Fraud, Waste & Abuse Policy

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The Independence Center (The IC) is committed to the responsible stewardship of our resources, and maintaining a comprehensive plan for detecting, preventing and correcting fraud, waste and abuse. To that end, The IC encourages any individual who is aware of or suspects acts of fraud, waste or abuse of The IC resources in any departmental area, by any provider or with any entity that The IC contracts with, to report such acts to The IC Compliance Officer (reference The Independence Center Whistleblower Protection Policy). The IC has zero tolerance for the commission or concealment of acts of fraud, waste or abuse.

I. Purpose

The purpose of this policy is to comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws. This document will provide information about certain federal and state laws concerning the submission of false and fraudulent claims for payment to the government. These laws play a central role in the government's efforts to prevent and detect fraud, waste and abuse.

II. Definitions

Fraud – An intentional misrepresentation or deception, usually in the form of a false statement, to obtain money or some other unauthorized personal benefit by deliberate deception to the detriment of another party, organization or entity, such as the Medicare/Medicaid program. Fraud is an act that is committed knowingly, willfully, recklessly, or intentionally.

Waste – Incurring unnecessary costs as a result of deficient management, practices, systems or controls; the over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse - Incidents or practices that either directly or indirectly results in unnecessary costs to the Medicare/Medicaid program or other entities, although it is not an intentional misrepresentation. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings. Abuse can be a questionable practice, which is inconsistent with accepted medical, governmental or business policies.

Examples of fraud, waste and abuse activities include, but are not limited to:

- Forgery or alteration of documents (checks, contracts, purchase orders, invoices, time sheets, leave records, etc.).
- Misrepresentation of information on documents (employment history, time sheets, leave records, travel reimbursement requests, financial records, etc.).

- Theft, unauthorized removal, or willful destruction of The IC records, property, or the property of other persons (to include the property of employees, customers, or visitors).
- Theft or misappropriation of funds, equipment, supplies, or any other asset.
- Improprieties in the handling and reporting of financial transactions.
- Serious abuse of The IC time such as unauthorized time away from work or falsification of work hours reported.
- Authorizing or receiving payments for goods not received or services not performed.
- Vendor kickbacks.
- Misuse of authority for personal gain.
- Any computer-related activity involving the alteration, destruction, forgery, or manipulation of data for fraudulent purposes.
- Inappropriate use of The IC-provided electronic devices such as computers, tablets, cell phones or e-mail.
- Undeserved payment for a claim, which for example can include provider services.
- Falsification of reports to management or external agencies.

III. Applicable Laws

False Claims Laws

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to file civil actions against individuals to recover damages and penalties when individuals submit false claims. The Federal False Claims Act, the Program Fraud Civil Remedies Act of 1986, and Colorado law all address fraud and abuse in the Colorado Medicaid program.

Federal False Claims Act

Under the Federal False Claims Act ("FCA"), any person or entity that knowingly submits false or fraudulent claims, causes such claims to be submitted, makes a false record or statement in order to obtain payment from a federally funded program for such a claim, or conspires to get such claim allowed or paid is liable for significant penalties and fines. The civil fines include a penalty of up to three times the cost of the claim, plus penalties ranging from $5,500 to $11,000 per false claim, and the costs of the civil action against the person or entity that submitted the false claims.

The FCA applies to Medicare and Medicaid reimbursement and prohibits the following:

- Billing for services not rendered
- Billing for undocumented services
- Billing for services outside the scope of the Medicaid program
- Billing for unnecessary services
- Characterizing non-covered services or costs in a way that secures reimbursement

(The above list does not include the list of all prohibited activities.)

The FCA also allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The person who initiates the lawsuit is generally referred to as the "whistleblower". If the suit is ultimately successful, the whistleblower may be awarded a percentage of the funds recovered. The FCA also contains a provision that protects a whistleblower from retaliation by his or her employer. If an employee is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of bringing a false claims action, that employee may

bring an action in federal court seeking reinstatement, two times the amount of back pay plus interest, and other costs, damages and fees.

Federal Program Fraud Civil Remedies Act of 1986

A similar law is The Federal Program Fraud Civil Remedies Act of 1986 ("PFCRA"). It provides for administrative remedies against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services). A violation of the PFCRA may result in a maximum civil penalty of $5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

Colorado Law

Colorado has adopted a Medicaid anti-fraudulent statute that is intended to prevent the submission of false and fraudulent claims to the Colorado Medicaid program. The statute makes it unlawful for any person to make a false representation of material fact, present a false claim for payment or approval, or present a false cost document in connection with a claim for payment or reimbursement from the Colorado Medicaid program. Violations of this law will result in significant monetary civil penalties.

IV. Procedures

a. A Code of Ethics (see Appendix A) has been written which details expected behavior covering various areas. In addition, the Employee Handbook and policy and procedures manuals for each program detail procedures expected to be followed by employees.

b. Policies and procedures are revised to reflect changes in regulations and agency practices. Policies are included in employee orientation and on-going education.

c. Internal and external audits are performed periodically to ensure that billing of third party payers is in compliance with regulations.

d. The IC maintains an "open door" policy and employees are informed on how to report issues of concern. Communications will be kept confidential to the degree possible while conducting investigations of the concern. Client complaints will be investigated and documented in the same manner. All communications of this nature will be investigated thoroughly and fairly. Refer to The IC Whistleblower Protection Policy for further information.

e. The director and staff will conduct the business and clinical operations of the agency based on governing regulations. At least the following will be continuously monitored through the internet, journals, newsletters, attendance at educational offerings and participation in the Home Care Association of Colorado and Home Health Advisory Committee meetings by attendance or a review of minutes:
    - Conditions of Participation
    - Volume 8—Colorado Department of Health Care Policy and Financing
    - Health Facilities Division, State of Colorado
    - HIPAA and HITECH
    - Others that may apply

f. Billing occurs according to procedures developed by the particular funding sources and the agency follows these guidelines and bills for services accordingly.

g. Procedure Manuals are maintained by the Billing Department. Fiscal staff are oriented to billing and coding procedures upon hire and quality assurance staff review documentation regularly to assure established procedures are being followed.

h. There will never be financial incentives to patients who receive our services.

The IC will take appropriate disciplinary action (i.e. corrective action plans, employment termination or contract termination) against employees, providers, subcontractors, consultants, and agents found to have committed fraud, waste or abuse, in its sole discretion or at the direction of external regulatory agencies and/or entities.

APPENDIX A

CODE OF ETHICS

Board and committee members, volunteers and employees of The IC should subscribe to the following ethical principles:

- To remain sensitive to and be appreciative of the ethnic, cultural, religious and lifestyle diversity of staff, volunteers, clients and their families.

- To respect and protect the confidentiality of information concerning staff, volunteers, clients and families.

- To support staff in bringing constructive criticism of The IC through appropriate channels and avoiding public conversations regarding employee concerns.

- To recruit, select, orient, educate and evaluate each staff person and volunteer to ensure competency based on identified job requirements and to ensure that the health and safety of clients are put before any other concern or priority.

- To support staff in upholding the ethical codes and practices of the various professions and associations representative in our culture.

- To avoid behaviors which bring justifiable, critical comments on The IC by the general public.

- To support, affirm and empower the staff and volunteers in the delivery of care and service.

- To fully disclose ownership of potential patents, copyrights and interventions produced during working hours or arising from the workplace.