

Policy Number : 108607-00-28

Date Issued :02/27/08

**Title : Role of Federal and State Laws in
Preventing Fraud, Waste and Abuse**

ACTIVE

PURPOSE : To summarize Federal and State laws pertaining to detection and prevention of fraud, waste and abuse.

This policy is a reflection of the Core Values and the Mission set by Ascension Health.

POLICY : It is the policy of St. Mary's of Michigan to provide healthcare services in a manner that complies with all applicable federal and state laws and meets the highest standards of business and professional ethics. In compliance with Section 6032 of the Deficit Reduction Act of 2005, St. Mary's of Michigan is providing this information about the federal False Claims Act and applicable state law to all pertinent parties in an attempt to prevent and detect fraud, waste and abuse in federal healthcare programs.

St. Mary's of Michigan is committed to fully complying with all laws and regulations that apply to our health care ministry. We have established the Corporate Responsibility Program (CRP) as evidence of our commitment to operating with the highest degree of integrity. The CRP supports compliance with the above referenced state and federal laws by:

- Coordinating auditing and monitoring activity through the Audit Work Group and Corporate Responsibility Committee and reporting such activities to the Audit Committee of the Board.
- Educating associates that they are responsible for reporting any concerns about a possible false claim. Concerns should be reported to the immediate supervisor, manager or director or the Corporate Responsibility Officer. Anonymous referrals can also be made by calling the Ascension Health Values Line at 1-800-707-2198 or via the internet at www.AscensionHealthValuesLine.org.
- Investigating all concerns and correcting any billing errors identified.

Associates, Members of the Medical Staff, Volunteers, Students/Residents and Key Business Partners are asked to:

- Act with honesty and integrity in all business activities.
- Follow all laws and regulations that apply to work activities, including requirements of the Medicare, Medicaid and other federal health care programs. These requirements generally include maintaining complete and accurate medical records, applying appropriate charges and submitting only complete and accurate claims for services provided.
- Question supervisors, managers, director or the Corporate Responsibility Officer when they have a question about a possible false claim or other issues identified in the Ascension Health Standards of conduct.



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St. Mary's of Michigan policy and practice strictly prohibits retaliation, in any form, against an individual reporting an issue or concern in good faith.

DEFINITIONS:

1. **Federal False Claims Act (FCA)? -**

The objective of the FCA is to protect the funds and property of the federal government from fraudulent claims. A violation of the FCA occurs, with respect to Medicare, Medicaid or other federally funded healthcare programs when an individual or organization knowingly submits a false claim for payment or knowingly makes or uses a false record to obtain payment from the government. "Knowingly" includes having actual knowledge that a claim is false, or acting in "deliberate ignorance" or "reckless disregard" as to whether a claim is false. Examples of possible false claims include billing Medicare for services that were not provided, billing for a higher-level service than the service actually furnished (upcoding), or billing for services that were not ordered by a physician.

The False Claims Act contains provisions that allow individuals with original information (i.e., information not already the subject of legal proceedings or activities that have already been publicly disclosed) concerning fraud involving government programs to file a lawsuit on behalf of the government and, if the lawsuit is successful, to receive a portion of recoveries received by the government.

Financial penalties to the organization for submitting a false claim can total as much as three times the amount of the claim plus fines of \$5,500 to \$11,000 per claim. In addition to fines and penalties, an individual or organization that violates the False Claims Act is subject to exclusion from participation in federally funded healthcare programs.

The federal False Claims Act protects employees from being fired, demoted, threatened or harassed by his or her employer for filing an FCA lawsuit or providing information in good faith relative to a False Claims Act investigation or lawsuit. This is further supported by Michigan State law (see below) and St. Mary's of Michigan policy #108607-0016, *Non-Retaliation*.

2. **Program Fraud Civil Remedies Act -**

The Program Fraud Civil Remedies Act ("PFCRA") provides federal agencies, including the agencies responsible for federally funded health care programs, with administrative remedies against individuals and organizations that knowingly submit a false claim for payment, or knowingly make or use a false record or statement to get a false claim paid. The PFCRA is limited to situations where a false claim, or a group of related false claims, does not exceed \$150,000. The PFCRA provides civil penalties up to \$6,000 per false claim, plus an assessment equal to twice the amount of the false claim.

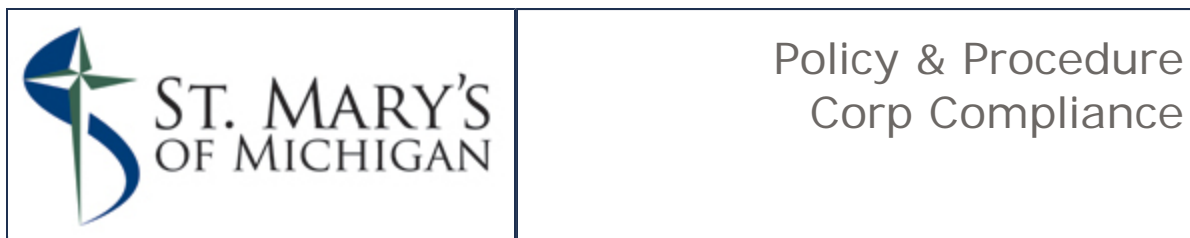


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3. **State Health Care False Claim Act -**
The objective of the Health Care False Claim Act is to protect the funds and property of both governmental and private health care insurers from fraudulent claims. A violation of the Health Care False Claim Act occurs when an individual or organization “knowingly” submits a false claim for payment, benefits, and/or solicits, offers, or receives a kickback or bribe in connection with furnishing services or making referrals that are reimbursed by a health care insurer. “Knowingly” is defined the same as the Medicaid False Claim Act defines it.
An individual or organization that violates the Health Care False Claim Act is guilty of a felony, punishable by imprisonment for not more than 4 years and/or by a fine of up to \$50,000. If conspiracy is proven, then a violation is punishable by not more than 10 years in prison and/or up to a \$50,000 fine.
4. **State Medicaid False Claim Act -**
The objective of the Medicaid False Claim Act is to protect the funds and property of the state government from fraudulent claims against the Medicaid program. A violation of the Medicaid False Claim Act occurs when an individual or organization “knowingly” submits a false claim for payment, benefits, Medicaid certification, and/or solicits, offers, or receives a kickback or bribe in connection with furnishing services or making referrals that are reimbursed by Medicaid. “Knowingly” does not include errors or mistakes, but rather that the individual is aware or should be aware that his or her conduct is “substantially certain” to result in a payment by Medicaid.
An individual or organization that violates the Medicaid False Claim Act is guilty of a felony, punishable by imprisonment for not more than 4 years and/or by a fine of not more than up to \$50,000. If conspiracy is proven, then a violation is punishable by not more than 10 years in prison and/or up to a \$50,000 fine.

The Medicaid False Claim Act contains a whistleblower provision, which allows an individual with material evidence not already the subject of a legal proceeding or activities that have not already been disclosed to the public, to bring a civil suit on behalf of the state concerning alleged fraud involving the Medicaid program, and if the lawsuit is successful, to receive a portion of the recoveries received by the government. The Medicaid False Claim Act also prohibits discrimination against any whistleblower or witness in a whistleblower suit unless the court determines that the case is frivolous, and provides remedies for any such discrimination.



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5. **State Whistleblowers' Protection Act -**
The Whistleblowers' Protection Act prohibits an employer from discriminating against an associate where the associate (or another individual acting on behalf of the associate) reports or is about to report a violation or suspected violation of a law or regulation to any branch of government or regulatory agency. The Act does not protect an associate where he or she has knowledge that the report is false or where the government or regulatory agency has subpoenaed the associate to participate in an investigation, hearing, or court action. If the associate can show that the employer violated the Act, then the court is required to fine the employer not more than \$500 and award the associate damages. An employer is not, however, required to compensate the associate for time spent participating in an investigation, hearing, or court action brought under this Act.

PROCEDURE: There is no associated procedure with this policy.

RELATED POLICIES:

- [\(108607-00-16\) - Non-Retaliation](#)
- [\(108607-00-01\) - Corporate Responsibility](#)

REGULATIONS: 1. **Federal False Claims Act (FCA)?**www.taf.org/federalfca.htm

REVIEWERS / STAKEHOLDERS :

- Corporate Responsibility Committee
- Audit Committee

APPROVALS: This policy has been signed per policy # 108850-00-01 The Policy & Procedure Process

- Andrew W. Allen, President / CEO (02/2008)