Policy Title: False Claims and Return of Overpayments (pka: CRP-0067)	**Original Policy Effective Date:** 08/13/2007
	Publication Date: 06/30/2017
Lead Department: SIU	

Purpose
To effectuate compliance with False Claims Laws.

Definitions
Abuse – broadly defined as practices that are inconsistent with sound medical or business practices that may directly or indirectly, result in unnecessary costs to the Medicare or Medicaid programs.

False Claims Law – Federal and state laws that define and prohibit false claims including the Deficit Reduction Act of 2005, the federal Civil False Claims Act as amended by the Fraud Enforcement and Recovery Act of 2009, the federal Patient Protection and Affordable Care Act of 2010, and the California False Claims Act. See **Attachment A: False Claims Law**.

Fraud - broadly defined as intentional misrepresentation that may result in unauthorized costs to the Medicare or Medicaid programs.

Overpayments –Broadly defined as any amount received under the Medicare or Medicaid programs to which the provider, supplier, or person is not entitled. An Overpayment includes payment that should not have been made and payments made in excess of the appropriate amount. Overpayments can result from inaccurate encounter data reporting, risk adjustment scores, coding, provider documentation, premium revenue, bids, prescription drug events, enrollment/disenrollment, health care (services, drugs, equipment) costs, medical loss ratio calculations.

SCAN – All SCAN affiliates excluding The SCAN Foundation.

Waste – Broadly defined as the use of health care funds without a real need.

Policy
To develop and implement internal controls and processes that ensure compliance with False Claims Laws, including internal controls and processes that assist with preventing and detecting Fraud, Waste, and Abuse in health care programs and that assist with identifying, reporting, and refunding Overpayments.

This policy applies to all SCAN employees, contractors, providers, and First Tier, Downstream, or Related Entity (FDR) employees.

Supporting Documents (letters/reports/forms)
N/A

Procedure

1. Training and Education.

   a. Compliance is responsible for ensuring that:

      - SCAN provides up to date information to all employees, contractors, providers, and FDR employees about False Claims Laws including remedies available under the law; and how employees and others can use them; and about whistleblower protections available to anyone who claims a violation of False Claims Laws.

      - All employees, contractors, providers, and FDR employees are advised of the steps SCAN has in place to detect health care Fraud, Waste, and Abuse, including any Fraud, Waste and Abuse related to Medicare Part D, through distribution and availability of SCAN Policies and Procedures, training, and communications.

   b. Human Resources is responsible for ensuring that:

      - The SCAN Employee Handbook provides up to date information on False Claims Laws.

      - Within 90 days of hire, all new employees are required to take Fraud, Waste and Abuse Training, which includes False Claims Laws.

      - Existing members of the SCAN workforce are required to take annual refresher training on the Federal False Claims Act and Anti-Fraud Program.

   c. Provider Network Management is responsible for ensuring that:

      - Information is provided to SCAN Health Plan, contractors, providers, and First Tier, Downstream, or Related Entity (FDR) employees and is available on the SCAN Website.

      - All SCAN contractors, providers, and FDRs establish and implement effective training and education.

   d. Compliance is responsible for routinely monitoring training and education requirements and content to ensure compliance with applicable regulatory requirements.

2. Reporting Potential Violations of False Claims Law. All employees have an affirmative duty to report potential violations of False Claims Law (including potential violations by affiliates or contractors and subcontractors, or agents of such organizations).

   a. Internal Reporting. Reports can be made to the:

      - Your supervisor
      - The Compliance Officer or assigned compliance specialist
      - "Report a Risk Issue" option in the Quick Links section on SCAN Central
      - EthicsPoint Hotline at 877-863-3362 or at www.Ethicspoint.com (reports may be made anonymously).

   b. External Reporting. Employees are not required to report a possible False Claims Act violation to SCAN first. Employees may report directly to the Federal Department of Health and Human Services. The Office of the Inspector General also maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

By Phone:	1-800-HHS-TIPS (1-800-447-8477)
By Fax:	1-800-223-2164 (no more than 10 pages please)
By E-Mail:	HHSTips@oig.hhs.gov
By Mail:	Office of the Inspector General HHS TIPS Hotline P.O. Box 23489 Washington, DC 20026

   c. No Retaliation. SCAN will not retaliate against any employee that reports a potential violation of False Claims Laws or otherwise lawfully exercises rights under the False Claims Laws. Employees who feel they have experienced retaliation or have knowledge that someone else has experienced retaliation should contact the Vice President of Internal Audit Services, Compliance Officer, or General Counsel for further investigation. Employees may also report retaliation to the SCAN EthicsPoint Hotline at 877-863-3362.

3. Investigation of Reports of Potential Violations of False Claims Law. All reports of potential violations of the False Claims Law will be triaged by the Chief Compliance Officer for investigation. The investigation will be conducted by Compliance, Legal, Special Investigations Unit and/or Internal Audit Services with the requisite expertise and objectivity. See CO-0018 Managing, Investigating, and Resolving Potential Compliance Issues (PCIs) for more details.

4. Repayments & Disclosures. Upon confirmation of an overpayment, the applicable business unit is responsible for consulting compliance and ensuring that repayment will be made timely in compliance with regulatory requirements and guidance and that appropriate regulatory agencies are notified where required. Refer to SIU-0006, Referring Suspected Cases of Fraud and Abuse to Law Enforcement for more information.

5. Internal Controls and Processes for Detecting Fraud and Abuse and Overpayments. Compliance is responsible for ensuring that each department implements internal controls and processes for detective Fraud, Waste, Abuse, and Overpayments.

   a. The following table shows examples of the primary accountability by functional area for internal controls and processes for detecting Fraud, Waste, and Abuse and Overpayments. Each function has department policies or procedures for detection and the return of Overpayments that meet compliance requirements.

Type of Overpayment	**Function with Primary Accountability**
Encounter Data, Risk Adjustment, Coding, Documentation	Health Care Informatics
Prescription Drug Events	Pharmacy
Medicare Premiums	Finance

   b. Immaterial potential Overpayments identified through normal business operations, unintentional in nature and non-systemic are repaid in compliance with applicable regulatory guidance.

6. Monitoring and Oversight. The functions listed above with primary accountability will provide summary reports to Enterprise Monitoring quarterly. Internal Audit Services and the Special Investigations Unit will perform data analytics and auditing using a risk-based approach.

Cross-referenced P&Ps
CO-0018, Processing Potential Compliance Issues

SIU-0006, Referring Suspected Cases of Fraud and Abuse to Law Enforcement

Regulatory/Accreditation Citations (as applicable)
31 USC § 3729; United States Code - Federal False Claims Act - General Provisions

31 USC § 3730 (h); United States Code - Federal False Claims Act – Relief from Retaliatory Actions

42 CFR 422.503(b) (4) (vi); Code of Federal Regulations - Basic Compliance Requirements

42 CFR 422.503 Code of Federal Regulations - General Requirements of a Medicare Advantage Plan

42 CFR 423.272; Code of Federal Regulations - Chapter IV-Centers For Medicare & Medicaid Services, Department Of Health And Human Services - Part 423 - Voluntary Medicare Prescription Drug Benefit - Review and negotiation of bid and approval of plans submitted by potential Part D sponsors

42 CFR 423.4; Code of Federal Regulations - Chapter IV--Centers For Medicare & Medicaid Services, Department Of Health And Human Services - Part 423 - Voluntary Medicare Prescription Drug Benefit - Definitions

42 CFR 423.504; Code of Federal Regulations Conditions for Part D Plans

42 CFR 423.504(b) (4) (vi) (H); Code of Federal Regulations - General Requirements of a Part D Plan

42 CFR 438.608; Code of Federal Regulations - Program Integrity Requirements

42 CFR 455.2; Code of Federal Regulations - Chapter IV - Centers For Medicare & Medicaid Services, Department Of Health And Human Services - Part 455 - Program Integrity: Medicaid – Definitions

CMS Prescription Drug Benefit Manual; Chapter 9 - Fraud, Waste and Abuse Requirements for Part D Plan Sponsors

California Government Code § 12650-12656; California False Claims Act - General Provisions

California Government Code § 12653; California False Claims Act - Relief from Retaliatory Actions

Attachment A: False Claims Law

1. The Federal False Claims Act allows civil action to be brought against any person or entity who:

a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;

b. Knowingly makes uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;

c. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;

d. Has possession, custody, or control of property or money used, or to be used, by the government and, intending to defraud the government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

e. Authorizes to make or deliver a document certifying receipt of property used, or to be used, by the government and, intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from a federal employee, who lawfully may not sell or pledge the property; or

g. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government (31 USC sec. 3729).

"Knowing or knowingly," as such terms relate to the Federal False Claims Act means that a person" (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. A person can act knowing or knowingly for purposes of the Federal False Claims Act without there being proof of a specific intent to defraud.

2. Examples of a False Claims resulting in overpayments by a federal program:

a. Billing for procedures not performed;

b. Violation of another law, for example, a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals);

c. Falsifying information in the medical record or in a claim;

d. Improper bundling or coding of charges; and

e. Misrepresentation by a member or provider to seek benefits provided by the health plan;

f. Risk adjustment including encounter data submitted to CMS that is not supported by medical record documentation;

g. Inaccurate Prescription Drug Even (PDE) and Direct and Indirect Remuneration (DIR);

h. Incorrect Low Income Premium Subsidy (LIPS) for Employer Group Waiver Plans (EGWPs);

i. Incorrect enrollment into Medicare Advantage Plans, Part D plans, and other government programs.

3. The Patient Protection & Affordability Care Act of 2010 (PPACA) expanded oversight of health care fraud, waste and/or abuse to ensure the integrity of federally financed and sponsored health programs; PPACA creates new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs. Relevant provisions include:

   a. Providers and suppliers must report and return overpayments to the Department of Health and Human Services (HHS), the state, or contractor by the later of 60 days after the date the overpayment (i.e., funds a person receives or retains to which person is not entitled after reconciliation was identified), or the date the corresponding cost report is due and provide written explanation of reason for overpayment. Any overpayment retained after the 60-day deadline is deemed an “obligation” for purposes of the False Claims Act. Knowing failure to report and return overpayments by the date due may result in penalties under the False Claims Act and Civil Monetary Penalties Law.

   b. Under the previous Medicare rules, a provider could submit claims for payment within three (3) calendar years following the date of service. Under PPACA, Medicare claims must be submitted within the period ending one (1) calendar year after the date of service (beginning with services furnished on or after January 1, 2010).

c. Medicare and Medicaid payments may be suspended pending investigation of “credible allegation of fraud” unless HHS determines there is good cause not to suspend payments.

d. Amended the U.S. Criminal Code to deem certain criminal offenses “federal health care fraud offenses.” If a particular offense is defined as a “federal health care fraud offense,” convictions for violation may be punishable by longer prison terms and/or higher fines.

e. The Office of Inspector General may obtain any supporting documentation necessary to validate claims for Medicare or Medicaid payment, including a prescribing physician’s medical records for an individual who is prescribed an item or service, and “any records necessary for evaluation of the economy, efficiency, and effectiveness of the Medicare and Medicaid programs.”

4. Remedies:

a. Violation of the Federal False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages that the government sustains because of the violation.

b. A Federal False Claims action may be brought by the U.S Attorney General.

c. An individual also may bring a qui tam action for violation of the Federal False Claims Act. This means the individual files a civil action on behalf of the government.

d. An individual who files a qui tam action receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government’s participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action.

e. A statute of limitations says how much time may pass before an action may no longer be brought for violation of the law. Under the Federal False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed.

5. Federal Whistleblower Protections:

   a. Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the Federal False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under the Federal False Claims Act, shall be entitled to all relief necessary to make the employee whole.

   b. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate District Court of the United States for such relief (31 USC 3730(h)).

6. California False Claims Act:

   a. California also has a State False Claims Act similar to the Federal False Claims Act. The California False Claims Act makes it illegal, among other things, for any individual to knowingly present or cause to be presented to a state employee a false claim for payment or approval, knowingly make, use, or cause to be made or used a false record or statement to get a false claim paid or approved by the State or by any political subdivision, or to conspire to defraud the State or any political subdivision by getting a false claim allowed or paid by the State or by any political subdivision (California Government Code Section 12650-12656).

   b. Violation of the California False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages that the government sustains because of the violation.

   c. The California False Claims Act also allows individuals to file *qui tam* actions.

7. California Whistleblower Protections:

   a. Any employee who is discharged, demoted, suspended, threatened, harassed, denied promotion to, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing

information to a government or law enforcement agency or in furthering a false claims action shall be entitled to all relief necessary to make the employee whole.

b. Such relief shall include reinstatement with the same seniority status that the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination, litigation costs and reasonable attorneys' fees, and, where appropriate, punitive damages. An employee may bring an action in the appropriate superior court of the state for such relief. (California Government Code Section 12653)

8. Medicare Part D Considerations:

a. The Company is a Plan Sponsor of the prescription drug benefit Medicare Part D (MA-PD/PDP).

b. Regulations relative to anti-fraud, waste, and abuse are contained in the Centers for Medicare and Medicaid Services (CMS), Chapter 9 – Prescription Drug Benefit Manual.

c. CMS contracts with Medicare Drug Integrity Contractors (MEDICs) to accept referrals and investigate suspected incidences of fraud against the Medicare drug benefit and/or beneficiaries.

d. The SCAN SIU refers cases of fraud, waste, and/or abuse within the Part D benefit to the MEDIC. Reference P&P CO-0018, Processing Potential Compliance Issues.