



CITY OF PORTLAND MAINE

Policies and Procedures

NAME: FALSE CLAIMS /FRAUD, WASTE & ABUSE/WHISTELBLOWER
PROTECTION RE: MEDICARE/MAINECARE PROGRAMS

PURPOSE:

The purpose of this Policy is to comply with the Federal False Claims Act, as recently amended by the Deficit Reduction Act of 2005. This Act is applicable to all recipients of \$5,000,000 or more in MaineCare funds, which includes the City of Portland. In brief, the False Claims Act imposes liability on any person who submits a claim for payment to the federal government (e.g. a Medicare or MaineCare [Medicaid] claim) that he or she knows is false. "Knows" means actual knowledge, or acting in reckless disregard or in deliberate ignorance of the truth or falsity of the information.

This policy defines for employees and contractors what the False Claims Act is, what is considered fraud, waste and abuse, and how "whistleblowers" are protected if they report on any type of false claim or fraud, waste, or abuse that they may have knowledge of. This policy will help to provide a better understanding of the types and practices that are forbidden under law.

SECTION 6032 OF DEFICIT REDUCTION ACT:

On February 8, 2006, the President signed the Deficit Reduction Act ("DRA" or the "Act") of 2005 (Public Law 109-171) which included a Title on "Eliminating Fraud, Waste, and Abuse in Medicaid." Of importance to City staff and contractors is Section 6032 which provides as follows:

"...any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall –

"(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any state laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs ...;

"(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

"(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse."

These Medicaid provisions were enacted as part of the DRA because of the increased pressure on the Federal budget due to rising costs for Medicare and Medicaid. Federal officials wanted more tools to combat any potential fraud and abuse in the Medicaid system.

EXAMPLES OF MEDICAL FRAUD:

"Phantom Billing" - Billing for tests not performed.

Performing inappropriate or unnecessary procedures.

Charging for equipment/supplies never ordered.

Billing Medicare/Medicaid for new equipment but providing the patient used equipment.

Billing Medicare/Medicaid for expensive equipment but providing the patient cheap equipment.

A drug or equipment supplier completing a Certificate of Medical Necessity (CMN) instead of the physician.

"Reflex testing" - Automatically running a test whenever the results of some other test fall within a certain range, even though the reflex test was not requested by a physician.

"Defective Testing" - When a test or part of a test was not performed because of technical trouble (ie: insufficient or destroyed sample, machine malfunction) but is billed for anyway.

"Code Jamming" - Laboratories inserting or "jamming" fake diagnosis codes to get Medicare/Medicaid coverage.

Offering free services or supplies in exchange for your Medicare or Medicaid number.

"Unbundling" - Using two or more Current Procedural Terminology ("CPT") billing codes instead of one inclusive code for a defined panel where rules and regulations require "bundling" of such claims.

Submitting multiple bills, in order to obtain a higher reimbursement for tests and services that were performed within a specified time period and which should have been submitted as a single bill.

"Double Billing" — charging more than once for the same service, for example by billing using an individual code and again as part of an automated or bundled set of tests.

"Up Coding" - Inflating bills by using diagnosis billing codes that indicate the patient experienced medical complications and/or needed more expensive treatments. (eg., billing for complex services when only simple services were performed, billing for brand-named drugs when generic drugs were provided, listing treatment as having been for a more complicated diagnosis than was actually the case.)

"Phantom Employees" - Expensing employees or hours worked that do not exist.

"Improper Cost Reports" — Submitting false cost reports seeking higher Medicare reimbursements than permitted by actual facts.

Providing substandard nursing home care and seeking Medicare reimbursement.

Routinely waiving patient co-payments.

WHISTLEBLOWER EMPLOYEE PROTECTIONS:

A. Federal Law

In 1986, Congress added anti-retaliation protections to the False Claims Act. These provisions, which did not exist previously, are contained in 31 U.S.C. Sec. 3730(h):

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of his employer or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

The protection against retaliation extends to whistleblowers whose allegations could legitimately support a False Claims Act case even if the case is never filed. The statute of limitations for Sec. 3730(h) claims is 6 years in most jurisdictions.

B. State Law, 26 M.R.S.A. 831-840:

This State law also protect employees from discrimination or adverse action for “whistleblowing” activities. **It is illegal for your employer to fire you, threaten you, retaliate against you or treat you differently because:**

1. You reported a violation of the law;
2. You are a healthcare worker and you reported a medical error;
3. You reported something that risks someone’s health or safety;
4. You have refused to do something that will endanger your life or someone else’s life and you have asked your employer to correct it; or
5. You have been involved in an investigation or hearing held by the government.

You are protected by this law ONLY if:

1. You tell your employer about the problem and allow a reasonable time for it to be corrected; or
2. You have good reason to believe that your employer will not correct the problem.

If you have taken these steps and believe that an adverse action has been taken against you as a result of reporting a false claim, you should contact Ed Anderson, Director of Human Resources, 389 Congress Street, Portland, ME 04101 (207)-874-8624 or you may contact:

The Maine Human Rights Commission
51 State House Station
Augusta, Maine 04333
Tel: (207) 624-6050
TTY: (207) 624-6040
www.Maine.gov/mhrc

CONTACT INFORMATION FOR REPORTING FRAUD, WASTE, & ABUSE:

If you believe the City of Portland or its employees have, or will, file a false claim under the Medicare/MaineCare Act, please report it to Anita Lachance, Assistant City Manager, 389 Congress Street, Portland, ME 04101 (207) 874-8673.

The state contact for administering MaineCare is

Office of MaineCare Services
442 Civic Center Drive
11 State House Station,
Augusta, Maine 04333-0011

Carefully review the facts as you know them and provide as much specific information as possible such as:

The provider's name and any identifying number you may have.
The item or service you are questioning.
The date on which the item or service was supposedly furnished.
The amount approved and paid by Medicare/MaineCare.
The date of the Medicare/MaineCare Summary Notice.
The name and Medicare/MaineCare number of the person who supposedly received the item or service.
The reason you believe Medicare/MaineCare should not pay, or should not have paid, the claim.

Any other information you may have showing that the claim for the item or service should not be paid by Medicare/MaineCare.

To further assist you, the Office of Inspector General maintains a hotline, which offers a confidential means for reporting vital information related to potential Medicare/Medicaid fraud. The Hotline can be contacted in the following ways:

By Phone:	1-800-HHS-TIPS (1-800-447-8477)
By Fax:	1-800-223-2164 (no more than 10 pages please)
By E-Mail:	<u>mailto:HHSTips@oig.hhs.gov</u>
By Mail:	Office of Inspector General U.S. Department of Health and Human Services HHS TIPS Hotline P.O. Box 23489 Washington, DC 20026

If you are attempting to report specific information proving Medicare/MaineCare fraud, please provide as much identifying information as possible regarding your concern. Such information should include subject's name, address and phone number etc. Details regarding the allegation should include the basics of who, what, when, where, why, and how.

Please note that it is current Hotline policy not to respond directly to written communications

PENALTIES FOR SUBMITTING FALSE CLAIMS:

Over the last decade, the risks associated with non-compliance have grown dramatically. The government has dedicated substantial resources, including the addition of criminal investigators and prosecutors, to respond to health care fraud and abuse. In addition to government investigators and auditors, private whistleblowers play an important role in identifying allegedly fraudulent billing schemes and other abusive practices. Health care providers can be found liable for submitting claims for reimbursement in reckless disregard or deliberate ignorance of the truth, as well as for intentional fraud. Because the False Claims Act authorizes the imposition of damages of up to three times the amount of the fraud and civil monetary penalties of \$11,000 per false claim, record level fines and penalties have been imposed against individuals and health care organizations that have violated the law.

In addition to criminal and civil monetary penalties, health care providers that are found to have defrauded the federal health care programs may be excluded from participation in these programs. The effect of an exclusion can be profound because those excluded will not receive payment under Medicare, Medicaid or other federal health care programs for items or services provided to program beneficiaries. The authorities of the OIG provide for mandatory exclusion for a minimum of five years for a conviction with respect to the delivery of a health care item or service. The presence of aggravating circumstances in a case can lead to a lengthier period of exclusion. Of perhaps equal concern to board members, the OIG also has the discretion to exclude providers for certain conduct even absent a criminal conviction. Such conduct includes participation in a fraud scheme, the payment or receipt of kickbacks, and failing to provide services of a quality that meets professionally recognized standards. In lieu of imposing exclusion in these instances, the OIG may require an organization to implement a comprehensive compliance program, requiring independent audits, OIG oversight and annual reporting requirements, commonly referred to as a Corporate Integrity Agreement.

The False Claims Act (31 U.S.C. Sections 3729-33) allows a private individual or "whistleblower", with knowledge of past or present fraud on the federal government, to sue on behalf of the government to recover stiff civil penalties and triple damages. The person bringing the suit is formally known as the "Relator." If the suit is successful, it not only stops the dishonest conduct, but also deters similar conduct by others and may result in the Relator's receipt of a substantial share of the government's ultimate recovery – as much as 30 percent of the total.

Generally, only the Relator who is the first to file a lawsuit can be rewarded for reporting the fraud. Even if one person uncovers the fraud, someone else can file the lawsuit first and bar the first whistleblower from sharing in any recovery.

If you think you have a case, it is important for you to contact an experienced Qui Tam lawyer right away.

STATEMENT OF POLICY:

The City of Portland will make efforts through sound business office operations, periodic audits, and staff training for the prevention of the following practices:

- Billing for services not rendered (for Medicare please note: 42 Code of Federal Regulations: Section 484.48 [HHA], 403.75 (L)(1) [SNF], 485.60 [CORF] and 482.24 [Hospital] Conditions of Participation: clinical records, addresses establishing and maintaining Medical records);
- Incorrect reporting of diagnosis or procedures to maximize reimbursement;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies;
- Misrepresentation of dates and descriptions of services furnished or of the identity of the beneficiary or the individual who furnished the services;
- Claims for non-covered services billed as covered services;
- Use of another person's Medicare/MaineCare card/number;
- Alteration of claims history to generate fraudulent payment;
- Split Billing Schemes, such as billing Medicare A and B for the services of hospital based physicians when the physician has a 100% Part B allocation, or billing both program components for Oxygen therapy in a Skilled Nursing Facility;
- Collusion between Intermediary employee acting on behalf of him/herself, and/or beneficiaries or providers;
- Not allowing hospital discharges their free choice of the following:

Post hospital Home Health Care Agency, DME supplier, Oxygen supplier, IV therapy or Enteral/Parenteral Nutrition provider

Examples of cost report fraud may include, but are not limited to:

- Incorrect apportioning costs on cost reports;
- Including costs of non-covered services, supplies or equipment in allowable costs (Effective 1/1/1998, the Balanced Budget Act of 1997 specifically excludes payment for certain "perks", such as sporting events, personal use of autos, etc. These benefits will no longer be considered and reviewed as part of owner/key employee compensation.);
- Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits;

- A pattern or history of deliberately billing beneficiaries rather than Medicare for covered services;
- Billing Medicare/MaineCare for costs not incurred or which were attributed non-program activities, other enterprises or personal expenses;
- Repeatedly including unallowable cost items on a provider's cost report except for purposes of establishing a basis for appeal (specific cost report instructions must be followed when including previously disallowed costs);
- Manipulation of statistics to obtain additional payment, such as increasing the square footage in the outpatient areas to maximize payment;
- Claiming bad debts without first genuinely attempting to collect payment;
- Certain hospital-based physician arrangements and amounts actually paid to physicians;
- Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;
- Days that have been improperly reported and would result in an overpayment if not adjusted;
- Depreciation for assets that have been fully depreciated or sold;
- Depreciation methods not approved by Medicare or MaineCare;
- Interest expense for loans that have been repaid for an offset of interest income against the interest expense;
- Program data where provider program amounts cannot be supported;
- Improper allocation of costs to related organizations that have been determined to be improper;
- Accounting manipulations.

Examples of abuse may include, but are not limited to:

- Claims for services not medically necessary (Example: progress vs. maintenance therapy);
- Billing for services grossly in excess of those needed by the patient;
- A pattern of improper billing practices:
 - Billing Medicare at a higher rate than non-Medicare or the submittal of bills of Medicare instead of another payer which is primary;
- Violations of Medicare or MaineCare Participation Agreements;

- Assignment agreement violations by routinely billing beneficiaries for items or services which they are not required to pay;
- Adjustments to depreciation for assets which have been fully depreciated or sold;
- Adjustments to amounts paid to owners or administrators which have been determined to be excessive.

Employees will have access to the FCA information during new employee orientation, when employees are renewing their yearly mandatory trainings, in the City's Department of Health and Human Services Policies, in the Fire/Emergency Medical Services Policies and on the City Internet and Intranet Web Sites.

City of Portland Contractors and Agents involved with Medicare/MaineCare programs will be mailed copies of this policy and will be sent updates if and when any changes to this policy are made.

Approved by Joseph E. Gray Jr.,
City Manager

4-4-08
Date:

Douglas Gardner, LTC Administrator

Date:

Original Issue Date:
Revised and Revised: