Medical Center Health System
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ADMINISTRATION

POLICY MEMORANDUM

POLICY TITLE:	FRAUD AND ABUSE
POLICY NUMBER:	MCH-1083
JCAHO FUNCTION AREA:	Leadership
POLICY APPLICABLE TO:	All Employees
POLICY EFFECTIVE DATE:	January 1, 2007
POLICY REVIEWED:	January 1, 2007; 7-12-10; 1-5-12
POLICY REVISED:	7-12-10; 1-5-12

ALTERNATE WORD SEARCH: Fraud, Abuse, False Claims, Qui Tam

POLICY STATEMENT:

Medical Center Health System, its related facilities and its employees shall comply with all laws and regulations requiring accurate billing to the Medicare and Medicaid programs for services and equipment provided by the Health System. This written policy is intended to provide detailed information about several federal and state laws prohibiting submission of false or fraudulent claims for payment to those programs and about Medical Center Health System's other policies and procedures designed to detect, prevent and report on fraud and abuse. The information in this policy shall be included in the Employees Handbook and distributed to all contractors and agents.

I. FEDERAL FALSE CLAIMS ACT [1]

A. Background

Although the False Claims Act had its origins during the American Civil War in the early 1860's, it remains the federal government's primary tool to identify and recover losses due to improper or fraudulent claims submitted to federal healthcare programs.

B. Prohibitions of The Federal False Claims Act

[1] Located at 31 USC 3729-3733.

The False Claims Act, among other things, prohibits any person or entity, such as MCHS, from:

a. Knowingly submitting or causing to be submitted to the federal government a false or fraudulent claim for approval or payment;
b. Knowingly making or using or causing to be made or used a false record or statement in order to get a false or fraudulent claim approved or paid by the government;
c. Conspiring to defraud the government by getting a fake or fraudulent claim allowed or paid;
d. Knowingly making or using or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to repay money to the government.

"Knowingly" has a special definition. It means that a person or entity (1) has actual knowledge that a claim or the information in a claim or statement is false or fraudulent; or (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Innocent mistakes and ordinary negligence, however, are not covered by this Act.

C. Penalties

Individuals or hospitals or other entities found to have violated the False Claims Act are liable for a civil penalty for each claim of not less than $5000 and not more than $10,000, plus up to three times the amount of damages sustained by the federal government.

D. Enforcement

The False Claims Act is enforced by the filing and prosecution of a civil complaint in a court by the United States Attorney General. This is simply a civil lawsuit by the government.

E. Qui Tam Provisions

The False Claims Act not only authorizes the United States Attorney General to bring suit for violations of the Act but it also authorizes private citizens to file a suit in the name of the United States for false or fraudulent claims submitted by individuals, hospitals or other entities that do business with or are reimbursed by the United States. These are commonly known as qui tam suits. The government may or may not take the lead role in prosecuting such a claim. As an incentive to bring these cases, the Act provides that whistleblowers who file a qui tam suit may receive an award of 15 to 30% of the monies recovered for or by the government plus attorney's fees and costs. The Act, however, also provides penalties for individuals who prosecute clearly frivolous qui tam claims.

F. Protection for Whistleblowers

Whistleblowers are offered protection against retaliation for bringing suit under the Act and for reporting suspected fraud and abuse covered by the Act. Employees who are discharged, demoted, harassed, or confront discrimination because of filing suit or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. This relief may include reinstatement, double back pay, and compensation for special damages including litigation costs and reasonable attorney's fees.

II. FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT [2]

A. Background

The Program Fraud Civil Remedies Act of 1986 ("PFCRA") authorizes certain federal agencies, including the Department of Health and Human Services, to investigate and assess civil penalties against persons who make or cause to be made false claims or false written statements to the agencies. The PFCRA was enacted as a means to address fraud in a lower dollar amount than the False Claims Act and it generally applies to claims of $150,000 or less.

B. Prohibitions of PFCRA

PFCRA provides for administrative remedies against any person or entity, such as MCH, who:

(1) makes, presents, or submits or causes to be made, presented or submitted to a federal agency, a claim or a written statement supporting a claim which the person or entity actually knows is false, fictitious or fraudulent; or

(2) acts in deliberate ignorance of the truth or falsity of the claim or statement, or who acts in reckless disregard of the truth or falsity of the claim or statement.

"Statement" has a special definition. It means any document, record, or accounting or bookkeeping entry made with respect to a claim or payment of a claim for healthcare services.

[2]Located at 31 USC 3801-3812.

C. **Penalties**

Individuals or entities such as hospitals are subject to monetary penalties of up to $5,000 for each claim or statement and instead of damages, a penalty up to twice the amount of each claim. The penalties may not exceed $150,000 for each group of claims.

D. **Enforcement**

Suspected violations of this statute are investigated by the office of the Inspector General of the Department of Health and Human Services. The results of this investigation are sent to the office of the Attorney General and, if approved by the Attorney General, enforcement proceedings begin with a hearing before an administrative law judge. This is just like a trial but there is no jury. Thereafter, penalties may be recovered by the Attorney General through a civil suit based on findings made by the administrative law judge. Penalties may also be recovered by the agency involved by simply offsetting the amount of the penalties against "clean" or "correct" claims.

III. TEXAS FALSE CLAIMS ACT [3]

A. **Background**

In 1995 the State of Texas enacted its own False Claims Act specifically directed at its Medicare program. It is similar to the federal law.

B. **Prohibitions of the Texas False Claims Act**

The Texas Act, in general, prohibits any person from:

(1) making or causing to be made a false statement or misrepresentation of a material fact, either intentionally or with conscious indifference to or reckless disregard for the truth or falsity of the information, in order to obtain unauthorized payments under the Medicaid program; and

(2) from conspiring with another to defraud the state by obtaining unauthorized payments under the Medicare program.

C. **Penalties**

[3] Located at §36.001-36.117, Texas Human Resources Code.

A person who violates the Texas False Claims Act may be liable for the amount paid by the State on a false claim, for a civil penalty of $1,000 to $15,000 for each act, and for damages in the amount of two times the amount of payments made by the State. In addition, the Attorney General may recover expenses incurred in conducting any investigation, reasonable attorney's fees, witness fees, court costs and other similar expenses and fees. A healthcare provider, such as Medical Center Health System, may even lose its Medicaid contract with the State or have that contract and payments suspended. The Texas Penal Code also provides criminal penalties for Medicaid fraud.[4]

D. **Enforcement**

Suspected violations of the Texas False Claims Act may be investigated by the office of the Inspector General of the Texas Health and Human Services Commission or by the Attorney General of the State of Texas. Depending upon the results of the investigation, the Attorney General may bring a civil action in court to recover the damages and penalties provided by the Act and the Commission may begin administrative proceedings which will affect the provider's Medicaid contract.

E. **Qui Tam Provisions**

The Texas False Claims Act, like its federal counter-part, also authorizes a private citizen to bring a civil action to recover damages and penalties under the Act on behalf of the State. The office of the Texas Attorney General may or may not take the lead role in prosecuting the claim. As encouragement to bring these cases, the Act provides that whistleblowers who file a qui tam action may receive an award of 10 to 15% of the monies recovered plus attorney's fees and costs.

F. **Protection for Whistleblowers**

Whistleblowers are offered protection against retaliation for bringing suit under the Act. A whistleblower who sues may not be discharged, demoted, suspended or in any other manner discriminated against in the terms of employment. Employees who are retaliated against are entitled to complete reinstatement and restoration of any lost pay and any lost benefits. Texas law[5] also prevents Medical Center Health System from retaliating or taking any adverse personnel action against employees who, rather than file suit, report suspected Medicaid Fraud and abuse to an

[4] Articles 35A.01 and .02, Texas Penal Code.

[5] Located at §554.001-554.009, Texas Government Code.

appropriate law enforcement authority. An "appropriate law enforcement authority" includes the county attorney, the district attorney, the office of the Texas Attorney General, the Texas Department of Health and Human Services, the U.S. Department of Justice and the U.S. Department of Health and Human Services.

IV. Examples of Fraud and Abuse

Some of the more common problems under the Federal and State False Claims Acts and the PFCRA include but are not limited to the following:

(1) Billing for services not rendered or goods or equipment not provided to the patient.

(2) Billing for services not medically necessary.

(3) Billing separately for services that should be a single service.

(4) Falsifying treatment plans or medical records to inappropriately increase or maximize payments.

(5) Failing to report overpayments.

(6) Duplicate billing.

(7) Unlawfully giving healthcare providers, such as physicians, inducements in exchange for referring patients to the hospital.

V. Reporting Fraud and Abuse

Any employee who has knowledge or information of any fraud or abuse in the Medicare program, the Medicaid program, or any other public funded healthcare program, should notify his or her supervisor or call the Compliance Hotline at 640-1900. The employee may also place a written note in one of the integrity boxes located near the time clocks or may call the MCH External Compliance line at 1-800-805-1642. Reporting can also be done electronically via the MCHS Intranet web page under Employee Links and then select Compliance Hotline. As always, any information may be reported anonymously. Information may also be reported to the U.S. Department of Health and Human Services OIG hotline at 1-800-447-8477. The Ector County Hospital District and Medical Center Health System prohibit any retaliation, retribution, or taking any adverse personnel action against employees who report suspected violations of law to their supervisor, the Compliance Office or an appropriate law enforcement official and those who file "whistleblower" lawsuits on behalf of the government. Any employee who believes that he or she has been subject to any such retribution, retaliation or adverse personnel action should report this on the internal or external Compliance Hotlines or report it directly to the Compliance office which is located between Health Information Management and the gift shop.

VI. MCHS Policies for Detecting Fraud and Abuse

In order to ensure Medical Center Health System's compliance with the Medicare and Medicaid programs, MCHS has a number of policies designed to detect and provide for reporting of and the investigation of fraud and abuse. These policies include the following:

a. MCH-1063. This policy requires that Medical Center Health System report to appropriate governmental agencies any violations of law or regulation which might require the return of funds received by MCH from Medicare or Medicaid.

b. MCH-1064. This policy provides a system through which employees can report criminal, illegal or unethical conduct by others within the hospital without fear of retaliation or retribution. It also provides for investigating these reports

c. Compliance Office-1003. This policy also provides for thorough investigation of complaints and information received by the Compliance Office, whether in person, by telephone or through an integrity box and whether or not the report or complaint is anonymous.

d. MCH-3016. This policy requires hospital employees to avoid conflicts of interest in their employment. This policy defines conflicts of interest and provides for obtaining guidance or advice if an employee has questions about any given situation.

AUTHOR'S SIGNATURE	
	Barbara Dingman, Compliance Officer
AUTHORIZING SIGNATURE(S)	
	William W. Webster Chief Executive Officer
END OF POLICY	