

**VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY  
POLICIES & PROCEDURES**

**Title:** Fraud and Abuse  
**Originated:** 02/09/10

**Number:** I.27  
**Approved By:** Executive Team

**BACKGROUND:**

All services are subject to review for conformity with accepted medical practice and Medicaid, Medicare and third party payor coverage and limitations. Post and pre-payment review of claims should be performed to ensure services are appropriate, necessary and comply with Medicaid, Medicare and third party payor laws, rules, or standards. In addition, claims review should also verify that services were billed appropriately and that third party resources were utilized to the fullest extent available.

The Michigan Department of Attorney General uses the following State laws for investigating Medicaid provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 tense.)  
An individual, whether a provider, an employee, or an accomplice, convicted of submitting false claims is subject to a fine of up to \$50,000 and a prison sentence of four to ten years for each count, as well as full restitution to the Medicaid Program for of all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

Some examples are:

- Billing for services not rendered.
  - Billing without reporting payments received from other sources such as Medicare.
  - Billing for a brand name drug when a generic substitute was dispensed.
  - Misrepresenting the patient's diagnosis in order to bill for unnecessary tests and procedures.
  - Billing a date of service other than the actual date services were rendered.
  - Accepting "kickbacks" as cash payments or gifts in exchange for favorable treatment.
  - Fraudulent Cost Reports.
- Social Welfare Act (MCLA 400.111d)
  - Public Health Code (MCLA 333.16226)

The Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) is an independent law enforcement agency mandated to investigate fraud in Social Security Administration (SSA) programs. The OIG investigates fraud, abuse and violation of HIPAA Privacy and Social Security regulations under federal laws.

Examples of criminal activity they would investigate are:

- False statements on claims
- Concealment of material facts or events affecting eligibility
- Misuse of benefits by a representative payee

- Buying or selling Social Security cards or SSA information
- SSN misuse involving people with links to terrorist groups or activities
- Crimes involving SSA employees

Other violations include:

- Conflict of interest
- Fraud or misuse of grant or contracting funds
- Significant mismanagement and waste of funds
- Standards of conduct violations

Allegations of identify theft will be referred by the OIG to the Federal Trade Commission.

The following federal laws are primarily used:

- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act)
  - Violations of Section 1128A include but are not limited to:
    - Billing for claims for medical items or services, which were not provided.
    - Billing codes for services that result in a higher reimbursement than what was actually rendered.
    - Services rendered by an individual who was not a licensed physician
    - Coverage not in effect on the date of service
    - Billing for services that were not medically necessary
    - Hospitals who knowingly make payment to a physician as an inducement to reduce or limit services
    - Physicians who accept such payments
- Social Security Act (Section 1909) which was re-designated 1128B
  - Violators under this section:
    - Convicted of a felony can be fined not more than \$25,000 or imprisoned for not more than five years, or both.
    - Convicted of a misdemeanor can be fined not more than \$10,000 or imprisoned for not more than one year, or both.

## **POLICY:**

All employees of Van Buren Community Mental Health, their delegates or individuals under contractual arrangements will comply with all State and Federal Laws by:

- Ensuring that claims presented for reimbursement are appropriately billed. Do not make assumptions and enter missing data.
- Entering claims for adjudication without alteration. All claims should be entered as billed. Providers may submit corrected claims if needed.
- Never accept gifts in exchange for special treatment.
- Report suspected fraud immediately.

In addition, every effort will be made to identify third party payment resources. Use diligence in reviewing these claims for secondary payment and re-verify other insurance no less than annually.

**PROCEDURE FOR REPORTING SUSPECTED FRAUD:**

The Program Investigation Section of the Michigan Department of Community Health (MDCH) is responsible for investigating all suspected Medicaid Provider fraud and/or abuse.

If you suspect claims fraud, report it to the Compliance Officer through one of the following mechanisms:

- Compliance Hotline: 1-800-292-5419
- Electronic Mail: [mfarrington@vbcmh.com](mailto:mfarrington@vbcmh.com)
- Telephone: 269-655-3323
- In Person or Mail Delivery to the following address:

Compliance Officer  
Van Buren Community Mental Health  
801 Hazen Street, Suite C  
Paw Paw, MI 49079