USC Office of Compliance

Policy Title: Detecting and Preventing Fraud and Abuse in Federal Health Care Programs				
Policy #:	**CO - 111**	***Issued:***	06/30/2015	***Reviewed/ Revision Date:***

PURPOSE

This policy complies with requirements under the Deficit Reduction Act of 2005 and other federal and state fraud and abuse laws. It provides guidance on activities that could result in incidents of fraud and abuse, and explains procedures for reporting suspected violations of fraud and abuse laws.

This policy applies to all healthcare professionals, employees, contractors, subcontractors, agents, or other persons who, on behalf of Keck Medicine of USC, furnish or otherwise authorize the furnishing of healthcare items or services, perform billing and coding functions, or in the monitoring of healthcare operations.

POLICY

USC is committed to the prevention of fraud and abuse in its healthcare operations at Keck Medicine of USC[1]. Areas at highest risk for fraud and abuse in our healthcare operations include documentation, coding, and billing claims to Federal healthcare programs such as Medicare, Medi-Cal, TRICARE and also private payers.

USC's compliance program promotes the detection and prevention of fraud and abuse and provides education on fraud and abuse risks. If USC discovers compliance deficiencies in our healthcare operations, USC will take appropriate corrective actions, adjust the affected claims, and refund overpayments to the government and/or private payers as required by law.

Any person with concerns about practices relating to documentation, coding, and billing is required to report those concerns to a supervisor, manager or the Office of Compliance (OOC). Through

[1] Those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

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prompt reporting USC can proactively address unintentional errors, identify non-compliant practices, and respond with appropriate corrective actions.

A summary of key federal and state fraud and abuse laws is an attachment to this policy.

PROCEDURE

1. Federal and state fraud and abuse laws support the integrity and quality of medically necessary healthcare services. The following are common examples of high-risk practices that can result in, or constitute, fraud and abuse:

    - Billing for services that were not rendered;
    - Billing for services that are not medically necessary;
    - Billing an outpatient service as an inpatient service;
    - Billing for services by an improperly supervised or unqualified person;
    - Billing for services performed by a person who has been excluded from participation in a federal or state healthcare program;
    - Billing separately for services already included in a global fee or as a bundled service;
    - Billing a non-covered service as a covered service;
    - Falsifying claims or medical records;
    - Accepting remuneration (cash, gifts, other items) for referrals.

2. USC's OOC addresses practices that may violate fraud and abuse laws in coordination with the USC's Office of General Counsel and other departments as appropriate. The OOC works collaboratively with auditors and these departments to ensure that a robust program of auditing and monitoring and education is in place to identify and address those areas at risk for potential fraud and abuse. This program is designed to:

    - Remediate risks identified through previous monitoring results;
    - Evaluate the sufficiency and accuracy of documentation requirements;
    - Assess compliance with coding and billing rules and other regulations;
    - Evaluate contractual agreements and other arrangements for compliance with physician self-referral laws and the Anti-Kickback Statute; and
    - Identify and address opportunities for improvement through education.

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3. USC has policies and procedures that support the prevention and detection of fraud and abuse including:

    a. USC Compliance Plan
    b. Cooperation with Compliance Investigations
    c. Healthcare Provider Billing Compliance Policies and Procedures
    d. Relationships with Industry Policy
    e. Misappropriation of University Assets
    f. Conflict of Interest in Professional and Business Practices

4. The OOC strongly encourages any person who knows or suspects a violation of federal or state fraud and abuse laws, to report their concerns to a supervisor, a manager, to OOC or to the USC Help and Hotline at (213) 740-2500. Reports to the Help and Hotline may be made confidentially or anonymously if desired. Supervisors or managers who receive a report of alleged fraud and abuse are expected to contact OOC immediately and could be subject to disciplinary action for unreasonable delays.

    a. A person with information concerning suspected fraud and abuse involving federal healthcare programs also may report directly to The Department of Health and Human Services Office of the Inspector General at 1-800-447-8477 or TTY 1-800-377-4950.
    b. A person with information concerning suspected fraud and abuse involving Medi-Cal also may report to the Office of the Attorney General, State of California Department of Justice, Fraud and Abuse Hotline at (800) 722-0432.

5. The OOC investigates all allegations of fraud and abuse. As outlined in the University's Cooperation with Compliance Investigations Policy, OOC expects all persons will cooperate with such investigations by responding promptly, completely, and accurately to any requests by the OOC or any other person it contracts with to perform an investigation. A USC member who fails to cooperate is subject to disciplinary action consistent with the above-mentioned policy.

6. Any person who raises a good faith concern about potential fraud and abuse is protected from retaliation by USC policy and by state and federal whistleblower protections. The addendum to this policy summarizes these protections.

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7. Questions regarding policies, procedures or interpretations should be directed to the USC Office of Compliance at (323) 442-8588 or USC Help & Reporting Line at (213) 740-2500.

REFERENCES

Deficit Reduction Act of 2005 (S. 1932) §§ 6031-6034
Federal Civil False Claims Act, 31 U.S.C. §§ 3729-3733
Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
Physician Self-Referral Law, 42 U.S.C. § 1395nn
Regulatory Safe Harbors, 42 CFR § 1001.952
Administrative Remedies, 31 U.S.C. §§ 3801, et seq.
California Government Code § 12650, et seq.
California Welfare & Institutions Code Section 14107
California Insurance Code Section 1871.7

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Attachment

Summary of Federal and State Fraud and Abuse Laws

1. **Federal False Claims Act (FCA)** – A federal law, 31 U.S.C. §§ 3729 – 3733, that imposes liability on those who commit acts of fraud against the government. Under the FCA liability occurs when any person who knowingly submits a false claim to the government or causes another person to submit a false claim to the government, or knowingly makes a false record or statement to get a false claim paid by the government. In addition, the FCA also covers "reverse false claims." A reverse false claim occurs when a person acts improperly to avoid having to pay money to the government. To violate the FCA, a person has knowledge of the falsity of the claim. Knowledge of false information is defined as (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the information. A person found liable under the FCA is subject to a civil penalty of between $5,500 to $11,000 for each false claim, and treble the amount of the government's damages. The FCA applies to any federally funded program, including Medicare and Medi-Cal (Medicaid), and TRICARE. The FCA also allows for qui tam actions and provides protection from retaliation for whistleblowers:

    a. **Qui Tam Action** – A qui tam action occurs when a private person files suit for violations of the FCA on behalf of the government. The person bringing the action is referred to as a "relator" under the law, and also may be referred to as a "whistleblower." If the government decides to intervene in the qui tam action, the relator is entitled to receive between 15 – 25% of the amount recovered by the government. If the government declines to intervene, the relator's share is increased to 25 – 30% of the recovery.

    b. **Whistleblower Protections** – The federal False Claims Act also contains a provision that protects a whistleblower against retaliation. This applies to any employee who is discharge, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of having brought forward a lawful false claims action. The whistleblower may bring suit in an appropriate district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages, such as litigation costs and reasonable attorney's fees.

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2. **California False Claims Act (CFCA)** – A state law modeled after the Federal FCA. CFCA prohibits any person from submitting false or fraudulent claims valued at over $500 to state or local government. The CFCA also makes it illegal for any person who benefits from a false claim and who later discovers the falsity of the claim, to fail to disclose the false claim to state or local government. A person found liable under the CFCA is subject to a civil penalty of between $5,000 to $10,000 per claim, treble the amount of the state's damages, and the plaintiff's costs and attorney's fees. A relator under the CFCA can receive 15 – 33% of any recovery if the state or local government intervenes, and 25 – 50% if the state or local government decides not to intervene. The CFCA does not apply to workers' compensation claims, tax claims, or claims against public entities and employees. Like the federal False Claims Act, whistleblowers ("employee, contractor or agent") are protected against retaliation for having brought a lawful action forward.

3. **The Anti-Kickback Statute** – A federal law that makes it a criminal officers to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration includes anything of value such as cash, free rent, expensive hotel stays, meals, and excessive compensation for medical directorships or consultancies. Acceptable arrangements must meet certain regulatory safe harbors. Civil penalties for a violation of this statute may include up to $50,000 per kickback plus three times the amount of the kickback. Criminal penalties may include fines, imprisonment or both.

4. The **Physician Self-Referral Law** ("Stark Law") prohibits a physician from making a referral for certain designated health services to an entity in which the physician or an immediate family member has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties include fines and exclusion from participation in all federal healthcare programs.

5. The **Exclusion Statute** requires the Department of Health and Human Services' Office of the Inspector General (OIG) to impose exclusions from participation in all federal healthcare programs on healthcare providers and suppliers who have been convicted of (a) Medicare fraud as well as any other offenses related to the delivery of items or services under Medicare; (b) patient abuse or neglect; (c) felony convictions for other healthcare-related fraud, theft, or

other financial misconduct; or, (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

6. The **Civil Monetary Penalties** (CMP) Law imposes CMPs for a variety of healthcare fraud violations and different amount of penalties and assessments that may be authorized based on the type of violation. Penalties range from $10,000 to $50,000 per violation. CMPs can also be assessed up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited or received.

7. **State Medical Assistance Program Fraud**. California Welfare & Institutions Code Section 14107 prohibits fraud involving the state's medical assistance programs, including Medi-Cal. Under this statute, both civil and criminal actions can be brought against any person who knowingly defrauds any state medical assistance program by submitting false claims or making false representations. There are no qui tam provisions under this statute. Penalties for a violation of this statute include imprisonment or a fine not exceeding three times the amount or value of the fraud.

8. **Fraud Against Private Insurers (Payers)**. California Insurance Code Section 1871.7 prohibits a person from knowingly presenting a false claim for a health care benefit to a private insurer. Actions under this statute can be brought by the district attorney, California Insurance Commissioner, or a qui tam lawsuit may be filed by an individual.