Shadowfax

Title	Organization Fraud Waste and Abuse
Policy Number	ORG.1017.000.000
Initiating Authority	Director of Human Resources
Approved By	Compliance Committee
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Associated Policies	ORG.1015.000.000 Reporting Concerns and No Retaliation
Associated Procedures	
Associated Documents	

I. **POLICY STATEMENT**

The Shadowfax Corporation is dedicated to reducing and/or eliminating incidences of fraud, waste and abuse within Federal and State healthcare programs and relative to Shadowfax responsibilities including the submission of accurate claims to all payers.

II. **PURPOSE**

The purpose of this policy is to communicate Shadowfax's commitment that all its activities will be conducted in a lawful and ethical manner. We will provide services to individuals with disabilities and to the community in a way that complies with all applicable Federal and State laws and regulations; and meets the highest standards of honorable behavior.

No misrepresentations will be made and no intentional false invoices or requests for payment or other documents will be submitted to any Federal, State or Local government agency, healthcare program or payer source. To further this policy, and to comply with bulletins and regulations, Shadowfax provides the following information and guidance.

III. **SCOPE**

This policy applies to all Staff Members, Management Employees (including officers of Shadowfax), Board Members, contractors and agents of The Shadowfax Corporation and of its subsidiaries and affiliates (collectively "Shadowfax").

Note: The term "Individual" is synonymous with resident, client, patient, consumer, or participant.

IV. **GENERAL**

1. The False Claims Act 31 U.S.C. §3729-3733
2. Anti-Kickback Statute 42 U.S.C. §1320a-7b(b)
3. Stark Law
4. Whistleblower Protection 43 Pa. C.S.A. §1421-1428, and whistleblower protections provided under other Federal and State laws
5. Exclusion From Participation 42 CFR Section 455.436
6. Health Insurance Portability and Accountability Act of 1996

V. **POLICY**

Definitions:

FRAUD means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 C.F.R. § 455.2)

Examples include:

- Knowingly billing for services not furnished or supplies not provided.
- Billing for non-existent prescriptions.
- Knowingly altering claim forms, medical records or receipts to receive a higher payment.

WASTE includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls. This could be the overutilization of services or other practices that directly or indirectly results in unnecessary costs.

Examples include:

- Conducting excessive visits or writing excessive prescriptions.
- Prescribing more medications than necessary for the treatment of a specific condition.
- Ordering excessive laboratory tests.

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ABUSE includes any practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to federal payor programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to federal payor programs. (42 C.F.R. § 455.2)

Examples include:

- Unknowingly billing for unnecessary medical services.
- Unknowingly billing for brand name drugs when generics are dispensed.
- Unknowingly excessively charging for services or supplies.
- Unknowingly misusing codes on a claim, such as up-coding or unbundling codes.

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost; but does not require the same intent and knowledge.

To detect Fraud, Waste and Abuse, you need to know the law. The following information will provide high-level information about the following notable laws that address healthcare fraud:

- The False Claims Act
- Anti-Kickback Statute
- Stark Law
- Whistleblower Protection
- Exclusion from Participation
- Health Insurance Portability and Accountability Act of 1996

THE FALSE CLAIMS ACT is a federal law that prohibits any person who knowingly and willfully submits false or fraudulent claims to the government or its contractors, including state Medicaid agencies, for payment or approval. The provision of the False Claims Act makes a person liable to pay damages to the Government if he/she knowingly:

- Presents a false or fraudulent claim for payment or approval.

- Makes or uses a false record or statement supporting a false claim.
- Conceals or improperly avoids or decreases an obligation to pay the Government.
- Carries out other acts to obtain property from the Government by misrepresentation.
- Conspires to violate the False Claims Act.

For more information, refer to 31 U.S.C. §3729-3733

There is no requirement that there be an intent to defraud. The requirement of doing something in a knowing manner is met by showing either actual knowledge, deliberate ignorance of the truth or falsity of the information, or reckless disregard for the truth or falsity of the information.

Damages and Penalties

- Civil Money Penalties increased as of August 1, 2016 to fines between $11,000 - $21,563 per false claim.
- Damages may be tripled.
- If convicted, the individual will be fined, imprisoned, or both. If the violations result in death, the individual may be imprisoned for any term of years or for life, or both.

THE ANTI-KICKBACK STATUTE is a statute that makes it a felony for healthcare professionals, entities, and vendors to knowingly offer, pay, solicit, or receive reimbursement of any kind to induce or reward referrals of business under a healthcare program.

For more information, refer to 42 U.S.C. Section 1320a-7b(b)

Damages and Penalties

- May include a fine up to $25,000, imprisonment up to 5 years per violation and exclusion from participating in certain healthcare programs.

STARK LAW prohibits physicians from referring patients for certain designated health services to an entity with which the physician or member of the physician's immediate family has a financial relationship.

For more information, refer to 42 U.S.C.A. §1395nn

Damages and Penalties

- Include possible exclusion from participation in federal healthcare programs and a monetary penalty of up to $100,000 for each violation.

WHISTLEBLOWER PROTECTION protects "any disclosure of information" by employees, former employees, or member of an organization that "reasonably believes evidences an activity constituting a violation of law, rules, or regulations, or mismanagement, gross waste of funds, abuse of authority or a substantial and specific danger to public health and safety."

It prohibits retaliation such as demotions, pay cuts, suspension threat, harassment or dismissals for blowing the whistle and provides legal remedies to whistleblowers who experience such retaliation. It also allows whistleblowers to make their disclosures confidentially.

For more information, refer to 43 Pa. C.S.A. §1421-1428

EXCLUSION FROM PARTICIPATION is a required screening required by the Department of Human Services' Office of Inspector General 42 CFR Section 455.436. All providers who participate in Medicare, Medicaid or any other federal health care program are required to screen their employees, contractors (vendors), both individuals and entities, as well as board members to determine if they have been excluded from participation in any of the aforementioned programs.

Employees should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT is a federal law that strengthened the protection of healthcare data and promoted standardization and efficiency in the health care industry. HIPAA standards deter unauthorized access to protected healthcare information. HIPAA safeguards sensitive patient health information from being disclosed without the patient's consent or knowledge.

The following types of individuals and organizations are subject to the Privacy Rule and considered covered entities:

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- **Healthcare providers**: Every healthcare provider, regardless of size of practice, who electronically transmits health information in connection with certain transactions. These transactions include claims, benefit eligibility inquiries, referral authorization requests, and other transactions for which HHS has established standards under the HIPAA Transactions Rule.
- **Health plans:** Entities that provide or pay the cost of medical care. Health plans include health, dental, vision, and prescription drug insurers; health maintenance organizations (HMOs); Medicare, Medicaid, Medicare+Choice, and Medicare supplement insurers; and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government- and church-sponsored health plans, and multi-employer health plans.
    - Exception: A group health plan with fewer than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity.
- **Healthcare clearinghouses*:*** Entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa. In most instances, healthcare clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or healthcare provider as a business associate.
- **Business associates:** A person or organization (other than a member of a covered entity's workforce) using or disclosing individually identifiable health information to perform or provide functions, activities, or services for a covered entity. These functions, activities, or services include claims processing, data analysis, utilization review, and billing.

Damages and Penalties

- Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

VI. ENFORCEMENT

Any staff member who violates this policy shall be subject to disciplinary action up to and including termination.

VII. OVERSIGHT

Shadowfax Compliance Committee or their designee(s) (the "Approved By") will be in charge of the administration of this Policy. The Approved By responsibilities include:

1. Identifying the action steps to come into compliance and directives to maintain compliance and implement the action steps.

2. Periodically reviewing this Policy and monitoring compliance to it.

3. Training responsible parties on their obligations under the Policy.

Revision History

Name	Date	Reason for Changes	Version