Fraud and Abuse/False Claims Act Policy

Policy

Ashe Memorial Hospital (AMH) is committed to effective and efficient operations, reliable financial reporting and compliance with all applicable laws and regulations. It is the policy of AMH to inform physicians, employees, and contractors of AMH of (i) the Federal False Claims Act; (ii) North Carolina Medical Assistance Provider False Claims Act (the " North Carolina False Claims Act"); (iii) whistleblower protections in the Federal False Claims Act and the North Carolina False Claims Act; (iv) the roles of such laws in preventing and deterring fraud, waste, abuse; and (v) internal processes at AMH for the prevention and detection of fraud and abuse. This policy is intended to effect compliance of AMH with the requirement under Section 6032 of the Deficit Reduction Act of 2005 (Pub. Law. 190-171, Feb. 8, 2006).

Program Goals

A. Maintain zero tolerance of fraud.

B. Prevent, detect, and respond to unacceptable legal risk and its financial implications.

C. Route non-compliance issues to appropriate areas.

Code of Conduct

A. AMH employees, physicians, physician extenders, contractors, and agents are expected to abide by a high standard of ethical behavior at all times and to obey the laws and rules that apply to AMH operations and their particular duties.

B. It is the duty of employees, physicians, physician extenders, contractors, and agents to report any transaction or conduct that they think may be a violation of federal, state, or local law or a violation of any AMH policy.

General Compliance Policy Statements

A. AMH will not take any adverse action or retribution against any employee/agent due to the good faith reporting of a suspected violation or irregularity.

B. Employees, physicians, physician extenders, contractors, and agents are expected to obey the law and report any suspected violations of the following:

1. Federal, state, and local laws and government regulations
2. AMH policies and procedures
3. AMH rules and regulations
4. Corporate Compliance Program
5. Code of Conduct

C. All clinical professional services will be documented in the medical record, and such documentation will comply with applicable payer regulations.

D. All clinical professional services will be coded to accurately reflect the documentation in the medical record.

E. All claims shall be submitted in compliance with applicable payer regulations or requirements.

F. Employees, physicians, physician extenders, contractors, and agents will not knowingly and willfully solicit, receive, offer, or pay any remuneration directly or indirectly, in cash or in kind, in exchange for Medicare and/or Medicaid referrals.

G. Employees, physicians, physician extenders, contractors, and agents will not knowingly and willfully:

1. Falsify, conceal or cover up a material fact,
2. Make any false, fictitious or fraudulent statement or representation, or
3. Make or use false writing or document known to contain false, fictitious, or fraudulent statement in information submitted o the government.

H. Employees, physicians, physician extenders, contractors, and agents will not conceal or fail to disclose knowledge of an event affecting an initial or continued right to any benefit or payment with intent to secure such benefit or payment fraudulently.

I. Employees, physicians, physician extenders, contractors, and agents will not knowingly present or cause to be presented false or fraudulent claims, including situations where the service was not provided as claimed, the service was provided during a period in which the provider was excluded from participating in Federal healthcare programs, and/or the service was provided due to false or misleading information on coverage in order to influence a decision regarding when to discharge a person from inpatient hospital services.

J. Employees, physicians, physician extenders, contractors, and agents will not knowingly make or present a false, fictitious, or fraudulent claim to a Federal

agency.

K. Employees, physicians, physician extenders, contractors, and agents will not use the U. S. Postal Service or electronic submission processes as part of a scheme to defraud the government or to obtain money by false or fraudulent pretenses.

L. Employees, physicians, physician extenders, contractors, and agents will not embezzle, steal, or otherwise convert to the benefit of another person or intentionally misapply money, funds, securities, premiums, credits, property, or other assets of a health care benefit program.

M. Employees, physicians, physician extenders, contractors, and agents will not willfully prevent, obstruct, mislead, delay, or attempt to prevent, obstruct, mislead, or delay the communication of information or records relating to violation of a Federal health care offense to a criminal investigator. (The Administrator on Call should be notified immediately of such an investigation).

False Claims Act

A. The False Claims Act prohibits the submission of "knowingly" false or fraudulent claims to the United States.

B. The law is not limited to claims submitted with fraudulent or actual knowledge of their falsity, but includes:

1. Deliberate ignorance
2. Reckless disregard of truth or falsity
3. Gross negligence

False Claims Act Liability

A. The False Claims Act, 31 U.S.C. §3729, provides for liability for triple damages and a penalty from $5,500 to $11,000 per claim plus triple damages for anyone who knowingly submits or causes the submission of a false or fraudulent claim to the United States.

B. Liability for certain acts - any person who:

1. Knowingly presents, or causes to be presented to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

2. 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 Government; conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

3. Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

4. Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

5. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

6. 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 Government.

***Qui Tam* Provision of False Claims Act**

A. *Qui tam* is a provision of the Federal Civil False Claims Act that allows private citizens to file a lawsuit in the name of the U. S. Government charging fraud by government contractors and others who receive or use government funds, and share in any money recovered.

B. If the Government joins, and successfully prosecutes the case, and the person who filed the suit (relator) was not involved in the wrongdoing, the relator can receive between 15 and 25 percent depending on the extent of the relator's contribution to the case.

C. If the Government does not join and relator successfully prosecutes the case, the relator will receive between 25 and 30 percent of the proceeds.

North Carolina False Claims-General Statutes §108A-70.12

It shall be unlawful for any provider to:

1. Knowingly present, or cause to be presented to the Medical Assistance Program (Medicaid) a false or fraudulent claim for payment or approval; or,
2. Knowingly make, use, or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Medical Assistance Program.

North Carolina False Claims Penalty

A A civil penalty may be levied of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) plus three times the amount of damages which the Medical Assistance Program sustained because of the act of the provider.

B. The provider can also be liable for the costs of a civil action brought to recover any penalty or damages.

Federal Healthcare Program Exclusion

A. The Office of Inspector General has exclusion authority as follows:

1. Conviction of program-related crimes. Minimum period: 5 years.
2. Misdemeanor conviction relating to health care fraud. Minimum period: 3 years.
3. Conviction relating to obstruction of an investigation. Minimum period: 3 years.

How to Report Compliance Issues

A. Notify a supervisor or manager.

B. Contact the Compliance Officer at compliance@ashememorial.org or **336-846-0709.**

C. Make a toll-free anonymous call to the compliance hotline (Health Care Values Line) at **1-800-273-8452**, any time, 24 hours a day, 7 days a week.

D. Office of Inspector General (OIG) at 1-**800-447-8477.**

Should employees, physicians, physician extenders, contractors, and agents feel that AMH has not taken appropriate action to address a potential violation, they can also lodge a complaint concerning waste, fraud, and abuse directly to the Federal Government to the Health and Human Service's Office of Inspector General.

Employee Empowerment and Accountability

A. It is the policy that AMH will not take any adverse action or retribution against any employees, physicians, physician extenders, contractors, and agents of the facility due to the good faith reporting of suspected violation or irregularity.

B. AMH encourages employees, physicians, physician extenders, contractors, and agents to report any suspected violations of law to the Compliance Officer and to ask questions if they are unsure of a regulation.