

# SECURITY HEALTH PLAN

## Policy & Procedure Statement

### *Administrative*

**SUBJECT: Education Concerning False Claims Liability, Non-Retaliation Protections, and Detecting and Responding to Fraud, Waste and Abuse**

**Revision Effective:** 10/6/09

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**Date(s) Revised:** 01/09/ 10/09

**REVISED BY:** J. Peter Weidenheim

**Original Effective Date:** January 1, 2007

**AUTHORED BY:** Compliance Committee

**Key Words:** False Claims, Fraud, Compliance, Protection, reporting, non-retaliation, CP01, CP08

**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.

#### **EXPECTATION/REQUIREMENT:**

##### 1. **Scope**

This policy applies to all corporate officers, directors, managers, staff, agents and contractors 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.

##### 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:

##### 4. **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 presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
- authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
- knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties of not less than \$5,000 and not more than \$10,000 per claim plus three times the amount of damages that the government sustained because of the illegal act.

Anyone may bring a *qui tam*<sup>1</sup> 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 at least 15% but not more than 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 not less than 25% and no more than 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 any person who makes a claim that the person knows or has reason to know:

- Is false, fictitious, or fraudulent;

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<sup>1</sup> QUI TAM - Latin abbreviation for "Who sues on behalf of the King as well as for himself." An action under a statute that establishes penalties for certain acts or omissions that can be brought by an informer or and in which a portion of the penalties, fines, awards can be awarded the whistleblower.

- Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- Includes or is supported by any 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 claims.

A violation of this section of the PFCRA is punishable of not more than \$5,000 for each wrongfully filed claim. Each claim for property, services, or money is subject to a civil penalty regardless of whether actually delivered or paid. A person subject to civil penalty shall also be subject to an assessment of not more than twice the amount of any unlawful claim.

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 in connection with a medical assistance program from:

- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in any application 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, Waste and Abuse - Detection, Prevention, and*

*Correction (A055), Fraud, Waste and Abuse-Reporting, Investigation and Corrective Action (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 written policies, procedures and standards of conduct, (3) designating a compliance officer and a compliance committee, (4) conducting appropriate training and education, (5) conducting internal monitoring and auditing, (6) responding appropriately to detected offenses, developing corrective action, and reporting to the Government, (7) enforcing standards through well-publicized disciplinary guidelines and developing policies addressing dealings with sanctioned individuals.

## 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)
- Hotlines: Internal: 1-715-221-9570 External: 1-877-373-0122
- E-mail Hotline: [shp.compliance@marshfieldclinic.org](mailto: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 – Effective Lines of Communication, Compliance Hotline Reporting, Usage, Monitoring, Documentation, and Non-retaliation; Privacy Reporting (A017) and Fraud, Waste and Abuse-Reporting, Investigation and Corrective Action (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:**

10/09 – Annual Review – Revised by Compliance Officer with changes.

**SHP CHIEF ADMINISTRATIVE OFFICER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Steven R. Youso

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