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Owner	Robyn Whalen: System Director of Compliance Regulatory
Area	Compliance
Applicability	Logan System

False Claims Act, A315

PURPOSE

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To provide detailed information to all Workforce Members about the federal and Montana False Claims Acts and Logan Health's Policy to detect and prevent fraud, waste and abuse.

POLICY

1. Logan Health takes health care fraud and abuse very seriously. Logan Health is committed to following applicable laws and regulations, in particular, those that address health care fraud, waste and abuse, and the proper billing of Medicare, Medicaid and other government-funded health care programs.
2. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States government funds is liable for significant penalties and fines. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.
3. Workforce Members will comply with applicable federal and Montana False Claims Act laws and regulations. As part of the Logan Health Compliance Program, Workforce Members will receive training on these laws, which are summarized in the Procedure below and will consult with the Compliance or Legal Department if they have any questions about the application of these laws to their job.
4. Logan Health prohibits retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistle blower" lawsuits on behalf of the government.
5. This policy will be made available to all contractors and agents [as required by 42 USC 1396a(a)(68)]

PROCEDURE

Reporting

1. To ask a question, seek guidance or raise a concern about a fraud, waste, or abuse issue, contact your manager.
2. If any Workforce Member has knowledge or information that prohibited activity may have taken place, the Workforce Member should notify his or her supervisor or call the Corporate Compliance Department.
3. Anonymous reporting is permitted.
   A. Information may be reported to the Corporate Compliance Department (833-594-0321) or anonymously to the Integrity Helpline (844-760-5833).
4. In addition, federal and Montana law and Logan Health policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistle blower" lawsuits on behalf of the government. Logan Health will not discharge, demote, suspend, threaten, harass or in any other manner retaliate against an employee based on that employee raising a concern in good faith about any actual or suspected misconduct or other risks to the business. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Corporate Compliance Office (see *Nonretaliation/Nonretribution, A333*).

Detecting and Preventing Fraud, Waste, and Abuse

1. Compliance provides staff training during orientation, annually and as needed.
2. Revenue Cycle Team applies "claims scrubbing" software to Logan Health's billing system (captures claims with potential billing errors and holds them until they can be manually reviewed).
3. Compliance investigates reports of potential violations from staff, patients, visitors, and outside parties (see *Compliance Investigation, A329*).
4. Revenue Cycle maintains internal departmental monitoring processes.
5. Compliance and Revenue Cycle perform ongoing internal audits.
6. Compliance performs internal risk assessments.

DEFINITIONS

1. "**Workforce Members**" include all Logan Health employees, volunteers, trainees, physicians, other clinical personnel, leaseholders, contractors, students, vendors, and other persons whose conduct, in the performance of work for Logan Health, is under the direct control of Logan Health, whether or not they are paid by Logan Health.
2. "**Knowingly**" means a person, with respect to information: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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3. **“Overpayment”** means the amount of money Logan Health has received in excess of the amount due and payable under any federal health care program requirements, including applicable federal statutes, regulations, Medicare or other federal health care program payment manuals, and Medicare Administrative Contractor Local Coverage Decisions. An Overpayment may be the result of non-adherence to federal health care program requirements, errors by Logan Health personnel, payment processing errors by the payer, or erroneous or incomplete information provided to Logan Health by the patient or responsible party.

REFERENCES

1. **Federal False Claims Act** - The Federal False Claims Act (**FCA**) prohibits a person or entity from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the federal government. FCA also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to federal health care programs, such as Medicare or Medicaid. A person or entity found guilty of violating FCA is obligated to repay all of the falsely obtained reimbursement and will be liable for a civil penalty of up to $11,000, plus three times the amount of actual damages sustained by the government as a result of the prohibited conduct for each violation of the FCA. In addition to being liable for damages and civil penalties, violating the FCA can subject a person or entity to exclusion from participation in federal health care programs, such as Medicare and Medicaid.

2. **Program Fraud Civil Remedies Act of 1986** (**PFCRA**) - This federal law makes it illegal for a person or entity to make, present or submit (or cause to be made, presented or submitted) a "claim" (i.e., a request, demand or submission) for property, services, or money to an "authority" (i.e., an executive department of the federal government, e.g., the U.S. Department of Health and Human Services (**DHHS**), which oversees Medicare and Medicaid programs) when the person or entity "knows or has reason to know" that the claim: (i) is false, fictitious or fraudulent; or (ii) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent; or (iii) includes or is supported by any written statement which omits a material fact, is false, fictitious or fraudulent because of the omission, and is a statement in which the person or entity has a duty to include such material fact; or (iv) is for the provision of items or services which the person or entity has not provided as claimed. This includes an omission of material fact when the person making the statement has a duty to include such fact in order to assure truthfulness and accuracy.

A. It is illegal to make, present or submit (or cause to be made, presented, or submitted) a written "statement" (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity "knows or has reason to know" such statement: (i) asserts a material fact which is false, fictitious or fraudulent or (ii) omits a material fact making the statement false, fictitious or fraudulent because of the omission.

B. The PFCRA provides for civil penalties of up to $5,000 for each false claim paid by the government, and, in certain circumstances, an assessment of twice the amount of each claim.

C. The law authorizes federal agencies such as the DHHS to investigate and assess penalties for

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the submission of false claims to the agency. If the agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. For health-related claims, the Office of Inspector General of DHHS would be the investigating official. The investigating official may issue a subpoena to further the investigation, or may refer the matter to the Department of Justice for proceedings under the False Claims Act.

D. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint (following approval from the Department of Justice) regarding the false claim. A hearing would be held, following the detailed due process procedures set forth in regulations implementing the PFCRA. If the law has been violated a monetary penalty may be assessed and an additional assessment of not more than twice the amount of the claim can be awarded to the government.

3. **Montana False Claims Act** -

A. The Montana False Claims Act includes prohibitions against:

    1. Knowingly presenting, or causing to be presented to an officer or employee of a governmental entity a false claim for payment or approval;
    2. Knowingly making, using or causing to be made or used, a false record or statement to get a false claim paid or approved by the government entity;
    3. Conspiring to defraud the government entity by getting a false claim allowed or paid;
    4. Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government entity or its contractors; and
    5. A beneficiary of an inadvertent submission of a false claim, after the discovering the falsity of the claim, failing to disclose it to the Medicaid agency within a reasonable time after discovery.

B. A court can assess a money penalty for each false claim of not less than two times or more than three times the damages suffered by the government entity because of the false claim. A money penalty cannot be assessed if the person involved fully cooperates with the government as set out in the statute, and no case had been filed nor was the person aware of an investigation into the Act.

C. The Montana Medicaid fraud statute (45-6-313) also prohibits, among other things, a person from receiving a Medicaid payment as a result of a false or misleading Medicaid claim or statement, or purposefully or knowingly failing to provide covered medically necessary service which the person was required to provide under a Medicaid managed care contract. Imprisonment and money fines may be imposed for violating this statute, as well as suspension from the Medicaid program.

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Approval Signatures

Step Description	Approver	Date

Final Admin Approval	Robyn Whalen: System Director of Compliance Regulatory	05/2024
Policy Committee	Kelly Stimpson: Associate General Counsel	05/2024
Reviewer 2	Amber Simonds: System Director Privacy	05/2024
Reviewer 1	Robyn Whalen: System Director of Compliance Regulatory	05/2024
Owner	Robyn Whalen: System Director of Compliance Regulatory	05/2024

Applicability

Logan Health (locations excluding LHMC), Logan Health Chester, Logan Health Conrad, Logan Health Cut Bank, Logan Health Medical Center, Logan Health Shelby, Logan Health Whitefish

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