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|  | **DIVISION OF CHILD & FAMILY SERVICES****Children’s Mental Health Services** |
| **SUBJECT:** | **FALSE CLAIMS ACT POLICY** |
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| **SUPERCEDES:** | 11.70 False Claims Act, March 2009 |
| **REFERENCES:** | **UNITED STATES CODE**31 U.S.C. § 3729 et seq. Federal False Claims Act31 U.S.C. § 3801 Federal Program Civil Remedies Act of 198642 CFR Parts 1003 and 1005Deficit Reduction Act of 2005Fraud Enforcement and Recovery Act of 2009 (FERA)Dodd-Frank Wall Street Reform and Consumer Protection Act, 2010Patient Protection and Affordable Care Act (ACA), 2010The Program Fraud Civil Remedies Act ("PFCRA")**NEVADA REVISED STATUTES**NRS 422.410 to 590NRS 193.130NRS 357.240 to 250**DCFS POLICIES AND RELATED RESOURCES**DCFS Personnel Manual (2008) DCFS HIPAA Privacy ManualDCFS Billing and Fiscal Policies*Criminal Penalties for Acts Involving Federal Health Care Programs*, Compilation of Social Security Laws, 42 U.S.C. SEC 1128B, 1320a-7b.*Public Law 109-171*, The Federal Register, February 8, 2006.**DHCFP MEDICAID SERVICES MANUAL** MSM 100MSM 400MSM 600MSM 2500MSM 3300**DCFS GLOSSARY OF TERMS:** (REV. 01-17-14) |
| **ATTACHMENTS:** | **Attachment A:** Compliance Violation Report Form**Attachment B:** Hotline/Consumer Posters |

1. **POLICY**

It is the policy of the Division of Child and Family Services to provide services in a manner that complies with all applicable federal and state laws and regulations and which meet the high standards of business and professional ethics.

It is also the policy of DCFS, pursuant to federal and state laws and regulations, to provide information and education to all DCFS staff and employees, contractors, and agents regarding the methods and procedures the Division has implemented to detect health care fraud, waste, and abuse.

**II. PURPOSE**

This policy contains an overview of the federal False Claims Act (FCA) and State of Nevada false claims statutes and outlines the measures DCFS has implemented in an effort to prevent fraud, waste, and abuse and to maintain the integrity of the Medicaid system and other federal health care funding.

The purpose of this policy is to educate DCFS staff about the FCA and similar laws in compliance with the Deficit Reduction Act (DRA) of 2005, Section 6032, and to affirm the Division’s commitment to detect and prevent fraud, waste, and abuse.

1. **PRODCEDURE AND PRACTICE GUIDELINES**

A. Introduction

The federal False Claims Act (FCA) is designed to prevent and detect fraud, waste and abuse in government funded healthcare programs. The federal law accomplishes this by authorizing the government to bring civil action to recover damages and penalties from, and criminal actions to prosecute, healthcare providers who submit false claims.

The federal FCA also allows lay people to bring lawsuits on behalf of the government against such providers; these lawsuits are called qui tam claims. The FCA allows states to design their own statutory requirements with regard to false claims; some states have adopted their own laws and some have not. In the State of Nevada, we have adopted our own state laws regarding fraud, waste and abuse of federal health care funding which is modeled on the federal law.

For the purposes of this policy and DCFS operations, federal health care funding includes payments or reimbursements from Title XIX (Medicaid), Title XX (Block Grants to States for Social Services and Elder Justice), Title XXI (CHIP – AKA Nevada Check Up), the Substance Abuse and Mental Health Services Agency (SAMHSA) Community Mental Health Services Block Grant, the Child Care Development Fund (ACF - Administration for Children, Youth and Families), National School Lunch Program (Department of Agriculture), etc.

The federal FCA (31 United States Code Sections 3729-33) and the State of Nevada statutes are anti-fraud laws. Violations of both include knowingly:

1. submitting a false claim for payment;
2. making or using a false record or statement to obtain payment for a false claim;
3. conspiring to make a false claim or to get one paid; or,
4. making or using a false record to avoid payments to the U.S. Government.

Examples of potential false claims may include knowingly billing for services that were not provided or making false statements as well as inappropriately increasing payments for products or services provided or submitting claims without the required documentation about the service provided or medical necessity.

The FCA and Nevada Revised Statutes (NRS) contain provisions which allow individuals with information concerning fraud, waste and abuse involving government programs (AKA “whistleblowers”) to file a lawsuit on behalf of the government; this is called a “qui tam” lawsuit. If the lawsuit is successful, the individual may be eligible to receive a portion of the recoveries received by the government and the person convicted becomes a felon and may be excluded from any federal health care funding program, including Nevada Medicaid. In the event a Medicaid provider hires someone who has been excluded from any health care funding program, that provider is held liable to return all federal reimbursement submitted and claimed from the date of hire of the excluded employee.

The FCA and NRS also prohibit an employer from taking any adverse action against an employee who files a qui tam lawsuit. Under federal law, a mistreated whistleblower may sue the employer in federal court for reinstatement to employment (if the employee was terminated as a means of retaliation), two times back pay plus interest, and any special damages, such as attorney’s fees.

1. Employee and Contractor/Agent Education

The DRA 2005 requires entities which claim $5M or more in federal health care funding to provide training to their staff, contractors and agents regarding the FCA; DCFS is such an entity.

DCFS provides program integrity training pursuant to the Nevada Medicaid Services Manual Chapter 3300 which includes a component addressing the False Claims Act including the methods and procedures the Division uses to detect and prevent fraud, waste and abuse as well as federal and state laws punishing the making of false claims or statements.

1. Types of Conduct and Activities Prohibited Under the FCA and NRS

Various DCFS program and fiscal staff members may be subject to liability under both the FCA and NRS in the event any of the following activities:

Knowingly:

1. Submitting claims for federal funding for clients who are not eligible recipients.
2. Submitting claims for federal funding without the required documentation to support medical necessity.
3. Submitting cost reports to federal funding sources that are inaccurate or incomplete.
4. Denying eligible clients access to medically necessary services.
5. Directing a DCFS staff member to do any of the above.

The above list is intended to be illustrative and not exhaustive. FCA liability exists for any knowing submission of false claims or statements that result in payment by a federal health care program to which DCFS or the provider is not entitled.

All DCFS staff and/or contractors are strictly prohibited from engaging in any conduct that violates the FCA or NRS regarding false claims. DCFS staff and/or contractors must take all steps specified in this policy to protect DCFS from FCA liability.

1. Reporting of False Claims Act Violations by DCFS Staff

Whistleblower statutes and protections for individuals reporting fraud, waste and abuse in good faith encourage reporting of such violations, creating broader opportunities to prosecute violators. Whistleblower statutes, such as those found in the FCA and in NRS create reasonable incentives for this purpose. Employment protections create a level of security DCFS staff needs to help in prosecuting these violations. DCFS encourages DCFS staff, stakeholders, contractors and agents to report any suspected fraud, waste or abuse or any allegation of fraud, waste or abuse to their supervisors, managers, the DCFS HIPPA Privacy and Security Officer, the State of Nevada Attorney General’s Office, OIG Hotline, or all of the above.

1. DCFS Internal Reporting

If a DCFS staff submits a fraud report internally, the DCFS supervisor or manager receiving the report shall complete the Compliance Violation Report Form (Attachment A) detailing the information received within 24 hours of receiving the information. The completed form should then be submitted to the appropriate Deputy Administrator or to the DCFS Administrator or to their designees.

If a supervisor or manager is apprised of employee misconduct which has the potential for criminal prosecution (i.e., embezzlement, theft, fraud, etc.) the supervisor or manager shall contact the appropriate Deputy Administrator within fifteen (15) minutes with the details of the episode and take necessary steps to ensure the safety of any client, family or DCFS employee involved. The Deputy Administrator shall then, within fifteen (15) minutes, contact the DCFS Administrator who is then responsible for contacting the Deputy Attorney General for advice on how to proceed, involve the Human Resources Chief and any other person/party with a need to know (Section 230.7.4 DCFS Personnel Manual).

1. DCFS Contractors and Agents

Each DCFS program contractor and/or agents shall ensure it communicates and makes available to all employees, stakeholders, contractors and agents, the contact information for the DCFS HIPPA Privacy and Security Officer, the Attorney General’s Office, and/or the federal OIG hotline numbers for reporting any allegation of fraud, waste or abuse. Hotline/customer service posters and brochures will be maintained in an open and public location in all DCFS offices (Attachment B).

1. Self-Reports regarding FCA Violations

DRA 2005 allows that DCFS has 30 days from the date of detection of any false claim to self-report the false claim activity in order to prevent FCA liability. DCFS staff is required to contact their supervisor or the HIPAA Privacy and Security Officer immediately if they have knowledge of or suspect any false claim activity or if they have any questions as to whether certain practices violate the federal or state FCA. DFCS supervisors, managers, administrators and other DCFS staff are prohibited from directing subordinates or peers not to report real or suspected FCA liability; any such directives are to be immediately reported to the DCFS Administrator and/or the State of Nevada Attorney General’s Office and/or the federal OIG Hotline.

Any DCFS staff that becomes aware of a false claim violation shall immediately report the violation to his or her supervisor who shall ensure this violation is reported to applicable program managers up to and including the relevant Deputy Administrator, pursuant the DCFS Personnel Manual (Section 230.7.4). The Deputy Administrator shall report the false claim violation to the DCFS Administrator within 15 minutes; the DCFS Administrator shall timely consult with the Deputy Attorney General and the DCFS Personnel Officer in order to ensure false claim violations are evaluated and investigated.

1. Qui Tam Lawsuits

DCFS staff or any other citizen has the legal right to file qui tam lawsuits if they become aware that DCFS has submitted a claim or claims for reimbursement to Medicaid or other federal or state government programs in violation of the FCA. In a qui tam lawsuit, the employee or citizen is referred to as a “relator”. The relator files the case under seal and requests that the federal government or the State Attorney General intervene and assume responsibility to prosecute the matter. If the relator’s lawsuit is successful, the relator may share in a portion of the recovery.

No employee of the State of Nevada is allowed to impede any DCFS employee or citizen from filing a qui tam lawsuit, through threats of retaliation or otherwise; any action by any employee of the State of Nevada to threaten or retaliate against a DCFS staff or citizen who files a qui tam lawsuit is subject to disciplinary action up to and including termination. However, all DCFS staff is encouraged to report and attempt to resolve suspected FCA violations through the internal procedures, as noted in section III, D. of this policy.

1. Procedures for Preventing and Detecting Fraud, Waste, and Abuse

At the time of hire or whenever this policy is revised, it will be provided to all DCFS staff. DCFS staff will receive training at initial hire and annually thereafter on applicable federal and state laws related to the FCA and the prevention and detection of fraud, waste, and abuse.

The content of this policy and information regarding any applicable federal and state requirements will be provided to all contractors and agents at the time of contract execution and as indicated thereafter.

Any DCFS staff who becomes aware of a false claim issue and fails to report it to his/her supervisor within 30 days of detection, will be disciplined up to and including termination.

1. Retaliation Prohibitions

DCFS staff, stakeholders, and contractors are encouraged to report any allegation of fraud, waste or abuse to either DCFS, to the State of Nevada Attorney General’s Office or to the Office of Inspector General (OIG) for the Centers for Medicaid and Medicare Services (CMS) without fear of retaliation or reprisal. Any employee, supervisor, or manager who engages in an act of retaliation against a DCFS staff, stakeholder and/or contractor for reporting fraud, waste or abuse will be disciplined in accordance with the State of Nevada Human Resource Policies and may be criminally charged as well pursuant to applicable federal and state laws. Reports of fraud or abuse may be made anonymously or in writing on the Compliance Violation Report Form (Attachment A) and submitted to the direct supervisor or manager for investigation. If submitted in writing, the Compliance Violation Report Form (Attachment A) shall be submitted to the appropriate Deputy Administrator or designee by the supervisor/manager within 24 hours. Reports of fraud, waste and abuse may also be made verbally to the State of Nevada Attorney General’s Office and to the OIG for CMS.

The confidentiality of any person who reports any FCA allegation shall be maintained to the extent permitted by law. Pursuant to federal regulations, retaliation against someone who has reported fraud, waste or abuse is a crime and shall be reported as such against any DCFS staff that retaliates against another for making such a report.

1. Fraud Prevention Policies and Practices

DCFS and all contractors and agents shall maintain policies and practices that outline and support the prevention and detection of fraud, waste, and abuse as indicated in the DRA 2005. These policies include, but are not limited to:

1. Code of Conduct;
2. Human Resource Policies / Employee Handbook;
3. Bookkeeping Policies;
4. Billing Policies;
5. Performance Improvement Polices; and
6. Contracting Policies.
7. Internal Auditing
8. HIPAA

The HIPAA Privacy and Security Officer will ensure that periodic compliance audits conducted by or on behalf of DCFS cover the submission of accurate claims and cost reports to all federal funding programs, including Medicaid, as well as any other activities deemed by the HIPAA Privacy and Security Officer to raise potential risks under the FCA. The HIPAA Privacy and Security Officer will oversee the development and implementation of a corrective action plan to address any compliance issues identified through such audits.

1. Fiscal

DCFS fiscal staff shall routinely review claims to ensure they are coded correctly and to ensure there is documentation supporting the request for reimbursement from Medicaid. DCFS fiscal staff shall provide a report of these reviews monthly to each applicable Clinical Program Manager II and to the DCFS Deputy Administrator. DCFS fiscal staff shall confirm claims audited are corrected, if needed, before they are submitted to Medicaid for reimbursement. DCFS fiscal staff is strictly prohibited from knowingly submitting any claim which is coded incorrectly, up-coded, bundled or for which there is no documentation supporting medical necessity.

1. Program

DCFS supervisors shall review a minimum of 15 cases per quarter to determine whether claims summited to federal funding programs for reimbursement are coded correctly and that there is documentation which supports reimbursement and medical necessity. The supervisor shall ensure that any claim they identify which was submitted incorrectly is immediately reported to fiscal staff for correction and to the Deputy Administrator in the event fraud is suspected pursuant to the DCFS Personnel Manual (Section 230.7.4).

Additional performance and claims data will be utilized by the HIPAA Privacy Officer, DCFS fiscal staff, DCFS program supervisors/managers, and the Planning and Evaluation Unit (PEU) to monitor fraud prevention and detection. These data will provide DCFS with information about potential risks that may result in additional auditing or follow-up. They may include but are not limited to:

1. Reported compliance trends and patterns;

2. Compliance Scorecards;

3. Employee Satisfaction Surveys;

4. Customer Satisfaction Surveys;

5. Regulatory Surveys;

6. Quality Indicators and Measures;

7. Medicaid Claims and Payment Reviews/Audits;

8. Medicaid claims denial trends and patterns;

9. Clinical and Peer Review Audits;

10. Customer Service Calls.

1. Disclosure of False Claims

Under the False Claims Act, DCFS may avoid damages and civil penalties if it discloses to the relevant federal health care program any false or fraudulent claims, and makes appropriate restitution of any overpayments, within 30 days of discovery of the false claim. Accordingly, the HIPAA Privacy and Security Officer or DCFS fiscal staff will promptly investigate all reports of potential False Claims Act violations in order to provide DCFS with an opportunity to make disclosure and restitution within this 30-day period.

1. Retaliation

An employer who discharges, demotes, suspends, harasses, threatens, or discriminates against an employee for disclosing fraud, waste, or abuse information, is liable to the employee for all relief necessary to correct the wrong, including, if needed:

1. Reinstatement with the same seniority as if the action had not occurred; or
2. Damages in lieu of reinstatement, if appropriate; and
3. 2 times the lost compensation, plus interest; and
4. Any special damage sustained as a result of the action; and
5. Punitive damages, if appropriate.

Any DCFS staff that retaliates against another for disclosing fraud, waste or abuse information will be disciplined up to and including termination.

1. Legal Remedies for False Claims and Statements
2. Civil Penalties

Under the FCA, anyone who violates the FCA is liable for a civil penalty as outlined in 31USC § 3729 through 3733, plus three times the amount of the damages the government sustains. Anyone intentionally participating in the submission of a false claim may be liable for the costs of a civil action brought to recover any penalties or damages.

Entities and providers in violation of any regulations regarding false claims or fraudulent acts will be subject to exclusion, suspension, or termination of provider status for participation in Medicaid and other government programs.

The same violation may be subject to multiple penalties if action is brought under federal law as well as state law.

1. Criminal Penalties

Under the Criminal Penalties for Acts Involving Federal Health Care Programs, those who knowingly and willfully cause false statements or representations of material facts in any benefit or payment under a federal health care program are subject to a felony conviction with a fine of up to $25,000 and/or 5 years imprisonment. Under NRS a person may be subject to incarceration, monetary fines, or both. The length of imprisonment and/or fine is dependent on the value of the fraudulent claim.

1. Civil Actions

A civil action may be brought against a person by:

1. The U. S. Attorney General, who is responsible for conducting investigations for violations of the federal False Claims Act;
2. The State Attorney General, who is responsible for conducting investigations for violations of the state False Claims Act;
3. A private person who has knowledge of a violation of either FCA. This is referred to a qui quo claim. The person must submit a written complaint and all material evidence and information they have regarding the false or fraudulent claim or statement.

When a private person brings a civil action, only the government can intervene or bring a related action based on the same violation. The government has primary responsibility for prosecuting an action brought by a person but the person can continue as a party to the action, and shall receive at least 15% but not more than 25% of the proceeds of any settlement.

A civil action cannot be filed on a violation if more than 6 years have elapsed since the act was committed. The time frame can be extended to 10 years if facts material to the case were made known within the previous 3 years.

**IV. DEFINITIONS**

1. Abuse

CMS defines “abuse” as incidents or practices of providers that are inconsistent with sound medical practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or medical necessity.

1. Claim

Includes any request or demand, whether under a contract or not, for money or property if the United States Government provides or reimburses any portion of the money or property, which is requested or demanded.

1. Contractor/Agent

A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of federally funded healthcare items or services, performs billing or coding functions, or is involved in monitoring of healthcare provided by the Covered Entity (Please see the DCFS HIPAA Privacy Manual for further details).

1. Entity

Means a governmental agency, organization, unit, corporation, partnership or other business arrangement, including Medicaid managed care organizations, whether for profit or not-for-profit, which receives or makes payments, under a state plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

*“An entity includes organizational units (a governmental agency, organization, unit, corporation, partnership, or other business arrangement) and individuals, as long as the organizational unit or individual receives or makes payments totaling at least $5 million annually under a Title XIX State Plan, State Plan waiver, or Title XIX demonstration project. It is the responsibility of each entity to establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents.”*

1. False Claims Law Investigation

Means any inquiry conducted for the purpose of determining whether any person or entity is or has been engaged in any violation of a false claim law.

1. Fraud

Means the intentional deception or misrepresentation that an individual or entity makes, knowing it to be false and knowing that the deception could result in an unauthorized benefit to himself or another person.

1. Knowingly

Means consciously or with knowledge or complete understanding of the facts or circumstances.

1. Qui tam

Refers to a type of lawsuit filed by an individual on behalf of the government.

1. Relator

An individual who bring a *qui tam* action

1. Retaliation

As the term relates to the whistleblower provisions in the FCA and NRS, retaliation means discharging, demoting, suspending, harassing, threatening, or discriminating against an employee.

1. Whistleblower

An employee who discloses fraud, waste or abuse information for investigation and potential prosecution.