SUBJECT:	**STATE FRAUD, ANTI-KICKBACK AND FALSE CLAIM LAWS**	**PAGE: 1 of 9**
DISTRIBUTION:	**ORGANIZATION WIDE**	**DATE: 11/2/09**

POLICY:
Stonewall Jackson Memorial Hospital (SJMH) has set forth the procedures to be used in response to a report from an officer, employee, consultant or vendor engaging in activity that may be contrary to applicable federal or state law or the requirements of the Hospital's policies.

PURPOSE:
To outline the Hospital's response to a report of fraud waste, or abuse.

PROCEDURES:

Investigation

A. **Purpose of Investigation**
In response to a complaint, an investigation shall be conducted to identify situations in which applicable federal or state laws, regulations and standards of the Medicare and Medicaid programs, or the Hospital's policies may not have been followed; to identify individuals who may have knowingly or inadvertently violated the law or the Hospital's policies; to facilitate the correction of any violations or misconduct; to implement procedures necessary to provide for future compliance; to protect the Hospital in the event of civil or criminal enforcement.

B. **Conduct of Investigation**
All reports of alleged fraud, waste or abuse must be forwarded to the Hospital's Corporate Compliance Officer. Serious or otherwise sensitive matters or investigations should be conducted by or under the direction of the Hospital's legal counsel (See Appendix A).

C. **Investigation Process**
Upon receipt of information concerning alleged fraud, waste, or abuse, the Corporate Compliance Officer shall oversee the following actions:

1. Prepare a report that includes, if known, the name of the employee who made the report, the date of the report, and a detailed narrative of the employee's concern and the nature of the alleged conduct. Anonymity of the individual who made the report (if requested) shall be honored and confidentiality shall be maintained. Retaliation or reprisal against anyone for reporting good faith belief that fraud, waste, or abuse has been committed is strictly prohibited.

2. If the involvement of legal counsel is warranted, contact legal counsel to initiate a direct investigation.

3. Provide that the investigation is conducted as soon as reasonably possible, but in any event not more than five (5) business days following receipt of the information. The investigation may include:

a. Interviews of persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether or not a violation has occurred.

b. Identification and review of relevant documentation, including where applicable, representative bills or claims submitted to the Medicare/Medicaid programs, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.

c. Interviews of persons who appear to have played a role in the suspected activity or conduct to determine the facts surrounding the conduct. The interviews shall include but shall not be limited to determining:
   a) The person's understanding of the applicable laws, rules and standards;
   b) Identification of relevant supervisors or managers;
   c) Training that the person received;
   d) The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws.

d. Preparation of a summary report that:
   a) Defines the nature of the alleged misconduct;
   b) Summarizes the investigation of the process;
   c) Identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws;
   d) Assesses the nature and extent of potential civil or criminal liability; and
   e) Where applicable, estimates the extent of any resulting overpayment by the government.

4. For all investigations in which the Hospital's legal counsel is not involved, determine whether the Hospital's legal counsel should be contacted.

5. Establish a due date for the summary report to otherwise prove that the investigation is completed in a reasonable and timely fashion and that the appropriate disciplinary or corrective action is taken, if warranted.

6. A copy of all completed reports is then filed with the Corporate Compliance Officer for organizational tracking and trending.

Organizational Response to Issues Identified

In the event the investigation identifies any fraud, waste, or abuse, the following actions shall be taken:

A. The Hospital shall, as quickly as possible, terminate the offending practice. If the conduct involves the improper submission of claims for payment, the Hospital shall immediately cease all billing of potentially affected by the offending practice until a correction is implemented.

B. The Hospital shall consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authorities or law enforcement agency is warranted.

C. If applicable, the Hospital shall calculate and repay any duplicate or improper payments made by the federal or state government program as a result of the misconduct.

D. Appropriate disciplinary actions shall be taken which may include, but is not limited to, reprimand, demotion, suspension and/or termination. If the investigation uncovers what appears to be criminal conduct on the part of an employee, appropriate disciplinary action against the employee or employees who authorized, engaged in or otherwise participated in the offending practice shall include at a minimum the removal of the person from any position of oversight and may include, in addition, suspension, demotion, termination, and/or criminal prosecution.

E. In instances where the employee or employees are not terminated, prompt appropriate actions and education to prevent a recurrence of the misconduct shall be undertaken.

F. A review of the applicable Hospital policies and procedures shall be conducted to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.

G. As appropriate, follow-up monitoring and auditing shall be conducted within the appropriate department with oversight from the Corporate Compliance Officer, to provide for effective resolution of the aberrant practice.

DUTY TO REPORT FRAUD, WASTE AND ABUSE: WHISTLEBLOWER PROTECTION

POLICY:
The Hospital mandates that any person who has knowledge or a good faith suspicion of false documenting, coding, or billing for services, equipment, or supplies or other wrongdoing in the Hospital's financial practices, shall report such knowledge or suspicion internally so that an investigation can be conducted and appropriate action taken. **Retaliation or reprisal against anyone for such reporting is strictly prohibited.** In addition to any violation of federal or state law, fraud, waste, and abuse may include violations of hospital policy with respect to billing (e.g. billing for services not performed at all or not performed as described, submission of claims for unnecessary or undocumented services, equipment, or supplies, double billing, upcoding, unbundling, misuse of coding modifiers, false cost reports, billing for services by an unlicensed or excluded provider, or paying or accepting money, gifts, or favors in return for referrals),

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PURPOSE:
To provide an explanation to employees, contractors, and volunteers that they must report false claims and that they are protected against retaliation for such reporting.

PROCEDURES:

A. Anyone who has knowledge or a good faith suspicion as to the existence of fraud, waste or abuse by another employee, a board member, a vendor, a contractor, or a volunteer should report it to the Corporate Compliance Officer.

B. The individual making the report may do so by reporting the concern in person, in writing or anonymously. The hospital shall attempt to maintain the confidentiality of the person reporting the concern.

C. Self-reporting is encouraged. Anyone who self-reports any violation of law or hospital policy shall be given due consideration in mitigation of any disciplinary action that may be taken.

D. Upon a report of fraud, waste, or abuse, the Corporate Compliance Officer shall oversee an appropriate investigation into the allegations.

E. If the charges are substantiated, then the Corporate Compliance Officer shall develop and implement a plan for appropriate corrective action and shall notify the President of the Hospital, the Corporate Compliance officer and Human Resources with respect to any disciplinary or other corrective action against the employee, board member, vendor, contractor or volunteer.

F. **Retaliation or reprisal in any form against anyone who reports fraud, waste or abuse, or cooperates in an investigation is strictly prohibited.** If an employee or a contractor believes that he/she has been retaliated against as a result of making a report or cooperating in an investigation pursuant to this or any other compliance policy, he/she should report it to the Corporate Compliance Officer. There shall be Corporate Compliance oversight of issues (i.e., tracking) for action plan through to resolution.

G. The Corporate Compliance Officer shall maintain a confidential log of all reports of compliance concerns and the Corporate Compliance Officer shall periodically update the Board of Directors.

H. Anyone who makes a report of fraud, waste, or abuse maliciously, frivolously, or in bad faith shall be subject to disciplinary action up to and including termination.

I. The Hospital seeks to investigate all non-frivolous claims of fraud, waste, or abuse internally so that corrective action can be instituted. However, any person who discovers wrongdoing that constitutes a false claim to the federal government for payment (e.g., a Medicaid claim) may also file a complaint under seal in court pursuant to the False Claims Act.

FALSE CLAIMS

POLICY:
All employees, contractors, and vendors involved with providing or obtaining reimbursement for medical services, supplies, or equipment from or on behalf of the Hospital are responsible for submitting honest and accurate bills to Medicaid, Medicare, and other federal and state healthcare programs, and for submitting honest and accurate invoices to the hospital. In addition to complying with the Hospital's standards, all employees, contractors, and vendors are expected to comply with federal and state laws designed to prevent fraud, abuse, and waste in federal and state healthcare programs. **Retaliation or reprisal against any employee for reporting a false claim is strictly prohibited by law and Hospital policy.**

PURPOSE:
To set forth and communicate the standards that are applicable to reimbursement for medical services, supplies and equipment in order to comply with the Hospital's standards and federal and state law.

PROCEDURE:

A. **Bill Only For Medically Necessary Services**

1. All services, equipment and supplies provided to patients shall be reasonable and medically necessary, in accordance with the applicable standard of care.

2. Those who provide services shall be properly credentialed and licensed and provide services within their respective scope of practice.

B. **Completeness and Accuracy in Medical Records and Billing**

1. Providers shall document the treatment performed in sufficient detail so that an accurate bill can be submitted for each treatment or procedure performed.

2. Bills submitted for services performed shall describe the services in sufficient detail, be based on proper documentation in the chart, not duplicate bills for the same services, be accurate, be based on the correct provider number, and be in compliance with federal and state law, as wells as the payor's contract.

3. Billing and coding staff shall comply with CMS program instructions and policies, National and Local Coverage Determinations (NCDs and LCDs), and Carrier Bulletins.

C. **Unacceptable Practices**
The following are examples of practices, which are unacceptable:

1. Billing for services that were not performed at all or not performed as described.

2. Submitting claims for medical equipment, supplies or services that were not necessary.

3. Double billing.

4. Upcoding or assigning a code that secures a higher reimbursement, rather than the code that matches the services performed.

5. Unbundling or billing separately for services that should be a single service.

6. Knowingly misusing provider numbers.

7. Failing to use coding modifiers accurately or appropriately.

8. Preparing or submitting false cost reports.

9. Billing for services performed by an unlicensed provider or one who has been excluded from a federal healthcare program.

10. Unlawfully giving healthcare providers, such as physicians, inducements in exchange for referrals for service.

D. **Compliance with Applicable Laws**

1. All Hospital employees, contractors and board members shall comply with federal and state laws and regulations concerning fraud and abuse in federal healthcare programs, especially the Federal False Claims Act and administrative remedies associated with its enforcement (see Appendix to this Policy).

2. No Hospital employee and/or contractor is permitted to give or accept cash, gifts, favors, payment, services, entertainment, tips or any other items of value from anyone in exchange for the referral of Medicaid, Medicare or other government healthcare program business to the Hospital.

3. Retaliation or reprisal against an employee for reporting a false claim, or lawfully acting in furtherance of an action under the False Claims Act, is strictly prohibited.

E. **Government Reporting**

1. All reports required to be submitted to state or federal healthcare programs must be truthful and accurate in all respects. No Hospital board member, officer or employee shall attest to the accuracy of a submitted report unless he/she has been able to satisfy himself/herself that the data submitted or the representations made are truthful and accurate.

2. If the Hospital determines that it has been overpaid by a government program, third party or patient, it will promptly refund the payment to the proper party.

3. All cost report's data, schedules and work sheets must be truthful, accurate and complete. The Hospital shall only report properly allowable costs that were actually and reasonable incurred by the Hospital.

4. No Hospital employee or contractor shall attempt to improperly influence the actions or decisions made by government bodies, officials, employees, or contractors.

5. The Hospital shall cooperate and be truthful in responding to government inquiries, requests, and investigations, including audits, surveys, and certification reviews.

APPENDIX A
FEDERAL LAWS
THE FALSE CLAIMS ACT

Civil False Claims Act (31 U.S.C. § 3729 et seq.): The False Claims Act is a statute that imposes civil liability potentially both (fines and treble damages) on any person or entity who:

- knowingly submits a false claim to the federal government for payment
- knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the federal government
- uses a false statement to decrease an obligation to the government

"Knowingly" means:

- actual knowledge of the truth of a claim or statement
- acting recklessly, or
- acting with deliberate ignorance of the truth or falsity of the claim

"Claim" means:

Any request or demand for money submitted to the U.S. Government or its contractors. For example, bill of invoice submitted to Medicaid or Medicare constitutes a "claim" under the Act.

Bringing an Action Under the False Claims Act:

- A private person can bring an action under the False Claims Act in the name of the United States.
- The person can file a complaint "under seal" or confidentially. "Under seal" means that the records are kept secret by the court.
- The U.S. Attorney has 60 days to review the complaint and consider the allegations and whether the U.S., through the Department of Justice, will join in and take over the complaint.

- The Department of Justice then investigates the allegations of violations of the False Claims Act and may involve the FBI or the Office of the Inspector General of the Department of Health and Human Services, and may issue subpoenas for documents or electronic records, may interview witnesses, and may compel testimony from certain individuals within the organization.
- After the investigation is complete, the Department of Justice decides whether it will intervene in the action filed by the employee, decline to intervene, or dismiss the complaint.
- Retaliation or reprisal against any employee for reporting a false claim, or lawfully acting in furtherance of an action under the False Claims Act, is strictly prohibited.
- If the lawsuit is successful, the person brining the lawsuit may be entitled to receive an award ranging from 15% to 30% of the amount recovered.

Under West Virginia law, it is illegal for a person to knowingly make or cause to be made a false statement or false representation of any material fact in the application for medical assistance under the medical programs of the West Virginia Division of Human Services (which includes the Medicaid program). It is also illegal to knowingly make or cause to be made a false statement or false representation of any material fact necessary to determine the rights of any other person to medical assistance under these programs, or to knowingly and intentionally conceal or fail to disclose any fact with the intent to obtain medical assistance under these programs to which any person is not entitled. Violations are a felony and, upon conviction, a person can be confined in the penitentiary not less than one nor more then 10 years or can be fined not to exceed $10,000 or both fined and imprisoned.

It is also illegal for any person to solicit, offer or receive any remuneration, including any kickback, rebate or bribe, directly or indirectly, with the intent of causing an expenditure of monies out of the West Virginia Human Services Medical Services Fund (which includes Medicaid funds) which is not authorized by applicable laws or rules and regulations. Further, it is illegal for a person to make or present or cause to be made or presented a claim under the medical programs of the West Virginia Division of Human Services (which, again, includes the Medicaid program) knowing the claim is false, fraudulent or fictitious or for any person to enter into an agreement, combination or conspiracy to obtain or aid another in obtaining the payment or allowance of a false, fraudulent or fictitious claim. Violations of these provisions are also a felony and, upon conviction, a person can be confined in the penitentiary for not less than one nor more than 10 years or can be fined not to exceed $10,000 or both fined and imprisoned.

In addition to the criminal penalties, any person who willfully, by means of a false statement or representation, or by concealment of any material fact, or by other fraudulent scheme, devise or artifice, obtains or attempts to obtain benefits or payments or allowances under these medical programs of the West Virginia Division of Human Services to which such person is not entitled, or in a greater amount than that which such a person is entitled, will be liable for three times the amount of the benefits, payments or allowances to which such person was not entitled, and will be liable for the payment of reasonable attorney fees and all other fees and costs of litigation.

These remedies and penalties provided above are in addition to and not in lieu of those penalties and remedies provided elsewhere by law.

References

Health Care Fraud, 18 U.S.C. § 1347. Accessed January 16, 2018
Sentence of Fine, 18 U.S.C. § 3571. Accessed January 16, 2018
WEST VIRGINIA CODE §9-7-1, et seq.. Accessed January 16, 2018