

Policies and Procedures

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| SECTION: Administration | NO. 2.1.21. | | |
| CHAPTER: General | ISSUED: 12/13/06 | REV. A 6/24/09 | REV. B |
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I. PURPOSE

The purpose of this Policy is to fulfill the requirements of Section 6032 of the Deficit Reduction Act of 2005 by providing to Creighton University employees and employees of contractors or agents of the University detailed information on pertinent University policies and procedures and federal and state laws.

II. POLICY

In accordance with the requirements of federal law, the University will provide its employees and employees of contractors or agents of the University with detailed information about (1) the University's policies and procedures for detecting and preventing fraud, waste and abuse with respect to federal health care programs, including Medicare and Medicaid; (2) federal and state laws that prohibit the submission of false claims for payment to federal health care programs such as Medicare and Medicaid, and (3) federal and state laws that provide protection to employees who bring action or assist in bringing action against their employers under the federal and state laws that prohibit the submission of false claims for payment.

III. SCOPE

This Policy applies to faculty, staff including student employees, fellows, and residents of the clinical departments of the School of Medicine; staff and other employees of Creighton Medical Associates; faculty, staff and other employees of the clinical departments of the School of Dentistry; faculty, staff and other employees of the clinical operations of the School of Pharmacy (i.e., the hospital outpatient pharmacy) and Health Professions; members of the University Subcommittee on Hospital and Health Affairs; the President's Office; staff and other employees of Student Health; staff of the Internal Audit Department; staff of the Controller's Office; staff of the Human Resources Department; staff of the General Counsel's Office; and staff of the Purchasing Department. To the extent required by the Deficit Reduction Act of 2005, this Policy applies to employees of contractors and agents of the clinical departments of the School of Medicine, Creighton Medical Associates, the clinical departments of the School of Dentistry, and the clinical operations of the School of Pharmacy. The individuals to whom this Policy applies are hereinafter referred to as "Employees, Agents and Contractors."

IV. PROCEDURE

The University, through its Health Sciences Schools, is involved in the delivery of health care services and items, some of which are paid for by Medicare and Medicaid. Through its Compliance Plan for Health Sciences Billing and Patient Services (the "Billing Compliance Plan," discussed further below), the University seeks to prevent, detect and correct any noncompliant activity leading to fraud, waste and abuse in its delivery of health care services. The federal government believes that individuals can play an important role in detecting and reporting noncompliant activity and thus preventing fraud, waste and abuse in federal health care programs, such as Medicare and Medicaid. The federal government has enacted a law to help individuals better understand their role in detecting and reporting noncompliant activity that leads to fraud, waste and abuse in federal health care programs. The law requires the University to provide information to Employees, Agents and Contractors on the laws that protect federal

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health care programs from fraud, waste and abuse. The law also requires the University to provide information to Employees, Agents and Contractors on the laws that protect individuals who detect and report noncompliant activity to the University or the government. Through this Policy, the University is providing the information required by law to its Employees, Agents and Contractors.

The University's Billing Compliance Office and Office of General Counsel may provide training on this Policy as they determine necessary.

A. *Creighton University's Policies and Procedures for Preventing and Detecting Fraud, Waste and Abuse: The Compliance Plan for Health Sciences Billing and Patient Services*

The University has adopted the Billing Compliance Plan to function as its policies and procedures for detecting and preventing fraud, waste and abuse with respect to health care programs, including Medicare and Medicaid. The Billing Compliance Plan includes provisions for compliance oversight, compliance reporting, standards of conduct, investigation of compliance concerns, screening of personnel, compliance training and education, monitoring and auditing, responses to noncompliance and enforcement. The Billing Compliance Plan is supported by additional separate compliance policies and procedures as adopted by the Health Sciences Schools. For further detail, please refer to the Billing Compliance Plan and its supporting policies and procedures, which can be found at: <http://www.creighton.edu/generalcounsel/billingcompliance/>

Under the Billing Compliance Plan, employees and agents of the University are provided with a mechanism for reporting to the University potential or actual noncompliant activity. The Billing Compliance Plan also states that employees and agents are required to make such reports to the University. The University prohibits retaliation against any employee who reports, in good faith, any potential or actual violation of the laws described in this Policy to the University or the government.

B. *The Federal False Claims Act*

The Federal False Claims Act, 31 U.S.C. § 3729 to § 3733 (the "FCA"), prohibits knowingly making a false claim against the government (for example, Medicare or Medicaid). In relevant part, the FCA provides civil liability for any person who:

- (1) knowingly presents, or causes to be presented, to the government a false or fraudulent claim for payment or approval;
- (2) 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;
- (3) conspires to commit a violation of the FCA; or
- (4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or

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knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

A bill for health care services submitted to Medicare or Medicaid by a hospital or physician is a claim filed with the government subject to the FCA. Examples of false claims include billing for services or supplies not provided, altering claim forms to obtain a higher payment amount, misrepresenting a diagnosis to justify the services or equipment furnished, or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving or providing the services, dates of services, or frequency, duration or description of services. For the purposes of the FCA, “knowingly” is defined as actual knowledge that the information is false or fraudulent, acting in deliberate ignorance of the truth or falsity of the information or acting in reckless disregard of the truth of falsity of the information. Liability arises for those individuals who create and those individuals who submit the information on a false claim (even if the claim is not paid by the government). The government can enforce the FCA against both an organization and individual employees who commit billing fraud.

An organization or individual who is found to have committed any acts prohibited by the FCA may be fined a civil penalty of not less than \$5,500 nor more than \$11,000 per claim, plus three (3) times the amount of damages sustained by the government for each false claim. Penalties under the FCA may be reduced if an organization self-reports a false claim to Medicare or Medicaid within 30 days of discovering the false claim and cooperates with the government in investigating the false claim provided that there is no government action underway against the organization at the time it self-reports. In addition to penalties under the FCA, the organization or individual submitting a false claim may be subject to criminal prosecution, other monetary penalties and exclusion from federal and state healthcare programs, including Medicare and Medicaid.

The government may enforce the FCA against individuals or organizations directly. In addition, the FCA authorizes private citizens to (1) sue, on behalf of the government, organizations or individuals who have knowingly submitted false claims to the government; and (2) to share in any monetary proceeds recovered as a result of the suit. Law suits brought by private citizens are known as “*qui tam* actions” or “whistleblower suits”. If the government or an individual is going to bring an action against an individual or organization for violation of the FCA, the action must be brought within six years of the date of violation of the law or three years after the date when material facts are known or should have been known by the government about the violation of the law, whichever date is later.

However, in no event can an action be brought for violation of the FCA more than ten years after the date on which the violation was committed. If the government intervenes in a whistleblower suit, for statute of limitations purposes, the government can relate back to the filing date of the whistleblower’s suit.

The FCA also protects employees, agents and contractors who initiate or assist in *qui tam* actions from retaliation. These employees, agents and contractors are sometimes referred to as “whistleblowers”. Under the FCA, an employee, agent and contractor who is terminated, demoted, suspended, or in any

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way discriminated against because of his/her initiation of or assistance in a *qui tam* action has the right to sue for reinstatement, back pay and other damages.

C. Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act, 31 U.S.C. §3801 to §3812 (the “PFCRA”), sets forth administrative procedures that address allegations of fraud against the government, including false claims against Medicare or Medicaid, when the amount of claims involved is less than \$150,000. The PFCRA provides for additional administrative penalties for false claims that are distinct from the FCA. Under the PFCRA, a person may not submit a claim that (1) is false, fictitious or fraudulent; (2) includes or is supported by a written statement which asserts a material fact which is false, fictitious or fraudulent; (3) includes or is supported by any written statement that omits a material fact, is false, fictitious or fraudulent as a result of such omission and the statement is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact; or (4) is for payment for the provision of property or services which the person has not provided as claimed. A person who violates these provisions of the PFCRA may be subject to penalties in the amount of \$5,500 for each claim and two times the amounts of claims submitted.

In addition, under the PFCRA, a person who makes, presents, or submits a written statement that the person knows or has reason to know (1) asserts a material fact which is false, fictitious or fraudulent; (2) omits a material fact and is false, fictitious or fraudulent as a result of such omission when the person has a duty to include such material fact; and (3) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement may be subject to a civil penalty of up to \$5,500 for each such statement.

Under the PFCRA, the government has up to six years after the false claim was submitted to impose penalties and it has up to three more years after it imposes penalties to bring an action in court to collect any penalties it imposes.

D. The Nebraska False Medicaid Claims Act

The Nebraska False Medicaid Claims Act, Neb. Rev. Stat. § 68-934 to §68-947 (the “Nebraska False Claims Act”), prohibits the same conduct that is prohibited by the FCA, as discussed above. The Nebraska False Claims Act also imposes civil liability on any person who:

1. When acting on behalf of a provider providing a good or service for which a claim is submitted to Medicaid, charges, solicits, accepts or receives anything of value in addition to the amount legally payable by Medicaid in connection with the provision of such good or service knowing that the charge, solicitation, acceptable or receipt is not legally payable; or
2. Having submitted a claim or received payment for a good or service under Medicaid, knowingly fails to maintain such records as necessary to fully disclose the nature of all the good or services for which a claim was submitted or payment was received for a period of at least six years after the date on which the payment was received or knowingly destroys such records within six years from the date payment was received.

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If an individual or organization is found to have violated the Nebraska False Claims Act, the person is subject to a civil penalty of not more than \$10,000 per claim and damages in the amount of three times the amount of the false claim submitted to the state. In addition, the person must pay for the state's costs and attorney's fees incurred in bringing the action against the person and recovering the penalties or damages imposed. If an organization or individual self-reports a false claim to the state within 30 days of discovering the false claim, cooperates with the state and there is no government action underway against the organization or individual at the time of reporting, the penalties may be reduced.

All actions brought for violations of the Nebraska False Claims Act must be brought within six years of the date the claim is discovered or should have been discovered but in no event more than 10 years after the date the violation was committed. The Nebraska False Claims Act currently contains no *qui tam* action or whistleblower protection provisions.

V. ADMINISTRATION AND INTERPRETATION

Any question regarding this Policy can be directed to the Billing Compliance Office (280-2107) or the Office of General Counsel (280-5589).

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This Policy may be amended or terminated at any time.

VII. REFERENCES

Section 6032, Deficit Reduction Act of 2005, Public Law 109-171; the federal False Claims Act, 31 U.S.C. § 3729-3733, and its administrative remedies, 31 U.S.C. § 3801-3812; Nebraska Revised Statutes § 68-934 to 68-947.