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Owner	David Lane
Policy Area	Compliance
Applicability	Providence St. Joseph Health Systemwide + PGC

PSJH-RIS-711 Fraud, Waste and Abuse Prevention and Detection

Executive Sponsor:	Sheryl Vacca, SVP/Chief Risk Officer
Policy Owner:	David Lane, VP/Chief Compliance Officer
Contact Person:	Karen J. Coleman, System Director Compliance Auditing & Monitoring

Scope:
This policy applies to Providence St. Joseph Health and its Affiliates (collectively known as "PSJH")[i] and their caregivers (employees), employees of affiliated organizations; members of system, community ministry and foundation boards; volunteers; trainees; independent contractors; and others under the direct control of PSJH (collectively referred to as workforce members). PSJH educational institutions are excluded from this healthcare related policy. This is a management level policy reviewed and recommended by the Policy Advisory Committee for approval by senior leadership which includes vetting by Executive Leadership Committee with final approval by the President, Chief Executive Officer or appropriate delegate.

Purpose:
This policy confirms PSJH's commitment to prevent and detect fraud, waste and abuse (FWA) by providing workforce members detailed information regarding: (1) the federal False Claims Act; (2) federal laws and penalties pertaining to reporting and returning overpayments; (3) state laws and penalties pertaining to false claims; and (4) whistleblower protections under certain laws.

Definitions:
For purposes of applying this policy, the following definitions apply:

1. *Agents:* Anyone directly performing services on behalf of PSJH.
2. *Caregiver:* Refers to all employees/workforce members of PSJH.
3. *Claim:* As defined in the federal False Claims Act, a "Claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made by a contractor, grantee, or other recipient, if the government provides any portion of the

money or property, or will reimburse the requesting entity for any portion of the money or property, that is requested or demanded.

4. *False Claims Act (FCA):* The federal False Claims Act (31 USC 3729-33) makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowingly" means that the person or organization:
    a. Knows the record or claim is false, or
    b. Seeks payment while ignoring whether the record or claim is false, or
    c. Seeks payment recklessly without caring whether the record or claim is false.
5. *Fraud:* An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to an organization or an individual. It includes any act that constitutes fraud under applicable federal or state law.
6. *Overpayment:* Funds that a person or organization receives or retains under Medicare or Medicaid/Medi-Cal to which the person or organization, after applicable reconciliation, is not entitled under those programs.
7. *Waste and Abuse:* Incidents or practices that are inconsistent with legal, ethical, accepted and sound business, fiscal or medical practices that result in unnecessary cost to federal health programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Medicare and Medicaid/Medi-Cal practices that result in unnecessary costs to a federal health program.
   Examples of potential FWA; this list is not conclusive:

Falsifying claims	Eligibility determination issues
Improper alteration of claim	Misrepresentation of medical condition
Incorrect coding	Failure to report third party liability
Double billing	Physical, mental, emotional, sexual abuse
Billing for services not provided	Neglect
Misrepresentation of services/ supplies	Discrimination
Improper substitution of services	Providing substandard care
Inaccurate cost reports	Providing medically unnecessary services
Kickback/Stark Law violations	Financial exploitation
Fraudulent credentials	Fraudulent recoupment practices
Embezzlement	Failure to refer for needed services
Under-utilization and over-utilization	Violations of Medicare's Conditions of Participation
Known retention of an overpayment	

8. *Whistleblower (Qui tam) Provision:* Allows a private person to bring a lawsuit on behalf of

the government where the private person has information that the named defendant has knowingly submitted or caused the submission of false or fraudulent claims to the government.

Policy:
It is the policy of PSJH to comply with applicable federal and state laws and regulations pertaining to FWA in federal and state health care benefit programs and to disseminate information to its workforce members regarding such laws and regulations. PSJH is committed to the diligent prevention and detection of FWA through its Board-approved Integrity and Compliance Program Description and Standards/Code(s) of Conduct.

Requirements:
PSJH will train and educate its workforce members and contractors as necessary to comply with the legal and regulatory requirements related to FWA and will work cooperatively with workforce members when problems are identified to resolve those problems as quickly as possible.
PSJH will follow federal and state False Claims Acts, to educate new workforce members within 90 days of hire or engagement and will educate existing workforce members and contractors annually thereafter to the policies and procedures intended to meet those requirements. PSJH will monitor education given to employees to verify this policy has been effectively implemented.
PSJH expects workforce members and contractors who are involved with creating and filing claims for payment for PSJH services will only use true, complete and accurate information to make the claim. Billing for clinical trials will follow clinical trial billing protocols and will be submitted in accordance with federal requirements.
PSJH will monitor and audit compliance with billing and coding requirements (through the Revenue Cycle department, Providence Health Plan and other appropriate departments) in order to detect errors and inaccuracies and will take appropriate actions to correct any issues causing billing inaccuracies. PSJH will exercise reasonable diligence to identify and investigate any instances in which an overpayment may have been received. In all situations where overpayments are identified, PSJH will report and return overpayments identified in a timely manner (i.e., no later than 60 days after identification and quantification) and in accordance with applicable federal and/or state requirements.
PSJH regions, ministries or facilities will create policies and procedures to comply with any applicable state-level False Claims Act requirements and will provide education to their existing workforce members and contractors on those policies and procedures and will train new workforce members upon hire or engagement.
Workforce members and contractors are expected to report any concerns about billing issues, a potential overpayment, or any other issue they feel is illegal or otherwise inappropriate, in accordance with the Code of Conduct. Concerns may be reported to the PSJH Integrity Hotline at (888) 294-8455 or to the Integrity Hotline online reporting system. Potential overpayment issues should be brought immediately to the attention of the Department of Legal Affairs, Compliance and/or Revenue Cycle department. Workforce members have the right to be protected against retaliation for good faith reporting of suspected wrongdoing or assisting in an investigation of possible wrongdoing. This commitment is expressed in our Code of Conduct and Non-Retaliation Policies. PSJH expects workforce members and contractors to be familiar with the Standards/ Code(s) of Conduct and other policies and to follow them.
Management is responsible for ensuring that workforce members are educated to the requirements of this policy and that the education is documented and producible upon audit. The form and extent of that training will be determined by the workforce member's function. Other

workforce members will receive informational materials or awareness training.
PSJH workforce members who do not follow this policy may be subject to disciplinary action up to and including termination of employment or contractual relationships.
A person who knows a claim was filed for payment in violation of the False Claims Act can file a lawsuit in Federal Court on behalf of the government, and in some cases, receive a reward for bringing original information about a violation to the government's attention. Some states have a False Claims Act that allows a similar lawsuit in state court if a false claim is filed with the state for payment, such as under Medicaid or Workers' Compensation. Penalties are severe for violating the federal False Claims Act and may include repayment of up to three times the value of the false claim, significant fines per claim (e.g., 2022 fines range from $12,537 to $25,036 per claim) and/or imprisonment for 5 years. In addition, individuals and entities can face administrative penalties such as exclusion from participating in federal and state-funded health care benefit programs, including Medicare and Medicaid.
PSJH will notify impacted plan sponsors of any individuals excluded from federal or state programs, as well as individuals with confirmed compliance and/or fraud, waste and abuse violations that may have provided services on behalf of the sponsor as applicable.

References:

- **PSJH Standards/Codes of Conduct**
- Integrity and Compliance Program Description
- PSJH-RIS-733 Non-Retaliation
- Federal False Claims Act
- Deficit Reduction Act of 2005
- Federal Register/Adjustment of Civil Monetary Penalty Amounts for 2022
- Section 1128J(d) (reporting and returning overpayments) and Section 1909 of the Social Security Act
  (establishes liability to state for false or fraudulent claims)
- 42 C.F.R. Part 401, Subpart D
- State False Claims Acts Reviewed by the OIG

State	***Links to False Claims Legislation or Information***
Alaska	http://www.legis.state.ak.us/basis/statutes.asp#47.05.210
California	The False Claims Act, Cal. Gov't Code §§ 12650 et seq.
Idaho	https://legislature.idaho.gov/sessioninfo/2004/legislation/S1332/
Montana	http://www.falseclaimsact.com/wp-content/uploads/2013/02/Montana.pdf
New Mexico	https://www.nmag.gov/medicaid-fraud-control.aspx
Oregon	https://www.doj.state.or.us/consumer-protection/sales-scams-fraud/medicaid-fraud/
Texas	https://oig.hhsc.texas.gov/report-fraud
Washington	https://apps.leg.wa.gov/rcw/default.aspx?cite=74.66&full=true; https://apps.leg.wa.gov/rcw/default.aspx?cite=74.09

Applicability:
[i] For purposes of this policy, “Affiliates” is defined as any not-for-profit or non-profit entity that is wholly owned or controlled by Providence St. Joseph Health (PSJH), Providence Health & Services, St. Joseph Health System, Western HealthConnect, Kadlec, Covenant Health Network, Grace Health System, Providence Global Center*, NorCal HealthConnect, or is a not-for-profit or non-profit entity majority owned or controlled by PSJH or its Affiliates and bears the Providence, Swedish Health Services, St. Joseph Health, Covenant Health, Grace Health System, Kadlec, or Pacific Medical Centers names (includes Medical Groups, Home and Community Care, etc.).
*Policies and/or procedures may vary for our international affiliates due to regulatory differences.

Approval Signatures

Step Description	Approver	Date
PSJH President/CEO	Cynthia Johnston: Compliance Spec PSJH	04/2020
PSJH Executive Council	Cynthia Johnston: Compliance Spec PSJH	04/2020
PSJH Policy Advisory Committee	Cynthia Johnston: Compliance Spec PSJH	04/2020