

VIRTUA HEALTH

<u>MANUAL TITLE</u> ADMINISTRATIVE/LEADERSHIP MANUAL		<u>POLICY NAME</u> FRAUD AND ABUSE PREVENTION		
<u>APPROVED BY</u> C. Mullin	<u>DATE OF ISSUE</u> 1/07	<u>DATE OF REVISION</u> 1/09	<u>REVIEW INTERVAL</u> 36 Months	<u>EFFECTIVE DATE</u> 1/09
<u>REVIEWED BY (Committees)</u> Corporate Compliance, Quality/Risk Safety				

POLICY

It is the policy of Virtua Health to obey all federal and state laws, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payments to Virtua Health from federal or state healthcare programs, and to provide protections for those who report actual or suspected wrongdoing.

PURPOSE

To satisfy the requirements of Section 6032 of the Deficit Reduction Act of 2005 by setting forth certain federal and state laws relating to liability for false claims and statements; protections against reprisal or retaliation for those who report wrongdoing; and Virtua Health policies and procedures to detect and prevent fraud, waste and abuse.

Explanation of Laws: The laws described in this policy create a comprehensive scheme for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums -- criminal, civil and administrative. This provides a broad spectrum of remedies to battle this problem.

Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need to assist with the prosecution of these cases.

Set forth below are summaries of certain statutes that provide liability for false claims and statements and Virtua Health's policies and procedures regarding fraud and abuse. These summaries are not intended to identify all applicable laws, but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005.

Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)

The Federal False Claims Act (FCA) imposes civil liability on any person or entity who:

- knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care programs;
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care programs; or
- conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.

“Knowingly” means:

- actual knowledge that the information on the claim is false;
- acting in deliberate ignorance of whether the claim is true or false; or
- acting in reckless disregard of whether the claim is true or false.

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A person or entity found liable under the Federal False Claims Act is subject to a civil money penalty of between \$5,500 and \$11,000 plus three times the amount of damages that the government sustained because of the illegal act. In health care cases, the amount of damages sustained is the amount paid for each false claim that is filed.

Anyone may bring a *qui tam* action under the Federal False Claims Act in the name of the United States in federal court. The case is initiated by filing the complaint and all available material evidence under seal with the federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint. The government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action will receive between 15 percent and 25 percent of any recovery if he or she was not involved with the wrongdoing, depending upon the contribution of that person to the prosecution of the case. If the government does not proceed with the case, the person who filed the action can bring a private action/lawsuit, and if successful, is entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys' fees and costs.

Federal Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 – 3812)

The Program Fraud and Civil Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act.

The PFCRA imposes liability on people or entities who file a claim that they know or have reason to know:

- is false, fictitious, or fraudulent; includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a \$5,500 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

In addition, a person or entity violates the PFCRA if they submit a written statement which they know or should know:

- asserts a material fact that is false, fictitious or fraudulent; or
- omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

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A violation of this section of the PFCRA carries a civil penalty of up to \$5,000 in addition to any other remedy allowed under other laws.

New Jersey False Claims Act, P.L. 2007, Chapter 265 (N.J.S. 2A:32C-1 to 2A:32c-17)

This law, which was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts: (a) the main part authorizes the NJ Attorney General and whistleblowers to file false claims lawsuits similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections; (b) another part makes violations of the NJ False Claims Act also give rise to liability under the NJ Medical Assistance and Health Services Act; and (c) a third part amends the NJ Medical Assistance and Health Services Act to increase the \$2000 per false claim civil penalty to the same level provided for under the Federal False Claims Act, currently between \$5,500 and \$11,000 per false claim.

New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S. 30:4D-17(a)-(d)

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to \$10,000, imprisonment for up to 3 years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to \$10,000, imprisonment for up to 3 years, or both; (c) kickbacks, rebates and bribes: fine of up to \$10,000, imprisonment for up to 3 years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to \$3,000, or imprisonment for up to 1 year, or both. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

New Jersey Medical Assistance and Health Services Act – Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a.:

In addition to the criminal sanctions discussed in section 3 above, violations of N.J.S. 30:4D-17(a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation, or violation of the New Jersey False Claims Act discussed below: recovery of overpayments, interest, up to triple damages, and based on a recent amendment in the NJ False Claims Act, between \$5,500 and \$11,000 for each false claim. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

New Jersey Health Care Claims Fraud Act N.J.S. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5

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Provides for criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds by:

- a. A practitioner who knowingly or recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;
- b. A person who is not a practitioner subject to paragraph a. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly or recklessly commits health care claims fraud.

New Jersey Conscientious Employee Protection Act, "Whistleblower Act", N.J.S.A. 34:19-4

This "Whistleblower Act" is the NJ law that protects individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies. You can refer to Virtua's CEPA Notice on the VINE under "Corporate Corner".

Virtua Health's Corporate Compliance Program and Code of Conduct provides a method for employees to report action or behavior that violate policies and procedures. Virtua strongly encourages employees to address questions and concerns through the use of the chain of command. Most situations can be resolved by management. Additionally, a Compliance Hotline is available for employees.

Virtua's Policies and Procedures for Detecting and Preventing Fraud:

Virtua's Corporate Compliance Program establishes and maintains standards through the Code of Conduct and provides a method for employees to report actions or behavior that violate our policies or procedures or any violation of law. Virtua strongly encourages employees to address questions and concerns through the use of the chain of command which is: 1) your supervisor; 2) Another member of management at your facility, 3) Your Human Resources representative. Employees can also contact the Corporate Compliance Officer. Additionally, a Compliance Hotline (800) 268-0502 is available for employees. Corporate Compliance concerns are kept confidential to the greatest extent possible. Virtua will not take any disciplinary action or treat any employee negatively for using the chain of command or Compliance Office or Hotline to report in good faith any concern. Virtua' Compliance Program policy is located in the Administrative/Leadership Manual, Compliance and at www.virtua.org.