False Claims Act Policies and Procedures

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Overview

The False Claims Act is one of many federal laws that helps prevent fraud, waste and abuse in the health care industry. Any submission of false information, records or claims regarding federal health care programs may violate the False Claims Act and can result in severe financial penalties. Examples of false claims can include billing for services not provided or medically necessary, billing for the same service more than once or making false statements to receive payment for services. Violators of the False Claims Act can submit a false claim either actively knowing that it is false, or can submit it with "reckless disregard" to whether or not the claim is false. With either case, violators may face steep fines and civil penalties that can equal three times the amount of the false claim plus additional fines per claim.

False Claims Act Policies and Procedures

Although False Claims Act penalties can be severe, health care organizations can implement standard policies and procedures to ensure that all levels of the workforce understand the False Claims Act. These policies and procedures also help workforce members learn how to remain compliant with the law in order to prevent possible violations and other fraud, waste and abuse in the workplace.

Standard False Claims Act policies include:

1. The organization will abide by all federal and state laws to effectively implement and enforce procedures to detect and prevent fraud, waste and abuse in receiving payments from federal health care programs.

2. The organization will educate and train workforce members about fraud and abuse, including the detailed provisions of the False Claims Act, state laws regarding civil or criminal penalties and qui tam provisions through compliance training.

3. All workforce members, management and contractors or agents will be knowledgeable and aware of laws regarding false or fraudulent claims.

4. The Compliance Officer is responsible for ensuring that the compliance program is effective in detecting and preventing potential incidents of fraud, waste and abuse. With oversight from the Compliance Officer, operations managers will establish and maintain

methods for detecting and preventing incidents of fraud, waste and abuse, including but not limited to:

a. A claims quality assurance program that monitors the accuracy of adjudicated claims
b. A compliance hotline
c. A process that identifies employees, contractors, vendors and providers that are debarred or excluded from participating in federal programs.

Further, it is the Compliance Officer's responsibility to ensure that any incidents are appropriately handled by qualified personnel, discussed, and reported to the appropriate law enforcement agency. If the Compliance Officer or legal counsel identifies any incidents of fraud and abuse, the organization will implement systematic changes and corrective action initiatives to prevent further offenses.

5. All workforce members will conduct themselves in an ethical and legal manner, including maintaining accurate records related to the rendering of items or services payable by federal health care programs.

6. The organization will fully cooperate with federal and state agencies that conduct health care fraud and abuse investigations.

7. All workforce members, contractors and agents will be responsible for reporting potential or suspected incidents of fraud and abuse and/or other wrongdoing directly to their supervisor and/or executive management or by using an internal reporting method such as a compliance hotline.

8. The organization will protect all workforce members from retaliation and retribution when they report suspected wrongdoing through any reporting method.

9. The Compliance Officer, in consultation with legal counsel, will be responsible for receiving and acting upon all information suggesting possible fraud, abuse or wrongdoing, and for directing all investigations.

10. The Compliance Officer, in consultation with legal counsel, will conduct an investigation into any allegations of suspected violations of any criminal, civil or administrative law.

11. The organization will include all policies and procedures in the workforce member handbook or manual and distribute all information to contractors and agents in accordance with the Deficit Reduction Act of 2005.

Standard False Claims Act procedures include:

1. Training on the False Claims Act will be delivered to all workforce members through the annual compliance program training. False Claims Act training will include:
    a. Detailed information on the False Claims Act and the administrative solutions for false claims and statements
    b. State laws pertaining to civil or criminal penalties
    c. Whistleblower rights

   d. The organization's requirements for preventing, detecting and reporting fraud, waste and abuse

2. Complaints, allegations, and concerns reported through the compliance hotline and/or received directly by the Compliance Office concerning fraud and abuse will be handled under the direction and coordination of the Compliance Officer.

3. To the extent practical or allowed by law, the Compliance Officer will maintain the confidentiality or anonymity of any workforce member when requested.

4. Retaliation or retribution for reporting issues in good faith is prohibited.

5. All Covered Persons employees, contractors and agents with knowledge of potential fraud and abuse situations will report them by notifying:
   a. Their direct supervisor
   b. Any supervisor or member of management
   c. Human Resources
   d. The Compliance Officer or Compliance Department, either in person or by phone
   e. The confidential compliance hotline

6. Any party who receives a report of fraud (e.g., management, Human Resources, legal counsel, etc.) will immediately inform the Compliance Officer, who will conduct an initial investigation before any other action is taken. No supervisor or manager should directly confront the workforce member alleged to have committed fraud, or otherwise discuss the issue with anyone suspected of engaging in fraudulent or abusive practices without prior approval from the Compliance Officer.

7. The Compliance Officer will direct or conduct fraud and abuse investigations. In doing so, the Compliance Officer will gather facts of the incident as promptly as possible.

8. If the Compliance Officer determines that there is sufficient evidence to support an allegation of violation of law or regulation, he/she will consult with legal counsel on further investigation, and whether legal counsel should conduct or direct the additional investigations. If an allegation is a criminal violation of law, the Compliance Officer will immediately refer the case to legal counsel.

9. If the organization's legal counsel assumes responsibility for the continued investigation, the organization will develop a memo that is signed by both the Compliance Officer and legal counsel stating:
   a. Whether inside or outside counsel will be leading the investigation
   b. That the investigation is being conducted in anticipation of litigation
   c. The role the Compliance Officer will have in the investigation

10. When legal counsel takes over a compliance investigation, they will evaluate the facts to determine if credible evidence of a violation of criminal, civil or administrative law exists. Legal counsel will notify the organization's senior management of the results of its compliance investigation, and provide the Compliance Office with sufficient details of the compliance investigation to show that it is properly addressing the issue.

11. The Compliance Officer may also use legal counsel to help determine the extent of liability resulting from false claims submission, as well as to assist in planning the appropriate actions to correct deficiencies and resolve any liability issues.

12. The organization will take appropriate disciplinary and enforcement action (i.e., corrective actions, employment termination or contract termination) against workforce members, providers, subcontractors, consultants, and agents found to have committed fraud and abuse violations.

In Review

Given the financial consequences of violating the False Claims Act, it is important for health care organizations to invest time and effort in making sure the workforce is informed about the details of this law and the ways in which they can help prevent violations and other non-compliant incidents. By implementing standard policies and procedures, and teaching the workforce about them, organizations can maintain compliance with False Claims Act regulations and requirements. This can help reduce instances of fraud, waste and abuse related to false claims submitted to federal health care programs that could potentially cost the organization thousands of dollars and its credibility in the health care industry.

About the Author

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About Compliance Resource Center

Compliance Resource Center has been leading the compliance industry since 2010 with our complete suite of solutions that are geared towards improving compliance program operations. Our solutions ensure that organizations regularly meet federal and state laws and supply the necessary resources to sustain long-term compliance.