



ESSENT HEALTHCARE, INC.

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| Section: Corporate Compliance | Effective Date: | 01/01/07 |
| Subject: Fraud and Abuse | Revision Date: | 09/11/07 |
| Policy #: CC-29 | Review Date: | 09/30/09 |
| Responsible Party: Corporate Compliance Officer | Revision #: | 3 |

Scope:

This policy applies to all workforce members of Essent Healthcare, Inc.

Purpose:

The purpose of this policy is to set forth our position regarding the Federal False Claims Act (and all State equivalent laws) and reporting known or suspected fraud, waste, and abuse.

Policy:

It is the policy of Essent to encourage and require all workforce members to report known or suspected wrongdoing (more specifically fraud, waste, or abuse) to the Corporate Compliance Officer or through other appropriate means (for example: The Compliance Reporting Hotline, Local Compliance Directors, Hospital Administration, or immediate supervisor). Any individual who reports known or suspected fraud or abuse, internally or as a “whistleblower” (as described below) shall be protected from retaliation. Furthermore, it is our policy that in instances where credible evidence of misconduct is obtained, our hospitals’ shall self-report to the appropriate authorities and make any necessary restitution for monies received in error.

Definitions:

- **Fraud** – A deception deliberately practiced in order to secure unfair or unlawful gain. As it relates to the False Claims act, fraud is defined as knowingly or intentionally making false statements in order to receive some benefit or payment for which no entitlement would otherwise exist.
- **Abuse** – Excessive and wrongful misuse of anything. As it relates to the False Claims act, abuse would include providing services that are inconsistent with established, sound medical practices; or practices that result in unnecessary costs to the Medicare or Medicaid programs.
- **Whistleblower** – One who reveals wrongdoing within an organization to the public or to those in a position of authority. An employee who has inside knowledge of illegal activities occurring within his/her organization and reports the wrongdoing to the public. The False



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Claims Act provides protection from retaliation for whistleblowers.

- **False Claims Act** - The Federal False Claims Act (FCA) was established to punish persons or entities that file false or fraudulent claims for payment with federal government agencies. These laws apply to all kinds of claims for payment from the federal government, not just health care claims. Generally, the FCA is violated when a service provider, *either knowingly or recklessly*, allows the filing of false or fraudulent claims for payment to government programs such as Medicare and/or Medicaid. Billing errors are not false claims so long as they are promptly corrected when found and refunds are processed appropriately. Violations of the False Claims Act may result in treble damages plus mandatory financial penalties ranging from \$5,000 to over \$11,000 *per claim* and exclusion from the Medicare and Medicaid programs.

Procedures:

1. Our Code of Conduct requires that all workforce members must report known or suspected wrongdoing. Reports can be made to the Corporate Compliance Officer, The Hospital Local Compliance Director, Hospital Administration, or the workforce member's immediate supervisor. Reports can also be made anonymously to the Compliance Reporting Hotline at 1-800-472-8868. Failure to report known or suspected wrongdoing is a violation of our Code of Conduct and may result in disciplinary action up to and including termination of employment.
2. With regards to fraud, waste, and abuse: The Deficit Reduction Act requires that any provider that receives more than \$5 million annually from the Medicaid Program, must implement policies and procedures for detecting and preventing fraud and abuse. These efforts must include workforce education which has been incorporated into our Corporate Compliance Program and annual compliance training.
3. In addition, Medicare Part C (Medicare Advantage/Medicare Managed Care) and Medicare Part D (Medicare Prescription Drug Benefit) both require that healthcare providers implement policies and procedures that are designed to detect and prevent fraud, waste, and abuse. Our Corporate Compliance Program contains all of the necessary elements for an effective fraud, waste, and abuse prevention program as outlined in the Medicare Prescription Drug Benefit Manual Chapter 9 (Please also see the *Employee Guide to Compliance*).



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4. Any individual making a good-faith report of wrongdoing shall be protected from all forms of retaliation. Intentionally making false allegations of misconduct will not be tolerated and may result in disciplinary action including termination of employment.
5. The Federal False Claims Act (FCA) was established to punish persons or entities that file false or fraudulent claims for payment with federal government agencies such as Medicare or Medicaid. These laws apply to all kinds of claims for payment from the federal government, not just health care claims.

Generally, the FCA is violated when a service provider, *either knowingly or recklessly*, allows the filing of false or fraudulent claims for payment to government programs such as Medicare and/or Medicaid. Violations of the False Claims Act may result in treble damages plus mandatory financial penalties ranging from \$5,000 up to approximately \$11,500 *per claim*.

It is important to point out that billing errors are not “false claims” if the errors are promptly corrected when found, and refunds are processed appropriately. However, a pattern of unaddressed or uncorrected billing errors may demonstrate “reckless disregard” and therefore may constitute a violation of the FCA. It is important to point out that under the FCA, the Government does not have to prove that there was any specific intent to defraud (or submit false claims). They only have to prove that the false claims were in fact submitted and that there was reckless disregard for the truth or deliberate ignorance of the truth.

Examples of FCA violations can include:

- Filing or *contributing* to the filing of a false claim for payment.
- Intentionally making or using a false records or statements to support a claim.
- Seeking reimbursement at a higher code or level than is appropriate for the service provided or “unbundling” claims for services that are required to be billed on a bundled basis.
- Claiming payment from federal programs for services that are not medically necessary or not authorized by the physician or practitioner who is treating the patient.
- Failing to have in place reasonable business practices to process and file accurate claims for payment, resulting in the filing of inaccurate or misleading claims.
- Billing Medicare or Medicaid substantially in excess of usual and customary charges.
- Filing false or erroneous cost reports.



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- Violations by a health care provider of other laws, such as the Anti-Kickback Statute and the Stark Law, may form the basis for an FCA action.

Another important feature of the FCA is the *qui tam* provision, or whistleblower statute. Under this provision, individuals are allowed to file suite on behalf of the Federal Government if they have independent knowledge of illegal activity including fraud and/or abuse.

Whistleblower actions are filed under seal (“*in camera*”) and remain secret for at least 60 days while the government decides if it wishes to intervene. If the government decides to intervene, it will take over the case and prosecute the wrongdoing or settle the charges. If the government refuses to intervene, the *qui tam* relator (whistleblower) may go forward with the prosecution at his/her own expense as long as the government does not object.

In cases where the government intervenes, the *qui tam* relator is entitled to between 15% and 25% of the recoveries as a reward for coming forward. In cases where the government refuses to intervene and the relator moves forward on his/her own, the relator is entitled to between 25% and 30% of the recoveries. Of course, if an action is brought by an individual who participated in the illegal activity, than the court may reduce the award to the extent that it feels is appropriate. If the individual is convicted of an offense resulting from his/her involvement in the activity then the individual shall not receive any share of the recoveries.

6. Whistleblowers are protected from retaliation under the FCA which states “...*any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his/her employer because of lawful whistleblower actions shall be entitled to all relief necessary to make the employee whole...*” Remedies may include two times back pay plus interest, reinstatement at the same level with the same seniority, plus legal fees and any other costs incurred by the employee as a result of the discrimination.
7. In an effort to prevent and detect fraud and abuse, Essent has implemented a compliance program containing all of the essential elements of an effective compliance program as outlined in the Federal Sentencing Guidelines and as outlined in the Prescription Drug Benefit Manual Chapter 9. In addition, Essent has implemented billing edits and routinely conducts monitoring activities designed to detect claim errors and/or fraudulent activities. The compliance program is outlined in the Essent *Employee Guide to Compliance* which is available from your Local Compliance Director and on the web site at



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8. All workforce members are required to attend annual compliance training to obtain updated information regarding the compliance program, regulatory changes, and updates regarding the prevention of fraud, waste, and abuse.
9. All employees are reminded of their obligation to report any and all known or suspected wrongdoing to the Corporate Compliance Officer either directly, or via the Compliance Reporting Hotline. **Failure to report known or suspected wrongdoing is a violation of the Essent Code of Conduct and may result in disciplinary action up to and including termination of employment.**

References:

Federal False Claims Act
Deficit Reduction Act
Medicare Part C (42 CFR 422.503)
Medicare Part D (FR 12/5/07; 68700) (42 CFR 423.504)
Federal Sentencing Guidelines for Organizations
Essent Employee Guide to Compliance