Anderson Healthcare

Title: Fraud, Waste, and Abuse

Responsible Department: Administration, Administration, Maryville Imaging, Surgery Center	Date Created: 08/01/2005
Approver(s): Board of Trustees, Corporate Compliance Committee, Keith Page (President), Medical Executive Committee (Manager)	Date Approved: 03/24/2022

SCOPE: This Policy applies to Anderson Healthcare, Anderson Hospital, Community Hospital of Staunton, Maryville Imaging, LLC, Anderson Medical Group, LLC, Anderson Surgery Center, Anderson Real Estate, LLC, Maryville Medical Services, LLC, Anderson Hospital Foundation, and Friends of Community Memorial Hospital (together "Anderson Healthcare").

POLICY STATEMENT: Anderson Healthcare is committed to conducting business ethically and in compliance with all applicable laws, rules, regulations, policies, and procedures. It is committed to establishing and maintaining strong internal controls to assist in the prevention, deterrence, and detection of Fraud, Waste, and Abuse. Covered Individuals shall not perpetrate, engage in, or otherwise facilitate Fraud, Waste, or Abuse. All Covered Individuals are responsible for reporting known or suspected violations of this Policy. Anderson Healthcare will investigate all allegations of Fraud, Waste, or Abuse.

PURPOSE: The purpose of this Policy is to prevent, deter, and detect Fraud, Waste, and Abuse. It provides a brief overview of laws governing Fraud, Waste, and Abuse and identifies prohibited conduct.

Questions regarding this Policy should be directed to the Chief of Compliance and Risk.

DEFINITIONS:

"Abuse" includes actions that may, directly or indirectly, result in unnecessary costs to a health care benefit program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

"Chief of Compliance and Risk" or "CCR" means the individual designated by the President/CEO as the chief compliance officer and charged with the responsibility of coordinating the implementation of the Compliance Program.

"Covered Individual" means any individual subject to Anderson Healthcare's Compliance Program. Covered Individuals include Employees, Professionals, Volunteers, students, contractors, consultants, suppliers, and Vendors.

"Designated Health Services" means any of the following services that are payable, in whole or in part, by Medicare: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

"Federal Healthcare Program" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program (with the exception of the Federal Employees

Health Benefits Program). The most significant Federal Healthcare Programs are Medicare, Medicaid, Tricare, and the Veterans programs.

"Fraud" means Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

"Knowing" or "Knowingly" means actual knowledge of the information or acting in deliberate ignorance or reckless disregard of the truth or falsity of the information.

"OIG" means the Office of Inspector General, U.S. Department of Health & Human Services.

"President/CEO" means the President and Chief Executive Officer of Anderson Healthcare.

"Professional" means an individual other than an Employee who is credentialed by Anderson Healthcare, including physicians, dentists, podiatrists, and allied health personnel, to the extent that the individual provides goods or services at or for Anderson Healthcare.

"Referral Source" means an individual or entity who makes a referral to Anderson Healthcare, who directs another person or entity to make a referral, or who controls referrals made by another person or entity. The term "Referral Source" also includes the professional corporation of which the individual is a sole owner.

"Referring Physician" means a physician who makes a referral to Anderson Healthcare or who directs another person or entity to make a referral or who controls referrals made by another person or entity. The term "Referring Physician" also includes the professional corporation of which the physician is a sole owner.

"Remuneration" means anything of value including, but not limited to, cash, free rent, expensive hotel stays and meals, or excessive compensation for medical directorships and consultancies.

"Vendor" means a company, including any employee, agent, or representative of the company, that currently supplies or has the potential to supply products or services to Anderson Healthcare or is otherwise in a position to do business with Anderson Healthcare.

"Volunteer" means an individual who provides uncompensated services to Anderson Healthcare, including members of any Anderson Healthcare entity's Board of Trustees

"Waste" is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program.

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GUIDELINES/PROCEDURE:

A. What is Fraud, Waste, and Abuse?

The difference between Fraud, Waste, and Abuse depends on the specific facts, circumstances, intent, and knowledge. The primary difference is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and Abuse may involve obtaining an improper payment or creating an unnecessary cost to a health care benefit program, but do not require the same intent and knowledge.

Generally speaking, mistakes (e.g. isolated incidents of incorrect coding) result in errors, inefficiencies (e.g. ordering excessive diagnostic tests) result in Waste, bending the rules (e.g. unintentional improper billing practices like upcoding) result in Abuse, and intentional deception (e.g. billing for services that were not provided) results in Fraud.

1. Fraud

Defrauding the Federal Government is illegal. Committing Medicare Fraud exposes individuals and entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties.

Examples of actions that may be Fraud include:

a. Knowingly billing for services at a level of complexity higher than services actually provided or documented in the medical records.
b. Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items.
c. Knowingly ordering medically unnecessary items or services for patients.
d. Paying for referrals of Federal Healthcare Program beneficiaries.
e. Billing payors for appointments patients fail to keep.

2. Waste

Although Waste is generally considered to be caused by the misuse of resources and not criminally negligent actions, Waste may give rise to Abuse.

Examples of actions that may be Waste include:

a. Conducting excessive office visits or writing excessive prescriptions.
b. Prescribing more medications than necessary to treat a specific condition.
c. Ordering excessive laboratory tests.

3. Abuse

Abuse involves payment for items or services when there is no legal entitlement to that payment when the provider has not Knowingly and/or intentionally misrepresented facts to obtain payment. Medicare abuse can also expose individuals and entities to criminal and civil liability.

Examples of actions that may be Abuse include:

a. Unknowingly billing for unnecessary medical services.
b. Unknowingly charging excessively for services or supplies.
c. Unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

B. Fraud, Waste, and Abuse Laws

There are many different complex Federal and State laws governing Fraud, Waste, and Abuse that specify the criminal, civil, and administrative penalties for committing Fraud and Abuse. Those laws include:

1. False Claims Act (FCA)

The FCA imposes civil liability on any person who Knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government. No specific intent to commit Fraud is required to violate the FCA. Knowingly submitting claims to Medicare for services not provided is an example of a FCA violation.

Civil penalties for violating the FCA may include up to three times the amount of damages in addition to penalties of $11,803 to $23,607 for each false claim submitted (the minimum and maximum penalty amounts are adjusted for inflation each year). The FCA permits *qui tam* suits to be brought on behalf of the government by private individuals who are then entitled to a portion of the penalties and damages. It also protects whistleblowers from retaliation.

In addition to civil penalties, individuals or entities may also face criminal penalties (e.g. fines, imprisonment, or both) for submitting false, fictitious, or fraudulent claims pursuant to the Federal criminal FCA.

The Illinois False Claims Act is very similar to the Federal civil FCA and imposes civil liability for any false claim for which the State provided any portion of the funds.

2. Anti-Kickback Statute (AKS)

The AKS makes it a crime to Knowingly and willfully offer, pay, solicit, or receive any Remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal Healthcare Program.

A provider receiving cash or below-fair-market-value rent for medical office space in exchange for referrals is an example of an AKS violation.

Violating the AKS may result in fines, imprisonment, and exclusion from participation in Federal Healthcare Programs. Civil penalties for violating the AKS may include up to three times the amount of the kickback.

3. Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, which is often called the Stark Law, prohibits physicians from referring patients to receive Designated Health Services from an entity with which they (or their immediate family) have a financial relationship, unless an exception applies.

A physician referring a patient to an imaging center owned by her husband is an example of a Stark Law violation.

Penalties for violating the Stark Law may include fines, civil monetary penalties for each referred service, repayment of claims, and exclusion from participation in Federal Healthcare Programs.

4. Social Security Act

The Social Security Act is a long, complex law setting forth many different requirements for healthcare providers. Two of the requirements are particularly relevant when dealing with Fraud, Waste, and Abuse: the Exclusion Statute and the Civil Monetary Penalties Law.

a. Exclusion Statute

The Exclusion Statute requires OIG to exclude individuals and entities convicted of healthcare related fraud, controlled substance crimes, or patient abuse and neglect. OIG also may impose exclusions for other reasons such as submitting false claims, engaging in unlawful kickbacks, defaulting on student loans, or providing unnecessary or substandard services.

Excluded providers may not participate in Federal Healthcare Programs. For more information on exclusions, please see the Anderson Healthcare Exclusion Screening Policy.

b. Civil Monetary Penalties (CMP) Law

The CMP Law authorizes OIG to seek financial penalties for a variety of healthcare Fraud violations. Different amounts of penalties and assessments apply based on the type of violation. CMP may also include fines of up to three times the amount claimed for each item or service.

Examples of violations that may justify CMP include violating the AKS or presenting a claim you know, or should know, is false and fraudulent or for an item or service not provided as claimed.

5. Criminal Health Care Fraud

The Criminal Health Care Fraud Statute prohibits Knowingly and willfully executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to defraud any health care benefit program or obtain any money or property owned or controlled by any Federal Healthcare Program.

C. Fraud, Waste, and Abuse Compliance

Anderson Healthcare and its Covered Individuals shall comply with all State and Federal laws, regulations, and policies, including all those issued by the Center for Medicare and Medicaid Services, the Medicare Administrative Contractor, and the Illinois Department of Human Services. Covered Individuals who are responsible for decisions that might involve Fraud, Waste, and Abuse laws shall obtain sufficient knowledge of those laws to ensure compliance.

Anderson Healthcare and its Covered Individuals shall not:

1. Engage in activities that constitute Fraud, Waste, or Abuse.

2. File false or fraudulent claims for payment or approval.

3. Make or enter any charge for a service that either was not provided or not ordered by an appropriately licensed provider.

4. Record a charge for a service that differs in any way from the actual service provided (including by entering a false, fraudulent, or erroneous CPT code).

5. Bill codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided (i.e. upcoding).

6. Submit a claim piecemeal or in a fragmented fashion to maximize reimbursement for tests and procedures that are required to be billed together (i.e. unbundling).

7. Falsely certify that a service was medically necessary.
   a. All services or supplies ordered for, or provided to, beneficiaries of a Federal Healthcare Program must:
      i. Be proper and needed for the diagnosis or treatment of the medical condition,
      ii. Be provided for the diagnosis, direct care, and treatment of the medical condition,
      iii. Meet the standards of good medical practice in the local area, and
      iv. Not be mainly for the convenience of the patient or provider.
   b. Medical necessity must be supported by documentation in the record.
   c. Services must meet specific medical necessity requirements as defined by National and Local Coverage Determinations (NCD sand LCDs).

8. Make or use, or cause another to make or use, any false record or statement in connection with:
   a. Obtaining payment for a false or fraudulent claim,
   b. Anderson Healthcare's compliance with Medicare or Medicaid conditions of participation or payment, or
   c. Any licensure or accreditation standards.

9. Knowingly and willfully solicit, receive, offer, or pay anything of value (directly or indirectly) for:
   a. Referring patients for services paid for by a Federal or State Healthcare Program, or
   b. Purchasing, leasing, ordering, recommending, or arranging for goods or services paid for by a Federal or State Healthcare Program unless an exception established by law or regulation applies.

10. Accept referrals from a Referral Source for Designated Health Services to an entity with which the Referring Physician has a financial relationship, unless an exception established by law or regulation applies.

11. Refer a patient to an entity with which the Referring Physician has a financial relationship for Designated Health Services, unless an exception established by law or regulation applies.

12. Consummate any agreement (whether written or oral) with any Referring Physician or Referral Source without the prior approval of the President/CEO.

13. Participate in any transaction (including, but not limited to, incentives, loans, guarantees, compensation arrangements, physician recruitment, or practice acquisitions) that could be perceived as providing an economic benefit to an officer, director, trustee, physician, or other influential person of Anderson Healthcare if the value of the benefit provided exceeds the fair market value.

14. File a false or fraudulent Medicare cost report.
    a. Covered Individuals involved with the preparation and submission of cost reports on behalf of Anderson Healthcare shall ensure:
        i. All costs claimed are based on appropriate and accurate documentation and in accordance with the guidelines published by the appropriate regulating agencies and entities.
        ii. Non-Medicare-related costs are not shifted to Medicare cost centers.
        iii. The allocation of Medicare costs to cost centers are accurately made and supported by verifiable and auditable data.
        iv. All unallowable costs are excluded from any claim for reimbursement.
        v. Any errors that are found after the submission of a cost report are corrected and promptly reported to the Medicare Fiscal Intermediary or other applicable agencies.

The list of prohibitions above is not exhaustive. Covered Individuals are responsible for ensuring compliance with all Fraud, Waste, and Abuse laws, regulations, policies, and procedures.

D. Fraud, Waste, and Abuse Concerns

Covered Individuals who believe, in good faith, that an activity may not comply with any applicable law, regulation, policy, or procedure shall report the activity pursuant to the Anderson Healthcare Reporting Compliance Concerns Policy. Covered Individuals reporting good faith compliance concerns are protected from retaliation pursuant to the Anderson Healthcare Non-Retaliation Policy. Anderson Healthcare will investigate all compliance concerns pursuant to its Compliance Monitoring and Investigations Policy.