

	POLICY AND STANDARDS
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Corporate Policy Applicability:

Magellan BH (M) NIA (N) ICORE (I) Magellan Medicaid Administration (A)

Corporate Policy:

Policy Number:	COM.1916.04.(M)-(N)-(I)-(A)
Policy Name:	False Claims Laws and Whistleblower Protections
Date of Inception:	January 1, 2007
Previous Approval Date:	December 07, 2009
Current Approval Date:	August 31, 2011

Corporate Policy Approvals:

John J. DiBernardi, Jr., Esq.	<i>Approval on file</i>	08-31-2011
Magellan Health Services, Corporate Compliance Officer		Date
Dan Gregoire, Esq.	<i>Approval on file</i>	08-31-2011
Magellan Health Services, Executive Vice President, General Counsel		Date

Cross Reference(s)

None

Policy Statement

The properly licensed affiliates and subsidiaries of Magellan Health Services, Inc. (Magellan) are subject to both federal and state laws designed to prevent fraud and abuse in government programs including Medicare and Medicaid and in federally funded contracts. Magellan, in conjunction with the appropriate government agencies, actively pursues all suspected fraud and abuse. As part of Magellan's corporate compliance program for the prevention of fraud, waste and abuse, Magellan complies with all state and federal requirements for government-sponsored programs and federally funded contracts, including the Federal False Claims Act, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act [PPACA] of March 2010, applicable Whistleblower Protection laws, and any state false claims statutes.

Purpose

The purpose of this policy is to identify the requirements of the Federal False Claims Act, the administrative remedies for false claims and statements and any applicable state laws pertaining to civil or criminal penalties for false claims and statements, including the remedies and whistleblower protections under these laws.

Scope

<input checked="" type="checkbox"/> Account Management	<input checked="" type="checkbox"/> EAP	<input checked="" type="checkbox"/> Marketing/Comm/Sales
<input checked="" type="checkbox"/> Claims (Service Ops)	<input checked="" type="checkbox"/> Employer Solutions	<input checked="" type="checkbox"/> Medicaid
<input checked="" type="checkbox"/> Clinical Operations	<input checked="" type="checkbox"/> Finance	<input checked="" type="checkbox"/> Medicare
<input checked="" type="checkbox"/> Compliance	<input checked="" type="checkbox"/> Health Plan Solutions	<input checked="" type="checkbox"/> Network
<input checked="" type="checkbox"/> CCM	<input checked="" type="checkbox"/> Human Resources	<input checked="" type="checkbox"/> Public Sector Solutions
<input checked="" type="checkbox"/> Credentialing/Recred	<input checked="" type="checkbox"/> Information Technology	<input checked="" type="checkbox"/> Quality Improvement
<input checked="" type="checkbox"/> Customer Service	<input checked="" type="checkbox"/> Legal	<input checked="" type="checkbox"/> Security

Key Terms

Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in MagNet, click on the below link: (*internal link(s) available to Magellan Health Services employees only*)

[Policy Terms & Definitions Glossary](#)

Standards

- I. Federal False Claims Act, 31 USC § 3279
 - A. The Federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs.
 - B. The act establishes liability for any person who:
 1. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
 2. Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
 3. Conspires to commit a violation of any of the provisions of the False Claims Act as outlined under Standard I.B.: 1., 2., 4., 5., 6., or 7. in this policy.
 4. Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
 5. Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
 6. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
 7. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.
 - C. For purposes of the False Claims Act, a “claim” includes any request or demand for money that is submitted to the Federal government or its contractors and subcontractors. Examples of false claims and false statements include, but are not limited to the following:
 1. Billing for services or procedures that have not been performed;
 2. Submitting false information about the services performed or the charges for services performed;
 3. Inserting a diagnosis code that has not been obtained from a physician or other authorized individual;
 4. Misrepresenting the services performed (for example, up-coding to increase reimbursement);
 5. Violation of another law. For example, a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals); and

6. Submitting claims for services ordered by a provider that has been excluded from participating in Medicare, Medicaid and other federally funded healthcare programs and federally funded contracts.
- D. For purposes of the False Claims Act, an electronic claim in the health care context is submitted using the HIPAA 837P for physician claims and the 837I for institutional claims.
 - If paper claims are submitted, then these claims would be submitted via Centers for Medicare and Medicaid Services Forms (CMS) UB-92 and the hospital cost report Form CMS 2552-96 for Part A services, and Form CMS 1500 for Part B services.
 - E. The statute of limitations under the Federal False Claims Act is six (6) years after the date of violation or three (3) years after the date when material facts are known or should have been known by the government, but no later than ten (10) years after the date on which the violation was committed.
- II. Liability under the Federal False Claims Act
- A. Persons and organizations (including health care providers and contractors) that violate the False Claims Act can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted.
 - B. In addition to a civil penalty, violators can be required to pay three times the amount of damages sustained by the U.S. government.
 - C. If a person or organization is convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude or suspend that person or organization from participation in federal health care programs.
- III. Qui Tam (Whistleblower) Provisions under the Federal False Claims Act
- A. To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a “qui tam” or “whistleblower” provision.
 - B. This provision essentially allows any person with actual knowledge of false claims activity to file a law suit on behalf of the U.S. government.
 - C. Such persons are referred to as “relators”. Relators who seek whistleblower status are subject to the following:
 1. Original Source
 - a) To prevail under a lawsuit, the relator must be the original source of the information reported to the federal government.
 - b) Specifically, the relator must have direct and independent knowledge of the false claims activities and voluntarily provide this information to the government.
 - c) If the matter disclosed is already the subject of a federal investigation, or if the health care provider, supplier or entity alleged to have violated the False Claims Act has previously disclosed the problem to a federal agency, the relator may be barred from obtaining a recovery under the False Claims Act.
 2. Whistleblower Procedures

- a) The relator must file his or her lawsuit in a federal district court.
 - b) The lawsuit will be filed under seal meaning that the lawsuit is kept confidential while the government reviews and investigates the allegation contained in the lawsuit and decides how to proceed.
3. Rights of Parties of Whistleblower Actions
- a) If the government determines that the lawsuit has merit and decides to join/ intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice.
 - At this point, the government will be the plaintiff or party suing the health care provider.
 - b) If the government decides not to intervene, the relator can continue with the lawsuit on his or her own.
4. Award to Whistleblowers
- a) If the lawsuit is successful, the relator may receive an award ranging from fifteen (15) to thirty (30) percent of the amount recovered by the government.
 - b) The relator may also be entitled to reasonable expenses, including attorney's fees and costs for bringing the lawsuit.
 - c) The False Claims Act entitles relators to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a relator for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim, providing testimony, or assisting in a False Claims Act action.

D. No Retaliation

1. Magellan does not retaliate against an employee for reporting or bringing a civil suit for a possible False Claims Act violation.
2. Magellan does not discriminate against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a False Claims Act action.
3. Magellan does not retaliate against any of its agents and contractors for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority.
4. Federal and state law also prohibits Magellan from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a False Claims Act action.

IV. Administrative Remedies for False Claims and Statements, 31 U.S.C. § 3802

- A. Under the Federal Program Fraud Civil Remedies Act, any person/organization that makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know is false, fictitious, or fraudulent shall be subject

- to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than \$5,500 for each such claim.
- B. Further, such person or organization shall also be subject to an assessment, in lieu of damages sustained by the Federal Government because of such claim, of not more than two times the amount of such claim.
 - C. A determination of liability under this section permits the OIG to seek to suspend or exclude any person who is eligible to enter into contracts with the federal government from participation in federal health care programs.
- V. The American Recovery and Reinvestment Act of 2009 (ARRA)
- A. “Covered funds” means any contract, grant, or other payment received by Magellan if:
 - 1. The Federal Government provides any portion of the money or property that is provided, requested, or demanded; and
 - 2. At least some of the funds are appropriated or otherwise made available by ARRA.
 - B. No Retaliation
 - 1. Magellan receives covered funds under ARRA through its contracts directly with state Medicaid agencies and as a subcontractor through its contracts with other entities that have contracts with state Medicaid agencies such as Medicaid Managed Care Organizations. Magellan also receives covered funds under ARRA through its contracts with the federal government and other federally funded EAP contracts.
 - 2. An employee of Magellan may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing, including a disclosure made in the ordinary course of an employee’s duties, to the Board, an inspector general, the Comptroller General, a member of Congress, a State or Federal regulatory or law enforcement agency, a person with supervisory authority over the employee (or such other person working for the employer who has the authority to investigate, discover, or terminate misconduct), a court or grand jury, the head of a Federal agency, or their representatives, information that the employee reasonably believes is evidence of:
 - a) Gross mismanagement of an agency contract or grant relating to covered funds;
 - b) A gross waste of covered funds;
 - c) A substantial and specific danger to public health or safety related to the implementation or use of covered funds;
 - d) An abuse of authority related to the implementation or use of covered funds; or
 - e) A violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) or grant, awarded or issued relating to covered funds.
 - 3. An employee who believes that he or she has been subjected to a reprisal prohibited by Standard V.B.2, may submit a complaint regarding the reprisal to the appropriate inspector general.

VI. The Patient Protection and Affordable Care Act [PPACA] of March 2010

- A. The PPACA links the retention of program overpayments to potential liability under the False Claims Act. Under Section 6502, retained overpayments are also grounds for program exclusion. Furthermore, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan or Medicare.
- B. Section 6402 (d): REPORTING AND RETURNING OF OVERPAYMENTS.—42 USCS § 1320a-7k
1. Failure to report and repay any overpayment within the timeframe outlined (in Section 6402) below may result in a violation of the False Claims Act, civil monetary penalty, or other penalties.
 2. In general, if a person has received an overpayment, the person shall:
 - a) Report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
 - b) Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
 3. An overpayment must be reported and returned by the later of:
 - a) The date which is sixty (60) days after the date on which the overpayment was identified; or
 - b) The date any corresponding cost report is due, if applicable.
 4. Enforcement: Any overpayment retained by a person after the deadline for reporting and returning the overpayment is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of the False Claims Act.
 5. Definitions:
 - a) Knowing and knowingly. The terms "knowing" and "knowingly" have the meaning given those terms in section 3729(b) of title 31, United States Code.
 - b) Overpayment. The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX [42 USCS §§ 1395 et seq. or 1396 et seq.] to which the person, after applicable reconciliation, is not entitled under such title.
 - c) Person. In general. The term "person" means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A) [42 USCS § 1396b(m)(1)(A)]), Medicare Advantage organization (as defined in section 1859(a)(1) [42 USCS § 1395w-28(a)(1)]), or PDP sponsor (as defined in section 1860D-41(a)(13) [42 USCS § 1395w-151(a)(13)]). Such term does not include a beneficiary.
- C. Section 6402(f): HEALTH CARE FRAUD.—42 USCS § 1320a-7b
1. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act pursuant to Section 6402(f).

2. Kickbacks. In addition to the penalties provided for in this section or section 1128A [42 USCS § 1320a-7a], a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [31 USCS §§ 3721 et seq.].
- D. Section 6502: MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS. 42 USCS § 1396a - State plans for medical assistance
1. Unpaid overpayments are also grounds for program exclusion. Furthermore, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan or Medicare.
 2. A State plan for medical assistance must provide that the State agency, the State health agency, or other appropriate State medical agency exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that):
 - a) Has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;
 - b) Is suspended or excluded from participation under or whose participation is terminated under this title during such period; or
 - c) Is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period.
- VII. State False Claims Acts
- A. State False Claim Acts are state-level extensions of the Federal False Claims Act and generally stipulate that those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds can be held liable for the government's damages plus civil penalties.
 - B. Similar to the Federal False Claims Act, State False Claims Acts contain qui tam, or whistleblower provisions that allow citizens with evidence of fraud against government contracts and programs to sue in state court on behalf of the government in order to recover the stolen funds - a portion of which may be awarded to the whistleblower.
 - C. Various states in which Magellan does business have enacted false claims acts. Please see our Magellan Health Services website www.magellanhealth.com for summaries of State False Claim Acts or by contacting the Compliance Hotline at (800) 915-2108 or emailing us at compliance@Magellanhealth.com. Internally, a summary of the State False Claims Acts can be accessed on our MagNet intranet site.

Associated Corporate Forms & Attachments (internal link(s) available to Magellan Health Services employees only)

[State False Claims Laws](#)

Magellan Deficit Reduction Act Compliance Statements (Internal and External versions)

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