SECTION: COMPLIANCE **SUB-SECTION:** GENERAL

SUBJECT: FEDERAL AND STATE FALSE CLAIMS ACT – DEFICIT REDUCTION ACT OF 2005

APPROVED BY: _____
Chief Executive Officer

POLICY

ARMC is committed to complying with all applicable laws and regulations which support the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements. This policy applies to all ARMC staff, medical staff, volunteers and contractors who do business with ARMC.

PROCEDURES

I. The False Claims Act applies to the submission of claims by health care providers for payment by Medicare, Medicaid and other federal and state health care programs. The FCA is the federal government's primary civil remedy for improper or fraudulent claims. It applies to all federal programs and prohibits the following (list not inclusive):

A. Billing for services or products that were not medically necessary
B. Billing for services or products that were not provided
C. Billing for services or products that have been "up-coded"
D. Billing for services or products to dead or discharged patients
E. Billing for services or products billed without the necessary, properly completed documentation
F. Billing for services or products under the wrong provider number
G. Billing for services by an unlicensed physician, provider or non-physician
H. Billing for services that were performed so poorly that they were effectively worthless
I. Billing for services that were unbundled
J. Billing for multiple or repeat procedures and global surgeries
K. Claiming "inpatient only" services performed in an outpatient setting
L. Billing for free samples
M. Retaining overpayments for which the hospital is not entitled to
N. Falsifying cost reports
O. Making false representations in applications for federally funded grants and programs

II. The FCA imposes liability not only on the person who submits a false claim (or false statement in support of a false claim), but also on the person who causes the submission of a false claim. Thus, a person may be liable under the FCA even if the person does not contract with or receive funding from the government and does not submit any claims to the government.

The United States Attorney General may bring civil action for violation of the FCA. As with most other civil actions, the government establishes its case by presenting a preponderance of evidence rather than by meeting the higher burden of proof that applies in criminal cases.

III. The FCA allows employee/individuals (relator) to bring civil suits against a provider in the name of the United States government for a violation of the FCA ("Whistleblowing"). The FCA requires that the relator file the initial complaint with the federal district court "under seal". This means the names of the relator and defendant are not available to the public. The complaint will remain under seal for a minimum of 60 days to enable the government to investigate the relator's allegations and determine if the government will intervene in the action.

The FCA provides protection to the employee from retaliation. An employee, who is discharged, demoted, suspended, threatened, harassed, or discriminated because of lawful acts conducted in furtherance of an action under the FCA, may bring action in federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages and fees.

IV. ARMC staff, medical staff, volunteers and contractors who do business with ARMC must conduct themselves in an ethical and legal manner, including the maintenance of accurate records related to their business activities. ARMC staff, medical staff, volunteers and contractors who do business with ARMC will not:

A. Knowingly and willfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program;
B. Knowingly and willfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment;
C. Present or cause to be presented a claim for a licensed provider's service for which payment may be made under a federal program and knows that the individual who furnished the service was not licensed at the time of service; and
D. Execute a scheme to defraud any health care benefit program or to obtain any money by false or fraudulent pretenses, representations or promises.

V. ARMC staff, medical staff, volunteers will receive training on the FCA during orientation, annually in the Annual Employee Update and periodically through emails, education sessions and newsletters. Contractors who do business with ARMC will be provided information regarding ARMC's Compliance Program and compliance with the False Claims Act and Whistleblower protection as appropriate.

VI. ARMC staff, medical staff, volunteers and contractors who do business with ARMC are responsible for reporting potential or suspected incidents of fraud and abuse or other wrongdoing to their supervisor, the Compliance Department or on the Compliance and Ethics Helpline (1-877-797-ARMC). Supervisors should immediately contact the Compliance Department if they receive information regarding a potential incident of fraud and abuse from an employee.

VII. ARMC will not take any adverse action or retribution against any employee due to the good faith reporting of potential or suspected incidents of fraud. Any ARMC staff, medical staff, volunteers and contractors who do business with ARMC who believe that he or she has been subject to any type of retribution or retaliation should report this to the Compliance Department.

VIII. The Compliance Officer will work to detect potential incidents of fraud and abuse and determine when incidents should be reported to the appropriate agencies. If incidents of fraud and abuse are identified, systemic changes and corrective action initiatives will be put in place as appropriate to prevent further incidents.

IX. In the event where the allegation is a potential violation of the FCA, the Compliance Officer will work with legal counsel (County or contract attorneys) as needed for determination as to where there is sufficient evidence to support referral to an appropriate government agency.

X. ARMC will fully cooperate with federal and state agencies that conduct health care fraud and abuse investigations.

REFERENCES:

FALSE CLAIMS ACT (31 U.S.C. §§ 3729-3733)
CALIFORNIA CODES GOVERNMENT CODE SECTION 12650-12656
DEFICIT REDUCTION ACT OF 2005, SECTION 6032

DEFINITIONS:

Federal False Claims Act (FCA) – Originally passed by Congress in 1863, and amended in 1986, making it illegal to knowingly present (or cause to be presented) to the federal government a false or fraudulent claim for payment or approval. The FCA prohibits a healthcare provider from knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, such as a fiscal intermediary, carrier, other claims processor or State Medicaid program.

California False Claims Act (CFCA) – The CFCA is modeled on the federal FCA and creates civil liability for the submission of false claims to the state or political subdivisions. The CFCA prohibits any person from submitting a false or fraudulent claim over $500 to the local government. The CFCA makes it illegal for any person who benefits from a false claim, and later discovers the falsity of the claim, to fail to disclose the false claim to the applicable state or local government.

False Claim – A false claim for payment, which a provider submits with knowledge, deliberate ignorance or with reckless disregard of the truth of the information contained in the claim submitted, for services or supplies that were not provided specifically as presented, or for which the provider is otherwise not entitled to payment.

Knowingly – The term knowingly is defined to mean that a person with both the submission and the falsity of the claim:

A. Has actual knowledge of the information;
B. Acts in deliberate ignorance of the truth or falsity of the information; or
C. Acts in reckless disregard of the truth or falsity of the information.

Deliberate Ignorance – An individual intentionally avoids learning facts that would reveal the falsity of the claim.

Reckless Disregard – The provider pays no regard to whether the information on a claim submitted for payment is true or false.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
7/20/15	**Deborah Pease, Associate Hospital Administrator** Applicable Administrator, Hospital or Medical Committee
3/25/14	**Board of Supervisors** Approved by the Governing Body

REPLACES: **Administrative Policy No. 1000.23 Issue 1**

EFFECTIVE: **10/26/10** **REVISED:** **07/15/15**

REVIEWED: **4/04/13**