False Claims and Payment Fraud Prevention

I. Purpose

The purpose of this policy is to inform employees, contractors and agents of LVHN of the federal and state False Claims Acts and to provide general information regarding LVHN's efforts to prevent and detect fraud, waste and abuse in LVHN and to describe the remedies and fines for violations that can result from certain types of fraudulent activities.

This policy supports the objectives of the LVHN Corporate Compliance Program which include the prevention, detection and correction of inappropriate claims for patient services and cost reports, thereby preventing related false claims and potential charges by the government for civil and criminal wrongdoing. The LVHN Code of Conduct policy describes the standard of conduct, duties and responsibilities expected of LVHN, its employees, agents and contractors regarding claims and payments for patient services and cost reports.

II. Scope

This policy covers all employees, contractors or agents of LVHN.

III. Definitions

Federal False Claims Act – The federal law providing specific monetary and criminal penalties against individuals and organizations who knowingly submit a false claim or statement to a federally funded program, or otherwise defraud the government, in order to receive payment. The Federal False Claims Act can be found at 31 U.S.C. § 3729-3733.

Qui Tam Relator – An individual with knowledge of fraud against the federal government who files a lawsuit on behalf of the government against the person or company that committed the fraud.

Whistleblower – An employee who provides information to a governmental entity or an investigator regarding any conduct that the employee believes is in violation of laws, rules, or regulations.

IV. Policy

1. LVHN Coding and Billing Policies

LVHN will comply with all governmental and third party claim and payment regulations and requirements and expects its employees, contractors and agents to uphold this standard.

LVHN has implemented policies, procedures and systems to facilitate accurate billing to governmental payers, commercial insurance payers, and patients. The policies, procedures and systems conform to pertinent federal and state laws and regulations. LVHN prohibits anyone from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious or fraudulent.

Federal and state laws and regulations can impose civil and criminal penalties for individuals and hospitals that submit claims which were: not provided; billed in a manner other than as actually provided; not medically necessary; or billed in a manner that did not comply with applicable government requirements.

2. Employees' Role in Reporting Fraud, Waste or Abuse

Any LVHN employee, contractor, or agent who is aware of any fraudulent and/or inaccurate billing by LVHN, or any fraud, waste or abuse in connection with the business of LVHN, should report such information to their manager so the potential problem can be assessed and appropriate action can be taken. Bringing issues and concerns to your manager is an important first step, not only to correct problems but also to improve the understanding and work processes that affect day to day operations. These reports are an important part of LVHN's compliance efforts to detect and prevent fraud, waste and abuse.

If you are not comfortable discussing an issue or concern with your manager, you may call the Compliance Hotline anonymously at 1-877-895-2905 or the Compliance Officer directly at 610-969-0501.

If you would like more information on the LVHN Corporate Compliance Program and specific compliance policies, or more information on how to report concerns, please contact the LVHN Compliance Officer at 610-969-0501.

Compliance is everyone's responsibility! An effective compliance program can help prevent fraud, waste and abuse within LVHN. If problems do arise, evidence that LVHN has adopted and implemented an effective compliance program can help mitigate potential penalties and enforcement actions.

3. Federal False Claims Act and Whistleblower Protections

The Federal False Claims Act is the federal government's chief tool in fighting fraud. The Federal False Claims Act provides specific monetary and criminal penalties against individuals and organizations found to have knowingly submitted a false claim or statement to a federally funded program such as Medicare or Medicaid, or otherwise conspired to defraud the government in order to receive payment. It also provides

protection and monetary rewards to individuals who "blow the whistle" and notify the government of wrongdoing.

The Federal False Claims Act attempts to create an environment where employees and others feel safe reporting concerns about fraud. LVHN fully supports that goal. Any person who lawfully reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by LVHN for making such a report. The Federal False Claims Act also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.

The key provisions, penalties for violation and whistleblower protection provisions of the Federal False Claims Act are described in greater detail below. You may also obtain a copy of these laws by contacting the Legal Services Department.

Federal False Claims Act	
Purpose	The purpose of the Federal False Claims Act is to protect the U.S. Treasury against growing and increasingly sophisticated fraud, and to establish a law enforcement "partnership" between federal law enforcement officials and private individuals. The federal government has a big job on its hands as it attempts to ensure the integrity of the nearly $1 trillion we spend each year on various programs and procurement. That job is simply too big if government officials are working alone.
Description	• Is a United States law • Provides a powerful legal tool to counteract fraudulent claims submitted for payment to the federal government • Allows individuals with insider knowledge of false claims in health care or other government spending programs (such as the Medicare and Medicaid programs) to be rewarded • Permits an individual with knowledge of fraud against the U.S. government, referred to as the "qui tam plaintiff", to file a lawsuit on behalf of the government against the person or company that committed the fraud • Rewards the qui tam plaintiff with a percentage of the funds recovered (generally between 15% and 30% of the total amount recovered) if the lawsuit is successful
Key Provisions	• A person violates the Act if she/he: o Knowingly presents, or causes to be presented to the U.S. government a false or fraudulent claim for payment or approval, or o 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 government, or o Conspires to defraud the government by getting a false or fraudulent claim allowed or paid
Penalties for Violation	• For each false claim filed, those who violate the Act are liable to the government for a civil penalty of: o Not less than $5,000 and not more than $10,000

	○ Plus treble (3 times) damages sustained by the government 31 U.S.C. § 3729(a)

Whistleblower "Qui Tam Relator" Actions and Protection	
Qui Tam Action	• An individual with knowledge of fraud or suspected fraud related to a healthcare payment may initiate a formal claim with the U.S. Department of Justice if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. • The government has sixty (60) days to investigate the claim, during which time the claim is kept confidential. Upon completion of the investigation, the government will decide either to pursue the case on its own or decline to proceed with the case. • If the government pursues the claim and any funds are recovered, a portion of the funds may be paid to the individual who initiated the formal claim, at the discretion of a federal court. This amount, if awarded, generally is between 15% and 30% of the total damage amount. • If the federal government declines the case, the individual may still proceed with the case on his or her own, but without the government's assistance, and at his or her own expense.
Individuals Entitled to Protection	• Available to any employee who is fired, demoted, threatened, harassed, or otherwise discriminated or retaliated against by his or her employer because the employee investigates, files or participates in a qui tam action.
Protection to Whistleblower	• Provides that any employee who is discharged, demoted, threatened, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole. • Relief may include reinstatement, double back pay with interest if the employee is fired, and compensation for any special damages including litigation costs and reasonable attorneys' fees. • Many states have wrongful discharge or other employment laws that may provide remedies for such discrimination. 31 U.S.C. § 3730(h)

4. Fraud and Abuse Control Provisions of Pennsylvania's Public Welfare Code

In addition to the Federal False Claims Act, the Commonwealth of Pennsylvania has also enacted laws in order to combat fraud, waste and abuse in the Pennsylvania Medicaid (Medical Assistance) program. These laws establish specific monetary and criminal

penalties for individuals and organizations found to have knowingly or intentionally submitted false claims or statements to the Medical Assistance program.

These laws are designed to facilitate the prosecution of fraud, waste and abuse. The key provisions and penalties for violation of the laws are described in greater detail below. You may also obtain a copy of these laws by contacting the Legal Services Department.

Fraud and Abuse Control Provisions of the Public Welfare Code	
Purpose	The purpose of the fraud and abuse control provisions of the Public Welfare Code is to establish criminal penalties and civil remedies for unlawful conduct in relation to the Pennsylvania Medical Assistance program. Pennsylvania must ensure the integrity of the Medical Assistance program in order to assure that the program remains solvent and that Medical Assistance recipients continue to receive benefits. The criminal penalties and civil remedies are designed to prevent individuals and organizations from taking advantage of the program.
Description	• Is a Pennsylvania law. • Designed to preserve the integrity of the Pennsylvania Medical Assistance program. • Establishes criminal penalties, including fines and imprisonment for individuals committing certain prohibited acts. • Establishes civil remedies, such as refunding any excess benefits or payments received and exclusion from participation in the Medical Assistance program, for individuals committing certain prohibited acts.
Key Provisions	• A person violates the fraud and abuse control provisions if she/he: o Knowingly or intentionally presents for allowance or payment any false or fraudulent claim or cost report for furnishing services or items under the Medical Assistance program, or o Knowingly presents for allowance or payment any claim or cost report for medically unnecessary services or items under the Medical Assistance program, or o Knowingly submits false information, for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or items under the Medical Assistance program, or o Knowingly submits false information for the purpose of obtaining authorization for furnishing services or items under the Medical Assistance program. • The following acts are also unlawful: o Submitting duplicate claims for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source; o Submitting a claim for services, supplies or equipment which were not rendered to a recipient;

	○ Submitting a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient; ○ Submitting a claim or referring a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient; ○ Submitting a claim which misrepresents the description of services, supplies or equipment dispensed or provided, the dates of services, the identity of the recipient, the identity of the attending, prescribing or referring practitioner, or the identity of the actual provider; ○ Submitting a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item; ○ Submitting a claim for a service or item which was not rendered by the provider, or ○ Submitting a claim for a service or item which was dispensed, or provided without the consent of the recipient, except in emergency situations.
Penalties for Violation	• Violations are punishable by 7 years imprisonment and/or a $15,000.00 fine (10 years/$25,000.00 for a second or subsequent offense). • In addition, a sentencing judge must order repayment in the amount of the excess benefit or payment received plus interest, plus a penalty of up to 3 times the amount of the excess benefit or payment received. • Anyone convicted is also ineligible to participate in the Medical Assistance program for a period of 5 years from the date of conviction. 62 P.S. § 1407

V. Attachments

None

VI. Distribution

Administrative Manual

VII. Approval

Signature	President & CEO Title	3-15-10 Date
Signature	President, Medical Staff Title	3-15-10 Date
Signature	Sr. V.P., Finance/CFO Title	3-11-10 Date

VIII. Policy Responsibility

Compliance Officer	*In Coordination with*: Legal Services

IX. References

LVHN Corporate Compliance Program
U.S. False Claims Act 31 U.S.C. § 3729-3733
Fraud and Abuse Control Provisions of Pennsylvania Public Welfare Code 62 P.S. § 1407

X. Disclaimer Statement

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the department of Legal Services.

XI. Date

Origination Date: December 2006
Reviewed/Revised: February 2010