Anti-Fraud Laws and Compliance Program Information

PURPOSE

Bluestone Physician Services (BPS) is committed to preventing and detecting health care fraud, waste and abuse and to complying with the requirements under the Federal Deficit Reduction Act (DRA) of 2005 and other federal and state fraud, waste, and abuse laws. and potential Corporate Integrity Agreements (CIAs). The purpose of this policy is to provide guidance, education and information to all BPS's covered persons* including employees, contractors, and agents, on activities that result in or could result in incidents of fraud, waste, and abuse, i and on the applicable federal and state laws. This policy advises covered persons of their obligation and right to report violations or suspected violations and explains procedures for reporting them.

> * Covered persons include all owners, persons, board members, and employees of BPS; all contractors who furnish patient care items or services or perform billing or coding functions on behalf of BPS, and all physicians and other non-physician practitioners who are members of BPS's active medical staff.

SCOPE

This policy applies to all *covered persons of Bluestone Physician Services, P.A., Bluestone National, LLC, and Bluestone Physician Services Wisconsin, and its subsidiaries and affiliates, (collectively, Bluestone Physician Services (BPS)).

*Covered persons means: (a) all owners who are natural persons, officers, board members, and employees of Provider; (b) all contractors who furnish patient care items or services or perform billing or coding functions on behalf of Provider; and (c) all physicians and other non-physician practitioners who are members of Provider's active medical staff.

POLICY

The purpose of this policy is to comply with certain requirements set forth in Sections 6031 and 6032 of the Deficit Reduction Act of 2005 (DRA) with regard to federal and state false claims laws

Bluestone Physician Services (BPS) is committed to the prevention of fraud, waste, and abuse in its healthcare operation. If BPS discovers compliance deficiencies in our healthcare operations, BPS will take appropriate corrective actions, adjust the affected claims, and refund overpayments to the government and/or private payers as required by law or contract.

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Any person with concerns about practices relating to documentation, coding, and billing is required to report those concerns to a supervisor, manager, or the Corporate Compliance Office.

No employee shall be subject to any reprisals or punishment for good faith reporting of suspected violations of this policy. Federal and state laws also protect employees who report illegal conduct. (see supporting document noting whistleblower protections).

Definitions:

Abuse: practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Contractor or Agent: Any contractor, subcontractor, agent, or other person who furnishes, or otherwise authorizes the furnishing of, health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by BPS.

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

Waste: generally understood to encompass over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

PROCEDURE

I. Examples of Fraud, Waste, and Abuse

Federal and state fraud, waste, and abuse laws support the integrity and quality of medically necessary healthcare services. A summary of key federal and state fraud, waste, and abuse laws is a supporting document to this policy. The following are common examples of high-risk practices that can result in, or constitute, fraud, waste, and abuse:

A. Billing for services that were not rendered.
B. Billing for services that are not medically necessary.
C. Billing an outpatient service as an inpatient service.
D. Billing for services by an improperly supervised or unqualified person.

E. Billing for services performed by a person who has been excluded from participation in a federal or state healthcare program.
F. Billing separately for services already included in a global fee or as a bundled service.
G. Billing a non-covered service as a covered service.
H. Falsifying claims or medical records.
I. Accepting remuneration (cash, gifts, other items) for referrals.

II. Auditing, Monitoring, and Education Program

BPS's Corporate Compliance Department addresses practices that may violate fraud, waste, and abuse laws in coordination with the BPS Legal Counsel and other departments as appropriate. The Corporate Compliance Department works collaboratively with auditors and departments to ensure that a program of auditing and monitoring and education is in place to identify and address those areas at risk for potential fraud, waste, and abuse. This program is designed to:

A. Remediate risks identified through previous monitoring results;
B. Evaluate the sufficiency and accuracy of documentation requirements;
C. Assess compliance with coding and billing rules and other regulations;
D. Evaluate contractual agreements and other arrangements for compliance with physician self-referral laws and the Anti-Kickback statute; and
E. Identify and address opportunities for improvement through education.

III. Reporting

A. BPS strongly encourages any person who knows or suspects a violation of federal or state fraud, waste, and abuse laws to report their concerns to a supervisor, a manager, a department head or chair, the Corporate Compliance Department, the BPS hotline at 800-928-0084 (Organization pin: 131274 / site ID: 1) or submit a hotline report online at Complyline.

B. Reports to the hotline may be made anonymously if desired. Confidentiality will be observed to the greatest extent possible.

C. Leaders who receive a report of alleged fraud, waste, and abuse are expected to contact the Corporate Compliance Department immediately.

IV. Investigations

A. The Corporate Compliance Department investigates all allegations of fraud, waste, and abuse.

B. All persons will cooperate with such investigations by responding promptly, completely, and accurately to any requests by the Corporate Compliance Department or any other person responsible for performing an investigation.

C. Any BPS employees who fail to cooperate are subject to disciplinary action consistent with the Human Resource Policy.

D. Any person who makes a good faith reporting about potential fraud, waste, and abuse is protected from retaliation by state and federal whistleblower protections. The supporting document (Summary of Federal and State and Abuse Laws) attached to this policy summarizes these retaliation (whistleblower) protections.

V. Training

BPS will provide training to all new employees at their time of hire, and annually to existing employees, regarding its compliance program; including the obligation of all employees to promptly report any suspected compliance issues as well as any potential False Claims. Such training will include information regarding the False Claims Act (see supporting document) and procedures for reporting matters.

VI. Discipline/Penalties

A. BPS Disciplinary Action

1. Employees who are determined to have engaged in a violation of this policy will be subject to disciplinary action.

2. Vendors and contractors who violate this policy may be subject to revocation of their contract or termination of their business relationship with HHS.

B. Civil Penalties

1. Any person who violates the False Claims Act (see supporting document) may be liable for a civil penalty for each violation and up to three times the government's damages.

2. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in federal healthcare programs.

C. Rights of Private Persons to File Lawsuits

1. The False Claims Act also allows a private person to file a lawsuit on behalf of the federal government. This person, also called a whistleblower or relator, must file his or her lawsuit under seal in a federal district court.

a. The government may decide to intervene with the lawsuit, in which case the United States Department of Justice will direct the prosecution.

b. If the government decides not to intervene, the person may still continue the lawsuit independently.

2. If a lawsuit is successful, the person may receive between 10 to 30% of the recovery, depending on the government's participation and other factors, as well as reasonable attorney's fees and costs. In addition, there can be no retaliation against the person for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

ENFORCEMENT

All staff whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination.

RESOURCES

Deficit Reduction Act of 2005, Sections 6031;
Federal False Claims Act – 31 U.S.C. Sections 3729 - 3733 et seq;
Program Fraud Civil Remedies Act – 31 U.S.C., Section 3801, et seq.;
Anti-Kickback Statute - 42 U.S.C. § 1320a-7b(b);
Physician Self-Referral Law (Stark Law) -42 U.S.C. § 1395nn;
Civil Monetary Penalties Law - 42 U.S.C. § 1320a-7a;
The Civil Monetary Penalties (CMP) Law (42 U.S.C. § 1320a-7a):
Minnesota False Claims Act – Minnesota Statutes Section 15C.01 et seq;
Minnesota Medicaid Fraud Statute – Minnesota Statutes Section 256B.064;
Minnesota Whistleblower Protection Law – Minnesota Statutes Section 181.932;
Florida False Claims Act, Fla. Stat. 68.081-68.092;
Florida Anti-Kickback Statute – § 456.054, Fla. Stat.;
Florida Patient Brokering Act, Florida Statute § 817.505. Florida Self-Referral Act (Florida Stark Law) Florida Statute §456.053;
Wisconsin Statutes Section 49.49 (Wisconsin Fraud Statute);
Wisconsin Statutes Section 146.997 (Wisconsin Whistleblower statute)

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Approval History

Date (MM/YYYY)	Stakeholders	Name/Title
8/9/24	Exec. Compliance Committee	Approved at 8/9/24 ECC meeting

Revision History

Date (MM/YYYY)	Revisions	Name/Title	Version
7.29.24	Original	Compliance Officer	V1.0
7.31.24	Incorporate Redline version from Genco	Nanc MacLeslie, Compliance Team	V1 Draft

SUPPORTING DOCUMENTS

Summary of Federal and State Fraud, Waste, and Abuse Laws

Summary of Federal and State Fraud and Abuse Laws

Federal False Claims Act (FCA): A federal law, 31 U.S.C. Section 3729 – 3733 et seq, that imposes liability on those who commit acts of fraud against the government. Under the FCA, liability occurs when any person who knowingly submits a false claim to the government or causes another person to submit a false claim to the government, or knowingly makes a false record or statement to get a false claim paid by the government. In addition, the FCA also covers "reverse false claims." A reverse false claim occurs when a person acts improperly to avoid having to pay money to the government. To violate the FCA, a person has knowledge of the falsity of the claim. Knowledge of false information is defined as (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the information.

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A person found liable under the FCA is subject to a civil penalty of between $5,500 to $11,000 for each false claim, and triple the amount of the government's damages. The FCA applies to any federally funded program, including Medicare and Medi-Cal (Medicaid), and TRICARE. The FCA also allows for qui tam actions and provides protection from retaliation for whistleblowers:

1. **Qui Tam Action**: Occurs when a private person files suit for violations of the FCA on behalf of the government. The person bringing the action is referred to as a "relator" under the law, and also may be referred to as a "whistleblower." If the government decides to intervene in the qui tam action, the relator is entitled to receive between 15 – 25% of the amount recovered by the government. If the government declines to intervene, the relator's share is increased to 25 – 30% of the recovery.

2. **Whistleblower Protections**: The federal False Claims Act also contains a provision that protects a whistleblower against retaliation. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of having brought forward a lawful false claims action. The whistleblower may bring suit in an appropriate district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages, such as litigation costs and reasonable attorney's fees.

The Anti-Kickback Statute: A federal law that makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration includes anything of value such as cash, free rent, expensive hotel stays, meals, and excessive compensation for medical directorships or consultancies. Acceptable arrangements must meet certain regulatory safe harbors. Civil penalties for a violation of this statute may include up to $50,000 per kickback plus three times the amount of the kickback. Criminal penalties may include fines, imprisonment, or both.

The Civil Monetary Penalties (CMP) Law: A law that imposes CMPs for a variety of healthcare fraud violations and different amounts of penalties and assessments that may be authorized based on the type of violation. Penalties range from $10,000 to $50,000 per violation. CMPs can also be assessed up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received.

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The Exclusion Statute: A statute that requires the Department of Health and Human Services' Office of the Inspector General (OIG) to impose exclusions from participation in all federal healthcare programs on healthcare providers and suppliers who have been convicted of:

1. Medicare fraud as well as any other offenses related to the delivery of items or services under Medicare;
2. Patient abuse or neglect;
3. Felony convictions for other healthcare-related fraud, theft, or other financial misconduct; or
4. Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The Physician Self-Referral Law (Stark Law): A law that prohibits a physician from making a referral for certain designated health services to an entity in which the physician or an immediate family member has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties include fines and exclusion from participation in all federal healthcare programs.

Minnesota:

MN False Claims Act: Minnesota has statutes modeled on the federal False Claims Act, which apply to the same types of conduct and contain similar penalty provisions, qui tam provisions, and whistleblower protections. The Minnesota False Claims Act (Minnesota Statutes Section 15C.01 et seq.) applies generally to claims submitted to the state, including the Medicaid agency, or a state contractor.

MN Medicaid Fraud Statutes: Minnesota has other laws that specifically provide for sanctions for false claims or false statements in connection with the provision of medical services reimbursed by the state. Minnesota law provides for administrative sanctions including fines and suspension or termination from participation in the program (Minnesota Statutes Section 256B.064).

MNWhistleblower Protection Laws: Minnesota has other laws that prohibit retaliation or discrimination against employees who report in good faith violations of any federal or state law or regulation or situations in which the quality of care provided by a healthcare facility or provider violates established standards and poses a potential risk to public health or safety. (Minnesota Statutes Section 181.932).

Florida:

The Florida False Claims Act (FFCA) is patterned after the federal FCA. In 2013, Florida amended its own act with the specific intent to conform to recent changes to the federal FCA. Thus, both statutes are in conformity and help facilitate dual prosecution and enforcement by state and federal agencies. However, the FFCA prohibitions apply to claims paid by instrumentalities of the state which include instrumentalities of all three branches of state government and local entities with budgetary autonomy such as counties, local municipalities, school districts, water management district and Public Service Commission. The Attorney General may file a lawsuit directly, or a private individual may begin a qui tam suit on behalf of the state by notifying and providing all material evidence to the Attorney General and Chief Financial Officer and filing a sealed complaint in the Second Judicial Circuit in and for Leon County. State officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist or participate in an action under the FFCA are protected from workplace retaliation. Florida contains an additional whistleblower statute that provides a reward to a person who reports a violation of the state's Medicaid fraud laws. The Florida Medicaid Provider Fraud Laws provides criminal penalties and fines for false statements or representations, among other things, made to the Medicaid program. This statute establishes grounds for criminal actions against any person who knowingly defrauds the state Medicaid program. A violation constitutes either a first, second or third degree felony, depending upon the monetary amount of the false claim at issue, and also subjects the violator to a mandatory statutory fine. This statute is prosecuted by state officials and may not be brought by private individuals and provides the individual who furnishes original information about the fraud the lesser of 25% of the amount recovered or $500,000.

Wisconsin:

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The Wisconsin **False Claims Act** (Wisconsin Statutes Section 20.931) applies specifically to Medicaid claims submitted to the state or an agent of the state.

Fraud Statute: Wisconsin law provides for criminal sanctions and recovery of damages equal to three times the amount of actual damages (Wisconsin Statutes Section 49.49).

WhistleBlower: Wisconsin has other laws that prohibit retaliation or discrimination against employees who report in good faith violations of any federal or state law or regulation or situations in which the quality of care provided by a healthcare facility or provider violates established standards and poses a potential risk to public health or safety. (Wisconsin Statutes Section 146.997).

[1]

Approval History

Date (MM/YYYY)	Stakeholders	Name/Title
8/9/24	Executive Compliance Committee	Approved at Auguest ECC meeting

[1] Prepared at the direction, request, and in furtherance of the purposes of a review organization and any and all information and documentation prepared in furtherance of this policy is confidential and should not be shared outside of Bluestone Physician Services or its Affiliates. Protected under Wis. Stat. 146.38 and Minn. Stat. 145.61et seq. and FL Stat 766.101. The information contained herein is provided for informational purposes only and does not constitute legal, medical, or professional advice. Further, these policies and procedures are subject to change without prior notice, and Bluestone makes no representation to reliance on users of outdated information. Users should check back here for updates regularly.