

<b>Title: False Claims and the Deficit Reduction Act</b>	<b>No.: CC 1.15</b>
	<b>Effective: 1/1/2007</b>
	<b>Revised: 12/08</b>
<b>Approved By: Chris Sorensen, VP/Chief Compliance Officer</b>	<b>Page 1 of 3</b>

**Entity: Health First**

**I. OBJECTIVE**

To help our associates, agents, and contractors understand the provisions of the federal and state laws regarding the submission of a false claim for reimbursement and all the associated implications, as well as to inform our associates of their right to report violations of federal and state law.

**II. DEFINITIONS**

For purposes of the False Claims Act, a **Claim** includes any request or demand for money that is submitted to the US government or its contractors.

**Federal False Claims Act (31 USC § 3729)** – The False Claims Act is a statute that imposes civil liability (between \$5,500 and \$11,000 per claim and three times the total damages) on any person or entity who: 1) knowingly submits a false claim to the federal government for payment; 2) knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the federal government; and 3) uses a false statement to decrease an obligation to the government. If convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude the provider from participation in federal health care programs.

**Program Fraud and Civil Remedies Act (PFCRA) (31 USC § 3801 – 3812)** – The PFCRA is another tool the federal government can use to penalize false claims (\$5,000 per claim and assessment of twice the amount of the claim) involving federal agencies and is designed to provide them with an administrative remedy (or countermeasure) for losses resulting from false claims.

**Florida False Claims Act (Sections 68.081 – 68.09 Fla. Stat.)** – The purpose of the Florida False Claims Act is to deter persons from knowingly causing or assisting in causing state government to pay claims that are false or fraudulent, and to provide remedies for obtaining treble damages and civil penalties for state government when money is obtained from state government by reason of a false or fraudulent claim. Civil liability is not less than \$5,500 and not more than \$11,000 and treble the amount of damages the agency sustains because of the act or omission.

**Knowingly** is defined to mean that a person, with respect to information: 1) has actual knowledge of falsity of information in the claim; 2) acts in deliberate ignorance of the truth or falsity of the information in a claim; or 3) acts in reckless disregard of the truth or falsity of the information in a claim.

Qui tam is a provision of the federal False Claims Act which enables a private person (known as a “relator” or whistleblower) to bring a lawsuit in the name of the US government if (s)he has personal knowledge of a false claim.

### **III. POLICY**

The Deficit Reduction Act of 2005 (DRA), effective January 1, 2007, is a bill designed to achieve savings in Medicare and Medicaid programs. Section 6032 of the DRA is essentially the first sweeping compliance-program mandate in that providers receiving \$5 million or more in Medicaid funds per year must provide, as a condition of payment, education to associates, agents, and contractors about the federal and state False Claims Acts, the PFCRA, and the federal “qui tam” or whistleblower provision. Health First must comply with this mandate and provide this policy & procedure as a measure to educate all associates, agents, and contractors.

The Federal False Claims Act (also known as the “Lincoln Law”) was originally passed during the Civil War at the request of President Lincoln as a remedy by the federal government against companies that sold faulty supplies and equipment, but it now applies as much to health care billing as it does to Department of Defense contracting. Although billing errors and honest mistakes do not constitute false claims, the term “knowingly” is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance of the truth or falsity of the claim, or in reckless disregard of the truth or falsity. Examples of fraud, waste, or abuse that can constitute false claims and result in liability include billing for services/supplies not rendered or documented and falsifying records to obtain payment or a higher rate of reimbursement.

Each associate, agent, and contractor involved with providing or obtaining reimbursement for medical services, supplies, or equipment from or on behalf of Health First is responsible for submitting honest and accurate bills to Medicare, Medicaid, and other federal and state health care programs, and for submitting honest and accurate invoices to Health First. In addition to complying with the Health First *Code of Ethics & Business Conduct* (“Code”) and other applicable Health First policies and procedures, all associates, agents, and contractors are expected to comply with federal and state laws and administrative remedies designed to prevent fraud, abuse, and waste in federal and state health care programs.

In the effort to prevent and detect false claims and other fraudulent activity, Health First’s Corporate Ethics and Compliance Program (“Compliance Program”) includes an ongoing and system-wide evaluation process using auditing and monitoring techniques (refer to CC 1.12 “Corporate Compliance Auditing and Monitoring Policy”). Auditing involves the use of a retrospective approach to evaluate the effectiveness of internal controls and compliance with policies, procedures, and applicable laws; whereas monitoring is the routine and ongoing review of overall processes to test compliance with policies, procedures, and applicable laws.

Even more critical in this effort is each associate’s responsibility to be the “eyes and ears” of the Compliance Program and immediately report any known or suspected

fraudulent activity to the Corporate Compliance Department or to the anonymous hotline (refer to CC 1.04 “Developing Effective Lines of Communication”). The Corporate Compliance Department is committed to taking each report seriously and following established procedures for investigation and resolution (refer to CC 1.07 “Responding to Detected Compliance Offenses and Corresponding Corrective Action” and CC 1.17 “Internal Handling of Health First Compliance & HIPAA Hotline Calls”). If Health First does not respond appropriately when given notification of a potential violation, associates, agents, and contractors may notify the government themselves and initiate the qui tam procedure. Associates who lawfully report potential fraudulent conduct, or who otherwise assist in an investigation, action or testimony are protected from retaliation under Health First policy and federal and state laws, and may share in recovery under federal and state False Claims Acts.

#### **IV. PROCEDURE**

N/A

#### **V. REFERENCES**

Title 31 United States Code § 3729

Title 31 United States Code § 3801 – 3812

Sections 68.081 – 68.09 Florida Statutes

Section 6032 of the Deficit Reduction Act of 2005

Health First *Code of Ethics & Business Conduct*, current edition.

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