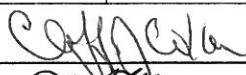

 <b>UHHS/CSAHS - CUYAHOGA, INC.</b> The Sisters of Charity of St. Augustine Health System      UniversityHospitals HealthSystem	<b>ADMINISTRATIVE POLICIES AND ROCEDURES</b>	
	<b>Section: Corporate Compliance</b>	<b>Policy No. CC-010</b>
	<b>Subject: Fraud and Abuse Prevention</b>	<b>Effective: 12/23/08</b>
		<b>Reviewed:</b>
<b>Revised:</b>		
<b>Approval:</b>		
<b>President &amp; CEO SJWS:</b>		<b>Date:</b> <u>1/20/09</u>
<b>President &amp; CEO SVCH:</b>		<b>Date:</b> <u>1/22/09</u>

**PURPOSE:**

The purpose of this policy is to address the requirements of Section 6032 of the Deficit Reduction Act of 2005 by communicating certain federal and state laws relating to liability for false claims and statements; protections against reprisal or retaliation for those who report wrongdoing; and UHHS/CSAHS-Cuyahoga, Inc. ("Corporation") policies and procedures to detect and prevent fraud, waste and abuse.

**POLICY:**

It is the policy of UHHS/CSAHS-Cuyahoga, Inc. to obey all federal and state laws, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payment to UHHS/CSAHS-Cuyahoga and its related facilities from federal or state healthcare programs.

All corporation employees, medical staff members, students, volunteers, agents and contractors shall abide by the Federal False Claims Act and Ohio's false claim provision. Those reporting fraud, waste and abuse concerns ("Whistleblowers") shall be protected from retaliatory action.

In order to assure that UHHS/CSAHS-Cuyahoga, Inc. meets its legal and ethical obligations, obeys all federal and state laws, implements and enforces procedures to detect and prevent fraud, waste and abuse, the Corporation has implemented a Corporate Compliance Program. The program is designed to comply with the Office of Inspector General ("OIG") Compliance Program Guidance for Hospitals. The Executive Leadership in its capacity as the Administrative Compliance Committee and Joint Audit Committee of the Board of Directors oversee the program through regular reports.

**PROCEDURE:**

- A. Federal False Claims<sup>1</sup>: No Corporation employee, medical staff member, students, volunteers, agent or contractor shall knowingly present or cause to be presented a false or fraudulent claim for payment by the United States Government (including but not limited to Medicare and Medicaid reimbursement).
  - a. "Knowingly" includes the following circumstances:
    - i. Having actual knowledge of the information;
    - ii. Acting in deliberate ignorance of the truth or falsity of the information; or
    - iii. Acting in deliberate disregard of the truth or falsity of the information.
  - b. Penalties: In general, any person violating the Federal False Claims Act is subject to the following penalties:

<sup>1</sup> 31 USC §§3729-37733

- i. For a civil lawsuit by the Attorney General or a Qui Tam (whistleblower) action by a private party: A civil penalty of not less than \$5,500 and not more than \$11,000, plus three (3) times the amount of damages sustained by the federal government due to the person's act.
- ii. For an administrative action: A civil penalty up to \$5,500 per false claim or statement. If a false claim was made, the government may make an assessment in lieu of damages in an amount not more than twice the amount of each false claim. An assessment shall not be made if the federal government has not already paid the false claim.

B. Ohio False Claims Provisions<sup>2</sup>

- a. "Medical Assistance Program" under Ohio law refers to the program established by Ohio's Department of Job and Family Services to provide medical assistance, as well as the Medicaid program promulgated under federal law.
- b. No Corporation employee, medical staff member, students, volunteers, agent or contractor shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from Ohio's medical assistance program (including but not limited to Medicaid).
- c. No Corporation employee, medical staff member, students, volunteers, agent or contractor, with purpose to commit fraud or knowing that the person is facilitating fraud, shall do either of the following:
  - i. Charge, solicit, accept or receive, goods or services provided under Ohio's Medical Assistance Program, any property, money or other consideration in addition to a reimbursement amount under the Medical Assistance Program, the applicable provider agreement, and any authorized deductibles/co-pays.
  - ii. Solicit, offer or receive any remuneration, other than any deductibles or co-pays, in connection with furnishing goods or services that are wholly or partially reimbursed by Ohio's Medical Assistance Program.
- d. No Corporation employee, medical staff member, students, volunteers, agent or contractor (having submitted a claim under Ohio's Medical Assistance Program) shall knowingly alter, falsify, destroy, conceal or remove any records related to reimbursement of the claim for at least six (6) years.
- e. No corporation employee, medical staff member, students, volunteers, agent or contractor shall knowingly participate in Medicaid eligibility fraud or assist in the occurrence of such fraud.
- f. Penalties:
  - i. Medicaid fraud in an amount less than \$500 is a first degree misdemeanor. Medicaid fraud valued at \$500 - \$5000 is a fifth degree felony. Medicaid fraud valued at \$5000 - \$100,000 is fourth degree felony. Medicaid fraud valued at \$100,000 or more is a third degree felony.
  - ii. Any person convicted of Medicaid fraud shall pay for costs incurred through investigating and prosecuting the case.
  - iii. A provider who violates Ohio's false claim provisions shall be liable for all of the following civil penalties:

---

<sup>2</sup> ORC §§ 124.34, 2913.40, 2913.401, 2921.13, and 5111.03

- (1) Payment of interest at the maximum rate on the excess payments from the date the payments were made until the date on which repayment is made;
  - (2) Payment of an amount equal to three times the amount of any excess payments;
  - (3) Payment of \$5000 - \$10,000 per false claim; and
  - (4) Payment of all reasonable expenses incurred by the State in legal enforcement.
- iv. Upon the conviction of or entry of a judgment against a Medicaid provider or its owner, officer, authorized agent, associate, manager or employee, the Director of Job and Family Services shall terminate the provider agreement and stop reimbursement of claims for up to five (5) years. No provider, owner, officer, agent, associate, manager or employee may provide services to any other Medicaid provider or risk contractor, arrange for Medicaid services, render Medicaid services, or order Medicaid services during the terminated period. No reimbursement will be made to such individuals during the termination period from or through any participating provider or risk contractor.

C. Whistleblower Obligations and Protections:

- a. All Corporation employees, medical staff members, students, volunteers, agents and contractors are responsible for promptly reporting actual or potential infringements of law, regulation, policy, or procedure related to Federal or State fraud and abuse provisions, including the false claims provisions discussed in this policy.
- b. Any employee or other party may report concerns in accordance with the procedures set forth in Reporting Compliance Concerns: Hotline Policy no. CC-003. **The toll-free hotline number is: 800-507-6291.** All such reports will be examined and investigated by the Compliance Officer in accordance with Investigating Compliance Concerns Policy no. CC-005. Further information regarding the prevention and deterrence of fraud, waste and abuse can be found throughout Corporation's Compliance Policies, annual compliance training and Code of Conduct and Ethical Behavior.
- c. Under no circumstances will the reporting of any concerns or possible impropriety serve as a basis for any retaliatory action(s) against any employee, medical staff member, patient, or other person reporting such concerns.

D. Fraud, Waste and Abuse Prevention and Deterrence:

- a. Corporation expects all employees, medical staff members, students, volunteers, agents and contractors to play an active role in preventing and deterring fraud, waste and abuse with regards to government healthcare programs. Corporation actively pursues legal compliance through implementation and enforcement of its Compliance Policies, Compliance Training, and Code of Conduct and Ethical Behavior.

**RELATED POLICIES:**

- Reporting Compliance Concerns: Hotline Policy. Administrative Policy no. CC-003
- Investigating Compliance Concerns Policy. Administrative Policy no. CC-005
- Non-Retaliation for Reports of Non-Compliance. Administrative Policy no. CC-004

**RELATED DOCUMENTS:**

Code of Conduct and Ethical Behavior

**REFERENCES:**

- Deficit Reduction Act of 2005; § 6032

- Federal False Claims Act; 31 USC §§ 3729-3733
- Federal Program Fraud Civil Remedies Act; 31 USC 3801-3812
- Ohio False Claims Provisions; ORC §§ 124.34, 2913.40, 2913.401, 2921.13, and 5111.03