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| | Title: False Claims, Fraud, Waste and Abuse | | |
| | Department: Compliance | | |
| | Effective Date: 12/27/2018 | Approval Date: 08/04/2023 | Approved By: Compliance and Privacy Program Manager |

1. Principle / Purpose

It is the policy of National Jewish Health (“NJH”) that all employees, affiliates, vendors, consultants and agents are educated about the Federal and Colorado false claims laws in place and the obligation to prevent and detect fraud, waste and abuse in federal health care programs and other federal programs under which claims are made for payment for goods and/or services.

2. Definitions

Abuse: includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Claim: any request or demand, whether under a contract or otherwise, for money or property which is:

- Presented to an officer, employee or agent of the United States or
- Made to a contractor, grantee or other recipient, if the United States Government provides any portion of the money or property which is requested or demanded, or if the United States Government will reimburse such contractor, grantee or other recipient for any portion of the money or property which is requested or demanded.

Fraud: is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretense, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Knowingly:

- Requires no proof of specific intent to defraud;
 - Means that a person with respect to the claim or information material to the claim:
 - 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.

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False Claim Violation: occurs when any person:

- Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim or obligation to pay the government;
- Knowingly delivers or causes to be delivered less than all of money or property in its possession, custody or control which is due and owing to the government; or
- Conspires to commit one of the above.

Waste: is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

3. Scope

All NJH workforce members including officers, managers, faculty, affiliates, volunteers and others working at or on behalf of NJH, whether or not they are paid by NJH and National Jewish Vendors, Consultants and Agents.

4. Policy

4.1. Compliance Program

4.1.1. Annual Renewal.

Every year, NJH's employees and affiliates acknowledge the NJH Code of Conduct and receive general compliance training, including training about false claims. Only Compliance Office staff members (e.g. Chief Compliance and Privacy Officer or designee) may develop or revise the specified training. Final approval by the Chief Compliance Officer is required.

4.1.2. Other Policies and Practices.

In addition to the Code of Conduct, departments within NJH have a variety of policies, systems and practices in place in order to be certain that claims filed for payment are:

- Backed up by accurate documentation,

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- Appropriate to the level of services(s) provided or applicable contractual requirements, and
- Correctly aligned with the coding methodologies or other regulatory requirements of the applicable payer.

4.1.3. Examples of False Claims, Fraud, Waste and Abuse

- Billing for services or goods not provided;
- Altering claims forms and/or receipts in order to receive a higher payment amount;
- Duplicating billings that including billing both the Medicare program and the beneficiary, Medicaid or some other insurer in an effort to receive payment greater than allowed;
- Offering, paying soliciting or receiving bribes, kickbacks or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by Medicare, Medicaid or other government program;
- Submitting or maintaining inaccurate or insufficient records or documentation in support of a claim;
- Obtaining interim payments from Medicare throughout the year and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program;
- Falsifying a certificate of medical necessity and bills for services that did not meet the Medicare definition of “medically necessary” or for a patient not personally and professionally known by the provider;
- Billing separately for services that should be billed together;
- Failing to report overpayments or credit balances;
- Billing for services performed by an unlicensed person when a license is required to perform the service.

4.1.4. Investigation, Correction.

If an employee or other individual is not in a position to resolve the problem him or herself, NJH expects that anyone with a concern about a possible false claim at a NJH facility will report it immediately so that NJH can investigate and correct any errors.

4.2. **Reporting Required, Whistleblower Protections**

4.2.1. How to Report.

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Options for reporting concerns about unethical behavior and legal violations as it relates to NJH or any third party contract (i.e. Medicare Plans), including the preparation and filing of false claims or other false requests for payment, include:

- An employee’s own supervisor, manager or director;
- Compliance Office staff (303-398-1466)
- The Chief Compliance Officer
- The Corporate Compliance Hotline (844-369-5635 or NJHealth.ethicspoint.com.)
 - Please see NJH Policy Reporting HIPAA and Compliance Issues, Retaliation Prohibited for additional details.

4.2.2. Good Faith Reporting Protected.

Any employee who, in good faith, becomes concerned that incorrect information or some other flaw in a particular instance or due an ongoing practice or system may result in a bill or other request for payment being wrong is:

- Required to report this information, and
- Protected from retaliation for having done so.

4.2.3. Enforcement Actions.

- The Federal False Claims Act contains:
 - authority for a private person to bring a civil action in the name of the United States and against the person or entity who has committed a False Claim Violation; and
 - authority for relief from retaliatory actions (including discharge, demotion, suspension, threats, harassment or other discrimination) taken because of lawful acts done in furtherance of such a civil action or other efforts to stop one or more False Claim Violations.
- The Colorado Medicaid False Claims Act contains similar provisions when the money or property concerned is used by the State of Colorado in connection with the Colorado Medical Assistance Act.

5. Legal Requirements

5.1. The Federal False Claims Act.

Penalties and sanctions extend to all False Claim Violations (including those involving federal healthcare programs.)

- Fines (up to three times the damages suffered by the Government):
- Additional penalties of from \$5,500 to \$11,000 per false claim filed; and
- Exclusion from participation in (being able to bill and accept payment from) federal healthcare programs including Medicare and Medicaid.

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5.2. The Federal Program Fraud Civil Remedies Act.

Penalties extend to all False Claim Violations (including those involving Federal health care programs.)

5.2.1. Administrative Recoveries by Federal Agencies.

- The law is violated when a person submits a claim that the person knows is false or contains false information or omits material information.
- The agency receiving the claim makes its own determination of whether a claim is false.

5.2.2. Penalties. The agency may impose the following fines and penalties administratively:

- Up to \$5,000 for each claim; and
- Additional monetary penalties up to twice the amount of the claim;
- Maximum authority of \$150,000.

5.3. Civil Monetary and Criminal Penalties for False Claims in Federal Health Care Programs

Provides for monetary and criminal penalties over and above those provided by other laws for False Claims Violations as well as additional activities, including kickbacks, that constitute fraud or abuse.

- Examples of civil monetary penalties include:
 - Not more than \$10,000 for each item or service or, in certain cases, \$15,000 for each individual with respect to whom false or misleading information was given;
 - Not more than \$10,000 for each day a prohibited relationship occurs
 - Not more than \$50,000 for certain prohibited acts,
 - In addition, an assessment of not more than 3 times the total amount involved.
- Examples of criminal penalties include a felony conviction with:
 - A fine of up to \$25,000 and/or
 - Imprisonment for not more than 5 years

5.4. Federal Anti-Kickback Statute.

5.4.1. Kickback Defined - knowingly and willfully soliciting or receiving, or paying anything of value (remuneration) including any kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program.

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5.4.2. Exceptions Exist. The law contains several “safe harbors” that provide protection from prosecution for certain transactions and business practices with further guidelines provided in 42 C.F.R. §1001.952.

5.4.3. Penalties, Criminal Violation. Punishment for felony conviction for violating the anti-kickback law is:

- A fine of not more than \$25,000 or imprisonment for not more than 5 years, or both;
- Administrative civil money penalties of up to \$50,000; and
- Exclusion from participation in federal health care programs.

5.5. **The Deficit Reduction Act of 2005**. This federal law made numerous changes to Medicaid and some other federal programs. It requires that entities that receive or make annual payments of at least \$5 million under a state Medicaid plan establish written policies that provide detailed information about false claims, whistleblower protections & preventing and detecting fraud, waste and abuse.

5.6. **Colorado Medicaid False Claims Statute**. Civil penalties extend to False Claims Violations made under the Colorado Medical Assistance Act.

5.6.1. Fines in the amount of 3 times the damages that the state sustains;

5.6.2. Additional penalties between \$5,000 and \$11,000 per false claim filed (these penalties automatically increase to match those under the Federal False Claims Act).

5.7. **Other State False Claims Statutes**

5.7.1. Kentucky - Kentucky has not enacted a false claims statute with a qui tam provision comparable to the federal False Claims Act. However, Kentucky law does permit the Kentucky Attorney General to prosecute any individual or entity that:

- knowingly or wantonly devises a scheme or plan a scheme or artifice, or enters into an agreement, combination, or conspiracy to obtain or aid another in obtaining payments from any medical assistance program by means of any fictitious, false, or fraudulent application, claim, report, or document submitted to the Cabinet for Health and Family Services, or intentionally engages in conduct which advances the scheme or artifice;
- intentionally, knowingly, or wantonly makes, presents, or causes to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious, or fraudulent statement, representation, or entry in any application, claim, report, or document used in determining rights to any benefit or payment;

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- with intent to defraud, knowingly makes, or induces, or seeks to induce the making of a false statement or false representation of a material fact with respect to the conditions or operations of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled-nursing facility, intermediate-care facility, home-health agency, or other provider of services to the Medical Assistance Program; or
- knowingly falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry.
- The complete set of Kentucky laws governing Medicaid fraud and abuse may be found at Kentucky Revised Statutes §205.8451-205.8483.

5.8. Offering a False Instrument for Recording. It is a crime in Colorado to present or offer a written instrument that contains a material false statement or material false information to a public office or a public employee with the knowledge or belief that it will be registered, filed or recorded or become a part of the records of that public office or public employee.

5.8.1. Felony violation occurs when a person knowingly and with intent to defraud commits the crime of offering a false instrument for recording. The penalty is imprisonment from 1 to 3 years, a fine between \$1,000 and \$100,000, or both.

5.8.2. Misdemeanor violation occurs when a person knowingly commits the crime of offering a false instrument for recording. The penalty is imprisonment for up to 1 year, a fine of up to \$1,000, or both.

6. Responsibilities

6.1. Employees, Affiliates, Vendors, Consultants and Agents

6.1.1. Be aware of the serious penalties for False Claims Violations, Fraud, Waste and Abuse.

6.1.2. Feel free to ask questions and be sure to report any good faith concerns to the individuals outlined above or to the Corporate Compliance Hotline 844-369-5635 or NJHealth.ethicspoint.com.

6.2. Supervisors and Managers

6.2.1. Educate employees about the application of this policy to the activities in your department.

6.2.2. Encourage good faith reporting so that NJH can identify any potential violations and remediate them if indicated.

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6.2.3. Advise the Compliance Office of any reports received and assist with any investigation if requested to do so.

6.2.4. Assist with developing a Corrective Action Plan if requested to do so.

6.3. Compliance Office

6.3.1. Review reports received and investigate if indicated.

6.3.2. Assure development, implementation and completion of any indicated Corrective Action Plan(s) by the involved department(s).

6.3.3. Fulfills reporting obligations as applicable pursuant to federal or state law or contract.

6.3.4. Develops, reviews, approves and revises training in Fraud, Waste, and Abuse and general training on the institution's compliance program.

7. References

The Federal False Claims Act, 31 USC § 3729 et seq.

The Program Fraud Civil Remedies Act, 31 USC § 3801, 3802

Federal Civil Monetary Penalties, 42 USC § 1320a-7a

Federal Criminal penalties for acts involving Federal health care programs, 42 USC §1320a-7b

Federal Anti-Kickback Statute, 42 USC § 1320a-7b

The Deficit Reduction Act of 2005, Social Security Act § 1902(a)(68)

Colorado Medicaid False Claims Statute, CRS §§ 25.5-4-303.5 to 25.5-4-310

Offering a False Instrument for Recording, CRS § 18-5-114

Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines

NJH Code of Conduct: Fraud and Abuse and The False Claims Act

NJH Policy: Training and Development – Safety and Healthcare Compliance

NJH Policy: Reporting HIPAA and Compliance Issues, Retaliation Prohibited

8. Tags or Linked Documents

[Reporting HIPAA and Compliance Issues Policy](#)

[Non-Retaliation Policy](#)