LOUISIANA STATE UNIVERSITY
HEALTH CARE SERVICES DIVISION
BATON ROUGE, LA

POLICY NUMBER: 8514-24

CATEGORY: Compliance Policies

CONTENT: False Claims Act (FCA)

APPLICABILITY: This policy applies to all employees of the Health Care Services Division Administration and Lallie Kemp Medical Center to include classified, unclassified, students, volunteers, and other persons having an employment relationship with the agency.

EFFECTIVE DATE:

Issued:	December 15, 2009
Reviewed:	June 2, 2011
Revised:	September 14, 2011
Reviewed:	October 20, 2011
Reviewed:	May 2, 2014
Reviewed:	March 19, 2015
Revised:	January 27, 2017
Reviewed:	January 24, 2020
Reviewed:	September 14, 2022
Reviewed:	November 3, 2023
Revised:	December 1, 2023
Reviewed:	October 25, 2024
Reviewed	November 14, 2024

INQUIRIES TO: LSUHCSD Compliance Section
Post Office Box 91308
Baton Rouge, LA 70821-1308

Note: Approval signatures/titles are on the last page

LOUISIANA STATE UNIVERSITY
HEALTH CARE SERVICES DIVISION
False Claims Act (FCA) Policy

I. POLICY STATEMENT/PURPOSE

The purpose of this policy is to comply with the Deficit Reduction Act of 2005 and the Federal False Claims Act. This policy will assist Louisiana State University Health Care Services Division (HCSD) employees, medical staff, vendors, and Business Associates (personnel) to understand the provisions of the federal and state laws regarding submitting a false claim for reimbursement and all the associated implications, as well as to inform all personnel of their right to report violations of federal and state law.

Note: Any reference herein to HCSD also applies and pertains to Lallie Kemp Medical Center (LKMC).

II. IMPLEMENTATION

This policy and subsequent revisions to the policy shall become effective upon the approval and signature of the HCSD Chief Executive Officer (CEO) or Designee.

III. PROCEDURE

It is the policy of HCSD to submit only claims that are complete and accurate in all respects, thus avoiding the submission of false claims. Detailed information regarding both state and federal false claims laws is provided in Attachment I to this policy. It is important that all personnel understand the provisions of these laws, and how to avoid submitting false claims.

The government defines (in part) a false claim as knowingly making, using or causing to be made or used a false statement or record to get a claim paid or approved. This includes everything from documenting false items in the medical record, to not coding appropriately or using the wrong revenue code. There are numerous different data elements that are included when submitting a bill and all must be accurate.

All personnel should be aware that not knowing the law is not an excuse for a violation. The regulations place an obligation on HCSD personnel to know and understand the rules regarding submission of claims. The government publishes this information in many forms and all personnel must understand the rules and regulations before submitting a claim for reimbursement.

IV. FEDERAL FALSE CLAIMS ACT (31 USCS §3729-3733)

Filing false claims may result in fines not less than $5,000 and no more than $10,000 plus up to three times the program's loss. HCSD has in place internal and external audits and subscribes to many publications to help detect and prevent any problems with claims. These fines can be eliminated by HCSD finding its own errors, notifying Medicare and cooperating in correcting the matter. The statutes require HCSD to respond to investigators as they investigate potential wrongdoing. [Refer to HCSD's Policy 8501 - Code of Conduct, Policy 4528 – Investigations, and any other policies that apply].

HCSD personnel should also be aware that they may notify the government themselves if they believe the hospital does not respond appropriately when given notification of a potential violation. HCSD is prohibited from taking any adverse actions whatsoever against the employee or clinician should said person notify the government directly. [Refer to the Code of Conduct and 8505 Whistleblower & Non-Retaliation policy].

V. ADMINISTRATIVE REMEDIES (31 USCS §3801 et seq.)

Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission or is for payment for the provision of property or services which the person has not provided as claimed:

A. Shall be subject to a civil penalty of not more than $5,000 for each such claim and an assessment, in lieu of damages sustained by the United States because of such claim, of not more than twice the amount of such claim.

B. An authority can take administrative or contractual action to suspend or debar any person from entering into contacts with the Federal Government.

VI. CONSEQUENCES

All personnel responsible for any part of a claim submission shall be familiar with this policy and the information in Attachment I. Anyone found to be in violation of this policy may be subject to disciplinary action, up to and including termination of employment or services.

VII. EXCEPTION

The HCSD CEO or designee may waive, suspend, change, or otherwise deviate from any provision of this policy deemed necessary to meet the needs of the agency as long as it does not violate the intent of this policy, state and/or federal laws, Civil Service Rules and Regulations, LSU Policies/Memoranda, or any other governing body regulations.

ATTACHMENT I

INFORMATION REGARDING FEDERAL AND STATE FALSE CLAIM LAWS

With the high stakes involved in False Claim Act lawsuits and/or regulatory actions, health care providers cannot afford to leave billing and coding compliance up to chance. Health care billing and coding compliance refers to HCSD's ability to operate within the rules, regulations and policies set by the government, insurance programs and fiscal intermediary (a commercial insurer contracted by the Department of Health and Human Services for the purpose of processing and administering Medicare claims).

Many employees are directly involved in development of a claim, including admissions, nursing, coding and billing; however, it is important that all employees and clinicians have a basic understanding of the state and federal False Claims Acts.

Health care providers that do not comply with certain government rules and regulations face harsh penalties that could result in their exclusion from government-sponsored programs (i.e. Medicare and Medicaid). Health care providers suspected of fraud or abuse must deal with government audits and reviews. These investigations can result in costly civil monetary settlements.

What is the False Claims Act or FCA? The government relies mostly on the FCA to prosecute billing fraud. The FCA imposes civil liability on hospitals (and individuals) that make or cause false or fraudulent claims to the government for payment. Anyone who violates the FCA is liable to the U.S. government for a civil penalty between $5,000 and $10,000 for each claim, plus three times the amount of the damages that the government sustains. In addition, the government can exclude violators from participating in Medicare, Medicaid and other government programs.

Who is liable under the FCA? The government can use the FCA against both individuals and organizations that commit billing fraud.

The FCA applies to any person who does the following:

(1) Knowingly presents the government with a false claim for payment or approval.
(2) Knowingly makes a false statement to get a fraudulent claim paid by the government.
(3) Conspires to defraud the government by getting a false or fraudulent claim paid.
(4) Knowingly makes a false record or statement to conceal, avoid, or decrease an obligation to pay the government.
(5) Causes a false claim to be submitted.

Simply put…..

- A hospital submits a claim for payment to the government.
- The claim is false.
- The submitter knew it was false.
- The government relied on the information and as a result there was harm to the government.
- The key element is the fact that the submitter knew it was false!

Examples of False Claims….

- billing of items or services that were never rendered by the health care provider
- billing for services that are medically unnecessary

- upcoding (practice of billing for Medicare/Medicaid using a billing code providing a higher payment rate than the billing code intended to be used for the service or item furnished to the patient)
- billing separately for services that should be bundled
- billing separately for outpatient services that were provided within 72 hours after an inpatient stay to Medicare for acute care hospitals; or 24 hours before or after an inpatient stay to Medicaid
- billing for a discharge in lieu of a transfer

Important to remember…….**NEVER** submit a false claim to the government. If you know of someone who has submitted a false claim, report it immediately to your supervisor, if appropriate, and/or your Compliance Officer.

What are qui tams? The FCA includes an important provision that allows private citizens to initiate a lawsuit on behalf of the federal government and request the government to join in the suit. In return, that citizen may share a percentage of any recovery or settlements. This type of lawsuit is known as a qui tam and the individual who reports evidence of the crime is a "whistleblower". The purpose of this qui tam provision is to give an incentive for whistleblowers to come forward to help the government discover and prosecute fraudulent claims by awarding them a percentage of the recovery.

First, to prevail under a lawsuit, the whistle-blower (or relator) must be the "original source" of the information reported to the federal government. Specifically, the whistle-blower must have direct and independent knowledge of the false claims activities and voluntarily provide this information to the government. If the matter disclosed is already the subject of a federal investigation, or if the health care provider or supplier has previously disclosed the problem to a federal agency, the whistle-blower may be barred from obtaining a recovery under the FCA.

Whistleblower Protection – Federal Law

- The FCA protects employees who are discharged, demoted, suspended, harassed or in any manner discriminated against by their employer because of their participation or assistance (e.g., testimony, initiation of investigation) in a false claim action.

- The Act entitles employees to relief to "make them whole", including reinstatement with the same seniority status they would have had but for the discrimination, twice the back pay, interest on back pay, and compensation for any special damages sustained as a result of the discrimination including litigation costs and reasonable attorneys' fees.

Louisiana False Claims Act (Act No. 1373)

Louisiana has its own FCA. The following are the general elements of the Act.

- The Louisiana False Claims Act states, a "false or fraudulent claim" means a claim which the healthcare provider or his billing agent submits knowing the claim to be false fictitious, untrue, or misleading in regard to any material information. "False or fraudulent claim" shall include a claim which is part of a pattern of incorrect submissions in regard to material information or which is otherwise part of a pattern in violation of applicable federal or state law or rule.

• No person shall solicit, receive, offer or pay any remuneration, including but not limited to kickbacks, bribes, rebates or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:
    - for referrals to a healthcare provider or to another person for the referral to a healthcare provider,
    - for furnishing or arranging to furnish any good, supply or service for which payment may be made,
    - For purchasing leasing or ordering, or for arranging for or recommending purchasing, leasing or ordering, any good, supply or service or facility for which payment may be made,
    - To a recipient of goods, services or supplies, or his representative,
    - To obtain a recipient list, number, name or any other identifying information
    - Safe harbor exceptions are also in place for the above.

State Whistleblower (Qui Tam) Protection

• No employer of a whistleblower shall discharge, demote, suspend, threaten, harass or discriminate against a whistleblower at any time arising out of the fact that the whistleblower brought action, unless the court finds that the whistleblower has instituted or proceeded with an action that is frivolous, vexatious or harassing.

• A person who is or was a public employee or public official or a person who is or was acting on behalf of the state shall not bring a Qui Tam action:
    - if the person has or had a duty or obligation to report, investigate or pursue allegations of wrongdoing or misconduct by the health care providers,
    - or if the person has or had access to records of the state through the normal course and scope of his employment relative to activities of health care providers.

• Refer to HCSD Policy 8505 Whistleblower/Non-Retaliation.

Louisiana State False Claims Penalties (La. R.S. 46:437.1, et seq)

Penalties for violating the State False Claims Act include

- Payment of actual damages;
- A civil fine not to exceed $10,000 per violation; OR
- A civil fine not to exceed three times the value of the illegal remuneration, whichever is greater.
- Payment of interest on the mandatory civil fine imposed.

Document Metadata

Document Name:	8514 - 24 False Claims Act (FCA).doc
Policy Number:	8514
Original Location:	/LSU Health/HCSD/8500 - Compliance
Created on:	01/24/2020
Published on:	11/14/2024
Last Review on:	10/25/2024
Next Review on:	10/25/2025
Effective on:	12/15/2009
Creator:	Townsend, Kathy *HCSD Human Resources Director*
Committee / Policy Team:	Main Policy Team
Owner/SME:	Simien, Tammy *Staff Attorney*
Manager:	Reeves, Rebecca *Compliance and Privacy Officer*
Author(s):	Wicker, Claire M. *PROJECT COORDINATOR* Reeves, Rebecca *Compliance and Privacy Officer* Simien, Tammy *Staff Attorney*
Approver(s):	Wilbright, Wayne *Chief Medical Informatics Officer* Reeves, Rebecca *Compliance and Privacy Officer* Simien, Tammy *Staff Attorney*
Publisher:	Wicker, Claire M. *PROJECT COORDINATOR*

Digital Signatures:

Currently Signed

Approver:
Reeves, Rebecca
Compliance and Privacy Officer

11/14/2024

Approver:
Simien, Tammy
Staff Attorney

11/14/2024

Approver:
Wilbright, Wayne

11/14/2024