PHI for personal gain.</li> <li>▪ Compiling a mailing list to be sold for personal gain or for other personal use.</li> <li>▪ Intentional disclosure to the public or other abusive use of PHI.</li> </ul>

**Attachments**

N/A

**Related Forms**

Corporate Compliance Fraud-Abuse Record  
Corporate Compliance Privacy Record

**Related Materials**

MDHHS/PIHP Master Agreement

**References/Legal Authority**

- Bullard-Plawecki Employee Right to Know Act
- 31 USC 3729-3733 (Civil) False Claims Act
- 45 CFR Parts 160, 162 and 164 Privacy, Security and Breach Rules
- 42 CFR Part 2 Confidentiality of SUD Patient Records
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- 42 USC 1320a-7k Medicare and Medicaid Program Integrity Provisions
- 42 CFR 455 Medicaid Program Integrity
- 42 CFR 438.608 Medicaid Managed Care: Program Integrity

<b>SUBMISSION FORM</b>				
<b>AUTHOR/ REVIEWER</b>	<b>APPROVING BODY/ COMMITTEE/ SUPERVISOR</b>	<b>APPROVA L/REVIEW DATE</b>	<b>ACTION (Deletion, New, No Changes, Replacement or Revision)</b>	<b>REASON FOR ACTION If replacement, list policy to be replaced</b>
M. Wolber	J. Pinter, CCO	12/16/13	NEW	Compliance with HIPAA and Medicaid/Medicare Program Integrity requirements
J. Pinter, Corp Comp Committee	Strategic Leadership Team	08/01/17	Revised	Added communication requirements and consequences for substantiated investigations
J. Pinter	Corporate Compliance Committee	09/21/21	Revised	Updated to match current practices; adjusted error level items.
K.Amon	Corporate Compliance Committee	1/30/25	No Changes	Review