

# POLICIES AND PROCEDURES MANUAL

KEYSTONE COMMUNITY RESOURCES, INC.

KEYSTONE INDEPENDENT LIVING, INC.



**Policy Title:**  
Medicaid Fraud, Abuse and Waste

**Chapter:**  
05 - Fiscal

**Effective Date:**  
1/15/2009

**Revision Date:**

**Policy Number:**  
05-300-001

**Executive Director**

## SCOPE:

All Keystone Programs and services

## INTRODUCTION:

Keystone demonstrates our commitment to compliance with laws and regulations to prevent fraud abuse and waste in the use of Medicaid funding through the development and distribution of written standards of conduct, as well as written policies and procedures that promote commitment to compliance throughout our agency.

Adherence to compliance is an element in evaluating managers and employees. This policy addresses:

- Specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals.
- The designation of a chief compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to state authorities.
- The development and implementation of regular, effective education and training programs for all affected employees;
- The maintenance of a process to receive complaints, protecting the anonymity of complainants and to protect them from retaliation;
- The system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements;
- The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area; and

- The investigation and remediation of identified systemic problems and the non-employment or retention of sanctioned employees.

## **DISCUSSION:**

### **STANDARDS OF CONDUCT AND RISK AREAS**

Keystone management employees and contractors shall not engage in any of the following acts:

- Knowingly present, or cause to be presented to the Government a false claim for payment;
- Knowingly make, use, or cause to be made or used, a false record or statement to get a false claim paid or approved by the government;
- Conspire to defraud the Government by getting a false claim allowed or paid;
- Falsely certify the type or amount of property to be used by the Government;
- Certify receipt of property on a document without completely knowing that the information is true;
- Knowingly buy Government property from an unauthorized officer of the Government;
- Knowingly make, use, or cause to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government..

These standards of conduct prohibit fraudulent acts including:

- Billing for items or services not actually rendered;
- Providing medically unnecessary services;
- Duplicate billing;
- False cost reports;
- Unbundling of billing claims;
- Patient's freedom of choice;
- Financial arrangements between facilities and providers that violate the anti-kickback statute or other similar Federal or State statute or regulation;
- Joint ventures;
- Knowing failure to provide covered services or necessary care to members of a health maintenance organization.

The following risk areas are regularly assessed and incorporated into staff training as part of Keystone's compliance program.

- Claim development and Submission Process
- Cost Reports
- Medical Necessity – Reasonable and Necessary Services
- Anti-Kickback and Self Referral Concerns
- Bad Debts
- Credit Balances
- Retention of Records

- Compliance as an Element of a Performance Plan

New and current employees are subject to background checks for criminal convictions. Those who are listed as disbarred, excluded or otherwise ineligible for participation in Federal health care programs shall be ineligible for employment.

## THE ROLE OF THE COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

Keystone has designated a Compliance Officer to serve as the focal point for compliance activities and establish a compliance committee to assist in the implementation of the compliance program.

The Compliance Officer shall have authority to review all documents and other information held by Keystone or contracted providers or sub-providers that are relevant to compliance activities, including but not limited to client records, billing records, employee records, contracts, policies and procedures.

The Compliance Officer shall be trained and certified by the Pennsylvania Department of Public Welfare as an Incident Management Certified Investigator.

The Compliance Officer's primary responsibilities include:

1. Overseeing and monitoring the implementation of the compliance program;
2. Reporting on a regular basis to the Executive team, government authorities and the compliance committee on the progress of implementation
3. Assist these components in establishing methods to improve the efficiency and quality of services, and to reduce Keystone's vulnerability to fraud, abuse and waste;
4. Periodically revising the program in light of changes in the needs of entities contracting services and in the law and policies and procedures of Medicaid;
5. Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State standards;
6. Ensuring that independent contractors and agents who furnish medical services to the Keystone are aware of the requirements of our compliance program with respect to coding, billing, and marketing, among other things;
7. Coordinating personnel issues with the Keystone's Human Resources department to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, medical staff and independent contractors;
8. Assisting the Keystone's financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;
9. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all Keystone components, providers and sub-providers agents and, if appropriate, independent contractors;

10. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

The Compliance Committee's functions include:

- Analyzing the Keystone's industry environment, the legal requirements with which it must comply, and specific risk areas;
- Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program;
- Working with appropriate Keystone components to develop standards of conduct and policies and procedures to promote compliance;
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Keystone's standards, policies and procedures a part of its daily operations;
- Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and
- Developing a system to solicit, evaluate and respond to complaints and problems.

## TRAINING AND EDUCATION

New employees shall receive the information contained in this policy within 30 days of hire.

Employees involved with compliance activities and risk areas may attend relevant training as warranted.

Each employee shall be made aware of the name, address, phone number and email address of the Compliance Office and their rights to protection from retaliation as whistleblowers via the educational material.

Each employee shall be made aware of the Department of Human Services Medicaid Fraud Hotline via the education material and posters to be displayed in employee common areas.

## RECEIVING AND RESPONDING TO COMPLAINTS

The Compliance Officer will receive complaints, interview complainants, and review these policies with them during the interview, including confidentiality and protection from retaliation.

Internal investigations of allegations of improper or illegal activities shall be investigated by the Compliance Officer or designated PA DPW Incident Management Certified Investigator and/or reported to Federal, State or Local law enforcement as warranted.

Employees who do not comply with the policies and procedures or who have otherwise engaged in wrongdoing shall be subject to disciplinary action up to and including termination, criminal and civil prosecution.

Keystone shall cooperate fully with all external auditing and monitoring activities to ensure compliance

Keystone management shall develop a plan of corrective action to address remediation and correction of founded complaints.

## FEDERAL AND STATE LAWS ON FALSE CLAIMS; FRAUD, WASTE AND ABUSE

### Federal False Claims Act, 31 U.S.C. 3729-3733

The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government--tax fraud excepted. In summary, the Act prohibits:

- a. Knowingly presenting, or causing to be presented to the Government a false claim for payment;
- b. Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
- c. Conspiring to defraud the Government by getting a false claim allowed or paid;
- d. Falsely certifying the type or amount of property to be used by the Government;
- e. Certifying receipt of property on a document without completely knowing that the information is true;
- f. Knowingly buying Government property from an unauthorized officer of the Government, and;
- g. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

Any individual or entity engaging in any of the seven categories of prohibited actions listed in 31 U.S.C. 3729(a), including the submission of false claims to federally-funded health care programs, shall be liable for a civil penalty which currently is not less than \$5,500 and not more than \$11,000 per false claim, plus three times the amount of damages sustained by the federal government. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

### Health Care Claims Fraud Act N.J.S. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5

Provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

- a. A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is

subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;

- b. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to 1 year;
- c. A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;
- d. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

## THE RIGHTS OF THE EMPLOYEES TO BE PROTECTED AS WHISTLEBLOWERS

31 U.S.C. 3730(h) provides that any employee who is subject to retaliation or discrimination by an employer in the terms and conditions of employment because the employee lawfully sought to take action or assist in taking action under this act “shall be entitled to all relief necessary to make the employee whole.” This includes reinstatement with seniority restored to what it would have been without the retaliation or discrimination, double the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the employer’s actions, including litigation costs and reasonable attorney’s fees.

## ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS OR STATEMENTS.

### Federal Program Fraud Civil Remedies Act, 31 U.S.C. 3801-3812

Provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are \$5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S. 30:4D-17(a)-(d)

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to \$10,000, imprisonment for up to 3 years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to \$10,000, imprisonment for up to 3 years, or both; (c) kickbacks, rebates and bribes: fine of up to \$10,000, imprisonment for up to 3 years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to \$3,000, or imprisonment for up to 1 year, or both. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a.:

In addition to the criminal sanctions discussed in section 3 above, violations of N.J.S. 30:4D-17(a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation: recovery of overpayments, interest, up to triple damages, and, as indicated in section V.D.8, below, a penalty (which was increased from \$2,000 to \$5,500 to \$11,000) for each false claim as a result of the NJ False Claims Act. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

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- a. A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;
- b. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to 1 year;

- c. A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;
- d. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

The Uniform Enforcement Act N.J.S. 45:1-21. b. and o.

Provides that a licensure board within the N.J. Division of Consumer Affairs “may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board” who as engaged in “dishonesty, fraud, deception, misrepresentation, false promise or false pretense:, or has “[a]dvertised fraudulently in any manner.”

N.J. Consumer Fraud Act N.J.S. 56:8-2, 56:8-3.1, 56:8-13, 56:8-14 and 56:8-15

Makes unlawful the use of “any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact”, with the intent that others rely upon it, in connection with the sale, rental or distribution of any items or services by a person, or with the subsequent performance of that person.

## **NOTES**

**Reference NJ DHS Circular #54**