VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 278
VERSION: 3

SUBJECT/TITLE: FALSE CLAIMS ACT

POLICY: As part of its effort to comply with all federal and State laws and regulations intended to prevent health care fraud and abuse, ValleyCare will inform its employees, and contractors and agents who furnish or authorize the furnishing of Medicaid services, of the laws related to the submission of false claims or the making of false statements.

The laws described in this policy are intended to control fraud in federal and state healthcare programs by giving certain governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued at three different levels: criminal, civil and administrative. This provides a wide range of remedies to help battle fraud and abuse. Additionally, whistleblower statutes and protections for individuals reporting fraud, waste and abuse encourage the reporting of this misconduct by creating financial incentive and employment protections.

This policy includes the following information concerning tools used to fight fraud, waste and abuse:

- A summary of the Federal False Claims Act
- A summary of federal administrative remedies found in federal law for the submission of false claims
- A summary of laws of the State of California that impose civil or criminal penalties for false claims or statements related to providing health care

DHS Policy 1000, "DHS Compliance Program/Code of Conduct" describes DHS' program for detecting and preventing fraud, waste and abuse of the federal healthcare programs.

I. FEDERAL LAWS

A. Federal False Claims Act, 31 U.S.C. § 3729 et seq.

1. Circumstances Leading to Liability

This law creates liability for any of the following actions:

(a) Presenting or causing to be presented a false or fraudulent claim for payment;
(b) Making or using, or causing to be made or used, a false record or statement to get a false claim approved;
(c) Conspiring to defraud the federal government by getting a false or fraudulent claim paid or approved;
(d) Making, using or causing to be made or used a false document to avoid or decrease the amount to be paid or delivered to the federal government.

Before such actions can lead to penalties, the person or entity making the claim must have a particular intent, or state of mind, when he or she acts. Except for actions (c) above, the required intent is actual knowledge of the false or fraudulent nature of the information, or willful ignorance of the truth of the information or reckless disregard of the truth of the information. For (c) an actual intent to defraud (i.e., an intent to deliberately deceive) the federal government must exist.

2. Penalties

If a person or entity has been found to violate the federal False Claim Act, the person/entity may be responsible for paying three times the amount improperly paid for each false claim and a penalty of $5,500 to $11,000 per claim. Self-disclosure and cooperation with the government can reduce the penalty.

3. Who Can Bring the Lawsuit

Generally, the United States Department of Justice (DOJ) brings actions under the False Claims Act.

However, a private party known as a "qui tam plaintiff" or "whistleblower" may bring the case on behalf of the federal government and may share in the recovery the government receives.

The whistleblower must first inform the DOJ of the facts and circumstances which he or she knows. The DOJ has the right to investigate and decide whether it wants to be involved in the prosecution of the case. If the DOJ intervenes and there is a settlement or judgment against the defendant, the whistleblower is generally entitled to 15-25% of the money, which is recovered from the defendant, but this amount can be reduces in certain situations.

If the whistleblower proceeds alone, he or she is entitled to 25-30% of

the recovery. However, the whistleblower may be responsible for the defendant's attorney's fees if he or she loses and the case was clearly frivolous, or was brought for purposes of harassment.

4. Protections for Those Involved in Investigating or Prosecuting False Claims Actions

The False Claims Act prohibits discrimination, such as discharge, demotion or harassment against employees who assist in the investigation or prosecution of an action under the False Claims Act, and provides such employees with certain right such as the right to two times the back pay or reinstatement with comparable seniority if they have been victims of discrimination.

B. Federal Administrative Remedies for False Claims, 31 U.S.C. §§ 3801-3812

1. Circumstances Leading to Liability

In addition to any administrative procedures that might exist under a particular government program like Medicare, the law gives federal executive departments, like the Department of Health and Human Services, the right to issue administrative penalties (i.e., penalties which are not imposed by a court) for false claims and statements. Actions which can lead to these penalties are:

(a) Making, presenting or submitting, or causing to be made, presented or submitted a false or fraudulent claim; or
(b) Making, presenting, or submitting or causing to be made, presented or submitted a claim that is supported by a "statement" which is false or fraudulent either because of what it says, or because it leaves out material fact which is supposed to be in the statement; or
(c) Making, presenting or submitting a written statement which contains a false or fraudulent fact, or leaves out a material fact which the person has a duty to include and is therefore false or fraudulent, if the statement is accompanied by a certification of the truthfulness and accuracy of the contents of the statement.

The terms claims and statement have special, defined meanings.

For a person to be assigned penalties under these administrative sanction procedures, he or she must know, or have reason to know, that the claim or statement meets one of the requirements above. There does not have to be an intent to defraud.

This administrative process cannot be used, however, if the amount claimed is greater than $150,000 or has a value of more than $150,000. Moreover, although it does apply to applications for Medicare and Medi-Cal benefits, it does not apply to many other kinds of benefit applications.

2. Penalties

A civil penalty of $5,000 per claim will be assessed. In addition, if a false claim was paid, the responsible person will have to repay an amount equal to two times the amount of the claim. This second amount acts as payment for the government's damages.

3. Alternative Administrative Remedies

In addition to this statute, there are the administrative penalties, which can be imposed by the Office of the Inspector General for the Department of Health and Human Services (OIG) under laws that specifically address federal healthcare programs. Under the statute at 42 U.S.C. § 1320a-7a, the OIG is authorized to impose money penalties and/or exclude from participation in federal healthcare programs, individuals for a variety of behaviors, including, but not limited to, the knowing submission of inaccurate claims, or claims which violate the assignment of other program rules, or which are based on kickbacks, or other inappropriate inducement.

II. STATE LAW PROVISIONS

A. California False Claims Act, Cal. Gov. Code §§ 12650-12656

1. Circumstances Leading to Liability

This law, which is very similar to the federal law discussed above, creates civil (i.e., not criminal) liability for the following actions, among others, in connection with the State or county government:

(a) Presenting or causing to be presented to the State or county government a false or fraudulent claim for payment;
(b) Making or using, or causing to be made or used, a false record or statement to get a false claim approved or paid;
(c) Conspiring to defraud the State or county government by getting a false or fraudulent claim approved or paid:

(d) Making, using, or causing to be made or use, a false document to avoid or decrease the amount to be paid or delivered to the State or county government;
(e) Failing to inform the State or county government within a reasonable period after discovery, that it is the beneficiary of an inadvertent submission to the State or county government of a false claim. In essence, this provision make individuals responsible for telling the State of county about a payment they received which they should not have gotten, even when they did not intend to get the incorrect payment.

There are exceptions where this section does not apply.

As with the federal law, to be responsible under this law, the person doing the action must do so with knowledge of the falsity of the information, or with reckless disregard of its truth, or in deliberate ignorance of its truth except with item (c). An intent to defraud is not required except with item (c) above.

2. Penalties

If a person or entity has been found to violate the California False Claim Act, the person/entity will be responsible for paying three times the amount of actual damages and a penalty of up to $10,000 per claim. These can be reduced by self-disclosure of the facts and cooperation with the government.

3. Who May Bring a False Claim Action

Generally, the California Attorney General's Office brings actions under the California False Claims Act for false claims to the State, and the County Counsel brings actions for false claims to the county. However, a private individual known at a "qui tam plaintiff" or "whistleblower" may also bring the case on behalf of the State or county government.

As is the case under federal law, the whistleblower must first inform the government of the facts and circumstances which he or she knows before he or she files the complaint. Additionally, if the whistleblower is a government employee who discovers the fraud in the course of his or her job, he or she must use, to the fullest extent possible, internal agency processes for reporting the fraud and seeking recovery through official channels, and the agency

must have failed to act on the information within a reasonable time period, before the employee has a right to file the action. The qui tam plaintiff must file his or her complaint in the court under seal.

If the government intervenes and there is a settlement or judgment against the defendant, the whistleblower is entitled to 15 – 33% of the proceeds, unless the whistleblower was involved in the violation, in which case his or her shave can be reduced. In fact, he or she can be denied any compensation altogether. There is also no minimum award if the whistleblower is a government employee who learned about the false claim in the course of his or her employment.

If the government does not intervene, and the whistleblower proceeds alone, he or she is entitled to 25 – 50% of the recovery. However, under certain circumstances related to publicly disclosed information, the whistleblower may not proceed alone. The whistleblower (as well as the State or county government, if they intervene) may be responsible for the defendant's attorney's fees if the defendant wins and the case was clearly frivolous or designed solely for the purposes of harassment.

B. Improper Claiming to Medi-Cal, Cal. Welfare & Institutions Code § 14123.2

1. Circumstances Leading to Liability

Liability may exist for presenting or causing to be presented a claim for services:

a) Which were not provided as claimed;
b) Which were provided by a suspended individual;
c) Which were substantially in excess of the needs of the patient or were of a quality that fails to meet recognized standards;
d) Which were part of a pattern or practice of abusive billing;
e) Which included a false statement or representation, whether done intentionally, or negligently;
f) Which was submitted in violation of an agreement between the State and the individual.

Except for those actions discussed in item (e) above, to be liable for these actions, they need to be taken either with knowledge of the underlying facts or with reckless disregard of deliberately

ignorant of facts.

2. Penalties

The California Department of Health Services may assess a fine of up to three times the amount claimed.

C. Grounds for Exclusion or Additional Civil Penalties, Cal. Welfare & Instructions Code § 14123.25

1. Actions Which Create Liability

Under this statute, the following actions are forbidden, when the provider has been warned at least twice not to take the actions:

Billing Medi-Cal improperly for a service

Improperly calculating an amount on a cost report where the costs are used to determine rates or payment, and where the provider has received two or more warnings from the Department of Health Services (DHS) about the billing or cost reporting practice.

In addition, the same actions that would give the OIG the right to exclude a provider from Medicare or impose a civil money penalty can create liability under State law as well. These reasons include, but are not limited to, conviction of a crime involving Medicare or health care fraud, providing services which are substantially in excess of what is needed by the patient, and making a claim for services which were not provided as claimed.

2. Penalties

For these actions, the California Department of Health Services (DHS) may assess civil money penalties. For the actions in items (a) and (b), the amount of the civil money penalty depends on the number of warnings and is at least $100. In addition, the Department may exclude a provider from participation in Medi-Cal for the same reasons as the OIG can exclude a provider from Medicare.

D. Unprofessional Conduct, Cal. Business & Professions Code § 810

1. Circumstances Leading to Liability

Health care professionals licensed in California are guilty of unprofessional conduct when they do the following actions:

(a) Present or cause to be presented any false or fraudulent claim for a loss under an insurance policy;
(b) Make any writing, with the intent to use it or allow someone else to use it to support a false or fraudulent claim;
(c) Violate the criminal false claims rules contained in Cal. Penal Code § 550 (described below)
(d) Are convicted of a felony involving fraud in connection with services to a Medi-Cal beneficiary (or a person covered by workers' compensation).

This generally applies to professionals licensed under Division 2 of the Business and Professions Code, which includes, but is not limited to physicians, occupational, physical and speech therapists, nurses, pharmacists, dentists, psychologists, and marriage and family therapists. It also applies to osteopaths and chiropractors. However, item (d) only applies to chiropractors, osteopaths, dentists, physicians, psychologists, optometrists and pharmacists.

To be responsible under items (a) and (b), you must act knowingly (i.e., with knowledge that the claim is false or fraudulent).

2. Penalties

The actions in items (a) and (b) will qualify as unprofessional conduct and depending on the circumstances, will lead to different penalties, which could include suspension or revocation of your license. The actions in item (c) may lead to suspension or revocation of your license. If there is only one felony, then the acts in items (d) will lead to automatic suspension but if you have been convicted of multiple felonies in more that one prosecution under item (d), your license will automatically be revoked.

The suspension or revocation of your license will also cause the suspension of your right to participate in Medicare or Medi-Cal. (See Cal. Welfare & Institutions Code § 14043.6 and 42 U.S.C. § 1320a-7(b)(4)).

E. Denial of Program Participation, Cal. Health and Safety Code § 100185.5

1. Actions Which Lead to Liability

If the California Department of Health Services ("Department") suspends or disenrolls a provider from one program it is responsible for, like Medi-Cal, or Healthy Families, because of fraud, abuse or willful misrepresentation, and the Department thinks the provider could take the same actions and cause loss or harm to a participant in another program it is responsible for, the Department may suspend or disenroll the provider from that other program. If may also refuse to enroll the provider in another program it administers. The Department may also refuse to enroll a provider in a different program it Medi-Cal has imposed special utilization controls on that provider.

F. General Protections for Reporting to Government, Cal. Labor Codes § 1102.5

1. Actions Which Make Up the Crime

This statute protects, under certain circumstances, employees whose employers are violating State or federal laws or regulations.

This statute prohibits an employer from establishing a rule or policy which would prevent an employee from telling the government information which the employee reasonable believes reflects a violations of law. The statute also prohibits the employer from taking a negative action (i.e., retaliating) against an employee who tells the government such information unless to do so violates the attorney-client privilege or the physician-patient privilege.

This statute also prohibits the employer from retaliating against an employee who refuses to participate in a violation of law.

2. Penalty

An employer who violates this law may have to pay a penalty up to $10,000 for each violation.

III. STATE LAW CRIMINAL FALSE CLAIMS

In addition to the civil fines and penalties discussed above, the submission of false or fraudulent claims can lead to criminal prosecutions and prison.

A. False Claims Against the Government, Cal. Penal Code § 72

1. Actions Which Make Up the Crime

Presenting a claim or bill for payment or allowance to a State or local officer which is false or fraudulent. Such action must be taken with an intent to defraud, which means that the individual must know that the claim is incorrect and intend for the person receiving it to believe that it is genuine. (This intent requirement is generally what distinguishes a criminal violation from a civil violation.)

2. Penalties

Depending on the circumstances of the crime, false claims can be punished by a year or less in County jail, a fine of up to $1,000 or both, imprisonment in a State prison and/or a fine of up to $10,000.

B. Criminal False Claims, Health Care Benefits, Cal. Penal Code § 550

1. Actions Which Make Up the Crime

(a) Presenting, or causing to be presented, a false or fraudulent claim for healthcare benefits, including a claim for payment for services provided pursuant to that benefit;
(b) Submitting a claim for a healthcare benefit which was not used by or on behalf of the claimant;
(c) Presenting more than one claim for a payment for the same healthcare benefit, with an intent to defraud;
(d) Requesting supplemental payment for an undercharge without also, at the same time, presenting information to reconcile known overcharges for that same claimant;
(e) Assisting or conspiring to prepare, present, or cause to be presented a false statement in support of a claim for insurance benefits;
(f) Assisting or conspiring to conceal, or knowingly failing to disclose, the occurrence of an event which affects the entitlement or amount of any benefit or payment.

To violate these provisions, the action must be taken knowingly, which means that there must be a deliberate submission of information which the person knows is incorrect.

2. Penalties

The penalty depends on whether the amount of claim is more or less than $400. Crimes involving more than $400 may lead to 2-5 years in State prison, and/or a fine of as much as $50,000, although county jail or lesser fines can also be imposed in certain cases.

C. False Claims Specifically Related to the Medi-Cal Program, Cal. Welfare & Institutions Code § 14107

1. Actions Which Make Up the Crime

(a) Presenting a false or fraudulent claim for goods or services payable under the Medi-Cal program, with the intent to defraud;
(b) Knowingly submitting false information for the purpose of getting more payment for a good or service than what you are legally entitled to;
(c) Knowingly submitting false information to get an authorization to provide a good or services;
(d) Knowingly and willfully executing or trying to execute a scheme to defraud Medi-Cal or any other healthcare program operated by the California Department of Health Services or getting money or property from the Medi-Cal or other healthcare program operated by the California Department of Health Services by false or fraudulent statements or promises.

2. Penalties

Imprisonment for 2-5 years may be imposed. If such activities lead to great or serious bodily injury, as defined by the Penal Code, or death, the length or imprisonment can be extended. In addition, a civil fine of up to three (3) time the amount of the improper payment may be levied. The defendant may also be subject to asset forfeiture.

In addition, for violation of this section 14107, or any other criminal conviction related to fraud and abuse in the Medi-Cal program, the person or entity shall be suspended from

participation in Medi-Cal, under Cal. Welfare and Institutions Codes § 14123, and may also be excluded from participation in Medicare (See 42 U.S.C. § 1320a-7(a) and (b).

Moreover, a billing agent who is involved in the illegal submission of claims may have his or her registration suspended or revoked pursuant to Cal. Welfare and Institutions Code Section 14040.5.

3. Rewards for Helping

Under Cal. Welfare and Institutions Code § 14107.12, persons who provide specific information about criminal behavior of an identified provider which leads to a recovery of improperly paid Medi-Cal funds may receive a reward, pad out of the money which is recovered. The award may not be greater than 10% of the amount recovered, or $1,000, whichever is greater. Government employees or contractors who discover the information in the course of their job may not receive a reward.

D. False Certification on Medi-Cal Cost Reports, Cal. Welfare and Institutions Code § 14107.4

1. Actions Which Make Up the Crime

(a) Causing Materially false information to be included in a Medi-Cal cost report;
(b) Certifying a cost report as true and correct even though you have not disclosed any significant beneficial interest that the Board of Supervisors or a County employee has in a contractor or vendor.

To violate the law, either action must be done with intent to defraud.

2. Penalties

This offense can be punished by either a term in the County jail or State prison and/or a fine of $5,000.

PURPOSE: As required by the Deficit Reduction Act of 2005, the purpose of this policy is to inform employees, and contractors and agents who furnish or authorize the furnishing of Medicaid services, about federal and State laws dealing with false

claims and about ValleyCare's commitment to follow the law.

DEPARTMENTS: All

DEFINITIONS:

PROCEDURE:

AUTHORITY: Deficit Reduction Act of 2005 (S. 1932), Section 6032
Federal False Claims Act, 31 U.S.C. §§3729-3733
Federal Administrative Remedies for False Claims, 31 U.S.C. §§ 3801-3812
Civil Monetary Penalties, 42 U.S.C. § 1320a-7a
Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. §1320a-7b

References: DHS Policy 1000, DHS Compliance Program/Code of Conduct DHS CODE OF CONDUCT False Claims Act, Cal. Govt. Code §§ 12650-12656, False Claims Act California Welfare & Institutions Code (see policy for sections) California Health & Safety Code (see policy for sections) California Penal Code (see policy for sections) California Business & Professions Code (see policy for sections) California Labor Code (see policy for sections)	
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