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False Claims, Fraud, Waste and Abuse

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Policy

PURPOSE

To communicate Denver Health and Hospital Authority's ("DHHA") commitment to complying with all applicable federal and state False Claims Acts in accordance with section 6032 of the Deficit Reduction Act of 2005 ("DRA").

SCOPE

Inclusion: Denver Health Employees, Affiliates, Vendors, Consultants, and Agents

POLICY

DHHA complies with all applicable federal and state laws and regulations. To ensure compliance with federal and state false claims laws, DHHA has policies, procedures, and plans in place to detect and prevent fraud, waste, and abuse, and also supports the efforts of federal and state authorities in identifying incidents of fraud and abuse.

DHHA informs and educates all employees, affiliates, vendors, consultants, and agents about the federal and Colorado false claims laws and DHHA's obligation to prevent and detect fraud, waste, and abuse in federal health care programs under which claims are made for payment for goods and/or services in

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compliance with the DRA.

As a condition of receiving federal funds, entities that receive or make annual payments of at least five million dollars under a state Medicaid plan must establish written policies for all employees and certain contractors that provide detailed information about:

- The federal False Claims Act;
- Federal administrative remedies for false claims and statements;
- Any state laws pertaining to civil or criminal penalties for false claims and statements;
- Whistleblower protections under such laws; and
- Hospital policies and procedures for preventing and detecting fraud, waste, and abuse.

PROCEDURES

A. **Responsibilities**

1. **Employees, Affiliates, Vendors, Consultants, and Agents**
    a. Be aware of the serious penalties for false claims violations and fraud, waste, and abuse.
    b. Feel free to ask questions and report any good faith concerns to the individuals outlined in the "Reporting Concerns" section below or to the ValuesLine by calling 1-800-273-8452 or submitting a web report using http://www.denverhealth.ethicspoint.com/.

2. **Supervisors and Managers**
    a. Educate employees about the application of this policy and procedure to the activities in your department.
    b. Encourage good faith reporting so that DHHA can identify any potential violations and remediate them if indicated.
    c. Advise Enterprise Compliance Services of any received reports of fraud, waste, and abuse, or other related wrongdoing and assist with any investigation if requested to do so.
    d. Assist with developing a Corrective Action Plan ("CAP") if requested to do so.

3. **Enterprise Compliance Services**
    a. Review reports received and investigate.
    b. Assure any involved department(s) develop, implement, and complete any CAP(s).

B. **Legal Requirements To Be Aware Of**

1. **Federal False Claims Act.** The False Claims Act ("FCA") is a federal statute that

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prohibits fraud involving any federally funded program, including the Medicare and Medicaid programs.

a. **Claims:** The FCA imposes liability on any person or entity who:
    i. Knowingly submits or causes to be submitted a false or fraudulent claim for payment to Medicare, Medicaid, or other federally funded health care program;
    ii. Makes a false record or statement in order to secure payment for such a claim; or
    iii. Conspires to get such a claim allowed or paid.
    iv. Under the FCA, the term "knowingly" means that a person:
        a. Has actual knowledge that the information on the claim is false;
        b. Acts in deliberate ignorance of whether the claim is true or false; or
        c. Acts in reckless disregard of whether the claim is true or false.

        The FCA does not require proof of a specific intent to defraud for there to be a violation of the law. Examples of the types of activities prohibited by the FCA include billing for services that were not actually rendered, double-billing for items or services, up-coding (the practice of billing for a more highly reimbursed item or service than the one provided) or unbundling (the practice of billing services separately to secure a higher reimbursement).

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b. **Liability:** A person or entity that violates the FCA may be subject to civil penalties. A minimum penalty for a single false claim is $11,665 and the maximum penalty is $23,331. In addition to this civil penalty, health care providers may be required to pay an additional amount equal to three times the damages sustained by the federal government. If a provider is found liable under the FCA, the Office of Inspector General ("OIG") may seek to exclude the provider from participation in federal health care programs.

c. **Qui Tam Provisions:** The FCA provides for actions by private persons (a *qui tam* lawsuit) to encourage individuals to come forward and report misconduct involving false claims. A *qui tam* action allows any individual with actual knowledge of allegedly false claims, referred to as a "relator" or a "whistleblower," to file a lawsuit on behalf of the U.S. government.

    A *qui tam* lawsuit is initiated by filing a complaint in a federal district court. The complaint is filed "under seal," meaning the lawsuit is kept confidential while the government reviews and investigates the allegations contained

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in the complaint and decides how to proceed. After 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 whistleblower may continue with the lawsuit on his or her own.

If the lawsuit is successful and provided certain legal requirements are met, the whistleblower may receive between 15% but not more than 25% of the proceeds of the action or settlement of the claim depending on the extent to which the person substantially contributes to the prosecution of the action. The whistleblower may also be entitled to reasonable expenses, including attorney's fees and costs for bringing the lawsuit.

2. **Federal Program Fraud Civil Remedies Act of 1986.** The Program Fraud Civil Remedies Act of 1986 ("Administrative Remedies for False Claims and Statements") is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies, including the Department of Health and Human Services.

   The Administrative Remedies for False Claims and Statements statute defines "knows or has reason to know" as having actual knowledge of the information, acting in deliberate ignorance of whether the information is true or false, or acting in reckless disregard of whether the information is true or false. No proof of specific intent to defraud is required.

   The term "claim" includes any request or demand for property or money (e.g., grants, loans, insurance, or benefits) when the federal government provides or will reimburse any portion of the money.

   The federal government may investigate and, with the Attorney General's approval, commence proceedings if the claim is less than $150,000. A hearing must begin within six years from the submission of the claim. The Administrative Remedies for False Claims and Statements statute allows for civil monetary penalties to be imposed in administrative hearings, including penalties of up to $5,500 per claim, and an assessment, in lieu of damages sustained by the U.S., of not more than twice the amount of the claim.

3. **State False Claims Laws.**
   a. **False Medicaid Claims:**
      The Colorado False Medicaid Claims statute makes it unlawful for any person or entity to:
      i. Intentionally or with reckless disregard make or cause to be made any false presentation of a material fact in connection with a claim;
      ii. Intentionally or with reckless disregard present or cause to be

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presented to the state department a false claim for payment or approval;

iii. Intentionally or with reckless disregard present or cause to be presented any cost document required by the medical assistance program that the person knows contains a false material statement; or

iv. As to services for which a license is required, intentionally or with reckless disregard, make or cause to be made a claim with knowledge that the individual who furnished the services was not licensed to provide such services.

v. Civil penalties extend to false claims violations made under the Colorado Medical Assistance Act.

  a. Fines in the amount of three times the damages that the state sustains.

  b. A person is liable to the state for a civil penalty of not less than $5,500 and not more than $11,000 per false claim filed (these penalties automatically increase to match those under the federal FCA).

b. **Offering a False Instrument for Recording:**
The Colorado statute on offering a false instrument for recording provides criminal penalties for:

  i. Presenting or offering a written instrument that contains a material false statement or material false information to a public office or a public employee with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.

  ii. A person who violates this statute knowingly and with intent to defraud commits offering a false instrument for record in the first degree and is guilty of a felony. The penalty is imprisonment from 1 to 3 years, a fine between $1,000 and $100,000, or both.

  iii. A person who violates this statute knowingly commits offering a false instrument for record in the second degree and is guilty of a misdemeanor. The penalty is imprisonment for up to 1 year, a fine of up to $1,000, or both.

4. **Anti-Retaliation/Whistleblower Protection.**

  a. The state and federal FCA laws also include anti-retaliation protections for employees who make good faith reports of fraud, waste, and abuse. The FCA laws prohibit retaliation against a whistleblower for filing an action under the FCA or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, an FCA action. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of the FCA laws may bring

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an action in federal district court or appropriate state court to recover damages. An employee may seek reinstatement, two times the amount of back pay plus interest and other costs, damages, and fees.

C. **DHHA Policies and Procedures for Detecting and Preventing Fraud**
DHHA has policies and procedures in place to detect and prevent fraud, waste, and abuse in state and federal health care programs, ensuring that claims filed for payment are:

1. Backed by accurate documentation,
2. Appropriate for the level of service(s) provided or the applicable contractual requirements, and
3. Correctly aligned with the coding methodologies or other regulatory requirements of the applicable payer.
    a. The **Code of Conduct** is available on PolicyStat and addresses the clinical and administrative responsibilities for ensuring the accuracy of claims for reimbursement in the "Ensure Integrity in Financial and Billing Matters" section. The Code of Conduct "Accuracy in Documentation, Coding and Billing" section describes the ethical billing roles and responsibilities for admissions personnel, physicians and other providers, billers and coders, and management to ensure accurate and legal patient bills. Management is responsible for conducting internal and external reviews and audits of the billing process. Pursuant to the DHHA Code of Conduct, each employee has an obligation and responsibility to report any activity that appears to violate applicable laws, rules, regulations, or the DHHA Code of Conduct.
    b. The **Denver Health Enterprise Compliance Program** is available on PolicyStat and outlines the structure of the DHHA Enterprise Compliance Program that helps the organization mitigate financial exposure for non-compliance with the documentation, coding, and billing rules for Medicaid and Medicare programs. The program has seven key components for reducing risk:
        a. Oversight and Support
        b. Code of Conduct and Supporting Policies
        c. Mechanisms to Communicate Concerns
        d. Auditing and Monitoring
        e. Education and Training
        f. Responding to Reported Concerns
        g. Corrective Action

D. **The DHHA Human Resources** **Principles and Practices, Non-Retaliation** addresses procedures for internal reporting and whistleblower protection. Pursuant to this policy and procedure, DHHA prohibits retaliation against any DHHA employee who has reported, in good faith, their concern about actual or potential unethical or illegal behavior, including violations of federal or state rules or laws.

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E. **Reporting Required**
The Code of Conduct and the Enterprise Compliance Program provide all employees with a procedure for reporting actual or potential unethical or illegal behavior, including violations of federal or state rules, regulations, or laws, and DHHA policies or procedures, including the DHHA Code of Conduct standards. Employees are encouraged to report concerns regarding unethical or illegal behavior by any of the following avenues they feel best fit the circumstance:

1. To the employee's supervisor;
2. To any member of DHHA leadership;
3. To the Office of General Counsel or Enterprise Compliance Services;
4. To the ValuesLine by calling 1-800-273-8452 or http://www.denverhealth.ethicspoint.com/; or
5. To health care oversight agencies.

F. **Good Faith Reporting Protected**
Any employee who, in good faith, is concerned that incorrect information or some sort of flaw due to a particular instance or an ongoing practice/system may result in an incorrect bill or an incorrect request for payment is:

1. Required to report this information, and
2. Protected from retaliation for having done so.

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EXTERNAL REFERENCES

The Federal False Claims Act, 31 USC § 3729 et seq.

The Program Fraud Civil Remedies Act, 31 USC § 3801, 3802 Federal Civil Monetary Penalties, 42 USC § 1320a-7a

Federal Criminal penalties for acts involving Federal health care programs, 42 USC §1320a-7b Federal Anti-Kickback Statute, 42 USC § 1320a-7b

The Deficit Reduction Act of 2005, Social Security Act § 1902(a)(68)

Colorado Medicaid False Claims Statute, CRS §§ 25.5-4-304 through 25.5-4-306

Offering a False Instrument for Recording, CRS § 18-5-114

DHHA RELATED DOCUMENTS

Code of Conduct

Compliance Program

Non-Retaliation

Principles and Practices, Non-Retaliation

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ATTACHMENTS

None

Approval Signatures

Step Description	Approver	Date
	Robin Wittenstein: Chief Executive Officer	09/2021
DHHA Executive Compliance Committee	Catharine Fortney: Chief Compliance And Audit Officer	07/2021
DHMP CC	Lisa Artale Bross: Compliance Manager	07/2021
	Enid Wade: General Counsel	06/2021
	Danielle Elalouf-Veneziano: Compliance Specialist	06/2021
	Erica Austin: Hospital Compliance Manager	06/2021
	Bridget Johnson: Director of Compliance and Internal Audit	06/2021
Formatting Review	Colette Morris: Program Manager of Document Management	06/2021
Formatting Review	Lisa Artale Bross: Compliance Manager	06/2021
	Catharine Fortney: Chief Compliance And Audit Officer	06/2021

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