ADMINISTRATIVE POLICY AND PROCEDURE

POLICY/ PROCEDURE: Detection and Prevention of Fraud, Waste and Abuse in Claims **F - 14**								
ORIGINAL ISSUE DATE: 12/2006					**APPROVED BY:** **TITLE: President, COO/Administrator** **TITLE: Chief Medical Officer** **TITLE: Chief Nurse Executive**			
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REFERENCE:

- Federal False Claims Act, 31 U.S.C. § 3729 – 3733
- Federal Program Fraud Civil Remedies Act, 31 U.S.C. § 3801 - 3812
- New Jersey Medical Assistance and Health Services Act - Criminal Penalties, N.J.S. 30:4D-17(a) - (d)
- New Jersey Medical Assistance and Health Services Act - Civil Remedies, N.J.S. 30:4D-17 (a) – (d).; N.J.S. 30:4D-17(e) - (i); N.J.S. 30:4D-17.1.a.
- Health Care Claims Fraud Act, N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5
- Conscientious Employee Protection Act, N.J.S. 34:19-1 et seq.
- The NJ False Claims Act, N.J.S.A. 2A:32C-1 et seq.

PURPOSE:

It is the policy of Bergen Regional Medical Center (BRMC) to adhere to all federal and state laws to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payments to BRMC from federal or state healthcare programs, and to provide protections for those who report actual or suspected wrongdoing.

POLICY:

I. This policy applies to all members of the Board, administrators, managers, employees (including volunteers and students), contractors and agents of BRMC. Training and education shall be provided to all the above mentioned parties to ensure clear understanding of the statutes and the procedures involved in the enforcement of this policy.

II. Bergen Regional Medical Center will verify that any current or prospective employees (regular or temporary), contractors or subcontractors who directly or indirectly will be furnishing, ordering, directing, managing or prescribing items or services in whole or in part are not excluded, unlicensed or uncertified by searching the following databases on **a monthly basis:**

1. Federal exclusions database (mandatory):
   http://oig.hhs.gov/fraud/exclusions.asp

2. N.J. Treasurer's exclusions database (mandatory):
   www.state.nj.us/treasury/debarred/

3. N.J. Division of Consumer Affairs licensure databases (mandatory):
   https://newjersey.mylicense.com/verification/

http://12.150.185.184/dca/

4. N.J. Department of Health and Senior Services licensure database (mandatory): http://www.state.nj.us/health/healthfacilities/search.shtml

5. Certified nurse aide and personal care assistant registry (mandatory, if applicable): http://www.cnatips.com/registry/nurse-aide-nj.php

III. In addition to the monthly OIG Exclusion List verification, it is the policy of Bergen Regional Medical Center to ensure that any payments received from the State of New Jersey are not for items or services that are directly or indirectly furnished, ordered, directed, managed or prescribed in whole or in part by an excluded, unlicensed or uncertified individual or entity. Excluded individuals or entities are those identified by the State or Federal government as not being allowed to participate in State or Federally-funded health benefit programs, such as Medicaid, NJ FamilyCare, or Pharmaceutical Assistant to the Aged and Disabled (PAAD).

Stated below are summaries of certain statutes that provide liability for false claims and statements. These summaries are not intended to identify all applicable laws but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005.

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

The Federal False Claims Act (FFCA) imposes civil liability on any person or entity who:

- knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
- conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.

“Knowingly” means:

- Actual knowledge that the information on the claim is false;
- Acting in deliberate ignorance of whether the claim is true or false; or
- Acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the Federal False Claims Act is subject to a civil money penalty of between $5,000 and $10,000 plus three times the amount of damages that the government sustained because of the illegal act. In health care cases, the amount of damages sustained is the amount paid for each false claim that is filed.

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Anyone may bring a qui tam action under the Federal False Claims Act in the name of the United States in federal court. The case is initiated by filing the complaint and all available material evidence under seal with the federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint. The government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

The person who filed the action will receive a certain percentage of any recovery made as a result of substantiation of claims made by the person. Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulted from any such discrimination or retaliation.

B. Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 - 3812)

The Program Fraud and Civil Remedies Act (PFCRA) create administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal 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.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

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; or
- omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

A violation of this section of the PFCRA carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

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C. New Jersey Medical Assistance and Health Services Act- Criminal Penalties, N.J.S. 30:4D-17(a)-(d)

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of $15,000 to $25,000, imprisonment for up to 3 years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of $15,000 to $25,000, imprisonment for up to 3 years, or both; (c) kickbacks, rebates and bribes: fine of $15,000 to $25,000, imprisonment for up to 3 years, or both; and (d) false statements or representations regarding conditions or operations of an institution or facility for the purpose of qualifying for payments: fine of $10,000 to $25,000, or imprisonment for up to 1 year, or both. For any such subsequent offenses, the penalties shall be no less than $25,000 nor more than $150,000 per incident. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

D. New Jersey Medical Assistance and Health Services Act- Civil Remedies, N.J.S. 30:4D-17(a)-(d)., N.J.S. 304D-17(e)-(i); N.J.S. 30:4D-17.1.a.:

In addition to the criminal sanctions stated above, violations of N.J.S. 30:4D (a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation: recovery of overpayments, interest, up to triple damages, and up to $5,000-$11,000 for each false claim (the amounts as amended by the NJ False Claims Act). Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity accountable for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

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

Provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

- A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;
- A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to 1 year;

- A person who is not a practitioner subject to paragraph a. or b. above (for instance, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree of that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties dictated by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;
- A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties dictated by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

F. Conscientious Employee Protection Act, "Whistleblower Act," N.J.S. 34:19-4 et seq.:

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;

b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulations issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or

c. Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

d. Provides information regarding any perceived criminal or fraudulent activity, policy, or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employee or any governmental entity.

e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
   i. is in violation of a law, or a rule or regulation issued under the law or, if the employee is licensed or certified health care professional, constitutes improper quality of patient care;
   ii. is fraudulent or criminal; or
   iii. is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.

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The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy, or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears the physical harm as a result of the disclosure, provided that the situation is emergency in nature.

G. The NJ False Claims Act, N.J.S.A. 2A:32C-1 et seq.

Authorizes the NJ Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections. In summary, the Act prohibits:

a. Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval;
b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;
c. Conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the State;
d. Has possession, custody, or control of public property or money used or to be used by the State and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt.
e. Is authorized to make or deliver a document certifying receipt of property used or to be used by the State and, intending to defraud the entity, makes or delivers a receipt without completely knowing the information on the receipt is true;
f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property; or
g. Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.

Additionally, the Act makes several amendments to the NJ Medicaid statute- in order to make violations of the NJ False Claims Act give rise to liability under NJS 30:4D-17(e), as follows:

Any person, firm, corporation, partnership, or other legal entity which violates the provisions of any of the foregoing subsections of this section or any provisions of section 3 of P.L., c. (C.) (pending before the Legislature at this bill), shall, in addition to any other penalties provided by law, be liable to civil penalties of (1) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to said person, firm, corporation, partnership or other legal entity for the period from the date upon which payment was made to the date upon which repayment is made to the State, (2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and (3) payment in the sum of not less than $5,500.00 and not more than $11,000.00 per false claim civil penalty allowed under the federal False Claims Act (31 U.S.C. s. 3729 et seq.), as it may be adjusted for inflation pursuant to the federal Civil Penalties Inflation Adjustment Act of 1990, Pub.L.101-410 for each excessive claim for assistance, benefits or payments.

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Anti-Retaliation "Whistleblower" Protections: Individuals at BRMC who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies are provided protections under certain laws.

For example, protections are afforded to people who file qui tam lawsuits under the Federal False Claims Act. The Civil False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a qui tam action is entitled to recover damages. He or she is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys' fees.

Role of False Claims Laws: The laws described in this policy create a comprehensive scheme for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums -- criminal, civil and administrative courts. This provides a broad spectrum of remedies to battle this problem.

Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need to assist with the prosecution of these cases.

1. All members of the Board, administrators, managers, employees (including volunteers and students), contractors and agents of BRMC shall be trained on this policy to meet initial compliance requirements within the timeframes set forth by the law, as well as ongoing compliance to ensure all protocols are maintained under corporate compliance:

    a) Education to contractors and agents to maintain initial compliance of the law will be done through an educational mailing and a signed acknowledgement from contractors on having received and disseminated this policy and procedure to managers, employees, and agents
    b) Video and pamphlet presentation on this policy to all new employees during their orientation process, and to existing employees at appropriate training forums
    c) Information on the policy and procedure included in the BRMC employee handbook (via handbook insert) and in any BRMC Corporate Compliance plans

2. If any BRMC Board member, administrator, employee, contractor or agent observes activities or behavior that may violate the false claims statute in any manner as described previously in this policy, they can call the BRMC Corporate Compliance hotline at 1 888-203-9067. This is an anonymous toll-free 24-hour phone line which allows individuals to report any concerns in a private manner without having to provide their names and with no fear of retribution. Employees can also report any

concerns to their supervisor(s) or the BRMC Compliance Officer for further action.

3. Based on such concerns or complaints, the Corporate Compliance Committee shall investigate the issue to determine the occurrence of any fraud, waste or abuse in claims at BRMC.

4. The Corporate Compliance Officer will conduct a preliminary analysis of the issue and shall gather relevant information through discussions with person(s) concerned, review of regulations and available literature, and the review of related memos, correspondence, policies, procedures and contracts. A summary report of the findings will be presented by the Compliance Officer to the Board for final review, recommendations and action. If the complaint is substantiated through the investigation, the committee shall take all appropriate action as stated by law to remedy the situation. All civil and criminal penalties shall be in effect based on culpability.

5. On a proactive basis, internal audit procedures will be conducted periodically by the Internal Audit department which is appointed by the Board. This department will investigate any areas of the organization where there may be a possibility of corporate non-compliance. Detailed procedures on internal audits are maintained by this department. If a complaint is made, a further in-depth audit may be conducted as part of the investigative process.

6. This policy shall be reviewed annually by the Corporate Compliance Committee for any revisions based on changes to the law and to internal BRMC processes.