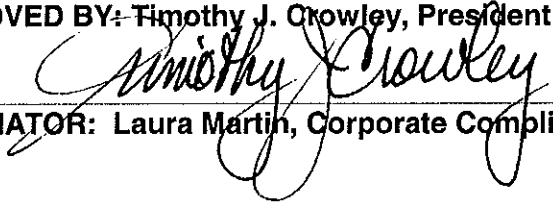


**CMH Regional Health System
Wilmington, Ohio**

TITLE: Detection and Prevention of Fraud, Waste, and Abuse and Applicable Federal and State Laws	POLICY NO: SPP 259
DEPARTMENT: Hospital-Wide	PAGE 1 OF 5 PAGES
APPROVED BY: Timothy J. Crowley, President & CEO 	EFFECTIVE DATE: March 1, 2007
ORIGINATOR: Laura Martin, Corporate Compliance Officer	
COLLABORATORS: Corporate Compliance Committee	

PURPOSE

This policy is required by the Deficit Reduction Act of 2005 and Ohio Revised Code Section 5111.101 and must be provided to every employee of CMH Regional Health System and every contractor and agent who furnishes or authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care provided by CMH Regional Health System. The purpose is to educate such individuals regarding CMH Regional Health System's policies and procedures to detect and prevent fraud, waste, and abuse (including the avenues for reporting concerns internally); to support the efforts of federal and state authorities in identifying incidents of fraud and abuse; and to provide an overview of the Federal Civil False Claims and Program Fraud Civil Remedies Acts and applicable state laws.

CMH CORPORATE COMPLIANCE PROGRAM

CMH Regional Health System has in place a Corporate Compliance Program. One of the purposes of the Compliance Program is to detect and prevent fraud, waste, and abuse in its hospital or system, including fraud, waste, and abuse in the Federal and State health care programs. The Corporate Compliance Handbook is available for review by all employees, agents, and contractors at www.cmhregional.com. (Follow the links "About Us"/"Corporate Compliance." The Handbook contains detailed information regarding how questions or concerns regarding possible fraud, waste, and abuse must be reported internally at CMH Regional Health System. In summary, if an individual becomes aware of a troublesome situation, they should ask their supervisor or manager for guidance and clarification. If these individuals are unable to help, or the concern persists, the individual should contact the CMH Corporate Compliance Support Coordinator or the Corporate Compliance Officer for assistance. If the concern is not promptly resolved, please call the Corporate Compliance Hotline at (888) 248-9808. Calls are treated with confidentiality. CMH Regional Health System prohibits retaliation against anyone who reports wrongdoing or unethical practices. Every employee has a duty to bring questions and concerns to the attention of appropriate individuals within CMH Regional Health System.

OVERVIEW OF FEDERAL AND STATE FALSE CLAIMS LAWS

The Role of Federal and State Laws in Preventing Fraud, Waste, and Abuse: The Centers for Medicare and Medicaid Services (CMS) defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as incidents or practices of providers that are inconsistent with sound medical practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are medically unnecessary.

The Federal Government and the State of Ohio have enacted criminal and civil laws pertaining to the submission of false or fraudulent claims for payment or approval to the federal and state governments and to private payors. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and also provide anti-retaliation provisions for individuals who make good faith reports of waste, fraud, and abuse.

The Federal Civil False Claims and Program Fraud Civil Remedies Acts, applicable State laws, and anti-retaliation provisions are summarized in the following sections.

1. FEDERAL CIVIL FALSE CLAIMS ACT

The **Civil False Claims Act** (31 U.S.C. §3729 *et seq.*) is a statute that imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- conspires to defraud the government by getting a false or fraudulent claim allowed or paid,
- uses a false record or statement to avoid or decrease an obligation to pay the Government,
- and other fraudulent acts enumerated in the statute.

The term "**knowingly**" as defined in the Civil False Claims Act ("FCA") includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and eleven thousand per claim, treble damages, and the costs of any civil action brought to recovery such penalties or damages.

The **Attorney General of the United States** is required to diligently investigate violations of the FCA, and may bring a civil action against a person. Before filing suit the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for **Actions by Private Persons** (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit has the right to conduct the action.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. If the *qui tam* plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty per cent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

Whistleblower Protection. The Civil False Claims Act also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

2. FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT OF 1986

The **Program Fraud Civil Remedies Act of 1986** ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 *et seq.*) is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

The term "**knows or has reason to know**" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The authority, i.e., federal department, may investigate and with the Attorney General's approval commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the submission of the claim. The Act allows for **civil monetary sanctions** to be imposed in administrative hearings, including penalties of five thousand five hundred dollars per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

3. STATE FALSE CLAIMS

Ohio law also regulates the filing of false claims in an attempt to defraud Medicaid. Under Ohio law, only providers can be civilly liable for obtaining or attempting to obtain "payments . . . to which the provider is not entitled pursuant to the Medicaid provider agreement, or the rules of the federal government of the department of job and family services." (Ohio Rev. Code §5111.03) Similar to the federal False Claims Statute, no actual intent to deceive or defraud the government is necessary. If convicted, the provider may be subject to several civil penalties, including but not limited to: payment of interest on the amount of the excess payment, payment of three times the amount of excess payments, a fine between five and ten thousand dollars (\$5,000.00 - \$10,000.00) for each false claim, and any other reasonable expense determined by the court. Further, the provider's provider agreement will be terminated for five years.

4. STATE CRIMINAL FRAUD STATUTES

The Ohio **Insurance Fraud** statute (Ohio Rev. Code. §2913.47) provides that a person who knowingly causes, assists with, solicits, or conspires in the presentation of a claim to an insurer, knowing that the statement or any part of the statement is false or deceptive, is, depending upon the amount of the claim, guilty of anywhere from a misdemeanor to a felony.

The Ohio **Medicaid Fraud Statute** (Ohio Rev. Code. §2913.40) provides **criminal** penalties and sanctions related to any person who knowingly makes a false or misleading statement or representation in obtaining reimbursement from the Medicaid program. The Statute also provides that it is unlawful for a provider to alter, destroy or conceal any records (for a period of six years after the reimbursement) that are necessary to fully disclose the nature of goods and services for which the claim was submitted or the income and expenditures upon which rates of reimbursement are based.

The Ohio **Medicaid Eligibility Fraud Statute** (Ohio Rev. Code §2913.301) provides civil and criminal penalties and sanctions related to anyone who makes or causes a false or misleading statement, conceals an interest in property, or fails to disclose certain property transfers in an application for Medicaid benefits, including in a document involving disclosure of assets for the purpose of determining eligibility for Medicaid benefits.

If convicted of any of the above fraud statutes, the individual could go to jail and/or be ordered to pay fines and repayments. Additionally, if someone, especially a licensed medical provider, is found guilty of Medicaid Fraud, either civilly or criminally, their license can come under review and be suspended or permanently revoked as a result of their fraudulent activity.

The Ohio **Workers' Compensation Statute** (Ohio Rev. Code. §2913.48) provides **criminal** penalties and sanctions related to any person who knowingly makes a false or misleading statement or representation in obtaining reimbursement from the workers' compensation program or to secure benefits. The Statute also provides that it is unlawful for a provider to alter, destroy or conceal any records necessary to establish the validity of any claim or to present a false statement concerning manual codes, employee classifications, payroll, paid compensation, or number of personnel, when such information is necessary to determine worker' compensation premium rates or assessments.

The Ohio **Falsification Statute** (Ohio Rev. Code. §2921.13) provides **criminal**

penalties and sanctions related to any person who knowingly makes a false statement: in connection with a variety of different activities, including but not limited to statements made: in an official proceeding; with the purpose to incriminate another; with the purpose to mislead a public official in performing their official function; with the purpose to secure governmental benefits; to secure a governmental license or provider agreement; before a notary public; in connection with a report required or authorized by law; to obtain Ohio's best Rx program enrollment card or payment from the Department of Job and Family Services.

5. STATE WHISTLEBLOWER PROTECTIONS

Employees who report violations of state or federal law or regulation are provided protection against retaliation or disciplinary action related to the report pursuant to the "**Whistleblower's Protection Act.**" (Ohio Rev. Code §4113.52) The Act prohibits a public body from dismissing, suspending, demoting, or taking other adverse actions against an employee based on the employee's filing of a report of wrongdoing with an appropriate authority.

This statute permits employees to report to their supervisor or other responsible officer of their employer, violations of state or federal statute or any ordinance or regulation of a political subdivision that the employer has authority to correct and the employee reasonably believes that the violation either is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety or is a felony. The employee shall orally notify the supervisor or other responsible officer of his employer of the violation and subsequently file a written report describing the violation.

This statute also provides that if the employer neither corrects nor makes a reasonable and good faith effort to correct the violation within twenty-four hours after receiving notice of the violation, the employee may file a written report of the violation with any of the following: 1) the prosecuting attorney of the county or municipal corporation where the violation occurred, 2) law enforcement, 3) any governmental entity that has regulatory authority over the employer, or 4) the inspector general (if the violation is within his jurisdiction).

If an employer takes disciplinary or retaliatory action against the reporting employee, the statute permits the employee to file a civil action for injunctive relief or other remedies in a court of common pleas, provided the action is brought within one hundred eighty days after the date the disciplinary or retaliatory action was taken. The court may render a judgment that may order reinstatement of the employee, payment of back wages, reinstatement of fringe benefits and seniority rights or any combination of remedies. The court may also award the prevailing party all or a portion of the costs of litigation in an amount the court determines to be appropriate.

The statute protects employees who follow the statutory procedures in reporting any of the previously stated matters. The employee must make a reasonable effort to ensure the accuracy of information included in the report and, if it is shown that the employee purposely, knowingly, or recklessly reported incorrect or false information, the employee is subject to disciplinary action, including suspension or removal.