WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

FRAUD AND ABUSE PREVENTION AND REPORTING – C – 3.13

Purpose:

Wasatch Mental Health Services Special Service District (WMH) establishes the following policy and procedures as part of its organizational commitment to integrity in all its workplace practices where fraud and/or abuse might occur. WMH is committed to the prevention of fraudulent and abusive practices, the establishment of processes for the early discovery of fraud and abuse; the prosecution of staff members, outside contracted providers and enrollees who engage in fraud and/or abuse and the education of staff members and outside contracted providers regarding fraud and abuse prevention, reporting, whistleblower protections, etc.

References:

Utah Code -- Title 67 -- Chapter 21 – Utah Protection of Public Employees Act

Utah Code -- Title 26 -- Chapter 20 –False Claims Act

US Code 3729. False claims

Definitions:

Utah State False Claim Act: Utah Code, Title 26, Chapter 20, False Claims Act. The law is designed as a mechanism to combat fraud and abuse in government health care programs. The law allows civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often also permit qui tam suits, which are lawsuits brought by individuals, typically employees or former employees, of healthcare providers that submit false claims.

Federal False Claim Act: United States Code 3729 thru 3733. The federal False Claims Act (FCA) forbids knowing and willful false statements or representations made in connection with a claim submitted for reimbursement to a federal health care program, including Medicare or Medicaid. The FCA extends to those who have actual knowledge of the falsity of the information as well as those who act in deliberate ignorance or in reckless disregard.

Wrongdoing: In addition to a violation of Federal or state law, wrongdoing includes violation of WMH's Standards of Conduct and impermissible billing practices. This includes, but is not necessarily limited to, billing for services not performed at all or not performed as described; submission of claims for unnecessary or undocumented services, equipment, or supplies; double billing; upcoding; unbundling; misuse of coding modifiers; false cost reports; billing for services by an unlicensed, or excluded provider; paying or accepting money, gifts, or favors in return for referrals.

Whistleblowers: Employees who come forward and disclose illegal activity (wrongdoing) in the workplace. Utah Code, Title 67, Chapter 21, Utah Protection of Public employees Act. Under the FFCA, employees who know that fraud against the government is taking place in their workplace can file suit called a Qui Tam lawsuit to stop the fraud.

Fraud: 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)

Elements of Fraud:

- The act (evidence of wrongdoing),
- Knowledge and intent (willfully intending to commit the act – generally evidenced by a pattern of wrongdoing),
- Benefit (some type of measurable benefit obtained from the act by the person committing the act).

Abuse: 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 result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Policy:

A. Wasatch Mental Health (WMH) shall, by law (2005 Deficit Reduction Act Section 6032), establish the following policies and procedures to ensure it does not engage in fraudulent and/or abusive practices, or wrongdoing in its administrative, clinical, and billing procedures.

B. WMH shall establish and document its mechanism(s) to verify that billed services were provided (see Related Plan and Policies referenced at the end of document).

C. All WMH staff members, outside contracted providers and affiliates shall exercise due diligence in the prevention, detection and correction of fraud and abuse, and ensure to the degree possible that all claims, billings, and/or encounters submitted are true and accurate.

D. WMH shall cooperate with the Division of Medicaid and Health Financing (Medicaid), Utah State Division of Substance Abuse and Mental Health, and other state and federal agencies associated with fraud and abuse detection and investigation.

E. WMH' Associate Director of Care Management Services shall serve as WMH's Corporate Compliance Officer (Compliance Officer) who shall designate a Compliance Committee for the purpose of creating a WMH fraud and abuse policy and procedures for combating fraud and abuse and to provide a mechanism for reviewing and investigating allegations and suspicions. The committee shall be comprised of members of the WMH Executive Committee, and others, on an ad hoc basis, as needed.

F. When charges of fraud/abuse/waste have been substantiated, the Care Management Services/Compliance Officer and the Compliance Committee shall promptly develop a corrective action plan and present it to the Executive Director and/or Authority Board for adoption and implementation.

G. WMH shall provide all staff members and outside contracted providers with information and training regarding (1) the federal False Claims Act and similar state laws, (2) an individual's right to be protected as a whistleblower, and (3) WMH's policies and procedures for detecting and preventing fraud, waste, and abuse in state and federal health care programs.

H. Any WMH staff member or outside contracted provider with knowledge of a false claim violation shall make a report, anonymously or openly, to the Care Management Services/Compliance Officer, or any WMH program manager or supervisor. WMH shall internally investigate all non-frivolous claims of wrongdoing so corrective action of violations can be instituted immediately. Any person discovering wrongdoing that is a false claim or statement may also report the information directly to the Department of Justice, or the U.S. Attorney by filing a complaint under seal in the court pursuant to the False Claims Act. Any staff member with actual knowledge of a WMH false claim violation shall not be prohibited from filing suit on the federal government's behalf.

I. Outside contracted providers who furnish WMH authorized Medicaid mental health services, and who perform billing and/or coding functions for services provided WMH clients shall adopt WMH's fraud and abuse prevention policies and procedures or develop similar policies and procedures as required by law.

J. WMH shall maintain the confidentiality of a staff member or outside contracted provider filing suit, and of the suit itself while the government conducts an investigation to determine the merits of the case. Should the government decide not to take the case, the staff member shall not be prohibited from individual pursuit of the suit.

K. WMH shall provide staff training and education concerning fraud, waste and abuse policies and procedures annually. At termination, staff members shall be asked to complete a survey form, which they can complete anonymously if desired (Attachment A, also see WMH policy HR-7.12 Terminations).

L. WMH shall hold in confidence, separate and apart from its administrative services, all information and property pertaining to a report of fraud and/or abuse during any ongoing investigation. Such information or property may be disclosed as required by law with governmental subpoena or court order.

M. WMH shall not take adverse action against a staff member, or outside contracted provider, who participates or gives information in an investigation, hearing, court proceeding, legislative or other inquiry, or other form of administrative review held by the public body. Any staff member who alleges a violation of the Utah Code may bring a civil action for appropriate injunctive relief or actual damages, or both, within 180 days after the occurrence of the alleged violation of the Utah Code (Utah Code Section § 67-21-3). Staff members who make a report of wrongdoing maliciously, frivolously, or in bad faith shall be subject to disciplinary action up to and including termination.

N. Staff members or outside contracted providers reporting complaints of suspected fraud and abuse shall not independently initiate investigation(s) of suspected fraud or abuse or alert any suspected individual(s) of a possible report or investigation.

O. WMH shall have the right to take appropriate action to recover assets lost as a result of fraud and/or abuse. WMH funds shall not be used to pay for losses for which an employee is responsible under this policy.

P. Any staff member, outside contracted provider, or person who fraudulently obtains or otherwise intentionally misuses WMH assets, or aids and abets others in so doing, or in any way engages in criminal activity with respect to WMH property, contracts, or other resources shall be subject to criminal prosecution.

Q. WMH shall annually provide the Medicaid a report of any preliminary or full investigation(s) of WMH fraud and/or abuse as required by the current Prepaid Mental Health Plan Medicaid contract.

R. WMH reserves the right to audit all relevant documents deemed to be important to detect fraud and abuse.

Procedures:

Prevention of Fraud and Abuse

1. Training Oversight: WMH's Care Management Services/Compliance Officer shall receive periodic training regarding corporate compliance and the duties of the Care Management Services/Compliance Officer, and oversee the provision of fraud and abuse prevention training of new staff members. Information about WMH policies and procedures and where they can be accessed on the website, will be included in outside provider contract agreements. WMH shall provide staff training in WMH's Fraud and Abuse Prevention and Reporting policy and procedures annually.
2. How to Report: Instruction shall be given in how to report suspicions or allegations of fraud and/or abuse (Attachments A and B). Staff members and/or outside contracted providers who believe, or know that fraud has been committed with respect to a government contract or against government funds, and want to file a false claims suit (Qui Tam), shall be instructed to first contact an experienced attorney to discuss his/her options.
3. Right to Report: Staff members and/or outside contracted providers shall receive instruction regarding their right to report fraud and abuse openly or anonymously, and their right to be free from adverse actions by WMH or its staff members for reporting. Retaliation or reprisal in any form against anyone who makes a report of wrongdoing, cooperates in an investigation, or participates in the compliance program is strictly prohibited. If a staff member or outside contracted provider believes he/she has experienced an adverse action in the form of reprisal or retaliation as the result of making a report or cooperating in an investigation pursuant to this or any other compliance policy should report it immediately to the Care Management Services/Compliance Officer and/or HR Department.
4. Proper Coding: Staff members shall receive training at hiring and periodically thereafter in properly coding billable services. New staff members shall receive training that all billable services they submit were performed by the provider personally, or by someone under their personal supervision, and were medically necessary. The staff member shall then be required to sign a document certifying he/she understands their legal responsibilities associated with submitting billable services for and in behalf of WMH. All billable services provided shall be properly and fully documented using WMH required procedures.
5. False Claims Act: Staff members shall be trained in innocent errors, claims errors, knowing or knowingly committing fraud/abuse, criminal intent, reckless disregard, deliberate ignorance, kickbacks, bribes, unbundling of services, conspiracy, false claim recoveries, etc.

Detection of Fraud and Abuse

1. The QAPI Peer Review Committee shall conduct qualitative peer reviews of sampled client clinical records quarterly using WMH's clinical audit assessment instrument. (See related policy C – 3.07 Quality Assessment and performance Improvement Program (QAPI).

2. Monthly and quarterly reports identifying those clients who potentially may be over or underserved shall be generated electronically using WMH's Junction database. Program management and clinical staff shall review the reports and make a clinical determination, on a case-by-case basis, whether a client is being over or under served. (See Policy C – 3.12 Peer and Electronic Record Review).

3. Supervisors shall review each staff member's time sheets bi-weekly to visually check for any obvious billing reporting errors.

4. The Outside Provider Peer Review Sub-Committee of the Peer Review Committee shall conduct audits of outside provider-required licenses, and billing practices by reviewing the providers' records, policies, and billing processes. Client clinical records and the associated billings generated shall be compared. The clinical aspects of an outside provider's clinical record audit shall be conducted using WMH's clinical audit assessment instrument included in WMH's Policy C – 3.12 Peer and Electronic Record Review.

5. Staff members shall take appropriate measures to prevent the misuse of enrollee benefits and report any knowledge of suspected fraud or abuse to the Care Management Services/Compliance Officer. Examples of enrollee fraud/abuse:
   - Excessive use or overuse of Medicaid
   - Using another's Medicaid Identification card
   - Lending, altering or duplicating a Medicaid ID
   - Providing incorrect eligibility or false information to a provider to obtain treatment
   - Simultaneously receiving benefits in another state
   - Knowingly assisting providers in rendering services to defraud the Medicaid program
   - Prescription fraud

Staff Fraud and Detection Procedures

At the time services are requested / initiate:

1. When an individual calls to make an initial appointment, the support staff shall ask for the type of benefit information and schedule an intake appointment with the appropriate intake staff. To verify the individual, the staff member will ask the individual to bring the following identification to the first appointment:
   i. A driver's license or photo ID. If photo ID is not available, the staff member will ask the individual to bring other identifying information such as; birth certificates, immunization records, social security card, bank card),
   ii. Insurance and/or Medicaid card(s),
   iii. Co-payment, if applicable,
   iv. Legal guardianship or custody papers if they are not the parent/step-parent,
   v. Referral, if applicable,

vi. If UNINSURED: a recent pay stub or other proof of income,

vii. IF UNINSURED: proof of address (such as a utility bill).

2. At the time of the initial appointment and at each appointment thereafter, the staff member checking in the client shall ask the client to show identification and their insurance and/or Medicaid card(s). The staff member shall review the insurance card(s) and identification to verify they match the description of the client. The staff member shall make a copy of the monthly Medicaid card and file in the client's clinical record.
3. At the initial appointment, the intake staff will review the identifying information and take a picture of the client, which will be stored in the client's clinical record.
4. If a staff member or providers become aware of inconsistencies in information on the insurance and/or Medicaid card versus verbal report (e.g., individual being called by a different name than what is on the Medicaid card, etc.), an individual is reluctant to verify information or staff or providers become aware of information leading to concerns about whether the client may have misrepresented facts in order to become or remain eligible for Medicaid, staff and providers shall report their concern to the Care Management Services/Compliance Officer.

Report of Fraud and Abuse by Employee and Agency

1. Staff members and outside contracted providers shall be trained to report suspected or confirmed instances of provider or enrollee fraud and abuse, anonymously or openly, directly to the Care Management Services/Compliance Officer. Staff members may also report suspected fraud, waste, and abuse to their immediate supervisor, program manager, or an appropriate administrative official.
2. All reports given to supervisory personnel by a complainant staff member or outside contracted provider shall be immediately forwarded to the Care Management Services/Compliance Officer. Information given to supervisory personnel shall be kept in total confidence until such time the supervisor is released from the responsibility by the Care Management Services/Compliance Officer.
3. Staff members or outside contracted providers reporting fraud shall be prohibited from independently initiating or conducting investigations of suspected fraud or abuse or alert any suspected individual(s) of a possible report or investigation.
4. The Care Management Services/Compliance Officer shall maintain all reports and investigational information regarding allegations, and ongoing investigations, of fraud and abuse in a secure location. The Care Management Services/Compliance Officer shall not share the complainant's identity with anyone without a properly signed court document with the exception of sharing requested information by the FBI, should it become involved in an investigation of the allegation.
5. When an investigation proves findings of potential fraud, waste or abuse, by a staff member or outside contracted provider, the Care Management Services/Compliance Officer, within fifteen (15) calendar days of detecting the incident, provide a written report of the incident to the Office of Inspector General of Medicaid Services or the Medicaid Fraud and Control Unit (MFCU) in the Attorney General's Office and the Division of Medicaid and Health Financing (Medicaid). (See attachment form A-7.0c Full Fraud or Abuse Investigative Report).When an investigation proves findings of potential fraud, waste or abuse, by an enrollee, the Care Management Services/Compliance Officer shall, within fifteen (15) calendar days of detecting the

incident, provide a written report of the incident to the Division of Workforce Services. Complaints may be filed on line through the Division of Workforce Service site or e-mailed to wsinv@utah.gov

Auditing and Monitoring

Screening for Excluded Providers:

1. Monthly, WMH shall conduct a search of the Inspector General HHS-OIG's List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) database to ensure that WMH staff members including providers, outside providers, and persons with ownership or control interest in WMH Are not under a current federal debarment, suspension, sanction or exclusion from participation in Medicare, Medicaid, and other Federal health care programs.
2. Documentation of all searches conducted shall be maintained by the Care Management Services/Corporate Compliance Officer's designee.
3. The designee shall immediately report any exclusion information to WMH's Care Management Services /Compliance Officer.
4. Other methods of auditing and monitoring may include onsite visits, questionnaires and state licensing inspections.

Preliminary Investigations:

All complaints of possible fraud, waste, or abuse shall be referred to the Care Management Services/Compliance Officer. The Care Management Services/Compliance Officer shall complete a preliminary investigation (see attachment C, Preliminary Fraud or Abuse investigative Report) within 30 days of the documented complaint. When the preliminary investigation gives reason to believe an incident of fraud or abuse has occurred, the Care Management Services/Compliance Officer shall under the direction of the executive director/authority board conduct a full investigation. WMH shall include a summary of the number of complaints that warranted preliminary investigations as part of its annual fiscal year performance report due July 31st following the close of the fiscal year.

Full Investigations:

For complaints that result in a full investigation, the Care Management Services/Compliance Officer shall submit a report within 15 days following the completion of a full investigation (see attachment D, Full Fraud or Abuse Investigative Report) to the Medicaid and other appropriate Utah State authorities as required. Depending on the nature of the fraud and/or abuse, the Care Management Services/Compliance Officer shall notify the local law enforcement agency.

Prosecution of Fraud and Abuse

1. WMH shall take appropriate action to recover assets lost as a result of fraud, waste, or abuse. Center funds shall not be used to pay for losses for which staff member is responsible under this policy.

2. WMH’s Executive Committee (EC Committee) and its legal counsel shall review all occurrences of asset losses as a result of fraud and/or abuse. Where sufficient evidence exists, in conjunction with other pertinent information to warrant prosecution, WMH shall take legal action against staff member(s) and/or others.

3. Loss recovery may include the following mechanisms:

   a. Voluntary Return or Repayment Generally, action to recover losses shall not be taken until an investigation has been completed. WMH may accept voluntary offers of reimbursement for losses due to alleged staff member dishonesty at its discretion. Repayments accepted shall be appropriately receipted and deposited to a WMH account. WMH shall inform the staff member that voluntary repayment shall not cause an ongoing investigation to stop, relieve the staff member of liability for future claims, nor prevent prosecution under criminal law.

   b. Demand for Repayment WMH may demand repayment from the person or entity verbally or in writing should an investigation conclude that an individual or entity's actions have resulted in loss of WMH assets.

   c. Withholding of Salary and Wages WMH may elect to recover losses associated with a staff member being charged with gross misconduct by withholding part, or the entire amount owed from his/her paycheck. The amount withheld must be communicated to the staff member in writing along with an explanation of the staff member's right to appeal the disciplinary action or termination to WMH’s Executive Director. Should the staff member request an appeal, the paycheck shall be held to the extent allowed by law pending the outcome.

   d. Legal Action When full recovery of assets attributed to fraud, waste, or abuse by staff members, other individuals, or entities is not realized from other means, legal action to obtain a judgment may be initiated when approved by WMH’s Authority Board.

Agency Reporting

1. When a staff member or outside contracted provider are found to be under a current federal debarment, suspension, sanction or exclusion from participation in Medicare, Medicaid, and other Federal health care programs, the Care Management Services/Compliance Officer shall submit a report within 30 days following the completion of a full investigation (see attachment D, C – 3.13 Full Fraud or Abuse Investigative Report) to the Medicaid and other appropriate Utah State authorities as required. This information shall also be documented and submitted to the BMHC using the approved document disclosure spreadsheet (electronic form 2 and attestation).

2. WMH shall also report in its annually mandated report (Performance Report) to BMHC all preliminary and full investigations underway during the required reporting period.

Related Plan and Policies

Wasatch Mental Health Corporate Compliance Plan

A – 1.05 Medicaid 834 Transaction Report

A – 1.06 Accuracy of Data

A – 1.10 Selection and Retention

C – 2.06 Clinician Authorization To Bill Third Parties
C – 2.08 Professional Ethics Standards
C – 3.07 Internal Quality Assessment and performance Improvement Program (QAPI)
C – 3.12 Peer and Electronic Record Review
C – 3.14 Termination of Contracted Outside Provider
C – 4.31 Intake, Recovery Planning…Outside Providers
HR – 1.82 Employee/Vendor/Volunteer
HR – 7.10 Corrective Actions
HR – 7.11 Disciplinary Actions
HR – 7.12 Terminations

Right to Change and/or Terminate Policy:

Reasonable efforts shall be made to keep staff members informed of any changes in the policy; however, WMH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

(Attachment A)

Wasatch Mental Health (WMH) Corporate Compliance Employee Separation Check Sheet (Form # HR-7.12c)

Name: ______________________________ Date: ______________

Do you know about or suspect that WMH or any of its staff members are now, or were, engaged in corporate fraud or abuse* anytime during your employment?

If you would rather discuss or explain your concerns more confidentially with the Center's the Care Management Services/Compliance Officer please contact:

WMH's Corporate Compliance Officer
750 No. 200 West, Suite 300
Provo, UT 84601
Or call 801-342-4206.

Sample Form

❑ No violations have taken place.

Check any boxes below where you believe there is a problem. This is not a complete list of possible wrongdoing. Include any other concerns you have.

- ❑ WMH or any of its staff member's failure to follow State, Federal or contractual regulations?
- ❑ Illegal or unethical billing practices including submitting false billings?
- ❑ Illegal payments to an staff member, organization, or person including a staff member making a false or inflated reimbursement request?
- ❑ Kickbacks to organizations or persons for special favors?
- ❑ Submitting false information in a report within or outside the organization?
- ❑ HIPAA privacy or security violations?
- ❑ Staff member using WMH resources for personal or other unauthorized use?
- ❑ Client services not reported, or over reported, for billing?
- ❑ Client services not documented accurately or timely?
- ❑ Are you suspicious of any staff member's behavior and believe he/she may be engaging in fraud or abuse?
- ❑ Other?____
  ____
  ____

Regarding HIPAA - You are under continued obligation to maintain the confidentiality of all clients' protected health information (PHI).

* Abuse: 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 result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

(Attachment B)

Wasatch Mental Health
Fraud and Abuse Complaint (Form # A-7.0a)

Sample Form

Instructions: Please provide only the information you are comfortable with. When completed, please submit or mail this form to:

Wasatch Mental Health the Care Management Services/Compliance Officer
750 North 200 West, Suite 300
Provo, UT 84601.

Your Name: Optional, your name will remain confidential – It is important if you want feedback, or if WMH needs more information____

Date of Complaint: ______________________________ **Date of Discovery**: ____________________

Name of Provider/Department/Agency you suspect: ____

Which of the following best describes the type of fraud or abuse you suspect?

- □ Incorrect coding (upcoding, unbundling, etc.)
- □ False data submission
- □ Duplicate billing
- □ Billing for services not rendered
- □ Misrepresentation of services
- □ Altering of claim, file or document
- □ Unlicensed professional or facility
- □ False documentation
- □ Using another's Medicaid Identification card
- □ Providing incorrect eligibility or false information to a provider to obtain treatment
- □ Other: ____

Specific details regarding the fraud or abuse you suspect:

____

____

____

How did you learn of the incident or practice indicated above?

____

____

____

Do you have specific evidence regarding the fraud or abuse you suspect?

□ Yes □ No

Would you be willing to discuss the matter with the Center's Compliance Officer and/or Executive Director?

□ Yes □ No

Have you discussed the above allegations with anyone else?

□ Yes □ No

If you answered yes to the question above, please provide the name of the person or persons with whom you discussed the above allegation.

____

____

Please provide any further information or details verifying the allegations described above:

____

____

____

Are you aware of any other individuals who may be able to provide further information regarding the above allegation?

□ Yes □ No

If you answered yes to the question above, please provide the name of the person or persons who may be able to provide additional information:

____

____

____

Sample Form

Wasatch Mental Health is required by law to take every measure to ensure your confidentiality. WMH may inform you at a future time, depending on circumstances, if or when your identity may become necessary.

(Attachment C)

Wasatch Mental Health - ID #:____________________

Preliminary Fraud or Abuse Investigative Report (Form # A-7.0b)

Source of Complaint: □ Individual □ Provider □ Center Staff member □ DOH/DHCF □ MFCU □ Other □ Anonymous

Date of Complaint: ___________________________ **Date of Discovery**: _________________________

Name of Complainant: (May be known but withheld)____

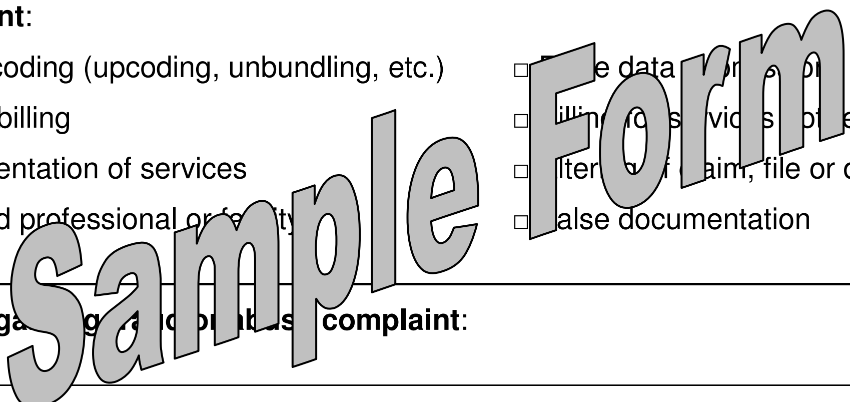
Position:____

WMH Contact Person:____

Name of Provider/Agency suspected of fraud or abuse: _______________________________________

Address: ____ **Phone #**: __________________

Nature of Complaint:



- □ Incorrect coding (upcoding, unbundling, etc.)
- □ Duplicate billing
- □ Misrepresentation of services
- □ Unlicensed professional or facility
- □ Other: ____
- □ False data or omission
- □ Billing for services not rendered
- □ Alteration of claim, file or document
- □ False documentation

Specific details regarding fraud or abuse complaint:

____

____

____

Estimated loss (approximate dollars involved): $ _______________

Reason to suspect fraud or abuse:

____

____

____

Evidence/documentation of fraud or abuse:

____

____

____

Legal and/or Administrative Disposition:

- □ Suspicion of fraud or abuse substantiated – referral for full investigation
- □ Suspicion of fraud or abuse unsubstantiated – investigation concluded

____ _____________

Executive Director or Corporate Compliance Officer Date

(Attachment D)

Wasatch Mental Health ID #:____________________

Full Fraud or Abuse Investigative Report (Form # A-7.0c)

Source of Complaint: ☐ Individual ☐ Provider ☐ Staff Member ☐ DOH/DHCF ☐ MFCU ☐ Other

Name of Complainant: (May be known but withheld) ______________________________

Title: ______________________________

Contact Information: ______________________________

Name of Provider/Agency suspected of fraud or abuse: ______________________________

Address: ______________________________ **Phone #**: ______________

Type of Provider: ☐ Staff Member ☐ Contracted Outside provider ☐ Inpatient ☐ Outpatient

Nature of complaint regarding the incident or practice suspected to be fraudulent or abusive:

- ☐ Incorrect coding (upcoding, unbundling, etc.)
- ☐ False data submission
- ☐ Duplicate billing
- ☐ Billing for service not rendered
- ☐ Other
- ☐ Misrepresentation of services
- ☐ Altering of claim, file or document
- ☐ Unlicensed professional or facility
- ☐ False or missing documents

Sample Form

1. Identification of the potential causes of the incident or practice (e.g., intentional conduct, lack of internal controls, circumvention of corporate procedures or Government regulations, etc):

____

____

____

2. Detailed description of the incident or practice, include how the incident or practice arose and continued:

____

____

____

3. Identification of the division, departments, branches or related entities that were involved and/or affected:

____

____

____

4. Identification of the impact on, and the risks to, health, safety, or quality of care posed by the matter being investigated:

____

____

____

5. Delineation of the period during which the incident or practice occurred:

6. Identification of corporate officials, staff members or agents who knew of, encouraged, or participated in, the incident or practice and any individuals who may have been involved in detecting the matter:

7. Identification of corporate officials, staff members or agents who should have known of, but failed to detect, the incident or practice based on their job responsibilities:

8. Description of federal funds involved (i.e., Title XIX) and estimation of monetary impact of the incident or practice upon Federal health care programs:

Sample Form

Discovery and Response

1. Description of how the incident or practice was identified, and the origin of the information that led to its discovery:

2. Description of the entity's efforts to investigate and document the incident or practice (e.g., use of internal or external legal, audit or consultative resources):

3. Detailed description of the chronology of the investigative steps taken in connection with the entity's internal inquiry into the disclosed matter, including:

   a. Listing of all individuals interviewed (including for each: business address, telephone number, position, title, dates of interviews, subject matter of each interview, and summary of each interview):

b. Listing of those individuals who refused to be interviewed as well as the reasons for refusal cited:

c. Description of files, documents, and records reviewed (with sufficient particularity to allow their retrieval, if necessary):

d. Summary of auditing activities undertaken and summary of the documents relied upon in support of the estimation of losses (documents and information must accompany the report, unless the calculation of losses is undertaken pursuant to the Self Assessment Guidelines (internal financial assessment), which contain specific reporting requirements):

Sample Form

4. Description of actions by the health care entity to terminate the inappropriate conduct:

5. Description of any related health care businesses affected by the inappropriate conduct in which the health care provider is involved, all efforts by the health care provider to prevent a recurrence of the incident or practice in the affected division, as well as in any related health care entities (e.g., new accounting or internal control procedures, increased internal audit efforts, increased supervision by higher management or through training):

6. Description of legal and administrative disciplinary actions taken against corporate officials, staff members and agents as a result of the disclosed matter:

7. Description of appropriate notices (if applicable) provided to other Government agencies, (e.g., Securities and Exchange Commission and Internal Revenue Service) in connection with the disclosed matter:

____

____

____

Certification Statement:

To the best of my knowledge, the above submission contains truthful information and is based on a good faith effort to bring the matter to the attention of UDOH and DHCF for the purpose of resolving any potential liabilities to the Government.

Sample Form

____
Signature of Authorized Representative

____
Title

____
Date

As per the 2011 Legislative General Session, The Utah Department of Health created a hotline to report improper billing by Medicaid Providers. The legislation requires any health care professional, a provider, or a state or local public official who becomes aware of Medicaid fraud, waste or abuse to report the activity. The bill also creates the Office of Inspector General of Medicaid Services (OIG); effective July 1 the OIG will assume responsibility for the new hotline.

Reports can be made by dialing the new toll-free hotline, 1-800-403-7283, by e-mailing the department at mpi@utah.gov, or by visiting the website www.health.utah.gov/mpi.