

False Claims, Fraud, Waste and Abuse

Principle:

Denver Health and Hospital Authority (DHHA) is committed to complying with all applicable federal and state laws and regulations. To ensure compliance with federal and state false claims laws, DHHA has policies, procedures, and plans in place to detect and prevent fraud, waste and abuse, and also supports the efforts of federal and state authorities in identifying incidents of fraud and abuse.

DHHA provides information to all employees, affiliates, vendors, consultants and agents about the Federal and Colorado false claims laws in place and the obligation to prevent and detect fraud, waste and abuse in federal health care programs and other federal programs under which claims are made for payment for goods and/or services in compliance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA").

The DRA requires that entities that receive or make annual payments of at least five million dollars under the state Medicaid plan, as a condition of receiving such payments, establish written policies for all employees and certain contractors that provide detailed information about:

- The federal False Claims Act;
- Federal administrative remedies for false claims and statements;
- Any state laws pertaining to civil or criminal penalties for false claims and statements;
- Whistleblower protections under such laws; and
- Hospital policies and procedures for preventing and detecting fraud, waste and abuse.

Practice:

A. Responsibilities

1. Employees, Affiliates, Vendors, Consultants and Agents

- a. Be aware of the serious penalties for False Claims Violations and Fraud and Abuse.
- b. Feel free to ask questions and be sure to report any good faith concerns to the individuals outlined in the "Reporting Concerns" section below or to the ValuesLine by calling 1-800-273-8452 or filling a web report using <http://www.denverhealth.ethicspoint.com/>.

2. Supervisors and Managers

- a. Educate employees about the application of this principle and practice to the activities in your department.
- b. Encourage good faith reporting so that DHHA can identify any potential violations and remediate them if indicated.

- c. Advise Enterprise Compliance Services of any reports received and assist with any investigation if requested to do so.
- d. Assist with developing a Corrective Action Plan if requested to do so.

3. Enterprise Compliance Services

- a. Review reports received and investigate if indicated.
- b. Assure development, implementation and completion of any indicated Corrective Action Plan(s) by the involved department(s).

B. Legal Requirements To Be Aware Of

1. **Federal False Claims Act** . The False Claims Act (FCA) is a federal statute that prohibits fraud involving any federally funded program, including the Medicare and Medicaid programs.

- a. **Claims:** The FCA imposes liability on any person or entity who:
 - Knowingly submits or causes to be submitted a false or fraudulent claim for payment to Medicare, Medicaid or other federally funded health care program;
 - Makes a false record or statement in order to secure payment for such a claim; or
 - Conspires to get such a claim allowed or paid.
- iv. Under the FCA, the term "knowingly" means that a person:
 - Has actual knowledge that the information on the claim is false;
 - Acts in deliberate ignorance of whether the claim is true or false; or
 - Acts in reckless disregard of whether the claim is true or false.

The FCA does not require proof of a specific intent to defraud for there to be a violation of the law. Examples of the types of activities prohibited by the FCA including billing for services that were not actually rendered, double-billing for items or services, up-coding (the practice of billing for a more highly reimbursed item or service than the one provided) or unbundling (the practice of billing services separately to secure a higher reimbursement).

- b. **Liability:** A person or entity that violates the FCA can be subject to civil money penalties of between \$10,781 and \$21,563 for each false claim submitted. In addition to this civil penalty, health care providers can be required to pay three times the amount of the damages sustained by the federal government. If a provider is found liable under the FCA, the Office of Inspector General (OIG) may seek to exclude the provider from participation in federal health care programs such as Medicare and Medicaid.
- c. **Qui Tam Provisions:** The FCA provides for actions by private persons (*qui tam* lawsuit) to encourage individuals to come forward and report misconduct involving

false claims. A *qui tam* action allows any person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the U.S. government. Such persons are referred to as "relators" or "whistleblowers".

A *qui tam* lawsuit is initiated by filing a complaint in a federal district court. The complaint is filed "under seal" which means that the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the complaint and decides how to proceed. After 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 whistleblower can continue with the lawsuit on his or her own.

If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive between 15% to 30% of any recovery. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit.

2. **Federal Program Fraud Civil Remedies Act of 1986.** The Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements") is a statute that 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 whether the information is true or false, or acts in reckless disregard of whether the information is true or false. No proof of specific intent to defraud is required.

The term "claim" includes any request or demand for property or money, e.g. grants, loans, insurance or benefits, when the federal government provides or will reimburse any portion of the money.

The federal government may investigate and with the Attorney General's approval commence proceedings if the claim is less than one hundred fifty thousand dollars (\$150,000). A hearing must begin within six years from the submission of the claim. The Act allows for civil monetary sanctions to be imposed in administrative hearings, including penalties of five thousand five hundred dollars (\$5,500) per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

3. **State False Claims Laws:**

1. **False Medicaid Claims**, Colorado Revised Statute 25.5-4-304 through 25.5-4-306.
The Colorado False Medicaid Claims statute makes it unlawful for any person or entity to:



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- Intentionally or with reckless disregard make or cause to be made any false presentation of a material fact in connection with a claim;
 - Intentionally or with reckless disregard present or cause to be presented to the state department a false claim for payment or approval;
 - Intentionally or with reckless disregard present or cause to be presented any cost document required by the medical assistance program that the person knows contains a false material statement;
 - As to services for which a license is required, intentionally or with reckless disregard make or cause to be made a claim with knowledge that the individual who furnished the services was not licensed to provide such services.
 - Civil penalties extend to False Claims Violations made under the Colorado Medical Assistance Act.
 - Fines in the amount of 3 times the damages that the state sustains;
 - Additional penalties between \$5,000 and \$11,000 per false claim filed (these penalties automatically increase to match those under the Federal False Claims Act).
2. **Offering a False Instrument for Recording** , Colorado Revised Statute 18-5-114.
- The Colorado statute on offering a false instrument for recording provides criminal penalties for:
- Presenting or offering a written instrument that contains a material false statement or material false information to a public office or a public employee with the knowledge or belief that it will be registered, filed or recorded or become a part of the records of that public office or public employee.
 - A person who violates this statute knowingly and with intent to defraud commits offering a false instrument for record in the first degree and is guilty of a felony. The penalty is imprisonment from 1 to 3 years, a fine between \$1,000 and \$100,000, or both.
 - A person who violates this statute knowingly commits offering a false instrument for record in the second degree and is guilty of a misdemeanor. The penalty is imprisonment for up to 1 year, a fine of up to \$1,000, or both.
4. **Anti-Retaliation/Whistleblower Protection:** The state and federal FCA laws also includes anti- retaliation protections for employees who make good faith reports of waste, fraud and abuse. The FCA laws prohibits retaliation against a whistleblower for filing an action under the FCA or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a FCA action. An employee who is discharged, demoted, suspended, threatened, harassed or discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of the FCA laws may bring an action in federal district court or appropriate state court to recover damages.

An employee may seek reinstatement, two times the amount of back pay plus interest and other costs, damages and fees.

C. DHHA Policies and Procedures for Detecting and Preventing Fraud

DHHA has policies and procedures intended to detect and prevent fraud, waste and abuse in state and federal health care programs by being certain that claims filed for payment are:

- Backed up by accurate documentation,
 - Appropriate to the level of services(s) provided or applicable contractual requirements, and
 - Correctly aligned with the coding methodologies or other regulatory requirements of the applicable payer.
1. **The [Code of Conduct](#)** is available in PolicyStat and addresses the clinical and administrative responsibilities for ensuring the accuracy of claims for reimbursement in the section entitled "Ensure Integrity in Financial and Billing Matters". The Code of Conduct "Accuracy in Documentation, Coding and Billing" and section describes the ethical responsibilities and roles in billing for admissions personnel, physicians and other providers, billers and coders, and management to ensure accurate and legal patient bills. Management is responsible for conducting internal and external reviews and audits of the billing process. Pursuant to the Code of Conduct, each employee has an obligation and responsibility to report any activity that appears to violate applicable laws, rules, regulations, or the Code of Conduct.
 2. **The [Denver Health and Hospital Authority Compliance Plan](#)** is available on PolicyStat and outlines the structure of the Enterprise Compliance Program for DHHA that helps the organization mitigate financial exposure to non-compliance with the documentation, coding, and billing rules for Medicaid and Medicare programs. The Plan has seven key components to reducing risk:
 - a. Oversight and Support
 - b. Code of Conduct and Supporting Policies
 - c. Mechanisms to Communicate Concerns
 - d. Auditing and Monitoring
 - e. Education and Training
 - f. Responding to Reported Concerns
 - g. Corrective Action
 3. **DHHA Human Resources [Principles and Practices, Non-Retaliation](#)** also addresses procedures for internal reporting and whistleblower protection. Pursuant to this Principle and Practice, DHHA prohibits retaliation against any employee of DHHA who intends to

or has reported, in good faith, his/her concern about actual or potential unethical or illegal behavior including violations of government rules/regulations and the law.

F. Reporting Required

The Code of Conduct and the Compliance Plan provide all employees with a procedure for reporting integrity concerns regarding a violation of any law, regulation, and/or DHHA policy and procedure or Code of Conduct standards, including fraud, waste and abuse. Employees have several different reporting options. Employees are encouraged to report concerns regarding unethical or illegal behavior by any of the following reporting alternatives that best fit the circumstance:

- To the employee's supervisor;
- To any member of DHHA leadership;
- To the Office of General Counsel or Enterprise Compliance Services;
- Contact the ValuesLine by calling 1-800-273-8452 or <http://www.denverhealth.ethicspoint.com/>; or
- To health care oversight agencies.

G. Good Faith Reporting Protected

Any employee who, in good faith, becomes concerned that incorrect information or some other flaw in a particular instance or due an ongoing practice or system may result in a bill or other request for payment being wrong is:

- Required to report this information, and
- Protected from retaliation for having done so.

Related Documents

[Denver Health Code of Conduct](#)

[Non-Retaliation Principle and Practice](#)

[DHHA Compliance Plan](#)

References

The Federal False Claims Act, 31 USC § 3729 et seq.

The Program Fraud Civil Remedies Act, 31 USC § 3801, 3802 Federal Civil Monetary Penalties, 42 USC § 1320a-7a

Federal Criminal penalties for acts involving Federal health care programs, 42 USC §1320a-7b
Federal Anti-Kickback Statute, 42 USC § 1320a-7b

The Deficit Reduction Act of 2005, Social Security Act § 1902(a)(68)

Colorado Medicaid False Claims Statute, CRS §§ 25.5-4-304 through 25.5-4-306

Offering a False Instrument for Recording, CRS § 18-5-114



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