Current Status: *Active* **PolicyStat ID:** *6537659*

Origination:	*10/2017*
Effective:	*11/2019*
Last Approved:	*11/2019*
Last Revised:	*11/2019*
Next Review:	*11/2020*
Owner:	*Bernard Hooper: Compliance Officer*
Policy Area:	*Compliance*
References:	

Fraud, Waste and Abuse Policy

POLICY

The Detroit Wayne Integrated Health Network ("Authority") will make every effort to remain in compliance with all state and federal regulations, including the federal Anti- Kickback statute, the federal False Claims Act ("FCA"), other applicable state and federal regulations, and the terms of various contracts with state and federal agencies. The Authority is committed to combating fraud, waste, and abuse, ("FWA") and follows strict guidelines in the event of any reported or suspected cases of fraud, waste, or abuse within the Authority, or against any contract that the Authority is responsible for administering. All suspicions reported will be investigated confidentially and in a timely manner, as specified in this Fraud, Waste & Abuse Policy ("Policy").

In addition, this Policy should be read in conjunction with the Authority's Compliance Plan, the Standards of Conduct, and the Conflict of Interest Policy, to understand the strong emphasis that the Authority places on complying with various federal and state laws.

PURPOSE

The purpose of this Policy is to inform employees, contractors, volunteers, and agents of the Authority of the various applicable statutes and regulations governing fraud, waste, and abuse. In addition, this Policy provides general information regarding the Authority's efforts to combat fraud, waste, and abuse, and to describe the remedies and fines for violations that can result from certain types of fraudulent activities.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare or Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It

also includes recipient practices that unintentionally result in unnecessary cost to the Medicare/Medicaid program. (42 CFR 455.2). This usually is a lesser offense than fraud (examples include excessive charges, improper billing, or overpayment due to lack of documentation).

2. **Anti-Kickback** refers to Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a- 7b[b]) which provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicaid program or other Federal health care programs. For the purpose of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
3. **False Claims Act** (31 U.S.C. §3729) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government, or the state Medicaid program.
4. **Fraud** means 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 (42 CFR 455.2). Some examples include:
    a. Theft or misappropriation of funds, supplies, property, or other resources;
    b. Forgery or alteration of documents or records (whether financial or operational); and
    c. Falsification of reports to management or external agencies.
5. **Waste** means over utilization of services or other practices that, directly or indirectly, results in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources or inefficient practices.
6. **Whistleblower/Whistleblower Protection** means that individuals are ensured, pursuant to applicable federal and state statutes, that they will not be retaliated against, sanctioned, or penalized by the Authority for reporting any good faith FWA violations.

STANDARDS

1. RESPONSIBILITY FOR COMPLIANCE:
   All individuals have the responsibility to comply with applicable statutory, regulatory and other requirements, including, but not limited to, the following:
    a. False Claims Act
    b. Anti-Kickback Statute
    c. Health Insurance Portability and Accountability Act (HIPAA)
    d. Criminal statutes
    e. Applicable Code of Federal Regulations
    f. All sub-regulatory guidance produced by Center for Medicare and Medicaid Services (CMS)
    g. State laws
    h. Contractual commitments
2. REPORTING:

a. Any individual having a reasonable basis for believing FWA or other wrongful acts have occurred is responsible for reporting such incidents to the Authority's Corporate Compliance Officer or the issue may be reported through use of the Authority's Compliance Hotline (313-833-3502). Reports to the Authority or state may be made anonymously. In reporting incidents, Individuals should endeavor to provide, at a minimum, the following information:

   1. Description of alleged event or policy violation;
   2. The date and location of the event or violation;
   3. Identity of the persons involved in alleged event or violation;
   4. Names of witnesses
   5. Unless maintaining anonymity, the name and contact information of the individual reporting.

b. It is not necessary to have proof of wrong-doing at the time of reporting, however, the report shall be made upon a good faith or reasonable belief of a violation. All investigations will be conducted by the Authority pursuant to its Compliance Plan and Investigation Policy.

c. In addition to reporting the potential FWA violation to the Authority's Corporate Compliance Officer, an individual may report the violation to the state:

MDHHS Office of Health Services Inspector General
PO Box 30062
Lansing, MI 48909
Toll Free Phone: (855) 643-7283
or
PO Box 30062
Lansing, MI 48909
Toll Free Phone: (855) 643-7283
or
Department of Attorney General
Health Care Fraud Division
P.O. Box 30218
Lansing, MI 48909
Fax (517) 241-6515 or (517) 241-1029 during business hours
24-hour Hotline 1-800-24-ABUSE/1-800-242-2873
E-mail: hcf@michigan.gov

3. WHISTLEBLOWER PROTECTION

   No individual, who in good faith reports an actual or suspected violation of law, shall experience any retaliation or retribution from the Authority as a result of such reporting, regardless of whether or not, upon investigation, a violation is found to have occurred. Retaliation, itself, is a violation of the Authority's Compliance Plan, which will not be tolerated and must be reported immediately. All individuals will be ensured Whistleblower Protection pursuant to federal and state law.

   Reports of retaliation or retribution will be investigated thoroughly and expeditiously to determine appropriate sanctions, including employment or contractual termination, and/or notification to the appropriate federal or state law enforcement agencies.

   A reporting party will not be afforded the protection of Whistleblower Protection if his or her allegation of a violation was knowingly fabricated, knowingly exaggerated, or otherwise distorted to adversely affect another person or to protect the reporting party.

4. TRAINING

Authority requires an education and training program concerning fraud, waste, and abuse awareness for its Board of Directors, administrative staff and all other employees annually. In addition, the Authority utilizes the computer based training program that is sponsored by CMS via the Medical Learning Network. Additionally, the Authority provides annual training in fraud, waste, and abuse issues to all staff as part of such staff's annual compliance training.
Agents, contractors, and or providers of the Authority are required by contract to have fraud, waste, and abuse educational training and shall utilize the CMS web- based training via the Medical Learning Network.

5. MONITORING
    a. All Authority divisions shall maintain policies and procedures to monitor/audit their respective areas for FWA. For example, the Authority's Quality division has adopted a "Claims Verification" policy to monitor provider claims on a quarterly basis and require the appropriate corrective action plan for any deficiency. In addition, the Authority performs additional monitoring and proactive measures:
        1. Prior to contracting, review all providers and contractors against the federal and state excluded individuals and entities list;
        2. Requiring providers to perform monthly review of provider clinical staff licensing and sanctions; and
        3. Annual provider environmental and clinical documentation reviews.
    b. In addition, all Authority contracts with providers and/or contractors include general language that require:
        1. Compliance with all Authority policies and procedures (as amended) or any appropriate regulatory agency for the detection and prevention of fraud and abuse committed by providers, employees, or agents.
        2. Any payments made to the providers or contractors are derived from federal and state funds and that the provider or contractor shall be held civilly and/or criminally liable, in the event of nonperformance, misrepresentation, fraud, or abuse of services rendered to Authority consumers.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of direct contractors and their subcontractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Anti-Kickback Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a- 7b[b])
2. 42 CFR 455.2

3. False Claims Act 31 U.S.C. §3729

RELATED POLICIES

1. Compliance Plan
2. Standard of Conduct Policy
3. Conflict of Interest Policy

RELATED DEPARTMENTS

1. Administration
2. Claims Management
3. Clinical Practice Improvement
4. Compliance
5. Customer Service
6. Information Technology
7. Integrated Health Care
8. Legal
9. Managed Care Operations
10. Management & Budget
11. Purchasing
12. Quality Improvement
13. Recipient Rights
14. Substance Use Disorders

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	11/2019

Approver	Date