

CONNECTICUT CHILDREN’S MEDICAL CENTER
[CCMC Organizational Manual]

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| Title: Prevention of Fraud, Waste and Abuse | |
| Date of Origination: November 2006 | Date Last Revised: August 2007 |
| Approved By: Corporate Compliance Committee | Approval Date: August 2007 |

Policy: It is the policy of Connecticut Children’s Medical Center that employees, contractors and agents of CCMC be informed of the details of the Federal False Claims Act, protections for reporting individuals, penalties for violations, and relevant State laws.

Statement of Purpose: The purpose of this policy is to inform employees, contractors and agents of CCMC of the State and Federal laws related to fraud, waste and abuse, as well as the Federal False Claims Act (referenced in this policy as “FCA”), and to provide general information regarding CCMC’s efforts to combat fraud, waste, and abuse in the healthcare system, and to describe the remedies and fines for violations that can result from certain types of fraudulent activities.

Reporting Fraud, Waste, or Abuse: All employees, contractors, agents, and volunteers of CCMC must immediately report to the medical center’s Compliance Officer or others in management positions, any suspicion of fraud, waste, or abuse in connection with the business of CCMC. CCMC engages in specific compliance efforts to detect and prevent fraud, waste, and abuse, such as education and training (at initial orientation, annual validation, and ongoing through each calendar year); organizational and department policies and procedures; Compliance Hotline (for anonymous reporting); Compliance Committee; and Director of Compliance.

If you would like more information on CCMC’s compliance program or policies, or on how to report any concerns, please contact the Director of Compliance (5-8123) or the Compliance Hotline (877-363-3073 or 800-297-8592 (Spanish)).

Definitions:

1. **Knowingly** – a person who (i) has actual knowledge of information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of the specific intent to defraud is required.
2. **Claim** – any request or demand, whether under a contract or otherwise, for money or property which is made to the institution if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse the institution for any portion of the money or property which is requested or demanded.

General Information:

Detailed Information of the Federal False Claims Act

The Federal False Claims Act (FCA) imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise

conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

The FCA is not confined to healthcare claims, but extends to any payment requested of the federal government. The FCA applies to billing and claims sent from CCMC to any government payor program, including Medicare and Medicaid.

It is the policy of CCMC that an employee, contractor, or agent of CCMC who submits a false claim will be reported to the necessary authorities. Anyone, or any company, that submits a false claim or statement to the government may be fined under the FCA between \$5,500 and \$11,000 for each such claim submitted, regardless of the size of the false claim, and the person or company could be required to pay an additional fine of three (3) times the value of any damages (or the value of the charges).

Part of the FCA's purpose is to create an environment where employees and others feel safe reporting concerns about fraud. CCMC fully supports that goal. Any person who lawfully reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by the CCMC for making such a report. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.

The FCA provisions are generally enforced by the U.S. Department of Justice. The FCA provides that a person may initiate a formal claim if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. If any damages (funds) are recovered, a portion of money damages (funds) may be paid to the person who initiated the formal claim, at the discretion of a federal court. This amount, if awarded, generally is between 15% and 30% of the total damages (funds) amount.

If a person wishes to file a claim regarding fraud or suspected fraud related to a healthcare payment directly with the government, he or she must first present a formal complaint, along with all material evidence relating to the alleged fraud, to the authorities at the U.S. Department of Justice. The authorities have 60 days to investigate, during which time the complaint is kept confidential. Upon completion of the investigation, the government will decide either to pursue the case on its own or decline to proceed with the case. If the federal government declines the case, the individual may still proceed with the case on his or her own, but without the government's assistance, and at his or her own expense.

A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government. (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances.)

Examples of acts that may result in a violation of the FCA include, without limitation:

- ✓ Billing for services not rendered or goods not provided;
- ✓ Falsifying certificates of medical necessity and billing for services not medically necessary;

- ✓ Billing separately for services that should be a single service;
- ✓ Falsifying treatment plans or medical records to maximize payments;
- ✓ Failing to report overpayments or credit balances;
- ✓ Duplicate billing;
- ✓ Unlawfully giving health providers, such as physicians, inducements in exchange for referrals for service; and
- ✓ Physician billing for services provided by interns, residents, and fellows in a teaching hospital.

Civil Investigative Demands

Whenever the Attorney General (AG) has reason to believe that any person may be in possession, custody, or control of any documentary material or information relevant to a false claim law investigation, the AG may, before commencing a civil proceeding under the false claims law, issue in writing and cause to be served upon such person, a civil investigative demand requiring such person:

1. to produce such documentary material for inspection and copying;
2. to answer in writing, written interrogatories with respect to such documentary material or information;
3. to give oral testimony concerning such documentary material or information; or
4. to furnish any combination of such material, answers, or testimony.

In the event of receipt of a civil investigative demand, contact the CCMC General Counsel or Compliance Officer to determine whether the investigative demand was properly served and for assistance in responding properly to the investigative demand.

Detailed Information of the Federal Program Fraud Civil Remedies Act

Persons or companies that commit fraud on the federal government, by false claim or statement, can be assessed money penalties in addition to the penalties of the False Claims Act because of a law called the Program Fraud Civil Remedies Act (referenced in this policy as "PFCRA"). Specifically, PFCRA penalties of \$5,000 per false claim or statement apply if a person or company submits a claim to the federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements containing false, fictitious, or fraudulent information; includes or is supported by written statements that omit a material fact, which causes the statements to be false, fictitious, or fraudulent, and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed.

The \$5,000 penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

Connecticut State Law

It is a crime in Connecticut to bill Medicaid or the general assistance program fraudulently. Any person who practices or attempts to practice fraud upon the state in the statement, proof or

allowance of a claim shall forfeit such claim to the state. Any person who knowingly presents, attempts to present, or knowingly participates in the preparation, presentation, or allowance of a false or fraudulent claim may be fined not more than \$200 or imprisoned not more than six (6) months or both.

Anyone who fraudulently provides services to a state Medicaid beneficiary is subject to possible imprisonment and/or criminal fines under state law. Depending upon the amount of the fraudulent services involved, such offenses carry potentially significant penalties, with a maximum of 20 years in prison and a maximum fine of \$15,000.

Anyone who fraudulently provides services to a recipient of Connecticut's general assistance program is also subject to civil and criminal penalties. Depending upon the amount of the fraudulent services involved, such offenses carry a minimum one year prison sentence and a maximum of 20 years, as well as a maximum fine of \$15,000. Any person who defrauds Connecticut's general assistance program is also excluded from participating in the program for a minimum of one year.

Any person who makes material false statements in any document or record which an institution licensed by the Department of Public Health is required to submit to such department or maintain on file may be guilty of false statement and subject to penalties for false statements.

All employees, contractors and agents of CCMC must immediately report suspicion of any criminal activity occurring at CCMC, including criminal fraud, to the hospital's Compliance Officer.

Connecticut law protects employees who report suspected violations of state or federal law, including reports of criminal fraud. An employer may not discharge, discipline or otherwise penalize an employee for reporting a violation of the law, or suspected violation, as long as the employee does not know the information being reported is false.

References:

Section 6032 of the Deficit Reduction Act of 2005

31 U.S.C. §§ 3729-3733 (Federal False Claims Act)

31 U.S.C. §§ 3801-3812 (Administrative Remedies for False Claims and Statements)

20 CFR 356.3

Connecticut General Statutes § 53a-290 *et seq.* (Vendor Fraud)

Connecticut General Statutes § 53-440 *et seq.* (Health Insurance Fraud)

Connecticut General Statutes § 53a-118 *et. seq.* (Larceny)

Connecticut General Statutes § 53a-155 *et. seq.* (Tampering With or Fabricating Physical Evidence)

Connecticut General Statutes § 53a-157b *et. seq.* (False Statement Intending to Mislead Public Servant)

Connecticut General Statutes § 17b-25a (Toll free vendor fraud telephone hotline)

Connecticut General Statutes § 17b-99 (Vendor Fraud)

Connecticut General Statutes § 17b-102 (Financial Incentive for Reporting Vendor Fraud)

Connecticut General Statutes § 17b-127 (General Assistance Fraud)

Regs. Connecticut State Agencies Sec. 17-83k-1 *et seq.* (Administrative Sanctions)
Regs. Connecticut State Agencies Sec. 17-102-01 *et seq.* (Financial Incentive for Reporting
Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud)
Whistleblower Protection Policy
CCMC Compliance Program
CCMC Employee Handbook