Policy Title: Fraud, Waste and Abuse Protection, the Federal Deficit Reduction Act of 2005 and the False Claims Act

Objective: To provide information and guidance about the requirements of the Federal Deficit Reduction Act (DRA) of 2005, the Federal False Claims Act, other laws pertaining to civil and criminal penalties for false claims and fraud waste and abuse protections contained in various state and federal laws and regulations. Under the Deficit Reduction Act of 2005 hospital employees and associates must be informed about laws regarding false claims, protection for whistleblowers, and procedures for detecting and preventing Medicaid fraud, waste and abuse.

Policy: The Shore Memorial Health System and its subsidiaries, including Shore Quality Partners do not tolerate making or submitting false or misleading claims or statements to any government agency or payer source. Participants shall be informed that it is illegal to **"knowingly"** submit an inappropriate bill to Medicare or Medicaid or to cause a false claim to be sent to Medicare or Medicaid.

Examples of unacceptable billing practices include, but are not limited to the following:

- Billing for services not provided;
- Billing for medically unnecessary services;
- Up coding & “DRG Creep” – claiming a higher level of service than was actually provided by using incorrect codes;
- Duplicate / double billing; and/or,
- “Unbundling” – billing separately for services required to be billed at a lower “package” rate

Scope: This policy applies to Shore’s approach to compliance with federal and state laws prohibiting the submission of false or misleading claims to any government agency or payer source (Medicare, Medicaid, etc.).

Definitions:

SHORE - Shore Memorial Health System, its subsidiaries, including Shore Memorial Hospital, D/B/A Shore Medical Center, Shore Memorial Health Foundation, Shore Health Services Corporation and Shore Quality Partners.

SUMMARIES OF FEDERAL AND STATE LAWS AS REQUIRED BY SECTION 6032 OF THE DRA:

Following are summaries of civil and criminal statutes enacted by the Federal Government and by the State of New Jersey which provide penalties for claims of false or fraudulent claims and broad investigative authority for federal and state authorities:

A. Federal Civil False Claims Act (31 U.S.C. §3729 et seq.)

This statute imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- conspires to defraud the government by getting a false or fraudulent claim allowed or paid,
- uses a false record or statement to avoid or decrease an obligation to pay the Government,
- and other fraudulent acts enumerated in the statute.

Potential civil liability includes penalties of between $5,500 and $11,000 per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.

B. Federal Program Fraud Civil Remedies Act of 1986 (38 U.S.C. §380 et seq.).

This statute establishes an administrative remedy against a 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.

The appropriate federal department may investigate and, with the Attorney General's approval, may initiate a recovery proceeding if the claim is less than one hundred and fifty thousand dollars. In addition, civil monetary sanctions may be imposed in administrative hearings, through an assessment, in lieu of damages, of twice the amount of the original claim.

The term "knows or has reason to know" includes actual knowledge as well as acts in deliberate ignorance, or 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 any money or property provided by the Federal Government.

C. The New Jersey Medical Assistance and Health Services Act (NJSA 30:4D-17(1)-(d)).

This statute prohibits willfully receiving of benefits, in the case of recipients, or payments in the case of providers, to which a person is not entitled.

The criminal provisions of this statute (MAHA) allow the imposition of penalties of $10,000, and imprisonment of up to 3 years or both, upon a recipient or a provider who is convicted for willfully receiving monies to which he or she was not entitled.

The civil provisions of MAHA (NJSA 30:4D-17(e) - (i)) allow: interest on the amounts of excess benefits or payments made; payment of up to three times the amount of excess benefits or payments received; and payment of $2000 for each excessive claim for assistance, benefits or payments.

D. The New Jersey Health Care Claims Fraud Act (NJSA 2C:21-4.2 and 4.3; NJSA 2C:51-5).

This statute provides for the automatic permanent forfeiture of health care licenses for persons convicted of health care claims fraud for crimes of the second degree, and a one-year suspension for those convicted of health care claims fraud for crimes of the third degree. One can also be imprisoned up to 10 years for fraudulent claims submitted for professional services as well as required to pay fines up to 5 times the amount of the fraudulent claim.

E. The New Jersey False Claims Act.

This statute amends the New Jersey Medicaid Statute, (NJSA 30:4D-17(e), and authorizes the Attorney General and/or whistleblowers to pursue false claims litigation similar to what is authorized under the Federal False Claims Act. The statute also imposes civil liability under NJSA 30:4D-17(3) for violations. In addition, the statute amends the New Jersey Medicaid Statute to increase the limits of false claim civil penalties under NJSA 30:4D-17(e)(3) to the same level provided for under the Federal False Claims Act. Penalties under the federal statute are currently between $5,500 and $11,000 per false claim.

F. The New Jersey Conscientious Employee Protection Act (NJSA 34:19-1 et seq.).

Under this statute, an employee is protected from retaliation in his/her employment if he/she: (1) Disclosed, or threatened to disclose, to a supervisor or public body an activity, policy or practice of the employer, or of another employer with whom there is a business relationship, that the employee reasonably believed to be in violation of a law, or a rule or regulation issued under the law or (2) Provided information or testimony to a public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship or (3) Objected to or refused to participate in any activity, policy or practice which the employee reasonably believed: (a) is in violation of a law, or a rule or regulation issued under the law; (b) is fraudulent or criminal; or (c) is incompatible with a clear mandate of public policy concerning the public health, safety and welfare or protection of the environment**.**

Procedures:

1. Employees or participants shall be educated and kept informed about penalties for violations of false claims acts during compliance training provided at new employee orientation and annually via on-line and/or live training modules. Individuals and hospitals can be fined based on the number of inappropriate claims and the amount overpaid and can be excluded from Medicare/Medicaid reimbursement.

2. Any employee or participant who suspects inappropriate or improper billing or other potential violations of Federal or State law must notify their supervisor and/or the Chief Compliance Officer, who can be reached at (609) 653-3226 or through the anonymous Compliance Hotline at 1-800-700-5420. It is hospital policy to not retaliate against an employee who in good faith (a) reports illegal activity or (b) refuses to participate in what they believe is an illegal activity.

3. Following analysis of the specific risk areas, hospital procedures designed to prevent and detect fraud in billing, waste and abuse in all Federal Health Care Programs including Medicaid and Medicare include the following will be performed, including, but not limited to the following:

   A. Evaluation of adequacy and effectiveness of Internal Controls;
   B. Departmental procedures for coding services provided and billing;
   C. Internal / departmental audits;
   D. Audits by consultants/others;
   E. Edits and flagging of errors by coding & billing software;
   F. Checking current and prospective employees for exclusion from the Medicare or Medicaid programs;
   G. Policies and procedures for reporting, investigating and addressing fraud, waste and abuse;
   H. Adequacy of training of employees and medical staff; and,
   I. Trends developed as a result of monitoring and oversight of the Compliance Hotline.