

**BAYONNE MEDICAL CENTER
ORGANIZATIONAL POLICY MANUAL**

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APPROVED BY PRESIDENT & CEO	PREPARED BY: VP of Audit & Compliance
APPROVED BY VP, AUDIT & COMPLIANCE	SUPERSEDES: 12/7/06; 7/24/09
EFFECTIVE DATE: May 27, 2010	TJC STANDARD(S): --
DISTRIBUTION: Organization-wide	REGULATIONS: Deficit Reduction Act of 2005 – Section 6032 and Various State Regulations referenced in the Policy

PURPOSE

To satisfy the requirements of Section 6032 of the Deficit Reduction Act of 2005 as well as various state regulations by setting forth required information concerning: (1) the federal False Claims Act and other laws pertaining to civil and criminal penalties for false claims; (2) protections against reprisal or retaliation for those who report wrongdoing; and (3) Bayonne Medical Center’s procedures to detect and prevent fraud, waste and abuse.

SCOPE

This policy applies to all directors, officers, administrators, managers, non-management staff, contractors and agents of Bayonne Medical Center and relates to the hospital’s approach to compliance with federal and state laws prohibiting the submission of false or misleading claims to any government agency or payor source (Medicare, Medicaid, etc.)

GENERAL POLICY

It is the policy of Bayonne Medical Center to obey all federal and state laws and to implement and enforce procedures to detect and prevent fraudulent or misleading claims to any government agency or payor.

DISTRIBUTION

This policy shall be distributed to all current Board members, officers, administrators, managers, non-management staff, contractors and agents of Bayonne Medical Center. All contractors and agents of BMC are required to distribute this policy to their respective staff for review. This policy is made accessible to contractors and agents via the hospital’s web site www.bayonnemedicalcenter.org by clicking on “About BMC” and then the Vendor tab on the home page.

EXPLANATION OF LAWS

Set forth below are is a summary of certain statutes that provide liability for false claims and statements. 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.

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FEDERAL FALSE CLAIMS LAWS

Federal False Claims Act (32 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 program;
- 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 program; 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.

A person or entity found liable under the Federal False Claims Act is subject to a civil money penalty of between \$5,000 and \$10,000 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, 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 will be entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys’ fees and costs.

Antidiscrimination: Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by Bayonne Medical Center. The employee is authorized under FCA to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation

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Program Fraud Civil Remedies Act: 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 \$5,000 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.

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.

Anti-Retaliation “Whistleblower” Protections: 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 are provided protections under certain laws.

For example, protections are afforded to people who file *qui tam* lawsuits under the Federal False Claims Act, which is discussed above. The Civil False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a *qui tam* action is entitled to recover damages. He or she is entitled to “all relief necessary to

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make the employee whole,” including reinstatement with the same seniority status, twice the amount of back pay (Plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys’ fees.

BMC’s Code of Conduct and Non-Retaliation Policy(1.25.2) reflects the commitment of the organization to the substance of the above by stipulating that no adverse action or retaliation will be taken against any employee because he/she reports in good faith a suspected violation against federal/state laws, policies etc.

Role of False Claims Laws: The laws described in this policy create a comprehensive basis 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.

As part of its ongoing commitment to ensure BMC’s adherence with federal and state false claim laws, on an annual basis the organization’s internal audit department shall carry out reviews of bills submitted to the government and other third party payers reporting the results of same to management and the Board Compliance Committee. As stated in its Code of Conduct under “Billing for Services”, BMC has implemented policies, procedures and systems to facilitate accurate billing to government, commercial payers and patients. BMC is consistently monitoring and updating policies to keep pace with regulatory changes.

In addition to previously cited statutes, the following is an outline of additional New Jersey major statutory provisions regarding liability for false claims.

Health Care Claims Fraud Act

N.J.S. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5

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

- A practitioner who knowingly 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;

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- A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to 1 year;
- A person who is not a practitioner (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 commits health care claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;
- A person who is not a practitioner is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

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, violations of N.J.S. 30:4D-17(a)-(d) can also result in the following civil sanctions:

- unintentional violations: recovery of overpayments and interest;
- intentional violation or violation of the New Jersey False Claims Act discussed below: recovery of overpayments, interest, up to triple damages, and 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 Medical Assistance and Health Services Act (N.J.S. 30:4D-17)

This law provides for civil and criminal penalties for fraud committed in connection with the NJ Medical Assistance (Medicaid) Program. The Act allows for the imposition of a criminal

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penalty of up to \$10,000 or imprisonment for not more than 3 years or both for willfully obtaining medical assistance benefits to which the person is not entitled or for willfully receiving medical assistance payments to which the provider is not entitled. Providers are also subject to suspension or disqualification from participation in the Medical Assistance Program if found guilty of violation of this Act.

New Jersey False Claims Act, P.L. 2007, Chapter 265

This law has three parts:

- 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;
- another part provides that violations of this statute give rise to liability under the NJ Medical Assistance and Health Services Act; and
- 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.

***Conscientious Employee Protection Act,
“Whistleblower Act”, N.J.S.A. 34:19-4***

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

- discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the
- case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
- provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

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- provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employee or any governmental entity.

- objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
 - is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;

 - is fraudulent or criminal; or

 - is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergency in nature.

Detecting and Responding to Fraud

BMC’s policies and procedures for detecting and preventing fraud are incorporated into its corporate compliance program. This program is based on specific “model program” guidance provided by the Office of Inspector General (OIG), US Department of Health and Human Services. In accordance with the Hospital’s Code of Business Conduct and Ethics document, employees are encouraged to bring to management’s attention any potential violations of its Compliance program and any governmental laws including those referenced above. Questions concerning compliance may be directed to an immediate supervisor, department director, the Human Resources Department or the Corporate Compliance Officer. In addition, if any staff member prefers, they may call the confidential Bayonne Medical Center compliance hotline number at 877-837-4437.

Employees receive information concerning compliance upon orientation, annual education and in the Code of Conduct booklet. The Hospital also has a Compliance Workgroup comprised of Hospital representatives from various departments as well as a Compliance Committee of the Board.