

	POLICY AND PROCEDURES		
	POLICY NUMBER:		CHLAMG-CI-1009
	ORIGINAL DATE: 11/1/2018	REVISED:	EFFECTIVE: 12/26/2018
DEPARTMENT: Compliance	APPROVED BY: Carl Grushkin, MD and Chief Compliance Officer		
POLICY TITLE: Detecting and Preventing Fraud, Waste and Abuse in Federal Healthcare Programs			

PURPOSE:

This standard complies with requirements under federal and state fraud and abuse laws. It provides guidance on activities that could result in incidents of fraud and abuse, and explains procedures for reporting suspected violations of fraud and abuse laws.

SCOPE:

This standard applies to all healthcare professionals, employees, subcontractors, agents or other persons who, on behalf of Children’s Hospital Los Angeles Medical Group (CHLAMG), furnish or otherwise authorize the furnishing of healthcare items or services, perform billing or coding functions, or in the monitoring of healthcare operations.

DEFINITIONS: None

POLICY:

CHLAMG is committed to the prevention of fraud and abuse in its healthcare operations. Areas at highest risk for fraud and abuse in our healthcare operations include documentation, coding and billing claims to Federal healthcare programs such as Medicare, Medi-Cal, TRICARE, and also to private payers.

CHLAMG’s Compliance Program promotes the detection and prevention of fraud and abuse and provides education on fraud and abuse risks. If CHLAMG discovers compliance deficiencies in its healthcare operations, we will take appropriate corrective actions, adjust the affected claims, and refund overpayments to government payers and/or private payers as required by law or contract.

Any person with concerns about practices relating to documentation, coding, and billing is required to report those concerns to a supervisor, manager, or to the CHLAMG Compliance Department. Through prompt reporting, CHLAMG can proactively address unintentional errors, identify non-compliant practices, and respond with appropriate corrective actions.

PROCEDURE:

1. Federal and state fraud and abuse laws support the integrity and quality of medically necessary healthcare services. The following are examples of high-risk practices that can result in, or constitute, fraud and abuse:
 - Billing for services that were not rendered or not provided as claimed;
 - Billing for services that are not medically necessary;
 - Billing for services by an improperly supervised or unqualified person;
 - Knowing misuse of a provider identification number which can result in improper billing;
 - Billing for services performed by a person excluded from participation in a federal or state healthcare program;

- Billing separately for services already included in a global fee or as a bundled service;
 - Failure to properly use coding modifiers;
 - Upcoding the level of service provided;
 - Accepting remuneration (cash, gifts, other items) for referrals.
2. Compliance addresses practices that may violate fraud and abuse laws in coordination with other CHLAMG/PMG departments. Compliance works collaboratively with auditors and these departments to ensure that a robust program of auditing and monitoring and education are in place to identify and address those areas at risk for potential fraud and abuse. This program is designed to:
- Remediate risks identified through previous monitoring results;
 - Evaluate the sufficiency and accuracy of documentation requirements;
 - Assess compliance with coding and billing rules and other regulations;
 - Evaluate contractual agreements and other arrangements for compliance with physician self-referral laws and the Anti-Kickback Statute; and,
 - Identify and address opportunities for improvement through education.
3. CHLAMG has policies and procedures that support the prevention and detection of fraud and abuse including:
- a. CHLAMG Compliance Plan
 - b. Billing and Documentation policies and procedures
 - c. Compliance Audit Protocols
 - d. Conflict of Interest Policy
4. CHLAMG requires any person who knows or suspects a violation of federal or state fraud and abuse laws or instances of payer fraud and abuse to report their concerns to a supervisor, manager, to Compliance, or to the Compliance Line at 1.877.658.8022. Reports to the Compliance Line may be made confidentially or anonymously. Supervisors and managers who receive a report of alleged fraud and abuse are expected to contact Compliance immediately. Unreasonable delay in reporting may result in corrective action.
- a. A person with information concerning suspected fraud and abuse involving federal healthcare programs also may report directly to the Department of Health and Human Services Office of the Inspector General.
 - b. A person with information concerning suspected fraud and abuse involving Medi-Cal also may report to the Department of Health Care Services (DHCS) Medi-Cal Fraud Hotline at 1.800.822.6222.
 - c. A person with information concerning suspected fraud and abuse involving a private payer also may report to the payer's fraud and abuse hotline.

5. Compliance will ensure investigation of any allegation of fraud and abuse. CHLAMG expects that all persons will cooperate with such investigations by responding promptly, completely and accurately to any requests from Compliance or any other person it contracts with to perform an investigation. A CHLAMG/PMG member who fails to cooperate is subject to disciplinary action in accordance with applicable policies.
6. Any person who raises a good faith concern about potential fraud and abuse is protected from retaliation by CHLAMG/PMG policy and by state and federal whistleblower laws. The addendum to this policy summarizes these protections.
7. Questions regarding policies, procedures and interpretations should be directed to Compliance at 323.361.2173 or by email to CHLAMGCompliance@chlamg.usc.edu.

REFERENCES:

Federal Civil False Claims Act, 31 U.S.C. §§ 3729-3733
Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
Physician Self-Referral Law, 42 U.S.C. § 1395nn
Regulatory Safe Harbors, 42 CFR § 1001.952
Administrative Remedies, 31 U.S.C. §§ 3801, et seq.
California Government Code § 12650, et seq.
California Welfare & Institutions Code Section 14107
California Insurance Code Section 187.7

RELATED POLICIES:

CHLAMG 15-0006, *Reporting Improper Conduct*
CHLAMG 15-0012, *Responding to External Requests for Information*

POLICY OWNER: CHLAMG Compliance Director

Approved by CHLAMG Executive Compliance Committee on December 26, 2018.

ATTACHMENT**SUMMARY OF FEDERAL AND STATE FRAUD AND ABUSE LAWS**

- A. **Federal False Claims Act (FCA):** The FCA is a federal, 31 U.S.C. §§ 3729-3733, that imposes liability on those who commit acts of fraud against the government. Under the FCA, liability occurs when any person knowingly submits a false claim to the government or causes another person to submit a false claim to the government, or knowingly makes a false record or false statement to get a false claim paid by the government. The FCA also covers “reverse false claims.” A reverse false claim occurs when a person acts improperly to avoid having to pay more money to the government. To violate the FCA, a person has knowledge of the falsity of the claim. Knowledge of false information is defined as (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the information. A person found liable under the FCA is subject to a civil penalty of which is annually re-indexed, but begins at approximately \$11,000 per claim up to approximately \$22,000 per claim, plus treble the amount of the government’s damages. The FCA applies to any federally funded program, including Medicare, Medi-Cal (Medicaid) and TRICARE. The FCA also allows for qui tam actions and provides protection from retaliation for whistleblowers:
1. **Qui Tam Action:** A qui tam action occurs when a private person files suit for violations of the FCA on behalf of the government. The person bringing the action is referred to as a “relator” under the law, and may also be referred to as a “whistleblower.” If the government decides to intervene in the qui tam action, the relator is entitled to receive 15-20% of the amount recovered by the government. If the government declines to intervene, the relator’s share increased to 25-30% of the recovery.
 2. **Whistleblower Protections:** The federal False Claims Act also contains a provision that protects a whistleblower against retaliation. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment for bringing forward a lawful false claims action. The whistleblower may bring suit in an appropriate district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay and compensation for any special damages such as litigation costs and reasonable attorney’s fees.
- B. **California False Claims Act (CFCA):** A state law modeled after the FCA. CFCA prohibits any person from submitting false or fraudulent claims valued at over \$500 to state or local government. The CFCA also makes it illegal for any person who benefits from a false claim and who later discovers the falsity of the claim, to fail to disclose the false claim to state or local government. A person found liable under the CFCA is subject to a civil penalty of between \$5000 to \$10,000 per claim, treble the amount of the state’s damages, and the plaintiff’s costs and attorney’s fees. A relator under the CFCA can receive 15-33% of any recovery if the state or local government intervenes, and 25-50% if the state or local government decides not to intervene. Like the federal FCA, whistleblowers are protected against retaliation for having brought a lawful action forward.

- C. **The Anti-Kickback Statute:** A federal law that makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration includes anything of value such as cash, free rent, expensive hotel stays, meals and excessive compensation for medical directorships or consultancies. Acceptable arrangements must meet regulatory safe harbors. Civil penalties for a violation of this statute may include up to \$50,000 per kickback plus three times the amount of the kickback. Criminal penalties may include fines, imprisonment or both.
- D. **The Physician Self-Referral Law (“Stark Law”):** This law prohibits a physician from making a referral for certain designated health services to an entity in which the physician or an immediate family member has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties include fines and exclusion from participation in all federal healthcare programs.
- E. **The Exclusion Statute** requires the Department of Health and Human Services’ Office of the Inspector General (OIG) to impose exclusions from participation in all federal healthcare programs on healthcare providers and suppliers who have been convicted or (1) Medicare fraud as well as any other offenses related to the delivery of items and services under Medicare; (2) patient abuse or neglect; (3) felony convictions or other healthcare-related fraud, theft, or other financial misconduct; or, (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
- F. **The Civil Monetary Penalties (CMP) Law** imposes CMPs for a variety of healthcare fraud violations and different amount of penalties and assessments based on the type of violation. Penalties range from \$10,000 to \$50,000 per violation. CMPs can also be assessed up to three times the amount claimed for each item or service or up to three times the amount of remuneration offered, paid, solicited or received.
- G. **State Medical Assistance Program Fraud.** California Welfare & Institutions Code Section 14107 prohibits fraud involving the state’s medical assistance programs, including Medi-Cal. Under this statute, both civil and criminal actions can be brought against any person who knowingly defrauds any state medical assistance program by submitting false claims or making false representations. There are no qui tam provisions under this statute. Penalties for a violation of this statute include imprisonment or a fine not to exceed three times the amount or value of the fraud.
- H. **Fraud Against Private Payers.** California Insurance Code Section 1871.7 prohibits a person from knowingly presenting a false claim for a health care benefit to a private insurer. Actions under this statute can be brought by a district attorney, California Insurance Commissioner, or a qui tam lawsuit may be filed by an individual.