1. Principle / Purpose

It is the policy of National Jewish Health (NJH) that all employees, affiliates, contractors, and agents are educated on the federal and state false claims laws and have the obligation to detect and prevent fraud, waste. To ensure compliance with federal and state laws, NJH has implemented policies and procedures to detect and prevent fraud, waste, and abuse.

2. Definitions

Fraud is an intentional deception, false statement, or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to oneself or another person.

Waste is defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of a health care benefit program, including Medicare and Medicaid. Waste results from misuse of resources or inefficient practices, systems, or controls, rather than criminally negligent or intentional actions.

Abuse is a practice that is inconsistent with professional standards of care, medical necessity, or sound fiscal, business, or medical practice, which results in unnecessary costs to health care programs, such as Medicare and Medicaid. Abuse involves causing a payment to issue for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented payment (distinguishing abuse from fraud).

3. Scope

This policy applies to all NJH workforce members, including employees, physicians, officers, directors, managers, faculty, affiliates, contractors, volunteers, and others working for or on behalf of National Jewish Health.

4. Policy

National Jewish Health workforce members must not knowingly submit or cause another person to submit a false or fraudulent claim for payment, knowingly make or use a false record or statement material to a claim, knowingly conceal or improperly avoid an obligation to pay the government, or conspire with others to commit a violation of state or federal fraud, waste, and abuse laws.

All National Jewish Health workforce members are obligated to detect and prevent fraud, waste, and abuse (FWA) in accordance with the False Claims Act (FCA), 31 U.S.C. §§ 3729–33, and all other federal and state laws, regulations, and guidelines in relation to claims made for payment of healthcare goods or services. ***Certain fraud, waste, and abuse laws are summarized at the end of this policy.***

National Jewish Health has established programs and requirements of workforce members to detect and prevent FWA. National Jewish Health will abide by whistleblower anti-retaliation protections under the law. NJH policy prohibits retaliation for good faith reports of suspected violations of law, policy, or the Code of Conduct. See the Reporting HIPAA and Compliance Issues policy. Any incidents of FWA will result in appropriate disciplinary action in accordance with policy.

I. Policies and Procedures for Detecting and Preventing Fraud, Waste, and Abuse

A. National Jewish Health maintains a Code of Conduct. It establishes responsibilities of all National Jewish Health workforce members. The Code of Conduct is maintained and reviewed on a regular basis in accordance with the Corporate Responsibility and Compliance Plan.

B. National Jewish Health maintains a Compliance Program. The program serves to assist the organization and promotion of compliance with legal obligations, fosters and ensures ethical conduct, and provides guidance to the NJH workforce. Elements of this plan include:
   1. Designation of a Chief Compliance Officer, Compliance Office, and Compliance Oversight Committee;
   2. Board of Directors oversight through the Board Audit and Compliance Committee;
   3. The Corporate Responsibility and Compliance Plan;
   4. Compliance policies and procedures;
   5. Education and training; and
   6. Enforcement of standards.

C. Exclusion Screening
   1. National Jewish Health will screen all workforce members against appropriate list upon hire and monthly thereafter, in accordance with the Identifying and Managing Excluded or Convicted Persons or Entities policy.
   2. National Jewish Health will screen contractors against appropriate exclusion lists prior to contracting and monthly thereafter, in accordance with NJH policy.

II. Awareness and Training

A. Upon hire and annually thereafter, National Jewish Health's workforce members are required to review and acknowledge the National Jewish Health Code of Conduct and complete compliance training. Pursuant to the Code of Conduct, each employee has an obligation and responsibility to report any activity that appears to violate applicable laws, rules, regulations, or the Code of Conduct. NJH training includes a course on FWA.

B. Non-employee contractors who work for NJH must review the National Jewish Health Orientation and Training Packet, which provides detailed information on the False Claims Act, fraud, waste and abuse laws, penalties, and whistleblower protections. Non-employee contractors who work for NJH for more than one year are required to complete all NJH annual employee training, including the training on fraud, waste, and abuse. Non-employee contractors also have access to the NJH intranet and the NJH policy database, which contain all compliance policies.

III. Individual Responsibility

A. The NJH workforce can promote compliance with the FCA and other state and federal FWA laws by adhering to the following.
   1. Create timely, accurate, and complete records supporting services and claims.
   2. Submit claims only when supported by documentation and applicable billing requirements.
   3. Seek guidance when coding, documentation, coverage, or payment requirements are unclear.
   4. Preserve original records and audit trails when making authorized corrections.

5. Complete assigned compliance training.
6. Cooperate truthfully with authorized audits and investigations.

B. Managers must reinforce these requirements, address identified control weaknesses, and promptly forward concerns to the Compliance Office. Managers may not discourage reporting or require personnel to obtain permission before contacting the Compliance Office.

C. Billing personnel must maintain controls for claim accuracy, payment reconciliation, duplicate billing, and overpayment identification.

D. The Compliance Officer will oversee reporting, investigations, training, monitoring, corrective actions, and reporting to leadership and the governing body.

IV. Reporting Required

A. National Jewish Health workforce members must promptly report known or suspected FWA or retaliation through any of the following:

E-mail: compliance @njhealth.org
Phone: 303-398-1466
Compliance Hotline: 844-369-5635 or NJHealth.ethicspoint.com ***Anonymous reporting is available through the Compliance Hotline.***

B. Reports should include available facts, dates, and affected claims or transactions, if available. Proof is not required before reporting.

V. Non-Retaliation and Confidentiality

A. Good-faith reporting of potential fraud, waste, or abuse is protected. National Jewish Health prohibits retaliation against anyone who raises a concern in good faith, participates in an investigation, or engages in legally protected efforts to stop violations. See the Reporting HIPAA and Compliance Issues policy.

B. Prohibited retaliation includes termination, demotion, threats, harassment, reduced hours, intimidation, and other adverse treatment because of protected activity.

C. Reports will be handled as confidentially as reasonably possible, consistent with a fair investigation and legal obligations. Absolute confidentiality cannot be guaranteed.

D. Suspected retaliation must be reported promptly through any reporting channel identified above and will receive an independent review when necessary.

VI. Audits and Monitoring

A. NJH will conduct periodic reviews of documentation and analyze claims data and provider billing practices to identify potential FWA.

B. The Compliance Office submits regular reports of audits and compliance issues to the Board of Directors Audit and Compliance Committee for review.

VII. Investigation

A. All compliance reports will be documented and investigated. Investigation will begin with the Compliance Officer and may involve legal counsel.
B. Assigned investigators will take the following steps:

1. Document and assess the concern promptly, including any immediate risk to patients, funds, or records.
2. Assign an impartial reviewer and involve legal counsel when appropriate.
3. Preserve relevant records and investigate the facts.
4. Coordinate holds on affected claims when warranted.
5. Document findings, affected transactions, and required corrective actions.
6. Assign responsible individuals and completion dates.
7. Verify that corrective actions are effective.

VIII. Corrective Action

A. Corrective action may include correcting claims, refunding overpayments, revising policy or procedures, providing training, strengthening controls, disciplinary action or making required disclosures.
B. Overpayments must be escalated promptly to the Chief Compliance Officer and Chief Financial Officer. These departments, with legal counsel, will determine applicable identification of repayment and disclosure requirements, and will ensure adherence to governing deadlines. Internal review must not be used to delay legally required action.

IX. The Law

NJH is committed to compliance with all applicable federal and state laws and regulations. The laws below prohibit fraud, waste, and abuse in federal health care programs, and all NJH workforce members are obligated to prevent and detect fraud, waste, and abuse as prohibited by these laws.

Federal False Claims Act (FCA), 31 U.S.C. §§ 3729 *et seq*. imposes liability on an individual or entity who knowingly submits or causes to be submitted a false or fraudulent claim to any federally funded healthcare program, who makes a false record or statement to secure payment for such a claim, or who conspires to get such a claim allowed or paid. Conduct is "knowing" and a person acts "knowingly" when a person, with respect to information, (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information. Violators of the FCA may be subject to monetary civil penalties and payments up to three times the damages sustained by the federal health care program, plus civil monetary penalties for each false claim submitted. The Office of the Inspector General (OIG) may impose additional sanctions or exclude a provider from participating in federal healthcare programs.

The **Colorado False Medicaid Claims Act**, Colorado Revised Statute § 25.5-4-303.5 *et seq.*, contains provisions similar to the FCA, making it illegal to knowingly submit, cause to be submitted, or make a false or fraudulent claim or record to Colorado's medical assistance programs, including Health First Colorado

(Medicaid). Violators can be fined up to three times the amount of damages the Medicaid program sustains, plus per-claim penalties.

Qui Tam (Whistleblower) Provisions under the FCA. Any individual (referred to as a relator or whistleblower) may file a lawsuit on behalf of the U.S. government based on their actual knowledge of alleged false claims by filing a complaint in a federal district court. The government reviews the relator's claim and has a right to decline to participate in the case, move to dismiss the case, or to take over the primary prosecution of the lawsuit. If the government declines to take over the lawsuit and the case is not dismissed, the individual relator may continue with the lawsuit on their own. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive a portion of any recovery. The whistleblower may also be entitled to reasonable expenses including attorneys' fees and costs for bringing the lawsuit.

Administrative False Claims Act (AFCA), 31 U.S.C. § 3801 *et seq.* This law 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. No proof of specific intent to defraud is required. The Statute allows for civil monetary penalties for false claims and an assessment of damages of not more than twice the amount of the false claims.

The Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, is a criminal law that prohibits the knowing and willful offer or transfer of remuneration (anything of value, most often money, but including discounts, gifts, free travel, etc.) to induce or reward patient referrals or the generation of business for services or items payable by a federal healthcare program.

The **Physician Self-Referral Law,** 42 U.S.C. § 1395nn, commonly referred to as the "**Stark Law**," prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. Civil sanctions for violation are refund of all monies to Medicare from referrals during a period of disallowance and civil monetary penalties.

The **Federal Civil Monetary Penalties Act**, 42 U.S.C. § 1320a-7a, authorizes the imposition of civil penalties for violations of the Anti-Kickback Statute and the Stark Law as well as a range of other violations. Penalties range from $10,000 to $50,000 per violation. These violations include, but are not limited to, Making false statements on applications or contracts to participate in a Federal health care program.

A number of other **federal criminal laws** prohibit health care fraud, including the wire fraud, mail fraud, and health care fraud statutes, and punish those crimes as felony offenses. See 18 U.S.C. §§ 1343, 1341, 1347.

Anti-Retaliation/Whistleblower Protections. Both the federal and Colorado FCA laws include anti-retaliation protections for employees who make good faith reports of fraud, waste, and abuse under the

applicable laws. NJH policy prohibits retaliation for good faith reports of suspected violations of law, policy, or the Code of Conduct.

Identification of Fraud, Waste, and Abuse

Various types of prohibited conduct for NJH workforce members to be aware of and identify include, but are not limited to, the list below. These examples are provided to assist employees in identifying FWA and are provided only by way of example.

- Billing for services, supplies, or visits that were not provided.
- Knowingly billing a higher service level than the facts support.
- Improperly separating services that must be billed together.
- Knowingly submitting duplicate claims to obtain duplicate payment.
- Falsifying diagnoses, service dates, time records, signatures, or clinical documentation.
- Billing for medically unnecessary services or pharmaceuticals while misrepresenting their necessity.
- Misrepresenting provider qualifications, supervision, or eligibility.
- Offering or accepting unlawful payments or benefits for referrals.
- Concealing suspected overpayments or failing to follow required repayment procedures.
- Ignoring credible information indicating that claims may be inaccurate.
- Pharmaceutical companies, medical device companies, or others outside of NJH offering or providing kickbacks, inducements, and other illegal benefits to NJH providers in exchange for referrals or the ordering of products billed to federal health care programs.

5. References

Deficit Reduction Act of 2005, 42 U.S.C. § 1396a(a)(68)
Federal False Claims Act, 31 USC § 3729 *et seq.*
Administrative False Claims Act, 31 U.S.C. § 3801 *et seq.*
Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b
Physician Self-Referral Law, 42 U.S.C. § 1395nn
Federal Civil Monetary Penalties, 42 U.S.C. § 1320a-7a
Colorado Medicaid False Claims Statute, C.R.S. § 25.5-4-303.5 *et seq.*

6. Tags or Linked Documents

Code of Conduct
Corporate Responsibility and Compliance Plan
Identifying and Managing Excluded or Convicted Persons or Entities
Reporting HIPAA and Compliance Issues