SUMMIT POINTE POLICY AND PROCEDURE MANUAL

Section: Corporate Compliance	**Policy Name:** Fraud, Waste, & Abuse	**Policy Number:** 3.1.7
Owner: Corporate Compliance Director	**Applies To:** ☒Summit Pointe Staff ☒Summit Pointe Contract Providers ☒Summit Pointe CCBHC Services ☐Summit Pointe CCBHC DCO Providers	
Approved By: Joann Goodrich		
Version Number: 3	**Revised Date: 01/12/2024**	**First Effective Date: 11/01/2018**

I. PURPOSE:

To provide Summit Pointe workforce members awareness to prevent fraud, waste, and abuse of federal and state funds, both federal and state of Michigan false claims laws, provide substantial civil, criminal, and administrative penalties for violation of such laws.

II. DEFINITIONS:

DEFINITIONS: Refer to the "Summit Pointe Policy and Procedures Definitions Glossary."

III. POLICY:

All employees of Summit Pointe, providers and others under contractual arrangements with Summit Pointe will comply with State and Federal laws and that Summit Pointe has a "zero tolerance" policy towards any illegal/unethical activity or knowing, intentional, or willing noncompliance, and is responsible for reporting a violation or potential violation.

IV. PROCEDURE:

Michigan Law:

Michigan's Office of the Attorney General uses the following state laws for investigating Medicaid provider fraud and abuse.

Medicaid False Claim Act (MCLA 400.601):

An individual, whether a provider, an employee, or an accomplice, convicted of submitting false claims is subject to a fine 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 all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period and, in some instances, his/her license to practice his/her 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

Refer to the Social Welfare Act (MCLA 400.111d) and Public Health Code (MCLA 333.16226).

Federal Law:
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.

Other violations include:

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

The following federal laws are primarily used:

Federal False Claims Act (FCA):
The federal False Claims Act (FCA) and the Program Fraud Civil Remedies Act (PFCRA) penalize individuals or entities that knowingly submit or cause the submission of a false or fraudulent claim to the federal government. Billing a federal health care program, including Medicare or Medicaid, for medically unnecessary services, or providing false certification regarding compliance with a federal law or regulation is considered false or fraudulent under the FCA. Another example of action that may be considered a false claim includes billing Medicaid for services provided to someone other than the Medicaid beneficiary. In summary, the FCA prohibits:

- Knowingly presenting the Government with a false claim for payment.
- Knowingly making a false statement to get a fraudulent claim paid.
- Conspiring to defraud the Government by getting a false claim paid by the government.
- Knowingly making a false record of statement to conceal, avoid, or decrease an obligation to pay the Government.
- Causing a false claim to be submitted.

Anyone who violates the FCA may be:

- Liable for a civil penalty of $5,500 to $11,000 per claim plus three times the amount paid.
- Liable for the costs of a civil action brought to recover any penalties or damages.
- Excluded from participating in Medicare, Medicaid, and other Government programs.
- Faced with Federal criminal enforcement for intentional participation in the submission of a false claim.

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 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.

Anti-Kickback Statute:
The anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration in order to induce the referral of a patient, or the purchasing, leasing, ordering (or arranging for or recommending the purchasing, leasing or ordering) of any good, facility, service, or item if any portion of that patient's care of the cost of the good, facility, service or item may be paid in whole or in part by a federal health care program such as Medicaid or Medicare. Illegal payments (or offers or solicitations of payments) include those in cash or in kind, those made directly or indirectly, and those made overtly or covertly. Where remuneration is purposefully paid in exchange for referrals of items or services that are paid for by a federal health care program, the anti-kickback statute is violated.

All employees of Summit Pointe, 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.

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

If you suspect claims fraud, report it to the Compliance Director via mail, email, phone, in person or via the intranet.

Any threat or reprisal against a person who makes a good faith report is against the Summit Pointe policies in accordance with the Whistleblower's provisions.

Qui Tam (Whistleblower) Law:
The qui tam 'whistleblower' law is a federal law that applies nationally. The qui tam law is designed to protect against the fraudulent use of public funds by encouraging people with knowledge of fraud against the Government to blow the whistle on the wrongdoers. The law provides for whistleblowers to receive a reward in the form of a share of the recovery. A qui tam lawsuit must be filed with the later of the following:

- Six years from the date of the FCA violation; or
- Three years after the Government knows or should have known about the material facts concerning the FCA violation, but in no event longer than ten years.

Anyone initiating a qui tam case may not be discriminated against or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job-related losses resulting from any such discrimination or retaliation.

V. REFERENCES:

Michigan Medicaid False Claims Act, MCL 400.601
Federal False Claims Act, 31 U.S.C.§§3729-3733
Civil Monetary Penalties Law, 42 U.S.C. §§ 1320a-7a, 42 CFR pt. 1003
Anti-Kickback Statute
Qui Tam (Whistleblower) Law

VI. ATTACHMENTS:

None