PROCEDURE # 9.7A		EFFECTIVE DATE	REVISED DATE
TITLE:	COMPLIANCE INVESTIGATIONS	1/1/2014	7/20/26
ATTACHMENT TO		REVIEW DATES	
POLICY #:	9.7		
POLICY TITLE:	COMPLIANCE REVIEWS AND INVESTIGATIONS FOR REPORTING		
CHAPTER:	COMPLIANCE		

I. PURPOSE

To articulate the process that will be used by Lakeshore Regional Entity in all managed care compliance investigations.

II. PROCEDURES

A. Suspected Medicaid Fraud, Waste, and/or Abuse:

1. LRE staff and its Provider Network shall report all suspected Medicaid fraud, waste, and abuse to the LRE Corporate Compliance Officer in accordance with standards established in the LRE Compliance Plan. Investigations shall be conducted in accordance with the LRE Compliance Plan, Compliance Reporting, and Ongoing Communication.
2. Reports will be made to the LRE Corporate Compliance Officer in writing utilizing the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) Fraud Referral Form.
3. LRE's Special Investigations Unit (SIU) will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists.
4. If there is suspicion of fraud, LRE's SIU will report the suspected fraud and abuse to the MDHHS OIG.
5. LRE's SIU will inform the appropriate provider network member when a report is made to the MDHHS OIG.
6. LRE will follow the guidance/direction provided by the MDHHS OIG regarding investigation and/or other necessary follow up.
7. Corrective action plans developed by the Provider Network, shall be submitted to the LRE Corporate Compliance Officer within thirty (30) days of the approved plan.
8. The LRE Corporate Compliance Officer shall review corrective action plans and ensure, as appropriate, prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the CMHSP designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

B. Suspected Violations and/or Misconduct (not involving Medicaid Fraud and/or Abuse):

1. LRE staff shall report all suspected violations and/or misconduct to the LRE Corporate Compliance Officer.
2. Reporting and Investigations shall be conducted in accordance with the LRE Compliance Plan, Compliance Reporting, and Ongoing Communications.
3. Where internal investigation substantiates a reported violation, corrective action plans will be initiated by LRE staff.

C. Required Reporting:
   1. LRE's Provider Network shall submit compliance activity reports quarterly to the LRE Corporate Compliance Officer utilizing the Office of Inspector General program integrity report template. Minimally the report will include the following:
      a. Tips/grievances received
      b. Data mining and analysis of paid claims, including audits performed based on the results
      c. Audits performed
      d. Overpayments collected
      e. Identification and investigation of fraud, waste, and abuse (as these terms are defined in the "Definitions" section of this policy
      f. Corrective action plans implemented
      g. Provider dis-enrollments
      h. Contract terminations

   2. Reporting Period/Due Dates to LRE:
      - January through March: April 30
      - April through June: July 31
      - July through September: October 31
      - October through December: January 31

D. The LRE Corporate Compliance Officer will prepare a quarterly summary report of the Provider Network and direct LRE compliance activities and present to the LRE Compliance Oversight Committee. An annual summary report of the regional compliance activities will be presented to the LRE Board of Directors.

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party
7/20/26	NEW Procedure – Language removed from policy	Compliance Manager