

## CORPORATE COMPLIANCE FALSE CLAIM PREVENTION

**POLICY:** It is the policy of the John J. Kane Regional Centers to consistently and fully comply with all laws and regulations pertaining to the preparation of, delivery of and billing for services which apply to participation in Medicare, Medicaid and other state and federal government programs. Several federal and state laws and regulations are designed to prevent and detect fraud, waste and abuse in federal health care programs. This policy will describe those laws and their role in preventing and detecting fraud, waste, and abuse, as well as the Regional Centers' policies and procedures for detecting and preventing fraud, waste, and abuse.

**PURPOSE:** To provide information for management and workforce members regarding the regulations and their role in prevention of false claims.

### DEFINITIONS:

#### Contractor

**or Agent:** Any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or other wise authorizes the furnishing of Medicaid and/or Medicare health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the John J. Kane Regional Centers.

The definitions of the Federal False Claims Act and the Federal Deficit Reduction Act of 2005 are incorporated herein by reference.

**PROCEDURE:** The John J. Kane Regional Centers maintains a compliance plan that is designed to detect fraud, waste, and abuse, as well as inadvertent billing and other issues. Employees, covered contractors, subcontractors and agents are provided with a copy of the Compliance Program and the False Claim Prevention Policy. Employees and contractors/agents must attest to compliance with the laws and our policies related to false claims prevention and must agree to adopt the provisions of our policy as part of our agreement with them. The John J. Kane Regional Centers include this policy as part of our RFP process to prospective contractors and agents. Applicable language from this policy, including adoption of our policy, is also included in our agreements with contractors and agents.

During Orientation and at least annually, employees are provided training pursuant to applicable Acts discussed in our policies, whistleblower rights, and our corporate compliance policies, which includes specific discussion of our policies and procedures for detecting and preventing fraud, waste, and abuse. Our employee handbook includes specific discussion of the Federal and state laws described in our written policies, our Corporate Compliance Policy and False Claim Prevention Policy, which further describes the employee's protection rights related to claims filed pursuant to the Federal False Claims Act.

The components of the Regional Centers compliance plan that are designed to detect fraud, waste, and abuse are as follows:

- The Code of Conduct and this policy, contains standards that require Regional Center's employees, contractors and agents to comply with applicable laws and standards of care, including those applicable to documentation and the submission of claims to governmental programs. Any employee who violates the Code and/or this policy is subject to disciplinary action up to and including termination of employment and any applicable civil or criminal penalties associated with violations of laws. Any contractor or agent who violates this policy is subject to termination of our agreement and any applicable civil or criminal penalties associated with violations of the law.
- The Regional Centers are committed to ensuring that all information we submit to the government is accurate. Each employee must know or believe the information contained in a claim or statement he or she submits on behalf of the Regional Centers is correct. Personnel cannot, either deliberately or carelessly, ignore questionable information in a claim that the Regional Center submits. Whether the information is true and accurate includes making reasonably sure that essential facts are accurate, and that no essential fact is omitted.
- Under the Regional Centers compliance policies, all employees have a responsibility to comply with the law and to report his or her good faith belief of any violation thereof. Any employee who has a good faith belief, based on objective information, that a false claim will or has been made, must report it to his or her supervisor, the Deputy Director of Compliance, or to the Compliance Hotline (412-422-8352). Failure to report a good faith belief that a false claim will or has been made will result in disciplinary action up to and including termination of employment.

- A Compliance Hotline has been established that allows employees to report possible incidents of fraud, violations of the Code of Conduct, or possible violation of the law. Employees may make a report anonymously. The Compliance Hotline number is 412-422-8352. The employee may also report any of the above to their supervisor, Administrator or to the Deputy Director of Compliance. Employees/others can also use the Privacy Complaint forms that are located in each Department and can be found under forms on the k-drive. Completed forms should be placed in a sealed envelope and sent to the Deputy Director of Compliance /Glen Hazel for follow up.
- The Regional Centers maintain a non-retaliation policy. An Employee may not be retaliated against because the employee made a good faith report through the compliance hotline or to a supervisor, Administrator or the Deputy Director of Compliance. Employees who lawfully report false claims are protected from retaliation by the Regional Centers' policy and federal and state laws. Employees have the right to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste or abuse in a Federal health care program, including the Medicare and Medical Assistance Programs, to the provider or to the appropriate authorities.
- All Compliance Hotline reports and compliance concerns are promptly investigated that are brought to our attention. If the investigation reveals a billing issue, the Regional Center will address the issue and notify the government, or other payor source of the issue and the manner in which it was addressed, including repayment where indicated. Corrective actions will be taken as necessary.
- The Regional Centers are committed to ensuring that claims that are filed are accurate and that the employees are properly trained. Audits are performed by the Regional Centers or a contracted service to detect and prevent false claims. Written policies detail our information and procedures for detecting and preventing waste, fraud and abuse. See policy A-C-60 for details regarding internal auditing and monitoring.
- All reports are investigated, and if it is determined that government programs (e.g., Medicare or Medicaid) or other payor source was improperly billed, a refund of any excess amounts will be made to the appropriate program. If the investigation reveals a billing issue, the Regional Center will address the issue and notify the government or other payor of the issue and the manner in which it was addressed.
- The Regional Centers routinely monitor and audit claims submitted to government programs to ensure compliance with the requirements of those programs. Resident charts are reviewed along with MDS data, and claims submitted to ensure that the resident's care was billed at an appropriate level. For Medicare and Medicaid residents, the chart is reviewed and claims submitted to ensure that services were appropriately ordered, documented, and billed and that the resident is in the appropriate RUGs category. As noted above, if a billing issue is discovered, overpayments will be refunded to the appropriate government agency or payor source.
- The Executive Director and Corporate Secretary/Treasurer is required to read Section 6033 of the Deficit Reduction Act of 2005 (the Act), and for examining the Regional Center's policies and procedures. Based on their review, they will make any adjustments needed to comply with the Act and will attest that the Centers are in compliance with the requirements of the Act to educate employees and contractors concerning the Federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs. The first review and attestation will be conducted and filed before December 31, 2007 and then annually thereafter.

**THE FEDERAL DEFICIT REDUCTION ACT, 2005, SECTION 6033:**

Provides that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall:

- a) establish written policies for all employees of the entity, and of any contractor or agent of the entity that provide detailed information about the False Claims Act
- b) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- c) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

**THE FEDERAL FALSE CLAIMS ACT**

In an effort to eliminate fraud with respect to government funds, the government has an arsenal of laws at its disposal. One such law is the False Claims Act. The Act makes it illegal for any person to knowingly present or cause to be presented to an officer or employee of the government a false or fraudulent claim for payment or approval or make, use, or cause to make or use, a false record or statement to get a false or fraudulent claim paid or approved by the government. The Act defines knowingly to mean:

- a) that a person has actual knowledge of the information
- b) acts in deliberate ignorance of the truth or falsity of the information
- c) recklessly disregards the truth or falsity of the information

The Act applies to false or fraudulent claims submitted to the Medicare program and, because it is partially federally funded, the Medicaid program. This would include, for example, false statements on Regional Center's cost reports, MDSs and billing statements. It would also apply to false or fraudulent documentation in connection with requests for payment under a waiver program, and it would apply to falsification of the chart of a Medicare or Medicaid beneficiary in order to obtain or justify payment from a government program.

An action for violation of the Act may be brought by the government or a private citizen on behalf of the government. Penalties for violations of the Act include damage of up to three times the amount of the false claim submitted, plus a civil penalty of between \$5,500 and \$11,000 for each false claim. Criminal penalties may also be imposed upon individuals who submit false claims.

The Act contains a provision that protects employees who lawfully report false claims from retaliation.

### **THE FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT**

In addition to the False Claims Act, the government may utilize the Program Fraud Civil Remedies Act, a law that allows the Department of Health and Human Services and other Federal agencies to impose an administrative penalty upon individuals and entities who submit such a claim or series of claims with a value of less than \$150,000. That law makes it unlawful for a person to submit such claims that the person knows or has reason to know:

- a) are false, fictitious, or fraudulent
- b) include or are supported by any written statement that is materially false, fictitious, or fraudulent
- c) include or are supported by any written statement that omits a material fact, is false, fictitious, or fraudulent as a result of such omission, and is a statement that the person submitting the statement has duty to include
- d) is payment for the provision of property or services that the person has not provided as claimed.

Similarly, the submission of false, fictitious, or fraudulent statements to a government agency will violate the Act if the statement is accompanied by an express certification of its truthfulness. Penalties for violation of the Act are up to \$5,500 per false claim or statement.

### **PENNSYLVANIA FRAUD AND ABUSE ACT**

Pennsylvania law also prohibits the submission of false claims and statements, but it is limited to claims for Medical Assistance. In accordance with this Act, no employee may:

- a) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under Medical Assistance, or knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under Medical Assistance, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the Regional Center is legally entitled for furnishing services or merchandise under Medical Assistance, or knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under Medical Assistance.
- b) Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.
- c) Submit a claim for services, supplies or equipment which was not rendered to a recipient.
- d) Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient.
- e) Submit a claim or refer a recipient to another provider by referral, order or prescriptions, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.
- f) Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider.
- g) Submit a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item.
- h) Submit a claim for a service or item which was not rendered by the provider.

Unlike the Federal laws described above, the Pennsylvania law has both criminal and civil penalties. If convicted, there are criminal penalties for each violation of up to seven(7) years in prison and a fine of up to \$15,000. However, if the violator has previously been convicted of violation of any state or federal law based upon conduct that would have violated any of Pennsylvania's provisions as described above, each subsequent violation of Pennsylvania's law will carry a penalty of up to 10 years in prison and a fine of up to \$25,000. In addition, if convicted, a provider must repay any amounts received on account of false claims plus interest at the legal maximum rate and pay an additional amount equal to three times the amount received on account of false claims.

A conviction will also result in exclusion from the Medical Assistance Program for five (5) years. Notice of such a conviction will be forwarded to the Medicaid Fraud Control Unit of the Department of Justice.

In addition to the criminal penalties described above, Pennsylvania allows the Department of Public Welfare to immediately terminate a provider's agreement with the DPW and institute a civil action claiming two (2) times the amount received in account of false claims if it determines that a provider has violated any of the provision described above.

If a provider's Medical Assistance participation is terminated as described above, whether through a criminal proceeding or action of DPW, that provider is prohibited from owning, arranging for, rendering or ordering any services for Medical Assistance recipients. Moreover, the provider may not receive any Medical Assistance funds, whether directly or in the form of salary, shared fees, contracts, or otherwise from or through a participating provider.

#### **PENNSYLVANIA INSURANCE FRAUD**

The Pennsylvania Insurance Fraud law makes it a criminal offense to knowingly submit any false, incomplete or misleading information concerning any material fact to an insurer or self-insured. If a claim is made by computer billing or other electronic means, there is a presumption that the "knowingly" requirement as been proven. Additionally, the law provides that a provider's knowledge of a potential violation without further action may trigger another provision of the law that makes it an offense to be an owner, administrator, or employee of a health care facility and knowingly allow the use of the facility by a person who is engaged in violating the law.

#### **CONTRACTORS AND AGENTS**

This policy and procedure applies to and is distributed to and integrated into agreements entered into with any of the John J. Kane Regional Center contractors or agents involved in the preparation and filing of public health program claims on behalf of the Centers.