



**CHRIST HOSPITAL  
POLICY AND PROCEDURE MANUAL**

POLICY: <b>FALSE CLAIMS RECOVERY</b>	MANUAL: <b>ADMINISTRATIVE</b>
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REVIEWED, NO CHANGES. NAME OF REVIEWER:	DATE:

**POLICY:**

It is the policy of Christ Hospital to obey all federal and state laws regarding fraud, waste and abuse, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal or state healthcare programs, and to provide protections for those who report in good faith actual or suspected wrongdoing.

Christ Hospital and its employees shall strive to meet the highest standards of legal and ethical conduct. All employees are expected to know and follow all applicable laws, rules and regulations of local, state and federal governments that apply to their respective job responsibilities.

**PURPOSE:**

Section 6032 of the Deficit Reduction Act of 2005 requires entities that receive annual Medicaid payments of at least \$5 million to provide employee education, and disseminate to its contractors and agents information, regarding false claims recovery. This policy satisfies these requirements by setting forth detailed information on the civil federal False Claims Act, remedies under the act, state laws pertaining to civil or criminal penalties for false claims, whistleblower protections under such laws, and information on Christ Hospital's policies for detecting and preventing fraud, waste and abuse.

**Definitions:**

Abuse – performing tasks that do not make good medical, financial or business sense which result in unnecessary costs, or improper reimbursement

Civil Fraud - not only intentional acts but acts taken in deliberate ignorance or reckless disregard of the law.

Criminal Fraud - intentional deception with intention of gaining an undeserved benefit.

Deliberate Ignorance - where a person chooses to ignore information that may be important.

Knowing / Knowingly - the person has (1) 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.

Original Source - an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the government before filing an action under the Act based on that information.



Qui Tam Relator - the False claims Act allows any person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the U.S. government. A private person who initiates a civil action for violations of the False Claims Act in the name of the United States is referred to as a *relator*. People who file qui tam suits are known as whistleblowers. The *relator* must meet certain criteria to qualify. One such criteria is that they must be the original source of the information.

Reckless disregard - choices made by a facility that cause incorrect information to be listed on a claim form

Whistleblower Protection - prohibits employers from taking any retaliatory action against an employee who reports, in good faith, fraud and abuse activities within the organization. Federal and State statutes provide for this protection with remedies to be provided to the employee who is retaliated against.

### **THE FEDERAL CIVIL FALSE CLAIMS ACT**

The federal civil False Claims Act (31 U.S.C. § 3729- 3733) was originally enacted in 1863 during the Civil War to prevent fraud and abuse by government contractors. It is the most frequently used law for prosecution when fraud and abuse is identified and allows the government to recover losses due to fraud. The False Claims Act is violated when any individual or company (including corporate officers or subordinates following the orders of superiors):

- Knowingly presents or causes to be presented to the US government (Medicare, Medicaid or other federally funded health care program) a false or fraudulent claim for payment
- Knowingly makes, uses or causes to be made or uses a false record or statement to get a false or fraudulent claim paid or approved by the government (Medicare, Medicaid or other federally funded health care program)
- Conspires to defraud the government (Medicare, Medicaid or other federally funded health care program) by getting a false or fraudulent claim allowed or paid

The government is not required to prove actual intent to defraud by submitting false claims to establish liability. They must only establish deliberate ignorance or reckless disregard for the truth of the claims. However, liability cannot be established on the basis of innocent mistakes or negligence.

Actions that may violate the False Claims Act:

- Submitting a false claim for payment
- Causing a false claim to be submitted
- Using a false medical record to get a claim paid

Examples of health care fraud include:

- billing for services not provided or goods not provided;
- changing the diagnosis to receive payment;
- unbundling (billing individually for tests when only 1 should be sent for a group of tests);
- billing for a higher service than actually furnished (upcoding);
- falsifying statements in a medical record and billing for services not medically necessary;
- falsifying treatment plans or medical records to maximize payments;
- failure to report overpayments or credit balances;
- duplicate billing;
- unlawfully giving physicians inducements in exchange for referrals for service;
- submitting billing with documentation that does not support the billed services



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The civil federal False Claims act authorizes the United States Attorney General and private citizens to file a lawsuit in the name of the United States for false or fraudulent claims. Civil actions for false claims must be filed within 6 years after the date on which the violation was committed or if brought by the government, within 3 years after the date when facts are known or should have been known but in no event more than 10 years after the date on which the violation was committed. Civil actions for false claims can be brought by either the Attorney General or private persons (*Qui Tam Relator*).

To initiate a qui tam action, the complaint and disclosure of all material evidence and information must be filed in a federal district court. The lawsuit is filed under seal during which time The U.S. government has 60 days to review the action to determine whether the lawsuit has merit and whether the US Department of Justice will take over the case. If the U.S. Department of Justice takes over the action, the defendant is served.

If the government proceeds with an action initiated by a qui tam relator, the qui tam relator is entitled to recover a minimum of 15% but not more than 30% of the proceeds, and is also entitled to reasonable expenses including attorneys' fees and costs. The amount awarded depends on the extent the qui tam relator contributed to the action.

If the government declines to take the case, the qui tam relator can proceed on his or her own. If the government elects not to proceed and the defendant prevails, the court may award to the defendant its reasonable attorneys' fees and expenses if the court finds the relator's actions were frivolous or brought primarily for the purposes of harassment.

## **FEDERAL AND STATE PENALTIES (Administrative, Civil and Criminal)**

Health care providers and suppliers who violate the federal False Claims Act can be subject to the following:

- Civil Monetary Penalty of \$5,500 to \$11,000 per each false claim submitted
- Fines (treble damages) up to three (3) times the amount of payment received
- Exclusion from participating in a federally funded healthcare program
- Mandatory participation in a Corporate Integrity Agreement
- For criminal liabilities, jail sentence in addition to the financial penalties listed above

## **FEDERAL AND STATE WHISTLEBLOWER PROTECTION LAWS**

To encourage employees to come forward and report misconduct involving false claims, the civil federal False Claims Act protects whistleblowers against retaliation under the Act. Employees who are discharged, demoted, harassed, threatened, or in any manner discriminated against by their employer in the terms and conditions of employment because of lawful actions taken in furtherance of a qui tam action (including filing an action under the False Claims Act, investigating a false claim or providing testimony for or assistance in a False Claims Act action) are entitled to recover damages. The employee is entitled to all relief necessary to make them whole including reinstatement with the same seniority status, twice the amount of back pay, interest on back pay, compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Christ Hospital has a policy of Non-Retribution, A-9500-406 which states that employees who in good faith report suspected or actual violations of applicable laws shall be protected against retaliation or retribution.



### **FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT**

The Program Fraud and Civil Remedies Act (PFCRA) provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. This act was enacted to address lower dollar frauds and generally applies to claims of \$150,000 or less. These penalties are separate from and in addition to any liability that may be imposed under the federal civil False Claims Act.

The PFCRA imposes liability on people or entities who 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.

Violators are subject to civil money penalties of up to \$5,000 per false claim and up to twice the amount of any unlawful claim that has been paid. Investigations are conducted by the Office of Inspector General.

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

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

Enforcement can begin with a hearing before an administrative law judge. Because of the availability of other criminal, civil and administrative remedies, cases are not generally prosecuted under this Act.

### **NEW JERSEY STATUTES/REGULATIONS**

#### **New Jersey Medical Assistance and Health Services Act – Criminal Penalties N.J.S. 30:4D-17(a) – (i)**

- Any person (hospital or physician) who knowingly receives payment for a claim they are not entitled to receive or receives payment for a higher amount than is appropriate, is guilty of a high misdemeanor and upon conviction, could be fined up to \$10,000 for the claim and could be subject to imprisonment for up to 3 years.
- Any person (hospital or physician) who knowingly and willfully makes or causes to be made a false statement (written or oral) on a claim form or any documents used to apply for benefits or payment or who conceals and does not disclose information that would affect the right to receive a benefit or payment could be criminally liable. For example:
  - a hospital or physician who knowingly lists wrong information about the amount of services provided on its bill to Medicaid
  - submitting a bill for an employed physician after discovering that the physician is excluded from Medicaid
- Knowingly and willfully converting benefits or payments for purposes other than intended is guilty of a high misdemeanor, and upon conviction could be liable to a penalty of up to \$10,000 per offense or imprisonment up to 3 years.



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- Soliciting, offering or accepting any kickback, rebate or bribe in connection with services for which payment is or may be received or whose cost is or may be reported is guilty of a high misdemeanor, upon conviction could be liable to a penalty of up to \$10,000 per offense or imprisonment up to 3 years .
  - For example, a hospital or physician accepting a bribe from an ambulance company who transports Medicaid recipients.
- Making false statements or misrepresentation of a material fact regarding conditions or operation of a facility in order for that facility to be certified or recertified as a hospital, skilled nursing facility, intermediate care facility or health agency is guilty of a high misdemeanor and shall be liable for a penalty of not more than \$3,000 or imprisonment for not more than 1 year or more.
  - For example, a skilled nursing facility states on its application to Medicaid that it provides certain services when it knows that it does not provide those services.
- A person or entity that violates this act will also be liable to civil penalties including interest on the amount of excess payments received, fine of up to 3 times the amount of excess payments received, and penalty of \$2,000 for each excessive claim.
- If an entity unknowingly submits a claim that unintentionally violates this act, the entity is liable to civil penalties of interest from the date the bill is paid by Medicaid.
- When so ordered by Medicaid, if a facility does not return monies paid within 10 days of the notice, Medicaid may enter a record with the Superior Court of the debt and may withhold funds to the hospital for other services provided by the hospital to Medicaid patients.

## **New Jersey Medical Assistance and Health Services Act – Civil Remedies, N.J.S. 30:4D-7.h.; N.J.S. 30:4(d)-17Ie)P – (i); N.J.S. 30:4D-17.1.a.**

- The New Jersey Commissioner of Human Services is responsible, through the Division of Medical Assistance and Health Services, to recover payment incorrectly made by Medicaid, or illegally received, not only from a provider such as a hospital or physician, but also from the physician's estate if the physician passes away, and also from a billing company or other entity responsible for the incorrect Medicaid payment. The Commissioner is also authorized to collect penalties for incorrect Medicaid payments.
- The Department of Medical Assistance and Health Services may remove a physician or other provider from the Medicaid program for "good cause," e.g., the provider pleads guilty to a crime.

## **Health Care Claims Fraud Act, N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5**

- This Act sets the liability and penalties for the submission of fraudulent health care claims by a licensed practitioner or any person licensed, registered or certified by any State agency to practice a profession or occupation in the State of New Jersey and also by a person who is not a practitioner but who is involved in processes involving payment or reimbursement for health care services. The Act specifies degrees of the crime for which a person can be convicted (Second/Third/Fourth) and also sets the penalties allowed (up to 5 times the benefit obtained or sought to be obtained) .
- A practitioner convicted of health care claims fraud shall forfeit his/her license and be forever barred from the practice of the profession unless the court finds that such license forfeiture would be a serious injustice. In such case, the court shall determine an appropriate period of license suspension which shall be for a period of not less than one year. A practitioner convicted of a substantially similar crime of health care claims fraud under the laws of another state shall have his/her license suspended and be barred from the practice of the profession for a period of at least one year.



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- Crime of the Second Degree – knowingly commits health care claims fraud in the course of providing professional services. In addition to all other criminal penalties allowed by law, the penalty upon conviction may be a fine up to 5 times the pecuniary benefit obtained or sought to be obtained.
  - For example, if a physician or chiropractor submits a claim to Medicaid for \$100 for an initial visit for someone who was never seen, that physician or chiropractor may be found liable for health care fraud and fined up to \$500 for that claim.
- Crime of the Third Degree - recklessly commits health care claims fraud . In addition to all other criminal penalties allowed by law, the penalty upon conviction may be a fine up to 5 times the pecuniary benefit obtained or sought to be obtained.
  - For example, if a patient left the waiting room before being seen by the physician, and the physician's billing company prepares a bill based upon the appointment calendar, and the physician signs the claims form without looking at it, and submits a claim to Medicaid for \$100, that physician can be found liable for health care fraud in the third degree and fined up to \$500 for that claim.
- If a practitioner bills for a treatment or procedure without having performed an assessment of the physical or mental condition of a patient, the court may find that the physician submitted a false claim for the treatment or physician.
- If a practitioner bills for treatments or procedures that could not have been performed during the time in which the treatments or procedures were represented to have been performed, the court may find that the physician's statements on the bill were false.
  - For example, if an intensivist (ICU physician) in a hospital bills Medicaid for 25 hours of physician services supposedly provided to ICU patients on the same 24 hour day, the court may find that the intensivist's statements on the bill for services provided were false.
- Non-Practitioners:
  - Crime of Third Degree - conviction of a person who is not a practitioner who knowingly commits health care claims fraud. In addition to all other criminal penalties allowed by law, the penalty upon conviction may be a fine up to 5 times the pecuniary benefit obtained or sought to be obtained. For example:
    - A physician's husband prepares her bills and submits to Medicaid a bill for services not performed by the physician, the spouse may be found liable for health care fraud.
  - Crime of Second Degree - conviction of a person who is not a practitioner who knowingly commits 5 or more acts of health care claims fraud and the aggregate pecuniary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, the penalty upon conviction may be a fine up to 5 times the pecuniary benefit obtained or sought to be obtained.
  - Crime of Fourth Degree - conviction of a person who is not a practitioner who recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, the penalty upon conviction may be a fine up to 5 times the pecuniary benefit obtained or sought to be obtained.
- If a person consciously disregards a substantial and unjustifiable risk that exists or will result from his conduct and that risk involves a gross deviation from the standard of conduct a reasonable person would observe, the court could find that the person/entity acted recklessly.

## **Conscientious Employee Protection Act, N.J.S. 34:19-1 et seq.**

- An employer cannot take any retaliatory action against an employee because the employee does any of the following:



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- Discloses or threatens to disclose a violation of law, rule or regulation by the employer; or in the case that the employee is a licensed or certified health care professional, discloses or threatens to disclose information regarding improper quality of patient care
- Provides information in response to an inquiry regarding a violation of law, rule or regulation by the employer, or in the case of a licensed or certified health care professional, provides information in response to an inquiry into the quality of patient care
  - For example: If an employee in a hospital billing department finds that her supervisor has submitted claims to Medicaid for services not rendered, and reports it to the hospital's Compliance Officer, no one at the hospital may take disciplinary action against that employee for making the report.
- Objects to or refuses to participate in any activity, policy or practice which the employee reasonably believes violate law, rule or regulation, (or if the employee is a licensed or certified health care professional, constitutes improper quality of patient care); or is fraudulent or criminal, or clearly harms public health;
  - For example, if a hospital employee is told to document services not provided to patients, and refuses to do so, she may not be disciplined because of her objection or refusal to document falsely.
- If an employee is concerned that her employer's actions are illegal or fraudulent and she wants to be protected from retaliation by her employer under NJ law, she must let her employer know about her concerns and give her employer a chance to correct the issue before she may disclose her concerns to a public body, unless the situation is an emergency and she is certain that the employer knows or she fears physical harm if she tell the employer.
- If an employer discharges or retaliates against an employee for disclosing an employer's illegal or fraudulent actions, as permitted by this NJ law, the employee may file suit and if she wins, the court may order that the employer reinstate the employee in her job, pay lost wages and costs, and pay a fine and possibly punitive damages.
- The rights of an employee under the whistleblower law (CEPA) does not affect the employee's rights under a union contract or employment contract. For example, if a unionized employee reports improper billing and is fired as a result, that employee can both bring a claim under NJ CEPA and bring an arbitration proceeding under his union contract.
- Non-religious organizations cannot force their employees to attend meetings whose purpose is to communicate an employer's views about religion, and non-political organizations may not force their employees to attend meetings whose purpose is to communicate an employer's views about politics.
- An employer may not discharge or discipline an employee who in good faith reports that an employer forced employees to attend meetings to communicate the employer's religious or political beliefs, except as allowed, or otherwise violated this law.

## **New Jersey State False Claims Act**

The New Jersey False Claims Act was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts: (a) the main part authorizes the NJ Attorney General and whistleblowers to file false claims lawsuits similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections; (b) another part amends the NJ Medicaid statute to make a violation of the NJ False Claims Act a violation of the Medicaid statute; and (c) a third part amends the NJ Medicaid statute to increase the \$2000 per false claim civil penalty to the same level provided for under the Federal False Claims Act, currently between \$5,500 and \$11,000 per false claim.



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## **CHRIST HOSPITAL POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE**

The Christ Hospital Corporate Compliance Plan was approved by the Board of Trustees in April 2005 and is a systematic program that promotes business and professional ethical standards, compliance with federal, state and local laws, prevention, early detection and correction of misconduct. The plan details:

- Benefits of Compliance Programs
- Elements of the Christ Hospital Corporate Compliance Plan
- Roles and Responsibilities
- Implementation of Plan Elements

The plan was distributed to all Board of Trustee members, senior staff, members of the hospital's Compliance Committee and is available to be viewed by all employees in Policy Medical/Administrative Manual/Compliance Section 4.

All employees receive the Christ Hospital Code of Ethics during orientation which provides information regarding the expectations the hospital has regarding conducting business in an ethical and legal manner. As part of the orientation, all employees are to be educated on compliance requirements, fraud and abuse laws, and whistleblower protections and are required to complete job specific compliance training within 60 days of hire.

No one in the organization has the authority to ask or knowingly allow any employee to violate a law, regulation or hospital policy. Any employee who is aware of a problem or suspects a violation of federal or state rules and regulations is expected to report their concerns to appropriate hospital management personnel. Employees are encouraged to use the chain of command, as well as other available venues to raise concerns regarding potential violations such as any member of the Christ Hospital management team, and if you are not satisfied with the response, to continue raising your concerns to the highest levels in the organization. Employees are also able to report their concerns anonymously through the Values Line (1-800-475-8376). Reports are to be promptly and thoroughly investigated and corrective action is to be taken for any violations, including returning any overpayments. Any person who retaliates against another person for making a good faith report is subject to disciplinary action.

The following hospital policies set forth the hospital's efforts to detect and prevent fraud, waste and abuse. Policy and Procedures can be viewed through Policy Medical which is accessed via the hospital's intranet.

- Non-Retaliation Policy & Procedure; A-9500-406 [Administrative Manual; Compliance Section 4]  
Purpose: to ensure that there will be no retaliation against any employee reporting, in good faith, any suspected or actual misconduct.
- Outpatient Services/Testing Documentation Requirements; A-9500-407 [Administrative Manual; Compliance Section 4]  
Purpose: to ensure all requests for outpatient services/testing will be supported by a written order which includes diagnosis(es) and/or symptom(s) for medical necessity.
- Values Line Operations; A-9500-409 [Administrative Manual; Compliance Section 4]  
Purpose: to provide an anonymous reporting system available to all employees and contracted vendors
- Compliance Monitoring and Investigation; A-9500-402 [Administrative Manual; Compliance Section 4]  
Purpose: To ensure that monitoring and reporting systems are in place to investigate all alleged violations of federal, state laws and regulations, Code of Ethics or Hospital Policies/Procedures.
- Compliance/HIPAA Orientation & Training; A-9500-404 [Administrative Manual; Compliance Section 4]  
Purpose: to provide employees with appropriate job specific compliance education needed to comply with State/Federal rules and regulations.



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- Patient Financial Services Office Compliance Program; PFS-9300-712 [Departmental Policies, Patient Financial Services]  
Purpose: The Patient Financial Services Office (PFS) Compliance Program is a key component of the Billing Compliance Program. Through the PFS Compliance Program, processes and controls for proper billing of patient accounts paid for by governmental agencies and third-party payors, such as Medicare, Medicaid, CHAMPUS and Black Lung are established. These processes and controls establishes standards of conduct or best practices, training new and incumbent employees and assessing employee competence in job performance.
- Billing Practices Policy; PFS-9300-700 [Departmental Policies, Patient Financial Services]  
Purpose: to specify the processes to ensure that claims submitted to third parties must comply with all federal, state and local government agencies regulations in billing for services provided.
- Compliance Concepts; PFS-9300-708 [Departmental Policies, Patient Financial Services]  
Purpose: Promote the overall integrity of our Hospital and department through proactive measures to prevent fraud and abuse and to promote high quality and ethics to achieve best business practices. Measures include orientation and training to promote staff awareness of legal issues and compliance monitoring to encourage adherence to ethical and quality standards.