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## Organizational Administration Policy #108

# False Claims Policy

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| **Federal Regulations:** Deficit Reduction Act (DRA) 2005, False Claims Act, 31 U.S.C. 3729-3733 (FCA), Federal Program Fraud Civil Remedies Act of 1986, 38 U.S.C. 3801 *et seq.(A),* Fraud Enforcement Recover Act 2009, Patient Protection and Affordable Care Act 2010 | **Effective Date: January 31, 2019** |
| **State Regulations:** | **Revision Date(s): February 27, 2023** |

**PURPOSE:** Hospice is committed to complying with all applicable laws and regulations. Hospice supports the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary procedures in place to prevent, detect, report, and correct incidents of fraud and abuse in accordance with contractual, regulatory, and statutory requirements. This False Claims Policy sets forth the guidelines to be followed by all employees (and others as applicable) regarding the False Claims Act, the Federal Program Fraud Civil Remedies Act of 1986, and in detecting and preventing fraud, waste, and abuse.

**POLICY:** Employees, governing body members, volunteers and other company agents and representatives (and other parties as applicable) must conduct themselves in an ethical and legal manner; follow laws and regulations and Hospice policies and procedures that apply to their work activities including requirements of the Medicare, Medicaid, and other federal healthcare programs.

Employees, governing body members, volunteers and other company agents and representatives are responsible for reporting actual, potential or suspected incidents of fraud and abuse, and other wrongdoing of Hospice directly to their supervisor, executive management, and compliance officer or by using one of the reporting methods described in the procedures section of this policy.

Hospice educates employees about fraud and abuse, including the detailed provisions of the False Claims Act, administrative remedies, State laws pertaining to civil or criminal penalties and *qui tam* provisions through mandatory compliance training.

The Compliance Officer in consultation with other Legal Counsel as needed has responsibility for receiving and acting upon information suggesting the existence of possible fraud, abuse, or wrongdoing; and for directing investigations arising from this information.

**DEFINITIONS**

**Fraud**: An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Abuse**: Practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes practices that result in unnecessary cost to government programs.

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**Federal False Claims Act**: The federal False Claims Act (the "FCA") is a statute that imposes liability on any person who:

- Knowingly presents or causes to be presented a false or fraudulent claim to the government.
- Knowingly uses a false record or statement to obtain payment on a false claim paid by the government.
- Engages in a conspiracy to defraud the government by the improper submission of a false claim for payment.

The term "**knowingly**" is defined to mean that with respect to information a person has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

The FCA applies to Medicare and Medicaid reimbursement and prohibits, among other things:

- Billing for services not rendered
- Billing for undocumented services
- Making improper entries on cost reports
- Billing for medically unnecessary services
- Assigning incorrect codes to secure higher reimbursement
- Characterizing non-covered services or costs in a way that secures reimbursement
- Failing to seek payment from beneficiaries who may have other primary payment sources;
- Failure to return overpayments, and
- Participating in kickbacks.

Damages and penalties of violating the FCA include:

- Civil penalties of not less than $5,500 and not more than $11,000 per violation, *plus*
- Three times the amount of damages, which the government sustains because of the violation, and the costs of any civil action brought to recover such penalties or damages.

The FCA also provides for actions by private persons (*qui tam* lawsuits), and private persons may bring a civil action in the name of the government for a violation of the FCA. Generally, the action may not be brought more than six years after the violation, but in no event more than ten years. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the government chooses not to intervene, the person who initiated the lawsuit (the "Whistleblower") has the right to conduct the action. In the event that the action is successful, the Whistleblower may be awarded a portion of the funds recovered. When the government intervenes, the Whistleblower may receive at least 15 percent but not more than 25 percent of the proceeds of the action depending upon the extent to which the individual contributed to the prosecution of the action. When the government does not intervene, the FCA provides that the Whistleblower may receive not less than 25 percent and

not more than 30 percent of the proceeds of the action as determined by the court. The Whistleblower may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the Whistleblower may have to pay the defendant its fees and costs. The amount received by the Whistleblower is decreased if he/she planned or initiated the violation, and no share is awarded if the Whistleblower is found guilty of a crime associated with the violation.

The FCA also provides for protection for employees, contractors, or agents from retaliation. If an employee is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA, that employee may bring an action in federal court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

**Federal Program Fraud Civil Remedies Act of 1986**: The Federal Program Fraud Civil Remedies Act of 1986 (the "Act") establishes an administrative remedy against any person who presents or causes to be 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 (including the Department of Health and Human Services).

The term *"knows or has reason to know*" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

With regard to this Act, the term *"claim"* includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The Act allows civil monetary sanctions to be imposed in administrative hearings, including penalties of $5,000 per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

Overpayments must be reported and returned within 60 days after the identification of the overpayment. Any person that knows of an overpayment and does not return the overpayment is liable for up to $10,000 for each item or service plus an assessment of up to three times the amount claimed for each such item or service. Failure to return overpayments may lead to exclusion from federal health programs.

**PROCEDURE:**

1) Silverado associates receive education relating to the provisions of the FCA and the Act during the annual compliance program training.

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2) This education includes:
   a) Detailed information on the FCA and amendments, the Act, and the other administrative remedies for false claims and statements
   b) State laws pertaining to civil or criminal penalties
   c) Whistleblower rights
   d) Hospice provisions for preventing, detecting, and reporting fraud, waste, and abuse.

3) Employees, contractors, and agents with knowledge of potential fraud and abuse situations report them through any of the following methods, as applicable:
   a) Notifying their supervisor, another managerial employee, administrator, or Compliance Officer.
   b) Anonymous reporting is available through the posted hotline number.

4) Anyone receiving a report of fraud should immediately inform the Compliance Officer before any action is taken. No supervisor or manager should directly confront an employee with the allegation of fraud or otherwise discuss the issue with anyone suspected of engaging in fraudulent or abusive practices without prior approval from the Compliance Officer.

5) It is the responsibility of the Compliance Officer to direct or conduct fraud and abuse investigations. In conducting an investigation of wrongdoing, facts should be gathered as promptly as possible.

6) The Compliance Officer is responsible for detecting potential incidents of fraud and abuse and determining when incidents should be reported to an appropriate law enforcement agency. This position is responsible for ensuring the design and development of methods for identifying fraud and abuse and responding appropriately and immediately to all detected program violations. If incidents of fraud and abuse are identified, systematic changes and corrective action initiatives are put into place as appropriate to prevent further offenses.

7) The Compliance Officer must establish and maintain methods for detecting and preventing incidents of fraud and abuse, including but not limited to a claims quality assurance program that monitors the accuracy of claims, a compliance hotline and a process that identifies employees, contractors, vendors, and providers that are debarred or excluded from participating in federal programs.

8) Complaints, allegations, and concerns reported through the “Hotline” and/or received directly by the Compliance Officer concerning fraud and abuse are handled under direction and coordination of the Compliance Officer.

9) In the case where the allegation is a criminal violation of law, the Compliance Officer confers with internal or outside legal counsel as needed for determination as to whether there is sufficient evidence to support referral to a duly authorized law enforcement agency.

10) To the extent practical or allowed by law, the Compliance Officer must maintain the confidentiality or anonymity of an employee or other individual reporting questionable activity to the extent possible when requested.

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11) Hospice fully cooperates with federal and state agencies that conduct healthcare fraud and abuse investigations.

12) Hospice takes appropriate disciplinary and enforcement action (i.e., corrective action plans, employment termination or contract termination) against employees, providers, subcontractors, consultants, and agents found to have committed fraud and abuse violations.

13) Retaliation or retribution for reporting issues “in good faith” is prohibited. Retaliation is subject to discipline up to and including dismissal from employment or termination of business relationship with Hospice.