

SECURITY HEALTH PLAN

Policy & Procedure Statement

Administrative

SUBJECT: Compliance – Education Concerning False Claims Liability, Non-Retaliation Protections, and Detecting and Responding to Fraud, Waste and Abuse
Revision Effective: January 1, 2007 **HMO:** 04 05 10 11 12
Date(s) Revised: **REVISED BY:**
Original Effective Date: January 1, 2007 **AUTHORED BY:** Compliance Committee
Key Words: False Claims, Fraud, Compliance, Protection, reporting, non-retaliation

DEFINITION/PURPOSE: This policy is written to comply with the Deficit Reduction Act of 2005 (DRA). The purpose of this Policy is to provide information about certain federal and state laws concerning the submission of false and fraudulent claims for payment to the government. These laws play a central role in the government's efforts to prevent and detect fraud, waste and abuse in federal health care programs.

The policy is effective January 1, 2007

EXPECTATION/REQUIREMENT:

1. Scope

This policy applies to all employees (including managers), contractors, and agents of Security Health Plan and Family Health Center of Marshfield, Inc. References to Security Health Plan below shall include Family Health Center.

2. Definitions

“Knowingly” means:

- Having actual knowledge that the information on the claim is false;
- Acting in deliberate ignorance of whether the claim is true or false; or acting in reckless disregard of whether the claim is true or false; or
- Acting in reckless disregard of whether the claim is true or false.

3. Policy

It is the policy of Security Health Plan to provide coverage for health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. To further this policy, and to comply with Section 6032 of the Deficit Reduction Act of 2005, Security Health Plan provides the following information about its policies and procedures and the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs:

Summary of Federal and State Laws

The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act, and Wisconsin's Medicaid Fraud Statute, and their role in preventing and detecting fraud waste, and abuse in federal health care programs.

(A) Federal False Claims Laws:

(1) False Claims Act; 31 U.S.C. §§ 3729 – 3733

The federal False Claims Act imposes liability on any person or entity who:

- Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care programs;
- Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care programs; or
- Conspires to defraud Medicare, Medicaid or other federally funded health care programs by attempting to have a false or fraudulent claim paid.

A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties of between \$5,500 and \$11,000 per claim plus three times the amount of damages that the government sustained because of the illegal act.

Anyone may bring a *qui tam* action under the False Claims Act in the name of the United States. The case is initiated by filing the complaint and all available material evidence under seal with a federal court. The complaint remains under seal for at least sixty days and will not be served on the defendant. During this time, the government investigates the complaint. The government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action often has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action may receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case and other factors. If the government does not proceed with the case, the person who filed the action may be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys' fees and costs.

(2) Program Fraud Civil Remedies Act; 31 U.S.C. §§ 3801 – 3812

The Program Fraud and Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act.

The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:

- Is false, fictitious, or fraudulent;

- Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- Is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a \$5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

In addition, a person or entity violates the PFCRA if they submit a written statement that they know or should know:

- Asserts a material fact that is false, fictitious or fraudulent; or
- Omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

A violation of this section of the PFCRA carries a civil penalty of up to \$5,000 in addition to any other remedy allowed under other laws.

(B) State False Claims Laws:

(1) Medicaid Fraud Statute, s. 49.49 (1), Wis. Stats.

The state Medicaid fraud statute prohibits any person from:

- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.
- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
- Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial, or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
- Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.

Anyone found guilty of the above may be imprisoned for up to six years or fined not more than \$25,000 or both, plus civil damages up to three times the amount of actual damages sustained as a result of any excess payments made in connection with the offense for which the conviction was obtained.

5. Security Health Plan's Policies and Procedures for Detecting and Preventing Fraud

Marshfield Clinic's Security Health Plan is committed to conducting business activities in an ethical and forthright manner and within the letter and spirit of all applicable laws and regulations. On November 9, 1998, the Marshfield Clinic Board of Directors approved its Corporate Compliance Program. The Security Health Plan established and its Board of Directors approved its Compliance

and Ethics Program. The compliance program encompasses policy and procedures including *Code of Business Ethics and Standards of Conduct* (the “Code”), *Fraud and Abuse - Detection, Prevention, and Correction (A055)*, *Fraud and Abuse-Reporting and Investigation (A056)* and certain other Compliance and Administrative policies and procedures related to Security Health Plan’s business. Collectively, the Compliance and Ethics Program, the Code, and the policies and procedures are designed to promote ethical behavior and compliance with all applicable laws and regulations. Security Health Plan’s parent company Marshfield Clinic maintains a Corporate Compliance Intranet site which includes compliance policies and procedures, the Corporate Compliance Handbook and other materials, references and education on compliance matters. The Reimbursement Center maintains a reimbursement intranet site which includes education on payor reimbursement issues.

- Corporate Compliance Intranet Site: <http://srdweb1/clinic/dept/compliance/>
- Reimbursement Center Intranet Site: <http://srdweb1/clinic/dept/reimburse/>

Security Health Plan’s Corporate Compliance Program also contains the core requirements of a corporate compliance program as set forth in compliance guidance documents issued by the Office of Inspector General of the Department of Health and Human Services. The core requirements are: (1) developing open lines of communication, (2) implementing compliance and practice standards, (3) designating a compliance officer, (4) conducting appropriate training and education, (5) conducting internal monitoring and auditing, (6) responding appropriately to detected offenses and developing corrective action, and (7) enforcing disciplinary standards through well-publicized guidelines.

6. Non-Retaliation Protections

A. Security Health Plan Protections:

Security Health Plan requires that all staff and employees who believe someone may be violating the law, the Code, or any of the Compliance Policies or Procedures or other policies must report it immediately to the Security Health Plan Compliance Officer, Security Health Plan’s Compliance Hotline, E-mail-Hotline, or to another Security Health Plan official (*e.g.*, the President, Chief Administrative Officer, or the individual’s Department Director, Manager or Supervisor).

- Compliance Officer: (715)-221-9550 (Ext. 1-9550 if calling from a Security Health Plan phone)
- Hotline: 1-715-221-9570
- E-mail Hotline: shp.compliance@marshfieldclinic.org

Reasonable precautions will be taken to maintain the confidentiality of anyone who reports violations even if it turns out that no violation has occurred. No one may punish or seek reprisal against another individual who has conscientiously made a report in good faith. Good faith simply means that the individual honestly had a reasonable belief that there may have been a compliance violation or the individual was not sure but was honestly questioning whether a compliance violation did or would occur. See policy and procedures *Compliance – Compliance Hotline Reporting, Usage, Monitoring, Documentation, and Non-retaliation; Privacy Reporting (A017) and Fraud and Abuse-Reporting and Investigation (A056)* for more information describing Security Health Plan’s non-retaliation and reporting policies.

B. Federal Law Protections:

The False Claims Act includes protections for people who file *qui tam* lawsuits as described above. The False Claims Act states that any employee who is discharged, demoted, suspended, threatened,

harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a *qui tam* action is entitled to recover damages. He or she is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys' fees.


References:

- False Claims Act; 31 U.S.C. §§ 3729 – 3733
- Section 6032 - Deficit Reduction Act of 2005
 - Employee Education About False Claims Recovery
- Program Fraud Civil Remedies Act; 31 U.S.C. §§ 3801 – 3812
- Medicaid Fraud Statute, s. 49.49 (1), Wis. Stats.
- Corporate Compliance Intranet <http://srdweb1/clinic/dept/compliance/>

LIMITATIONS/EXCLUSIONS: None.

COMMENTS:

SHP CHIEF ADMINISTRATIVE OFFICER:


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DATE: 12-20-06

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