

THE WILLIAM W. BACKUS HOSPITAL

Administrative Policy

Subject: Prevention of Fraud, Waste and Abuse
Origination Date: 12/06
Revision Date: 10/07
Review Date:

Policy: Inform employees, contractors and agents of The William W. Backus Hospital (Hospital) details of the Federal False Claims Act, Protections for Reporting Individuals, penalties for violations, and relevant state laws.

Statement of Purpose:

1. The purpose of this policy is to inform employees, contractors and agents of the Hospital of the federal False Claims Act (referenced in this policy as “FCA”), and to provide general information regarding the Hospital’s efforts to combat fraud, waste, and abuse in the healthcare system, and to describe the remedies and fines for violations that can result from certain types of fraudulent activities.

Procedure:

1. **Reporting Fraud, Waste, or Abuse**
 - a. All employees, contractors, agents, and volunteers of the Hospital must immediately report to the Hospital’s compliance officer, any suspicion of fraud, waste, or abuse in connection with the business of the Hospital. The Hospital engages in specific compliance efforts to detect and prevent fraud, waste, and abuse, such as ongoing monitoring initiatives at the department level, and audits conducted through the compliance office. In addition, employees receive information about the compliance program at the new employee orientation and at the annual mandatory inservice trainings.
 - b. If you would like more information on the Hospital’s compliance program or policies, or on how to report any concerns, please contact your supervisor, the compliance officer, the compliance coordinator, or any member of the Hospital’s administration.
2. **Detailed Information of The Federal False Claims Act**
 - a. The federal False Claims act (FCA) imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.
 - b. The FCA is not confined to healthcare claims, but extends to any payment requested of the federal government. The FCA applies to billing and claims sent from the Hospital to any government payor program, including Medicare and Medicaid.

- c. It is the policy of the Hospital that an employee, contractor, or agent of the Hospital who submits a false claim will be reported to the necessary authorities. Anyone, or any company that submits a false claim or statement to the government may be fined under the FCA between \$5,500 and \$11,000 for each such claim submitted, regardless of the size of the false claim, and the person or company could be required to pay an additional fine of three times the value of any charges.
- d. Part of the FCA's purpose is to create an environment where employees and others feel safe reporting concerns about fraud. The Hospital fully supports that goal. Any person who lawfully reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by the Hospital for making such a report. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.
- e. The FCA provisions are generally enforced by the U.S. Department of Justice. The FCA provides that a person may initiate a formal claim if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. If any funds are recovered, a portion of the funds may be paid to the person who initiated the formal claim, at the discretion of a federal court. This amount, if awarded, generally is between 15% and 30% of the total damage amount.
- f. If a person wishes to file a claim regarding fraud or suspected fraud related to a healthcare payment directly with the government, he or she must first present a formal complaint, along with all material evidence relating to the alleged fraud, to the authorities at the U.S. Department of Justice. The authorities have 60 days to investigate, during which time the complaint is kept confidential. Upon completion of the investigation, the government will decide either to pursue the case on its own or decline to proceed with the case. If the federal government declines the case, the individual may still proceed with the case on his or her own, but without the government's assistance, and at his or her own expense.
- g. A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government. (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances.)

3. **Detailed Information of The Federal Program Fraud Civil Remedies Act**

- a. Persons or companies that commit fraud on the federal government, by false claim or statement, can be assessed money penalties in addition to the penalties of the False Claims Act because of a law called the Program Fraud Civil Remedies Act (referenced in this policy as "PFCRA"). Specifically, PFCRA penalties of \$5,000 per false claim or statement apply if a person or company submits a claim to the federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements containing false, fictitious, or fraudulent information; includes or is supported by written statements that omit a material fact, which causes the statements to be false, fictitious, or fraudulent, and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed.

- b. The \$5,000 penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

4. **Connecticut State Law**

- a. It is a crime in Connecticut to bill Medicaid or the general assistance program fraudulently. All employees, contractors and agents of the Hospital must immediately report suspicion of any criminal activity occurring at the Hospital, including criminal fraud, to the hospital's compliance officer.
- b. Anyone who provides services to a state Medicaid beneficiary and seeks or accepts payment for unnecessary or improper services is subject to possible imprisonment and/or criminal fines under state law. Depending upon the amount of the fraudulent services involved, such offenses carry potentially significant penalties, with a maximum of 20 years in prison and a maximum fine of \$15,000.
- c. Anyone who provides services to a recipient of Connecticut's general assistance program and seeks or accepts payment for unnecessary or improper services is also subject to civil and criminal penalties. Depending upon the amount of the fraudulent services involved, such offenses carry a minimum one year prison sentence and a maximum of 20 years, as well as a maximum fine of \$15,000. Any person who defrauds Connecticut's general assistance program is also excluded from participating in the program for a minimum of one year.
- d. Connecticut law protects employees who report suspected violations of state or federal law, including reports of criminal fraud. An employer may not discharge, discipline or otherwise penalize an employee for reporting a violation of the law, or suspected violation, as long as the employee does not know the information being reported is false.

In addition to the education requirements regarding the False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act, an entity shall reference the following Connecticut State Statutes and Regulations in their employee policies:

Criminal:

- Conn. Gen. Stat. Sec. 53a-290 et seq. (Vendor Fraud)
- Conn. Gen. Stat. Sec. 53-440 et seq. (Health Insurance Fraud)
- Conn. Gen. Stat. Sec. 53a-118 et seq. (Larceny)
- Conn. Gen. Stat. Sec. 53a-155 (Tampering With Or Fabricating Physical Evidence)
- Conn. Gen. Stat. Sec. 53a-157b (False Statement Intending to Mislead Public Servant)

Fraud:

- Conn. Gen. Stat. Sec. 17b-25a (Toll free vendor fraud telephone hotline)
- Conn. Gen. Stat. Sec. 17b-99 (Vendor Fraud)
- Conn. Gen. Stat. Sec. 17b-102 (Financial Incentive for Reporting Vendor Fraud)
- Regs. Conn. State Agencies Sec. 17-83k-1 et seq. (Administrative Sanctions)
- Regs. Conn. State Agencies Sec. 17b-102-01 et seq. (Financial Incentive for Reporting Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud)

Whistleblower Protections:

Conn. Gen. Stat. Sec. 4-61dd (Whistleblowing)

Conn. Gen. Stat. Sec. 31-51m (Protection of Employee Who Discloses Employer's Illegal Activities or Unethical Practices)

Conn. Gen. Stat. Sec. 31-51q (Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights)

Regs. Conn. State Agencies Sec. 4-61 dd-1 et seq. (Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act)

References: Section 6032 of the Deficit Reduction Act of 2005
 31 U.S.C. §§ 3729-3733
 31 U.S.C. §§ 3801-8312
 Connecticut General Statutes § 31-51m
 Connecticut General Statutes § 53a-290 *et seq.*
 Connecticut General Statutes § 17b-127
 The William W. Backus Hospital Standards of Conduct
 The William W. Backus Hospital Corporate Ethics & Compliance Program