Licking Memorial Health Systems

Administrative Policies

Approval 1: Rob Montagnese, President
Approval 2: Craig B. Cairns, V.P. Medical Affairs
Approval 3: Cynthia Webster, V.P. Financial Services
Approval 4:
Committee Approval: Cabinet
Author: VP of Corporate Compliance
Internal Distribution: All LMHS employees, All Board Members, Vendors, Contract Agents
External Distribution:

Applicable To: All LMHS employees, All Board Members, Vendors, Contract Agents
Effective Date: 1/1/2007
Revised Date: 8/21/2013
Reviewed Dates: 5/10/2007 8/14/2007 8/22/2007 9/3/2009 5/12/2011 8/21/2013

Policy Subject: False Claims Recovery - Employee Education — Administrative Policies – **00001 02 30**

I. Policy

The purpose of this policy is to set forth the commitment of Licking Memorial Health Systems (LMHS) in complying with:

1. Federal False Claims Act, 31 U.S.C. section 3729,
2. Administrative Remedies for False Claims and Statements, 31 USC Chapter 38
3. Section 6032 of the Deficit Reduction Act (DRA) of 2005, 42 USC 1396(a)(68).
4. Various sections of Ohio Revised Code promulgated to comply with the DRA.

All Licking Memorial Health Systems employees, agents and contractors who provide services to Licking Memorial Health Systems are included in the scope of this policy. A summary of the relevant laws can be found in Exhibit A. Appropriate website links can be found in Exhibit B.

II. Procedure

Licking Memorial Health Systems' **Code of Ethics and Conduct (00001 04 20)** is written to provide a framework of behavior for our provision of care to our patients and in our business operations and dealing which complies with all relevant federal and state laws and regulations. No authority exists for anyone to approve or tolerate any violation of any of the laws described in this policy.

1. Any person with knowledge or reasonable belief that violation of the Federal False Claims Act, similar state laws, or other fraud and abuse laws has occurred by LMHS or it's employees, contractors or agents is required to immediately report such belief using established reporting procedure options. These options include:
    a) Contact Corporate Compliance at 220-564-7710,
    b) Contact any LMHS Compliance Auditor,
    c) Call the Corporate Compliance Hotline 220-564-INFO,
    d) Email the Corporate Compliance Office at CORP@ lmhealth.org, or
    e) Place a written communication in the Corporate Compliance Locked Comment box located by the Service Elevators, Ground floor of Licking Memorial Hospital.

    Other available reporting mechanisms which employees, contractors and agents may use in addition to these options are described in Exhibits A & B.

2. LMHS will not make or tolerate any intimidating or retaliatory act against an individual who, in good faith makes a report of practices reasonably believed to be a violation of this policy.

3. LMHS shall make available written materials regarding compliance with the false claims acts and relevant laws and regulations through Exhibits A and B of this policy.

4. LMHS's compliance program will continue to execute its Corporate Compliance Plan which is available on the LMHS intranet. This plan includes educational, monitoring and auditing activities intended to prevent and detect fraud, waste and abuse in Federal health care programs.

5. LMHS requires all contractors and agents abide by this policy and all applicable laws and regulations. Contractors and agents include but are not limited to the employees of LMHS vendors performing billing and coding functions. Other contractors or agents include those which or who, on behalf of LMHS, furnish or otherwise authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by LMHS.

EXHIBIT A

Federal False Claims Act. 31 USC section 3729

The False Claims Act is a federal stature that covers fraud involving any federally funded contract or program including Medicare and Medicaid. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment, conspires to defraud the government, or knowingly makes or uses a false record to conceal an obligation to refund monies.

The term "knowingly" is defined to mean that a person:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Health care providers can be prosecuted for a variety of conduct that leads to submission of a false claim such as falsifying records, double-billing for items or services, or submitting bills for services never performed. Persons and organizations violating the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. If a provider is convicted of a False Claims Act violation, the Office of the Inspector General may seek to exclude the provider or supplier form participation in federal health care programs.

Section 3730 in the False Claims Act is a qui tam provision allowing any person with actual knowledge of allegedly false claims being made to the government to file a lawsuit on behalf of the U.S. government, to participate in any resulting settlement, and to make such claim without fear of retribution from the employer.

Administrative Remedies for False Claims and Statements, 31 USC Chapter 38 / Program Fraud Civil Remedies Act of 1986 (PFCRA)

The PFCRA authorizes federal agencies such as the Department of Health and Human Services ("HHS") to investigate and assess penalties for the submission of false claims or statements to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. A person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim or statement that the person knows or has reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that –
- Omits a material fact;
- Is false, fictitious, or fraudulent as a result of such omission; and
- Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
- Is for payment for the provision of property or services, which the person has not provided as claimed.

The government agency may assess twice the amount of its damages and a civil penalty of up to $5,500 for each false or fictitious claim. The United States Attorney General has exclusive authority to enforce such assessments and penalties in federal court.

Deficit Reduction Act (DRA) of 2005, Section 6032.

The DRA establishes section 1902(a)(68) of the Social Security Act and relates to "Employee education about false claims recovery". Ohio has promulgated a series of sections of the Ohio Revised Code in response to the DRA. These sections are outlined below.

ORC §5111.101 – Fraud, Waste and Abuse Prevention and Detection

Requires each person that receives Medicaid payments in a calendar year of $5,000,000 or more to, *as a condition of receiving Medicaid payments*, do all of the following:

- Provide each employee, contractor, and agent detailed, written information about the role of all of the following in preventing and detecting fraud, waste, and abuse in federal health care programs:
    - Federal false claims law, 31 USC 3729-3733
    - Federal administrative remedies for false claims and statements, 31 USC 3801-3812
    - ORC 2913.40, 2913.401 and 2921.13 and any other state laws pertaining to civil or criminal penalties for false claims and statements

ORC §5111.03 – Offenses by Medicaid Providers

The Medicaid Provider Offenses Statute prohibits Medicaid providers from acting "by deception" to obtain or receive or attempt to obtain or receive payments to which the provider is not entitled, or to falsify any report or document relating to Medicaid

- "Deception" includes acting with reckless disregard or deliberate ignorance of the truth or falsity of information or withholding information
- Penalties for violation of the Medicaid Provider Offenses Statute include interest on excess payments, three times the amount of excess payments, civil penalties of $5,000 to $10,000 per claim, recovery of the costs of enforcement, and termination of the Medicaid provider agreement
- The Ohio Attorney General may enforce the provisions of this statute in state court
    - Whistleblower protections under the above laws

ORC §2913.40 – Medicaid Fraud

The Medicaid Fraud Act imposes criminal penalties for, among other things:

- Knowingly making or causing to be made a false or misleading statement or representation for use in obtaining Medicaid reimbursement
- Doing either of the following with the purpose to commit fraud or knowingly facilitating a fraud:
    - Charging, soliciting, accepting or receiving any amount in addition to the amount of reimbursement due from Medicaid and any authorized deductibles or co-payments;
    - Soliciting, offering or receiving any remuneration other than authorized deductibles and co-payments, in cash or in kind, including kickbacks or rebates, in connection with the furnishing of goods or services for which payment may be made under the Medicaid program.
- Knowingly altering, destroying, concealing or removing any records necessary to support a Medicaid claim or cost report
- The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

ORC §2913.401 – Medicaid Eligibility Fraud

The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

ORC §2921.13 - Falsification

Ohio criminal law prohibits persons from knowingly making false statements or swearing or affirming the truth of a false statement for the purpose of securing payment of benefits administered by a governmental agency or paid out

of a public treasury, for the purpose of securing a provider agreement with the government, or in connection with any report that is required or authorized by law, such as the Medicaid cost report.

ORC §4113.52 – Right of Employee to Report Violation of Law by Employer
Provides whistleblower protection for non-state employees who report violations of state or federal law that the employer has authority to correct and the employee reasonably believes is a criminal offense or likely to cause an imminent risk of physical harm or hazard to public health. Government may award employee back pay, interest, reinstatement, attorney fees, and court costs

EXHIBIT B

To find additional information about False Claims Acts

LMHS resources

Corporate Compliance Office: 220-564-7710
Corporate Compliance Hotline: 220-564-INFO
Corporate Compliance Auditors 220-564-4519
Corporate Compliance Locked Comment Box: Ground floor by service elevators in Licking Memorial Hospital building

United States Department of Justice
http://www.usdoj.gov

Department of Health and Human Services
http://www.hhs.gov

HHS Office of Inspector General
http://oig.hhs.gov

Ohio Department of Job and Family Services
http://jfs.ohio.gov