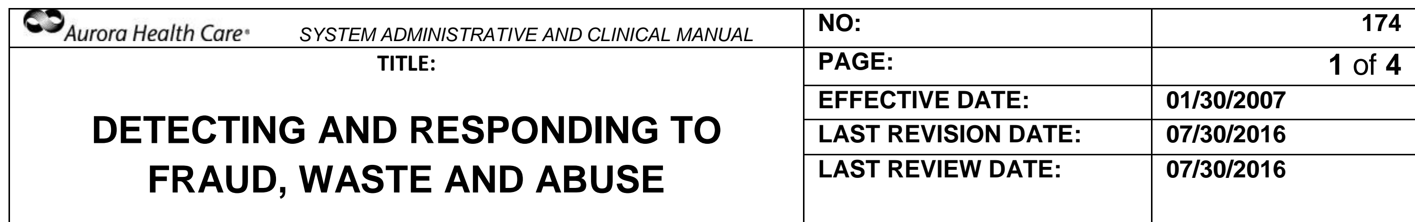

SYSTEM ADMINISTRATIVE AND CLINICAL MANUAL	NO:	174
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DETECTING AND RESPONDING TO FRAUD, WASTE AND ABUSE	EFFECTIVE DATE:	01/30/2007
	LAST REVISION DATE:	07/30/2016
	LAST REVIEW DATE:	07/30/2016

1. PURPOSE

To promote compliance with certain federal and state laws intended to prevent and detect fraud, waste, and abuse in federal and state health care programs.

2. SCOPE

This policy applies to all caregivers, contractors, and agents of Aurora Health Care, Inc. and its affiliates (collectively "Aurora.")

3. DEFINITION

Knowingly means having knowledge, and acting in deliberate ignorance or reckless disregard, of the fact that the claim is false.

4. POLICY

4.1 All Aurora caregivers shall provide health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. No action, whether large or small, will be deemed to be for the benefit of Aurora if it is in violation of any law or regulation.

4.2 Detection and Prevention of Fraud, Waste, and Abuse

(a) Aurora employs various auditing and other techniques, using appropriately credentialed staff and external consultants, to detect and prevent fraud, waste, and abuse.

(b) Every Aurora caregiver has the duty to report any improper conduct, either intentional or unintentional, so that it may be corrected. See the Reporting Compliance Concerns/Non-Retaliation Policy (AHC System Policy #199)

(c) All reported concerns will be taken seriously and will receive prompt attention. Where appropriate, formal investigations will be conducted by the Corporate Compliance & Integrity Department in a discreet, objective, and professional manner.

(d) Routine government audit/information requests, such as Office of the Inspector General audits and Office for Civil Rights information requests must be directed to the Compliance & Integrity Department which will oversee the response. When indicated, an internal audit or investigation will be conducted.

4.3 Federal False Claims Act

(a) The federal False Claims Act imposes liability on any person or entity who Knowingly does any of the following with regard to Medicare, Medicaid, or any other federally funded health care program:

i. Files a false or fraudulent claim for payments;

ii. Uses a false record or statement to obtain payment on a false or fraudulent claim; or

iii. Conspires to defraud to have a false or fraudulent claim paid.

(b) A person or entity found liable under the False Claims Act may be subject to civil monetary penalties of between $5,000 and $10,000 per claim plus three times the amount paid for each claim that is filed that is determined to be false.

(c) Anyone may bring a whistleblower action under the False Claims Act in the name of the United States. The government may choose to participate in the case, and if so, the person who filed the action will receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case. If the government does not participate in the case, the person who filed the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys' fees and costs.

4.4 Program Fraud Civil Remedies Act

(a) 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 False Claims Act. The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:

i. Is false, fictitious, or fraudulent;

ii. Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;

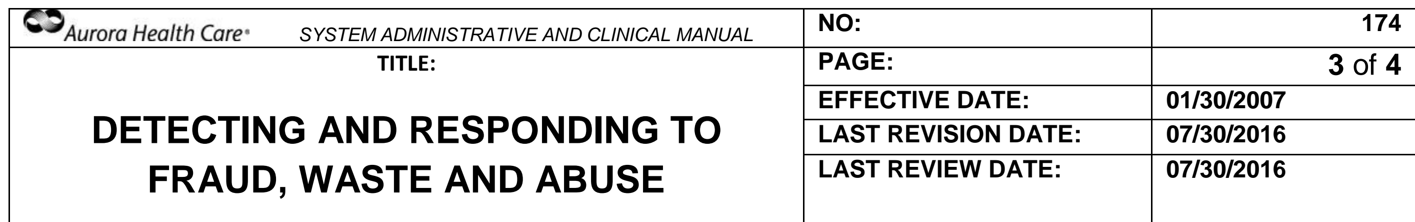
iii. Includes or is supported by a written statement that contains false, fictitious, or fraudulent information, and the person or entity submitting the statement has a duty to include the omitted fact; or

iv. Is for payment for property or services not provided as claimed.

(b) A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully denied claim, plus an assessment of twice the amount of any unlawful claim that has been paid. In addition, a person or entity violates PFCRA if they submit a written statement that they know or should know:

i. Asserts a material fact that is false, fictitious, or fraudulent; or

ii. 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.



(c) 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.

4.5 Wisconsin Medicaid Fraud Statute

(a) Wisconsin's Medicaid fraud statute prohibits any person from:

i. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.

ii. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.

iii. Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial or continued right to Medicaid benefits or receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit is authorized.

iv. Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, Knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.

(b) Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

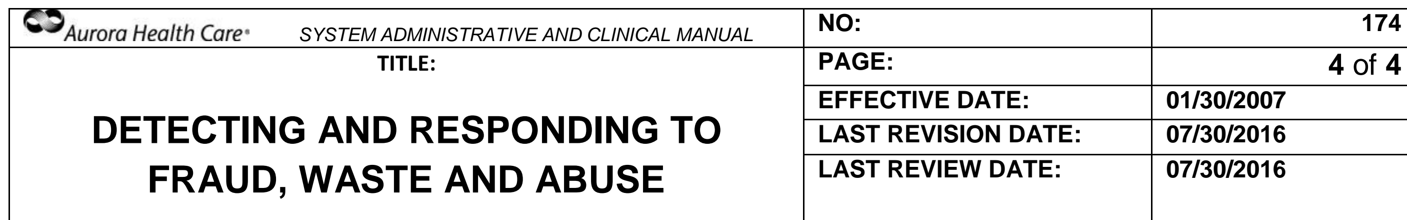
4.6 Non-Retaliation Protections

Aurora Health Care will not intimidate, threaten, coerce, discriminate against, or take any retaliatory action against a caregiver who in good faith and with honest and non-malicious intent reports or threatens to report information about a situation they feel is inappropriate, unethical, or potentially illegal. See REPORTING COMPLIANCE CONCERNS NON-RETALIATION for more detailed information.

4.7 Training

All Aurora caregivers shall complete the annual compliance course related to this policy and other compliance topics.

(a) All caregivers shall complete training on an annual basis, no later than June 30th of each year. Completion of the compliance course is a condition of employment; failure to complete the course by the deadline will result in suspension. If the course is not completed within 7 days following suspension, the caregiver will be considered to have voluntarily resigned.



(b) Newly hired caregivers shall complete training within 30 days of their start date.

5. PROCEDURE

5.1 The annual compliance course is located on Learning Connection, and is named "Compliance and HIPAA [YEAR]."

5.2 Additional guidance can be found in the Aurora *Code of Ethical Conduct*, which can be accessed on the Compliance & Ethics website on Caregiver Connect.

5.3 Any individual with questions about this policy shall contact Aurora's Chief Compliance Officer, Director of Compliance, or any business unit compliance officer. Contact information for these individuals is located on the Compliance and Ethics website.

CROSS REFERENCES:	REPORTING COMPLIANCE CONCERNS NON-RETALIATION GOVERNMENT REQUESTS, INVESTIGATIONS, SEARCH WARRANTS AND SUBPOENAS
REFERENCES:	Deficit Reduction Act of 2005, Sections 6031, 6032 Federal False Claims Act 31 U.S.C. 3729-3733 Program Fraud Civil Remedies Act *31 U.S.C. §§ 3801 – 3812* Wisconsin Medicaid Fraud Statute , s. 49.49(1), Wis. Stats)
PRIOR REVIEW / REVISION DATES:	07/08 04/11 11/13 02/14 07/16