POLICY
Federal and State Laws related to Fraud, Waste and Abuse

This Policy is Applicable to the following Spectrum Health sites:
Priority Health

Reference #:	167
Version #:	7
Effective Date:	05/20/2022
Functional Area:	Health Plan
Priority Health Department Area:	Special Investigations Unit (SIU)

1. Purpose

Priority Health requires all employees, providers, agents, vendors and contractors to comply with all applicable laws and regulations. In addition, Priority Health expects all employees, providers, agents, vendors and contractors to actively participate in the prevention and detection of fraud, waste and abuse. This policy provides an overview of key federal and state laws to ensure that all required parties are aware of applicable federal and state laws designed to prevent and detect fraud, waste and abuse. In addition, this policy provides information about whistleblower protections.

2. Policy

Federal and State False Claims Acts

As required by the federal and state False Claims Acts, all providers, contractors and vendors are prohibited from "knowingly" presenting (or causing to be presented) to the federal or state government a false or fraudulent claim for payment or approval. The acts define knowingly to mean a person that has actual knowledge of the false claim, 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. All individuals are prohibited from knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal or state government or its agents. The False Claims Acts are enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal or state government. Violation of the False Claims Acts can result in civil penalties from $5,000 to $10,000 per claim. In addition, an individual or entity may be excluded from participating in federal health care programs. Priority Health monitors the compliance of our contractors and subcontractors to the False Claims Acts.

The federal and state False Claims Acts permit individuals with knowledge of fraud against the federal or state government to file a lawsuit on behalf of the government against the individual/entity that committed the fraud. If the lawsuit is successful, the individual is entitled to a portion of the government's recovery. The False Claims Acts provide a "whistleblower" protection.

Whistleblower

The federal and state False Claims Acts include specific provisions to protect whistleblowers from retaliation by their employers. Any private party who initiates or assists with a False Claims Act case against his/her employer is protected from discharge, demotion, suspension, threats, harassment and discrimination in the terms and condition of his or her employment if the employer's actions are taken in response to the employees efforts on the case. A private party who does suffer retaliation for his or her assistance with a case against his/her employer is entitled to reinstatement, two times the amount of back pay, interest and compensation for special damages including attorney's fees.

Anti-Kickback Statute

As required by the Anti-Kickback Statute, individuals are prohibited from knowingly or willfully offering, paying, soliciting, or receiving remuneration (the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind) in order to induce and reward business payable (or reimbursable) under the Medicare or other federal health care programs. A criminal sanction may place those in violation of the law in jail for up to 5 years, assess a $25,000 fine and impose mandatory exclusion from the participation in any government funded health care programs. On the civil side, the monetary penalty of $50,000 per violation and treble damages that equal three times the dollar amount the government is defrauded may apply.

There are three objectives behind the federal anti-kickback law.

1) **to prevent over-utilization of health care programs**
2) **to limit patient steering**
3) **to promote market competition**

The Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against any person who makes, or causes to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. The Program Fraud Civil Remedies Act addresses lower dollar fraud and generally applies to claims of $150,000 or less.

Stark Law

The Stark law pertains to physician referrals under both Medicare and Medicaid and states that a physician cannot refer patients to an entity for the purpose of furnishing certain designated health services if the physician or an immediate family member has a financial relationship with that entity. The entity cannot bill for improperly referred services unless an exception or safe harbor applies. It is essential to realize that the Stark law has no state-of-mind requirement. The intention and motives of the parties involved are irrelevant. If statutory requirements are met, there is a violation, unless an exception or safe harbor applies.

The Stark law is targeted against over-utilization and improper patient steering and is intended to increase market competition. Sanctions and fines are civil and criminal penalties do not apply. Under the civil penalty, the entity that did the billing must refund the payments for improperly referred services. There is also a civil monetary penalty of up to $15,000 for any person who presents or causes a claim for improperly referred designated health services as long as they know that the claim is improper.

Exclusion Statute

Under the Exclusion Statute, the Office of Inspector General (OIG) must exclude from participation in all federal health care programs providers and suppliers convicted of:

- Medicare fraud
- Patient abuse or neglect
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service; or
- Felony convictions for unlawful manufacture, distribution, prescription or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds.

Excluded providers cannot participate in federal health care programs for a designated period. An excluded provider may not bill federal health care programs (including but not limited to Medicare, Medicaid, and State Children's Health Insurance Programs (SCHIP) for services he or she orders or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement. The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE) on the OIG website.

Reporting

Any potential case of fraud, waste or abuse related to Priority Health programs, including Priority Medicare and Priority Medicaid, may be reported to the following:

- Priority Health Customer Service at 616 942-4765 or 800 942-4765
- Priority Health Compliance Helpline at 800 560-7013 (available 24 hours a day).
- Write to:

  Fraud, Waste and Abuse Program
  Priority Health
  SIU Mail Stop 3175
  1231 East Beltline NE
  Grand Rapids, MI 49525
  Or
  Fax the information to: 616 942-7196 or email at: SIU@priorityhealth.com

Suspected cases of fraud related to Priority Medicaid may also be reported directly to the MDHHS OIG via the following ways:

- Call the MDHHS OIG toll-free at 1-855-MI-Fraud (855-643-7283). Office hours are Monday through Friday, 8:00 am to 5:00 pm. Voicemail available for after hours.
- Use the Online Complaint Form online at Michigan.gov/fraud
- Write to:

  Office of Inspector General
  PO Box 30062
  Lansing, MI 48909

Suspected cases of Medicare fraud may be reported to the Office of Inspector General via the following ways:

- Call toll free at 1-800-HHS-TIPS (1-800 447-8477)
- Fax: 1-800-223-8164
- TTY: 1-800-377-4950
- Write to:

  U.S. Department of Health and Human Services
  Office of the Inspector General

ATTN: OIG HOTLINE OPERATIONS
PO BOX 23489
Washington, DC 20026

- Online: Go to www.oig.hhs.gov/fraud/hotline

Suspected cases of fraud in the Federal Employees Health Benefits Program (FEHBP) may be reported via the following ways:

- Call Health Care Fraud Hotline: 877-499-7295
- Online: Go to www.opm.gov/oig
- Write to:
  OPM - Office of the Inspector General
  Fraud Hotline
  1900 E Street NW, Room 6400
  Washington, DC 20415-1100

3. Revisions

Spectrum Health reserves the right to alter, amend, modify or eliminate this policy at any time without prior written notice.

04/29/08, 4/10/09, 3/28/2016, 8/15/2016, 3/15/2018, 9/13/2021
Approved by Compliance Committee 02/03/2022

4. References

Compliance Verification:

- Policy listed on priorityhealth.com for all providers, contractors and vendors
- Provider contracts require compliance with all federal and state laws. All contracts are signed.

Reference Documentation:

- Section 6032 of the Deficit Reduction Act of 2005
- MCL 400.601-400.613
- 31 USC 3729-3733
- 31 USC 3801-3812
- 42 USC 1320a-7
- 42 USC 1320a-7b(b)
- 2015 Inflation Adjustment Act (Public Law 114-74, Sec. 701)
- Priority Health Compliance Program
- Fraud, Waste and Abuse Manual

Policies and Procedures:

- Fraud, Waste and Abuse Policy #169
- Fraud, Waste and Abuse Procedure 300
- Excluded Individuals/Entities Policy, 937

5. Policy Development and Approval

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6. Keywords

FWA, laws