False Claims Act Policy **650-117**
Effective Date 01/01/2007 **Compliance Manual**

POLICY

Monroe County Healthcare Authority is committed to the highest possible standards of ethical, moral and legal business conduct. Prevention of health care fraud, waste and abuse is the responsibility of all employees, staff, contractors, vendors and agents of our organization. This policy is applicable to all persons or entities that provide, approve, monitor, and/or bill for care provided to our customers. Our organization provides information to our staff, contractors, and agents about federal and state false claims acts, remedies available under these provisions, whistleblower protection, and hospital/staff responsibilities. Information is also provided regarding our procedures to prevent, detect, report and correct health care fraud and abuse.

The False Claims Act

The False Claims Act is a statute that creates liability for any person or entity who "knowingly" presents a claim for money to the U.S. government that is false or fraudulent; presents a false document to make that claim; conspires to defraud the government by getting a false claim allowed or paid.

The False Claim Act also applies to physicians if: the physician is not licensed; if licensed but such license was obtained fraudulently; is not certified in the specialty of the claim; provided services which were not "medically necessary"; receives $5 million in Medicaid reimbursement annually.

The government may exclude the person or entity from participating in the Federal Health Program as well as direct the appropriate State agency to exclude the person or entity from any State Health program. Consequences include: civil penalty of $10,000 per false claim; $10,000 per day that false condition continues; assessment of not more than 3 times the amount claimed for each case.

PROCEDURES

Hospital Responsibilities

Insure that claims filed are correct, supported by proper documentation and are "medically necessary". Audit claims before submission and after submission to insure accuracy. Evaluate questionable claims. Determine if federal monies were received improperly and make restitution immediately in that case. Should the claims filed be substantial, self-report this condition to the Asst. US Attorney in the District and present data for governmental review and resolution.

Reimburse governmental agencies and pay fines accordingly. Prepare a plan to insure that that type of claim will be filed correctly in the future.

Employee Responsibility

Our organization is committed to open communication and this policy aims to provide an avenue for employees to raise serious concerns and reassurance that they will be protected from reprisals or victimization for "whistle blowing" in good faith. Employees may report serious and sensitive issues believed to be illegal, or questionable to his/her supervisor and/or manager or the Compliance Officer. Employees may use the Hospital's "Grievance Procedure" outlined in the Employee Handbook, if so desired. Although the employee is not expected to prove the truth of an allegation, the employee needs to demonstrate to the person contacted that there are sufficient grounds for concern. Expect that the issues will be investigated thoroughly by the Hospital and reported back to the employee and corrected, if found to be true. Please note that the information provided by an employee may be the basis for an internal and/or external investigation into the issue and your anonymity will be protected to the extent possible. However, your identity may become known during the course of the investigation.

If the employee wishes anonymity, report the issue to the Hospital HealthCare Ethics Line (hotline) at 1-800-398-1496 English or 1-800-216-1288 Spanish. This call goes to the Light House, Inc. in Pennsylvania; they will notify the Compliance Officer. Giving all of the facts on the issue will allow the Compliance Officer to conduct a careful and thorough investigation. Consideration will be given to the seriousness of the issue raised; the credibility of the concern; and the likelihood of confirming he allegation from attributable sources. Malicious allegations may result in disciplinary actions.

The employee should expect a response to the issue raised. The employee should expect protection from the Hospital in its non-retaliation policy. This policy should prevent any adverse action against the employee because of reporting an issue to concern. Any adverse actions against the employee should be reported to the Compliance Officer/Human Resources Director for review. Harassment or victimization of the complainant will not be tolerated.

Federal and State False Claims Laws

In addition to following the provisions of the Federal False Claims Act, Monroe County Health Care Authority will abide by the provisions of all State False Claims Acts that may be legislated.

Civil Liability

Penalties between $5,000 - $11,000 per claim (currently)
Treble damages (award of money by a court of law)
Costs brought to recover such penalties or damages

Qui Tam Lawsuits

The False Claims Act allows a private person to bring a civil action for a false claims violation directly to the government. The government is required to investigate the Qui Tam filing and respond by agreeing, asking for more information, or dismissing the suit as well as state the reasons for the dismissal.

If a hospital fails to resolve the issue raised, the Qui Tam suit may be filed. It allows any persons with *actual* knowledge of the allegedly false claims to file suit. The claim must be filed on behalf of the government in federal district court. It is filed "under seal" which means it is kept confidential while the government reviews the merits of the case.

If the lawsuit is successful, and provided that the legal requirements are met, the qui tam relater might share financially in the amount recovered. If the civil action is frivolous, vexatious/troublesome, or reported mainly for harassment, the plaintiff may have to pay the defendant it fees and costs.

The U.S. Attorney General is required to thoroughly investigate violations of the False Claims Act (and may demand document production, written answers and oral testimony before filing the suit).

Protection for Employees

Employees are protected from retaliation by the False Claims Act. Discharge, suspension, demotion, discrimination, harassment, or threats may bring action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

Safeguards in Place

Monroe County Health Care Authority has safeguards such as reconciliations, routine audits, documentation review, electronic and non-electronic edits, and other procedures to help prevent the submission of a false claim.

To achieve compliance, every person in the organization must be aware of what they are doing and report questionable issues. All staff must make every effort to resolve all issues raised as well as document the issue, the investigation, and the solution(s).

In order to have an effective compliance program, a cooperative and communicative staff is required. Through effective communication, Monroe County Health Care Authority will succeed in serving the patients well and file claims properly so that proper reimbursement is received.

Adherence to Policy

All officers, employees, staff, vendors, contractors and/or agents acting on behalf of our organization or who do business with Monroe County Health Care Authority must strictly follow all policies, procedures and processes that assure accurate claims submissions or that prevent and/or detect fraud, waste, and abuse. They are also responsible for reviewing and adhering to the Federal False Claims Act and any future State Claims act.

GLOSSARY OF TERMS

Abuse – Incidents or practices of providers that are inconsistent with sound medical practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are medically unnecessary per CMS.

Claim – Any request or demand for money or property if the U.S. government provides any portion of the money requested or demanded.

False Claim – In 2005, the Deficit Reduction Act was passed and some of the requirements of the False Claims Act were included therein. A false claim could be any of the following: false statement regarding a claim for payment; double-billing for items or services; falsified information in the medical record; billing for services not performed/furnished; and claims submitted that are related to other violations of laws or rules.

False Claims Act (31 U.S.C. & 3729 *et seq)* – A law that creates liability for any person or entity who knowingly presents a claim for money to the government that is false or fraudulent; presents a false document to make that claim; conspires defraud the government by getting a false claim allowed or paid.

Fraud – Intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person (per CMS).

Knowingly – A person or entity has actual knowledge of the falsity of information in the claim; acts in deliberate ignorance or the truth; acts in reckless disregard of the truth. This applies equally to an individual as to an entity (such as a hospital).

Qui Tam – A private person may bring a civil action for a false claims violation directly to the government. The government is required to investigate and respond by agreeing, asking for more information, or dismissing the suit as well as state the reasons for the dismissal.

Remedies – The Program Fraud Civil Remedies Act (38 U.S.C. &3801 *et seq*) is a law that establishes an administrative remedy against any person who presents or causes to presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies.