# CORPORATE COMPLIANCE POLICY AND PROCEDURE

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| **Title: Fraud Waste and Abuse Laws in Health Care** | **Policy # 1011** | |
| **Sponsor: Corporate Compliance** | **Issued: June 25, 2007** | **Page: 1 of 7** |
| **Approved by: Carleen Dunne, Director, Corporate Compliance and Privacy Officer** | **Last Reviewed/Revised: 3/9/2016** | |

## I. PURPOSE

The purpose of this policy is to educate BlueCross BlueShield employees and contractors and promote compliance with the federal and state fraud waste and abuse laws regarding false claims, statements, or any other type of fraudulent activity prohibited by relevant fraud laws. These laws are intended to prevent and deter fraud, waste, and abuse.

## II. APPLICABILITY

This Policy Rule and Procedure applies to the following groups:

☒ **Management (Supervisor and Above)**

☒ **Salaried/Exempt**

☒ **Hourly/Non-exempt (excluding bargaining unit)**

☒ **Bargaining Unit**

☒ **Temporaries, Coops/Interns, Consultants/Contractors, Vendors**

## III. POLICY/RULE

***Applicable Fraud Laws:***

The **Federal False Claims Act** (31 U.S.C. § 3729) and amended by **The Fraud Enforcement Recovery Act of 2009 (FERA)** is violated if a person knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government. The potential penalties for violating the False Claims Act include treble damages (damages equal to three times the amount of the false claims), civil penalties of up to $11,000 per claim and exclusion from federal health care programs. In addition, the federal government may impose administrative sanctions of up to $5,500 plus twice the amount of the false claim under the Federal Program Civil Remedies Act of 1986 (31 U.S.C. § 3801).

There is a comparable **New York State False Claims Act** (Article 13 of the NYS Finance Law) governing claims submitted to state and local government agencies. Violations of this law may be punished by treble damages and penalties of $6,000 to $12,000 per claim.

Several other New York State laws also prohibit the making of false claims and statements. In addition, criminal penalties may be imposed for intentionally submitting a false claim to the Medicaid program (Section 366-b of the Social Services Law), knowingly making a false entry in a business record or filing a false instrument with a government agency (Article 175 of the NYS Penal Law), committing a fraudulent insurance act (Article 176 of the NYS Penal Law) or engaging in health care fraud (Article 177 of the NYS Penal Law).

**Anti-Kickback Statute** – prohibits persons or entities from knowingly and willingly offering, soliciting, or receiving remuneration in order to induce or reward the referral of business payable by a federal health care program. (42 USC § 1320a-7b (b))

To avoid potential violations of the federal anti-kickback statutes, as a BlueCross BlueShield employee, you may never solicit anything of value from a broker, vendor, supplier, provider, or subscriber. In addition, you should not accept any gifts of money, or gift cards with can be redeemed for cash or bank cards such as, Visa or MasterCard, no matter the amount, from these sources.

**The Stark Law** – prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician has a financial relationship and prohibits the designated health services entity from submitting claims to Medicare for those services resulting from prohibited referral. (42 USC §§1395 nn)

**Deficit Reduction Act -** The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities, which receive or make $5.0 million or more in Medicaid payments during a federal fiscal year to establish policies and procedures informing and educating their employees, providers and contractors about federal and state false claims acts and whistleblower protections. The Fraud, Waste, and Abuse (Whistleblower) Policy #1010 provides additional information for detecting FWA.

***Types of Conduct Implicating the Fraud Laws:***

BlueCross BlueShield its employees, contractors and agents may be subject to liability under the fraud laws for knowingly or with deliberate ignorance or reckless disregard, engaging in the following types of conduct:

- Submitting premium claims to the Medicaid program for individuals who are not BlueCross BlueShield members.

- Submitting cost reports to Medicaid which are inaccurate or incomplete.

- Accepting overpayments under the Medicare program.
- Denying members access to medically necessary services.

The above list is intended to be illustrative and not exhaustive. False Claims Act liability exists for any knowing or intentional submission of false claims or statements that result in payment by a federal health care program and for the retention of federal monies to which BlueCross BlueShield is not entitled.

All employees and contractors are strictly prohibited from engaging in any conduct that violates the fraud laws. Employees and contractors must take all steps specified in this policy to protect BlueCross BlueShield, its employees, contractors and agents from Fraud laws.

***Reporting of Fraud Law Violations by Employees***

Employees, contractors, consultants and agents of BlueCross BlueShield will be expected to report the preparation or submission to Medicaid or any other federal health care program of any claim or report that appears to be false or fraudulent, or any other conduct that appears to violate the fraud laws. Employees may make such reports through any of the mechanisms described in BlueCross BlueShield Code of Conduct and Compliance Program booklet, in the Company's Compliance policies and in the Company's Whistleblower Policy. All reports received from employees will be evaluated and investigated as necessary pursuant to such policy. Employees are encouraged to contact their supervisor or the Compliance Officer if they have questions as to whether certain practices violate any fraud laws.

***Qui Tam***

Employees have the legal right to file *qui tam* lawsuits if they become aware that BlueCross BlueShield has submitted claims for reimbursement to Medicaid or other government programs in violation of the False Claims Act. In a *qui tam* lawsuit, the employee, referred to as a "relator", files the case under seal and requests that the federal government intervenes and takes over prosecution of the matter. If the relator's lawsuit is successful, the relator may share in a portion of the recovery. BlueCross BlueShield will not seek to impede any employee from filing a *qui tam* lawsuit, through threats of retaliation, intimidation or otherwise. However, all employees are encouraged to report and attempt to resolve suspected False Claims Act violations through the internal report procedures established by BlueCross BlueShield prior to exercising qui tam rights.

***Employee and Contractor Education***

BlueCross BlueShield provides compliance training to employees and its consultants, contractors and related entities and includes a component addressing the False Claims Act as well as State laws punishing the making of false claims or statements. BlueCross BlueShield requires that in

connection with the execution of each contract by BlueCross BlueShield, the contractor receives relevant information regarding these laws.

***Internal Auditing***

BlueCross BlueShield requires that periodic audits conducted by or on behalf of BlueCross BlueShield cover the submission of accurate claims and cost reports to the Medicaid program, as well as any other activities deemed by the Compliance Officer to raise potential risks under the False Claims Act. The Compliance Officer will oversee the development and implementation of a corrective action plan to address any compliance issues identified through such audits.

***Disclosure of False Claims***

Under the False Claims Act, BlueCross BlueShield may avoid treble damages and civil penalties if it discloses to the relevant federal health care program any false or fraudulent claims, within 30 days of discovery of the false claim and makes appropriate restitution of any overpayments within 60 days of when the overpayment was identified.

It is BlueCross BlueShield policy to take appropriate disciplinary action, ranging from a verbal warning up to and including termination, for workforce members who fail to comply with this policy.

## IV. PROCEDURE

N/A

## V. DEFINITIONS

***Abuse*** practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or BlueCross BlueShield, or in reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care.

***Claim*** any request or demand for money or property and whether or not the federal, state or local government has title to the money or property that is presented to an officer, employee, contractor or government employee or is made to a contractor, grantee or other recipient if the money or property is to be spent or used on the government's behalf or to advance a government program or interest.

***Fraud*** any type of intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to himself/herself or another person.

***Knowing and knowingly*** that 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. No proof of a specific intent to defraud is required for a person to act knowingly.

***Waste*** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a healthcare program. Waste is generally not considered a criminally negligent act, but rather a misuse of resources.

***Work Force Members*** are Employees, temporary personnel, interns, consultants, contractors, board members and/or agents.

## V. RESPONSIBILITIES

All employees and contractors are accountable for following this policy and the related provision of the BlueCross BlueShield Code of Conduct. Employees are responsible to ensure that they do not engage in conduct that violates the federal False Claims Act as well as fraud laws and state laws punishing the making of false claims and statements. As stated above in the "Reporting of False Claims Act Violations by Employees" section, employees are expected to report the preparation or submission to Medicaid or any other federal health care program of any claim or report that appears to be false or fraudulent, or other conduct that appears to violate the False Claims Act or other fraud laws to the Compliance Officer or the Special Investigations Unit.

The Compliance Officer is responsible for ensuring the prompt investigation of all reports of potential fraud law violations to provide BlueCross BlueShield with an opportunity to make disclosure and restitution, as needed.

It is BlueCross BlueShield policy to take appropriate disciplinary action, ranging from a verbal warning up to and including termination, for workforce members who fail to comply with this policy.

## VII. RELATED POLICIES/REFERENCES

- Federal False Claims Act (31 USC 3729)
- New York State False Claims Act, Article 13 Sections 187 - 194
- Federal Deficit Reduction Act (DRA) of 2005 Section 6032 [(42 USC 1396a(a)(68)]
- Fraud Enforcement Recovery Act of 2009
- The Deficit Reduction Act (DRA) of 2005
- Anti-Kickback Statute [42 USC Section 1320a-7b(b)]
- The Stark Law (42 USC Section 1395 nn)
- Patient Protection and Affordable Care Act, Section 6402(d) (2)
- BlueCross BlueShield's Code of Conduct

## VIII. DISTRIBUTION

This Policy Rule and Procedure shall be distributed to all managers for communication to staff within their respective span of control. In addition, this document shall be available to all employees via the Intranet.

## IX. REVISION

It shall be the responsibility of the Compliance Officer (or designee) to review this Rule/Policy and Procedure on a regular basis and make revisions as appropriate. All rule/policy and procedure changes may be completed without prior notice. (As a policy applies to Bargaining Unit employees, the current agreement between BlueShield and the Office and Professional Employees International Union will be followed.)