

Denver Health

# Deficit Reduction Act

## Information for Employees, Contractors and Agents

**EFFECTIVE DATE: DECEMBER 31, 2006****PAGE 1 OF 5****Purpose:**

Provide a written policy that provides detailed information about federal False Claims Act, including Federal administrative remedies for false claims and statements, and state laws pertaining to civil or criminal penalties for false claims and statements, whistleblower protections under such laws; and Denver Health policies and procedures for preventing and detecting fraud, waste and abuse. To advise employees, contractors and agents about Denver Health's processes for reporting concerns about fraud, abuse and false claims.

**Policy:**

Denver Health is committed to complying with all applicable federal and state laws and regulations. To ensure compliance with federal and state false claims laws, Denver Health has policies and procedures 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.

Section 6032 of the Deficit Reduction Act of 2005 ("DRA") requires that entities that receive or make annual payments of at least five million dollars under the state Medicaid plan, as a condition of receiving such payments, 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.

In that Denver Health is such an entity, the following information is being provided in compliance with Section 6032 of the Deficit Reduction Act.

**Practice:**

**1. Federal False Claims Act.** The False Claims Act (FCA) is a federal statute that prohibits fraud involving any federally funded program, including the Medicare and Medicaid programs.

**1.1 Claims:** The FCA imposes liability on any person or entity who:

- Knowingly submits or causes to be submitted a false or fraudulent claim for payment to Medicare, Medicaid or other federally funded health care program;
- Makes a false record or statement in order to secure payment for such a claim; or
- Conspires to get such a claim allowed or paid.

Under the FCA, the term "knowingly" means that a person:

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

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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, upcoding (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).

**1.2 Liability:** A person or entity that violates the FCA can be subject to civil money penalties of between five thousand five hundred dollars (\$5,500) and eleven thousand dollars (\$11,000) for each false claim submitted. In addition to this civil penalty, health care providers can be required to pay three times the amount of the damages sustained by the federal government. If a provider is found liable under the FCA, the OIG (Office of Inspector General) may seek to exclude the provider from participation in federal health care programs such as Medicare and Medicaid.

**1.3 Qui Tam Provisions:** The FCA provides for actions by private persons (*qui tam* lawsuit) to encourage individuals to come forward and report misconduct involving false claims. A *qui tam* action allows any person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the U.S. government. Such persons are referred to as “relators” or “whistleblowers”.

A *qui tam* lawsuit is initiated by filing a complaint in a federal district court. The complaint is filed “under seal” which means that the lawsuit is kept confidential while the government reviews and investigates the allegations contained 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 can 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% and 30% of any recovery. 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 term “knows or has reason to know” is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of whether the information is true or false, or acts 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 an portion of the money.

The federal government may investigate and with the Attorney General’s approval commence proceedings if

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the claim is less than one hundred fifty thousand dollars (\$150,000). A hearing must begin within six years from the submission of the claim. The Act allows for civil monetary sanctions to be imposed in administrative hearings, including penalties of five thousand five hundred dollars (\$5,500) per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

### 3. State False Claims Laws:

#### 3.1 False Medicaid Claims, Colorado Revised Statute 25.5-4-304 through 25.5-4-306.

The Colorado False Medicaid Claims statute makes it unlawful for any person or entity to:

- Intentionally or with reckless disregard make or cause to be made any false presentation of a material fact in connection with a claim;
- Intentionally or with reckless disregard present or cause to be presented to the state department a false claim for payment or approval;
- 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;
- 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.

Any person or entity that violates provisions of this statute can be subject to civil penalties of between five thousand dollars (\$5,000) to fifty thousand dollars (\$50,000) per claim or two times the amount of all medical assistance received.

#### 3.2 Offering a False Instrument for Recording, Colorado Revised Statute 18-5-114.

The Colorado statute on offering a false instrument for recording provides criminal penalties for:

- 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 the public office or public employee.
- 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.
- A person who violates this statute knowingly commits offering a false instrument for record in the second degree and is guilty of a misdemeanor.

**4. Anti-Retaliation/Whistleblower Protection:** The FCA also includes anti-retaliation protections for employees who make good faith reports of waste, fraud and abuse. The FCA prohibits 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, a 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 may bring an action in federal district court to recover damages. An employee may seek reinstatement, two times the amount of back pay plus interest and other costs, damages and fees.

**5. Denver Health Policies and Procedures for Detecting and Preventing Fraud:** Denver Health has numerous policies and procedures intended to detect and prevent fraud, waste and abuse in state and federal health care programs. The Integrity Office has established an Integrity Program that tells employees about the rules they need to follow and provides resources to help employees meet those rules. The Integrity Program includes the Code of Conduct, a Corporate Integrity Plan and Integrity Office Policies and Procedures.

**5.1 The Code of Conduct** addresses the clinical and administrative responsibilities for ensuring the accuracy of claims for reimbursement in the section entitled “Billing for Services”. The Code of Conduct “Billing for Services” section describes the ethical responsibilities and roles in billing 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 Code of Conduct, each employee has an obligation and responsibility to report any activity that appears to violate applicable laws, rules, regulations, or the Code of Conduct.

The Denver Health Code of Conduct can be found on the Integrity Office Pulse Subsite: <http://pulsesps.hosp.dhha.org/sites/integrity/Integrity%20Program%20Code%20of%20Conduct/Forms/AllItems.aspx>.

**5.2 The Denver Health Corporate Integrity Plan** focuses on reducing Denver Health’s financial exposure to non-compliance with the documentation, coding, and billing rules for Medicaid and Medicare programs. The Plan has seven key components to reducing risk:

1. Oversight and Support
2. Integrity Officer/Office
3. Code of Conduct and Supporting Policies
4. Internal Reporting
5. Education and Training
6. Internal Control
7. Periodic Program Assessment

The Denver Health Corporate Integrity Plan can be found on Integrity Office Pulse Subsite at: <http://pulsesps.hosp.dhha.org/sites/integrity/default.aspx>

**5.3 The Integrity Office Policy and Procedure for Internal Reporting** provides all employees with a procedure for reporting integrity concerns regarding a violation of any Denver Health Code of Conduct standard, including fraud, waste and abuse. Employees have several different reporting options. Employees should report concerns to:

- The employee’s supervisor;
- Any other manager;
- The Integrity Officer or any of the Integrity Office staff;
- The Values Line at 1-800-273-8452

The Integrity Office Policies and Procedures can be found on the Pulse at: <http://pulsesps.hosp.dhha.org/sites/integrity/Policies%20and%20Procedures/Forms/AllItems.aspx>.

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**5.4 Denver Health Employee Principles and Practices #4-127, Non-Retaliation** also addresses procedures for internal reporting and whistleblower protection. Pursuant to this Principle and Practice, Denver Health prohibits retaliation against any employee of Denver Health who intends to or has reported, in good faith, his/her concern about actual or potential unethical or illegal behavior including violations of government rules/regulations and the law.

Employees are encouraged to report concerns regarding unethical or illegal behavior by any of the following reporting alternatives that best fit the circumstance:

- To the employee's supervisor;
- To the General Counsel or Integrity Officer;
- To any member of Denver Health management;
- Through the Denver Health anonymous phone line (Values Line);
- To health care oversight agencies.

The Non-Retaliation Principle and Practice can be found on the Pulse at: <http://pulsesps.hosp.dhha.org/HR%20Principles%20%20Practices/default.aspx>.