UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS
MANAGEMENT POLICY AND PROCEDURE

NO.: LD 4.07
APPROVAL DATE: February 9, 2017
EFFECTIVE DATE: February 10, 2017

SUBJECT: Prevention of False Claims

OBJECTIVE

To demonstrate UI Health's ongoing commitment to the accurate and appropriate billing of claims and to comply with the Federal Deficit Reduction Act. UI Health endeavors to prevent, detect, and eliminate fraud, waste, and abuse in all government funded programs by requiring employees, physicians, consultants, contractors and other agents to comply with all federal and state laws dealing with submitting false claims and false statements.

DEFINITIONS

For the purpose of this policy, the following definitions apply:

Claim means any request or demand for money that is made to a contractor, grantee, or other recipient if the federal or state governments provide any portion of the money that is requested or demanded, or if the governments will reimburse such contractor, grantee, or other recipient for any portion of the money that is requested.

False Claims Act (FCA), 31 U.S.C. §§ 3729-3733.
The False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services the physician knows was not provided. The False Claims Act imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that the contractor knows or should know is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which they may not be entitled, and then uses false statements or records in order to retain the money. An example of this "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

The FCA provides that private parties may bring an action on behalf of the United States. The private parties, known as qui tam relators, may share in a percentage of the proceeds from an FCA action or settlement. The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their pursuing an action. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS
MANAGEMENT POLICY AND PROCEDURE

Illinois False Claims Act, 740 ILCS 175 et, seq. (Previously known as the Illinois Whistleblower Reward and Protection Act)
The Illinois False Claims Act, previously known as the Illinois Whistleblower Reward and Protection Act, was enacted to protect the State from fraud. Individuals are encouraged to monitor and report fraudulent behavior. Individuals who report fraud against the State are legally entitled to a reward and are entitled to protection against retaliation from their current or past employer.

Under both the federal False Claims Act and the Illinois False Claims Act, "knowing" or knowingly" means that a person, with respect to information, has

- actual knowledge of the information;
- 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. No proof of specific intent to defraud is required.

Program Fraud Civil Remedies Act (PFCRA), 31 U.S.C §3801-3812.
The PFCRA is similar to the FCA, but is somewhat broader and more detailed, with differing penalties. PFRCA deals with the submission of improper "claims" or "written statements" by a person or entity for property, services, or money to an executive department of the Federal Government. Specifically, a person or entity violates this act if the person or entity knows, or has reason to know that the person or entity is submitting a claim that is:

- false, fictitious, or fraudulent;
- includes, or is supported by, written statements that are false, fictitious, or fraudulent;
- includes, or is supported by, a written statement that omits a material fact, or the
- statement is false, fictitious, or fraudulent as a result of the omission, and the person or entity submitting the statement has a duty to include the omitted facts; or
- for payment for property or services not provided as claimed.

POLICY

It is the policy of UI Health that all personnel (including employees, physicians, consultants, contractors and other agents) shall comply with all applicable federal and Illinois laws and regulations. UI Health has established various procedures to ensure compliance with these laws and to assist in preventing fraud, waste and abuse in state and federal health care programs. As part of UI Health's Compliance Program, personnel shall receive training on these laws and should consult with the Chief Compliance Officer if they have questions about the application of these laws to their job.

Some examples of false or fraudulent claims include:

A. billing for services not rendered or goods not provided;
B. billing for services that are not medically necessary;
C. duplicate billing; or
D. misrepresenting services rendered or product provided (e.g., upcoding, inappropriate coding);
E. misrepresenting the nature of the patient's condition (e.g., DRG fraud, DRG creep);
F. submitting bills to Medicare that are the responsibility of other insurers under the Medicare

UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS
MANAGEMENT POLICY AND PROCEDURE

Secondary Payer rule;

G. knowingly retain an overpayment after the due date for any corresponding cost report, or more than 60 days after identification of the overpayment, whichever is later.

UI Health is committed to the appropriate and accurate billing of claims. To the extent that UI Health employees believe that they have knowledge of any false or fraudulent claims being submitted to the federal or state governments, they should notify the UI Health Chief Compliance Officer immediately, so that an investigation can be conducted. UI Health will not retaliate or otherwise discipline any individual reporting suspected misconduct or non-compliance activities.

Anyone who violates the FCA can be held liable for civil monetary penalties ranging from $10,781 to $21,563 for each false claim submitted plus three times the amount of damages that the federal government sustains because of the false claim. Anyone who violates the Illinois False Claims Act is liable to the State for a civil penalty of not less than $5,500 and not more than $11,000, plus three times the amount of the damages that the State sustains because of the false claim.

A person may file a civil lawsuit for a violation of the FCA and/or the Illinois False Claims Act on behalf of the federal and/or state governments. If the lawsuit is successful, that person is entitled to recover a percentage of the proceeds from the lawsuit.

Employees who file a lawsuit for a violation of the FCA and/or the Illinois False Claims Act are protected from being discharged, demoted, threatened or harassed as a result of filing a lawsuit. If a court determines that an employee was retaliated against, the court can order reinstatement of the employee, back pay including interest, and payment of reasonable attorneys' fees and court costs.

PROCEDURE

In order to detect and prevent fraud, waste, and abuse, UI Health has a number of policies, procedures and processes in place. These include, but are not limited to:

A. Proper and timely documentation of all physician and other professional services prior to billing to ensure that only documented services are billed properly and accurately;
B. Claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained and available for audit and review;
C. Physician notes, and hospital records used as a basis for a claim submission are appropriately organized in a legible form so they can be audited and;
D. The diagnosis and procedures reported on the reimbursement claim form must be based on the medical record and other documentation, and that the documentation necessary for accurate code assignment is available to coding staff;
E. The compensation for department coders, billing staff, and consultants does not provide any financial incentive to up-code claims improperly;
F. Audits are performed to detect coding and billing errors.

When UI Health employees believe they have knowledge of any false or fraudulent claims being submitted to the state or federal governments, they should immediately notify their supervisor, director, and call the UI Health Compliance Hot Line 866-665-4296.

UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS
MANAGEMENT POLICY AND PROCEDURE

Keywords none

References

False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
Civil Monetary Penalties Inflation Adjustment , 28 CFR parts 20, 22, 36, 68, 71, 76, & 85
Program Fraud Civil Remedies Act (PFRCA), 31 U.S.C §3801-3812
Illinois False Claims Act, 740 ILCS 175
Fraud Enforcement and Recovery Act of 2009 (FERA)
UIC HRPP 303: Disclosure of Wrongful Conduct and Protection from Reprisal (Whistleblower)
Illinois Whistleblower Act, 740 ILCS 174/1

Addendum none

Rescission Date

October 2015
August 2012
September 2009

Policy Owner—Chief Compliance Officer, UI Health