KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY & PROCEDURE 10.02

Subject: Complaint and Investigation Process	**Section:** Compliance & Risk Management	
Applies To: ☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers		**Page:** 1 of 11
Approved: (Jeff Patton, Chief Executive Officer)		
Revised: 05/02/2017	**Supersedes:** 06/09/2015	**First Effective:** 04/14/2003

PURPOSE

To establish guidelines for Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) and its provider network regarding the filing of compliance complaints and the process for conducting complaint investigations. The Compliance Officer (CO) is responsible for objectively, uniformly, consistently and adequately coordinating and directing the investigation of all suspected fraud, abuse or waste, or reported violations of applicable laws and regulations for all covered services. The extent of the investigation will vary depending upon the severity of the issue.

DEFINITIONS

Abuse
As it pertains to compliance, means practices that are inconsistent with sound fiscal, business or clinical practices, and result in unnecessary costs to public agencies (e.g., CMS, MDHHS, PIHP) or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid Program.

Alleged Wrongdoing
Conduct which appears to be in conflict with a required law, regulation or Southwest Michigan Behavioral Health (SWMBH) or KCMHSAS policy (see "wrongdoing").

Complaint
Any report of "wrongdoing"

Complainant
The individual reporting the alleged compliance "wrongdoing" or improper conduct. A reporting person can be any KCMHSAS officer, board member, full-time, part-time and temporary employee, volunteer, student, applicant for employment, provider, vendor, contractor and any other person or entity that may become part of, or affiliated with, KCMHSAS provider network in the future.

Complaint Investigator
The Provider Compliance Officer or his/her representative, the Local Compliance Liaison (if formally designated by the KCMHSAS CO to investigate a Complaint and produce a Complaint Investigation Report).

Complaint Investigation Report
The written report issued by the Compliance Office designate containing a summary of the facts learned in the compliance investigation including any findings and follow-up action/recommendations.

Corporate Compliance
Consists of the mechanisms, including the written Compliance Program and Policies, that are collectively intended to prevent and detect unethical and/or illegal business practices and violations of law.

Disclosure
The process by which a Reporting Person reports that some organization or person has committed, or appears to have the intention to commit, wrongdoing.

Dissemination
The process by which information is spread widely.

Fraud
Knowingly presenting a false or fraudulent claim to the government for payment; Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved; Conspiring to defraud by getting a false or fraudulent claim allowed or paid; Knowingly making, using, or causing 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 government.

FWA
The federal term contained in the Deficit Reduction Act (DRA) that refers to any event pertaining to an alleged or actual wrongdoing of fraud, waste or abuse (i.e., generically known as "FWA").

Health Information
Any information, whether oral or recorded in any form or medium that: (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and that (b) relates to the past,

present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

Inquiry
An informal process whereby a person makes the Compliance Office aware of a potential compliance related concern and the CO examines the concern to determine if it merits a formal complaint and investigation. If the outcome of the inquiry determines that the matter is not FWA related, the CO will document the inquiry and outcome, and take any action necessary to rectify the concern. Conversely, if the outcome of the inquiry determines that a formal investigation is warranted, the CO will convert the informal inquiry into a formal complaint, and will conduct a formal investigation in accordance with KCMHSAS policy investigation guidelines.

Knowing/Knowingly
Defined under the Federal False Claims Act (FCA) to include the willful disregard of a regulation imposed upon an organization, the "deliberate ignorance" of the regulation's propriety, the submission of a claim in "reckless disregard" of the truth, or the falsity of claim. Managerial staff of the provider organization can be held accountable in situations where they refuse to explore a credible concern about the compliance requirements for a particular business or clinical practice, or a submitted bill or claim requiring use of federal funds for its reimbursement.

Defined under the Michigan False Claims Act, "Knowing" and "knowingly" means that a person is in possession of 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. Knowing or knowingly includes acting in deliberate ignorance of the truth or falsity of facts or acting in reckless disregard of the truth or falsity of facts. Proof of specific intent to defraud is not required.

Protected Healthcare Information *(PHI or "Confidential Information")*
All personally identifiable information and material about a recipient in any form or medium, and the information that an individual is or is not receiving services. The following is a list of protected identifiers:

1. Names;
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except

that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data)

There are also additional standards and criteria to protect individual's privacy from re-identification. Any code used to replace the identifiers in datasets cannot be derived from any information related to the individual and the master codes, nor can the method to derive the codes be disclosed. For example, a subject's initials cannot be used to code their data because the initials are derived from their name.

Provider
Any healthcare organization or individual practitioner that furnishes or renders health care services or items within the KCMHSAS network for which reimbursement will be sought. A Provider may also be a person who performs billing or coding functions, or is involved the reporting of health care services into KCMHSAS.

Qui Tam Provision
The federal False Claims Act (FCA) allows any person with direct knowledge of a false claim to bring a civil suit on behalf of the United States Government, known as a "*Qui Tam*" action. It derives from the Latin phrase "*qui tam pro domino rege quam pro se ipso in hoc parte sequitur,*" meaning "he who sues for the king as well as for himself." The individual must first formally notify the Department of Justice of the suspected fraud. The Department of Justice then has the option of either intervening in and prosecuting the action or allowing the individual to proceed on his/her own. If the suit is ultimately successful, the individual who initially brought the suit may be awarded a percentage between 15- 30% of the funds recovered.

Waste
Overutilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Whistleblower
A person who tells someone in authority about alleged dishonest or illegal activities (misconduct) occurring in a government department, a public or private organization, or a company. The alleged misconduct may be classified in many ways; for example, a violation of a law, rule, regulation and/or a direct threat to public interest, such as fraud, health/safety violations, and corruption.

Wrongdoing
An act or omission concerning (a) a violation of any law or regulation; (b) a breach of the Code of Ethical Conduct of KCMHSAS; (c) knowingly non-compliant with a KCMHSAS policy; (d) misuse of public funds or assets; (e) mismanagement of a nature sufficiently substantive which would lead one to reasonably believe that such mismanagement would have a potentially harmful impact on KCMHSAS's work, reputation or operations; or (f) conduct which includes such behaviors as intimidation, harassment and other unethical behavior. Under the federal Deficit Reduction Act (DRA), "wrongdoing" may be either an intentional act or an unintentional act (i.e., omission).

POLICY

It shall be the policy of KCMHSAS to vigorously combat fraud, waste and abuse (FWA) in federal and state healthcare programs by (a) establishing an effective Compliance Program; (b) providing information on federal and state criminal and civil laws and regulations that punish prohibited activities; (c) providing information on federal and state laws and regulations that protect individuals who report fraud, waste and abuse from retaliation; and (d) informing KCMHSAS officers/board members, employees, providers, contractors and other representative agents to combat fraud, waste and abuse.

It shall also be the policy of the KCMHSAS that any officer/board member, employee, provider, contractor, student, volunteer, or other party affiliated with KCMHSAS who suspects or has knowledge of fraud, waste or abuse must immediately report it to the KCMHSAS Compliance Office. All organizational providers who receive funds shall ensure adherence to this policy guideline, and shall be responsible for assuring that their officers/board members, employees, contractors, and agents comply with all applicable laws, and with all KCMHSAS policies applicable to their organization.

KCMHSAS's CO will coordinate and direct the investigation of all reported fraud, abuse or waste compliance allegations.

PROCEDURE

I. PURPOSE OF INVESTIGATIONS

A. Identify those situations in which the laws, rules and standards of Medicaid, Medicare, and other third-party payors may not have been followed as related to fraud, abuse and waste. This includes, but is not limited to, the following:

1. To identify individuals or processes which may have knowingly or inadvertently caused services to be provided or coded and/or claims to be submitted or processed in a manner which violated Medicaid, Medicare, and other third-party payor laws, rules, or standards;
2. To facilitate the correction of any practices not in compliance with the Medicaid, Medicare, and other third-party payors laws, rules and standards;
3. To implement those procedures necessary to ensure future compliance;
4. To protect KCMHSAS in the event of civil or criminal enforcement actions; and
5. To preserve and protect KCMHSAS's assets.

II. INITIAL INVESTIGATION

All suspected compliance-related complaints received by KCMHSAS's management and program staff shall be immediately forwarded to KCMHSAS's Compliance Office. Copies of all original data and information will be forwarded to the KCMHSAS CO including emails messages, voice mail message, written documents, etc.

A. The CO will document any suspected compliance issue/inquiry on the Compliance Review/Investigation Case Log. Each issue:
   1. Is logged into the form on date of contact
   2. Issued a unique identification number
   3. Indicates the date of completion
   4. Lists the corrective actions taken

B. A protected and unique Compliance Investigation Form (Exhibit C) will be created for each suspected compliance issue/inquiry and an Initial Investigation will be completed. In instances where the concerns were previously investigated, the CO will review the details of the previous investigation and actions taken, if any.

C. If the CO concludes, in consultation and with concurrence of the KCMHSAS CEO as applicable and appropriate, based on the Initial Investigation of the issues that no Formal Compliance Review is necessary, the CO will:
   1. Respond to the inquiry or question;
   2. Document the results on the Compliance Investigation form; and
   3. Close the compliance review on the Compliance Tracking Case Log.
   4. Inform KCMHSAS CEO and/or representative and KCMHSAS Compliance Committee of decision as applicable and appropriate.

D. If the CO concludes, in consultation and with concurrence of the CEO, based on the Initial Investigation, that the conduct reported likely or possibly constitutes noncompliance with any of the following, the matter shall be considered an open compliance investigation and a formal compliance review shall commence:

1. Medicaid, Medicare, and other third-party payors laws, rules and standards;
2. Policies and procedures of KCMHSAS; or
3. Applicable state and/or federal laws.

III. INVESTIGATIVE PROCESS

A. KCMHSAS's CO will notify and brief the CEO of the suspected compliance issue(s) and of the commencement of a Formal Compliance Review. The investigation will begin as soon as reasonably possible, but in no event more than 10 business days following the receipt of the report/audit/information/complaint regarding the potential noncompliance issue.

A compliance investigation work plan will be designed prior to the start of the Formal Compliance Review of the compliance issue. (See Attachment D) The investigation may include, but is not limited to, the following processes:

1. Review of all documents related to the issue (i.e. policies, communications, audit findings, etc.)
2. Review of bills or claims submitted (or to be submitted) to Medicaid, Medicare, and other third-party payors. This will aid in determining the nature, scope, frequency, duration, and the potential financial magnitude of the problem.
3. Review of all applicable electronic medical record (EMR) and other care related documents.
4. Conduct an interview of the complainant and other persons who may have knowledge of the alleged problem or processes. The purpose of the interview(s) will be to determine the facts related to the alleged activity, and may include, but shall not be limited to:
    a. Full review and documentation of factual findings;
    b. Individual understanding of the Medicaid, Medicare, and other third-party payors laws, rules, regulations, and standards;
    c. Identification of persons with supervisory or managerial responsibility in the process;
    d. Training protocols of the individuals performing the functions within the process; and
    e. Extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the Medicaid laws, rules or regulations
5. Preparation of a summary report which:
    a. Lists all known facts;
    b. Defines the nature of the problem
    c. Summarizes the investigation process
    d. Identifies any person or process(es) which the investigator believes to have contributed deliberately or with reckless disregard or intentional indifference or otherwise toward the Medicaid,

Medicare, and other third-party payors laws, rules, policies and standards;

e. Estimates the nature and extent of the resulting overpayment by the government or third-party payor, if any.

6. Review the statutes, regulations, policies and standards involved, both internal (KCMHSAS) and external (i.e. State, Federal standards, regulations, laws). Consult with internal and external resources as needed.

The KCMHSAS CO may solicit the assistance of any employee in conducting any of the specific investigative tasks noted above. The CO may also solicit the support of internal and external resources with knowledge of the applicable laws and regulations that relate to the specific problem in question. External resources may include legal counsel, consultants and auditors. These internal and/or external persons shall function under the direction of legal counsel and under attorney-client privilege and shall be required to submit relevant evidence, notes, findings and conclusions to legal counsel.

B. The CO may review all investigative findings with the CEO, KCMHSAS Compliance Committee and KCMHSAS legal counsel prior to developing remediation and repayment plans, and closing the case.

C. If the Formal Compliance Review results show that the act did not occur as alleged, or that no violation of applicable laws/regulations/policies occurred, the investigation shall be closed subject to KCMHSAS COO and KCMHSAS Compliance Committee concurrence and a written report filed. Once complete, documentation is to be preserved for a minimum of six (6) years.

D. If the Formal Compliance Review results show that a compliance violation exists, all documentation related to the investigation is kept as an "open" case until a remediation plan is completed and any related monitoring is completed and certified.

E. KCMHSAS will provide general feedback to the source regarding the investigation, provided the issue was not anonymously reported. Sources who report anonymously may call to receive feedback. Responses should be general in nature and not reveal information of a confidential nature such as an individual's name or corrective action taken.

F. Unless severely contraindicated or upon advice of KCMHSAS legal Counsel, the CEO (or designee) will be similarly and timely informed and briefed.

G. Under no circumstances is retaliation for submitting a compliance issue or inquiry acceptable. This includes, but is not limited to, questions and concerns an employee may discuss with an immediate supervisor, KCMHSAS's CO or CEO, or the KCMHSAS Compliance Committee.

IV. ORGANIZATIONAL RESPONSE

A. Possible Criminal Activity

In the event the Formal Compliance Review uncovers what appears to be criminal activity on the part of any contracted or subcontracted provider, or KCMHSAS employee or business unit, KCMHSAS shall undertake the following steps:

1. In the event that violations substantiate fraud, abuse or waste are found related to Medicaid, Medicare (duel eligibles project), counsel for KCMHSAS or the CO shall notify South West Michigan Behavioral Health (SWMBH) as determined by the KCMHSAS CEO. KCMHSAS, through legal counsel or the CO, shall attempt to negotiate a settlement of the matter with SWMBH.
2. KCMHSAS shall initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or undertaken with reckless disregard for the Medicaid, Medicare, and other third-party payors laws, rules and standards and/or regulations. Appropriate disciplinary action is outlined in KCMHSAS's personnel procedures.

B. Other Non-Compliance

In the event the Formal Compliance Review reveals billing or other problems which do not appear to be the result of conduct which is knowingly, willfully indifferent, or with reckless disregard for the Medicaid, Medicare, and other third-party payors laws, rules and standards, KCMHSAS shall nevertheless undertake the following:

1. Improper Payments

   In the event the problem results in duplicate payments by Medicaid, Medicare, and other third-party payors or payments for services not rendered or provided other than as claimed, KCMHSAS shall:

   a. Define and summarize the defective practice or procedures as quickly as possible;
   b. Calculate and make recommendations regarding repayment to the appropriate governmental entity or third-party payor for duplicate payments or improper payments resulting from the act or omission;
   c. Reverse encounter data in all systems which generated data submitted to the State that may have been affected;
   d. Make referral for disciplinary action as appropriate given the facts and circumstances;
   e. Promptly undertake a program of education to prevent future problems; and
   f. Convene a business process review team to analyze and remedy process, functional or information system deficits.

2. No Improper Payment

   In the event the problem has or does not result in overpayment by Medicaid, Medicare, and other third-party payors, KCMHSAS shall:

a. Define and summarize the defective practice or procedures as quickly as possible;
b. Reverse encounter data in all systems which generated data submitted to the State that may have been affected;
c. Make referral for disciplinary action as appropriate given the facts and circumstances;
d. Promptly undertake a program of education to prevent future problems; and
e. Convene a business process review team to analyze and remedy process, functional or information system deficits, under the CO's direction.

V. ENFORCEMENT

The CEO/Executive Director of the involved organization shall handle all corrective actions, including discipline of employees, with input from the Compliance Officer.

A. In administering employee discipline, the CEO/Executive Director may consider the following circumstances:
   1. The employee promptly reported his/her own violation.
   2. The employee's own report constituted the Compliance Officer's first notice of the violation and the employee's involvement.
   3. The employee cooperated fully in the investigation and correction of the violation.

B. Violations of this policy may have severe consequences, including, but not limited to, Provider Organization sanctions, Termination of the Provider Contract, employment termination, civil and criminal penalties as allowed under applicable federal and state laws, including the federal/state False Claims Act (FCA).

REFERENCES

- Federal False Claims Act
- MCL 400.602
- KCMHSAS policy 10.01 (Corporate Compliance), Section VI, for references germane to this policy guideline
- Southwest Michigan Behavior Health Policy
  - 10.6 (Compliance Reporting Responsibilities)
  - 10.8 (Compliance Reviews and Investigations for Reporting)

EXHIBITS

A. KCMHSAS Compliance Posting

B. KCMHSAS Compliance Violation Reporting

C. KCMHSAS Complaint Investigation

D. Compliance Investigation Work Plan Steps