POLICY

Gwinnett Health System, Inc. (GHS), and each of its subsidiaries that provide patient care services, including Gwinnett Hospital System, Inc., Gwinnett Medical Services, Inc., and Gwinnett Physician Group, LLC, are committed to honesty, accuracy and integrity in all patient charging, coding, billing and documentation activities. It is the policy of GHS to obey the law and to work to stop and eliminate waste, fraud and abuse with respect to payments to GHS from federal or state programs providing payment for patient care. This policy applies to all GHS colleagues including board members, officers, physicians, volunteers, contracted employees, agents and associates of GHS.

This policy includes information concerning tools federal and state agencies use to fight fraud, waste and abuse in the administration of federal and state health programs at GHS: Specifically, it addresses the following:

- A summary of the Federal False Claims Act, including a summary of administrative remedies found in the Program Fraud Civil Remedies Act and the Deficit Reduction Act.
- A summary of laws of the state of Georgia addressing fraud and abuse and training requirements on policies and procedures.
- The role of such laws in preventing and detecting fraud, waste, and abuse in federal and state health care programs.
- GHS commitment to charging, coding and billing compliance, and existing GHS policies and procedures for detecting and preventing fraud.

DEFINITIONS

A. APPLICABLE LAW

1. The Federal False Claims Act (FCA) (31 USC § 3279 through 3733)
   a. Summary of Provisions: The FCA prohibits knowingly making a false claim against the government. False claims can take the form of overcharging for a product or service, delivering less than the promised amount or type of service, delivering less than the promised amount or type of goods or services, underpaying money owed to the government and charging for one thing while providing another.
   b. Penalties: The FCA imposes civil penalties and is not a criminal statute. Therefore, no proof of specific intent as required for violation of a criminal statute is necessary. Persons (including organizations such as hospitals) may be fined a civil penalty of not less than $5,000 nor more than $11,000, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages in health care terms is the amount paid for each false claim that is filed.
   c. Qui Tam (Whistleblower) Provisions. Any person may bring an action under this law (called a qui tam realtor or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served
on the defendant so the government can investigate the complaint. The government may obtain additional time to investigate for good cause. The government on its own initiative may also initiate a case under the FCA. After the 60 day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court. If the government proceeds with the case, the qui tam relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, and the qui tam relator successfully prosecutes the claim, the relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorneys fees and costs. Any case must be brought within six years of the filing of the false claim.

d. Non-Retaliation: Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer by virtue of bringing the claim. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.

2. Program Fraud Civil Remedies Act
   The Program Fraud Civil Remedies Act creates administrative remedies for making false claims separate from and in addition to, the judicial or court remedy for false claims provided by the Civil False Claims Act. The Act is quite similar to the Civil False Claims Act in many respects, but is somewhat broader and more detailed, with differing penalties. The Act deals with submission of improper “claims” or “written statements” to a federal agency. Specifically, a person violates this act if they know or have reason to know they are submitting a claim that is:
   • False, fictitious or fraudulent; or,
   • Includes or is supported by written statements that are false, fictitious or fraudulent; or,
   • Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to include the omitted facts; or
   • For payment for property or services not provided as claimed.

   A violation of this prohibition carries a $5,000 civil penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid. A person also violates this act if they submit a written statement which they know or should know:
   • Asserts a material fact which is false, fictitious or fraudulent; or,
   • Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

   A violation of the prohibition for submitting an improper statement carries a civil penalty of up to $5,000.

3. Deficit Reduction Act of 2005, Section 6032, Employee Education About False Claims Recovery (DRA). Under the DRA, GHS is required to establish policies and procedures that provide information on the following laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal healthcare programs:
   b. Federal administrative remedies for false claims and statements.
   c. State laws pertaining to civil or criminal penalties for false claims or statements Whistleblower protections under such laws.
The DRA also requires organizations to include a discussion of these laws and the organization’s procedures for preventing fraud, waste and abuse in the entity’s employee handbook. At GHS, this discussion is included in the GHS Code of Conduct.

B. Georgia Anti-Fraud Laws and Training Requirements Related to Health Care
   1. O.C.G.A § 49-4-146.1. Unlawful to obtain benefits and payments under certain circumstances; penalties; procedures. This Georgia statute can be described as Georgia’s Medicaid Unlawful Payment Statute. Only part of the statute is included in this policy. O.C.G.A. 49-4-146.1 (b) provides that it shall be unlawful:
      a. For any person or provider to obtain, attempt to obtain, or retain for himself, herself, or any other person any medical assistance or other benefits or payments under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by:
      b. Knowingly and willfully making a false statement or false representation;
         • Deliberate concealment of any material fact; or
         • Any fraudulent scheme or device; or
         • For any person or provider knowingly and willfully to accept medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled, or knowingly and willfully to falsify any report or document required under this article.
      Any person violating paragraph (a) or (b) shall be guilty of a felony and, upon conviction thereof, shall be punished for each offense by a fine of not more than $ 10,000.00, or by imprisonment for not less than one year nor more than ten years, or by both such fine and imprisonment. The statute is a criminal statute and, the state has the burden of proving beyond a reasonable doubt that the defendant intentionally committed the acts for which he or she is charged. In addition to criminal penalties, any person committing abuse shall be liable for a civil monetary penalty equal to two times the amount of any excess benefit or payment.

      “Abuse” is defined in the statute as a provider knowingly obtaining or attempting to obtain medical assistance or other benefits or payments under this article to which the provider knows he or she is not entitled …. and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program.” Isolated instances of unintentional errors in billing, coding, and costs reports shall not constitute abuse. Miscoding shall not constitute abuse if there is a good faith basis that the codes used were appropriate under the department's policies and procedures manual and there was no deceptive intent on the part of the provider.

      In addition to any other penalties provided by law, each person violating this law shall be liable for a civil penalty equal to the greater of (1) three times the amount of any such excess benefit or payment or (2) $ 1,000.00 for each excessive claim. Additionally, interest on the penalty shall be paid at the rate of 12 percent per annum.

   2. STATE FALSE MEDICAID CLAIMS ACT , O.C.G.A. §§ 49-4-168 to 49-4-168.6
(Only part of the statute is included in this policy.) Similar to the Federal False Claims Act, the state of Georgia has **Civil penalties for false or fraudulent Medicaid claims for any person who:**

a. **Knowingly presents** or causes to be presented to the Georgia Medicaid program a **false or fraudulent claim** for payment or approval;
b. **Knowingly makes**, uses, or causes to be made or used, a false record or statement **to get a false or fraudulent claim paid** or approved by the Georgia Medicaid program;
c. **Conspires to defraud** the Georgia Medicaid program by getting a false or fraudulent claim allowed or paid;
d. **Has possession, custody, or control of property or money used**, or to be used by the Georgia Medicaid program and, intending to defraud the Georgia Medicaid program or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate of receipt;
e. Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the Georgia Medicaid program and, **intending to defraud the Georgia Medicaid program**, makes or delivers the receipt without completely knowing that the information on the receipt is true;
f. **Knowingly buys, or receives as a pledge of an obligation or debt, public property** from an officer or employee of the Georgia Medicaid program, who lawfully may not sell or pledge the property; or
g. **Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay, repay or transmit money or property to the State of Georgia,**

Any person violating paragraphs a-g shall be liable to the State of Georgia for a civil penalty of not less than $5,500.00 and not more than $11,000.00 for each false or fraudulent claim, plus three times the amount of damages which the Georgia Medicaid program sustains because of the act of such person. The provisions of this Code section notwithstanding, if the court finds that:

- The person committing the violation of this subsection furnished officials of the Georgia Medicaid program with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
- Such person fully cooperated with any government investigation of such violation; and
- At the time such person furnished the Georgia Medicaid program with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this article with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not more than two times the amount of the actual damages which the Georgia Medicaid program sustained because of the act of such person.

A person violating any provision of this Code section shall also be liable to this state for all costs of any civil action brought to recover the damages and penalties provided under this article.

3. Georgia has a **Patient Self Referral Act** which, while similar to the federal Stark law in some ways, it is significantly different in terms of when it applies and to whom it applies. It can be found at **O.C.G.A. § 43-1B-1**. It is not included in this policy since it addresses more financial arrangements and investment interest issues by physicians.
4. **GA Hospital Lisensure Rules 290-9-7-.12 Human Resources Management.** Georgia hospital licensing regulations require hospitals to train its employees on the hospital’s policies and procedures. Specifically, GA ADC 290-9-7.12 pertains to personnel training programs and provides that:

   Personnel Training Programs. The hospital shall have and implement a planned program of training for personnel to include at least:
   - Hospital policies and procedures;
   - Fire safety, hazardous materials handling and disposal, and disaster preparedness;
   - Policies and procedures for maintaining patients' medical records;
   - The infection control program and procedures; and
   - The updating of job-specific skills or knowledge.

5. **GA Hospital Lisensure Rules 290-9-7-.41 Enforcement of Rules and Regulations.** Georgia’s hospital licensing regulations also contains enforcement provisions. GA ADC 290-9-7.41 provides “A hospital that fails to comply with these rules and regulations shall be subject to sanctions and/or permit revocation as provided by law. The enforcement and administration of these rules and regulations shall be as prescribed in the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6, pursuant to O.C.G.A. Sec. 31-2-6.”

C. **The Role of Such Laws in Preventing and Detecting Fraud, Waste, and Abuse in Federal and State Health Care Programs.** The laws described in this policy create a comprehensive process 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 address the fraud and abuse problem. Moreover, whistleblower protections, such as those included in the DRA, Federal False Claims Act and the State False Medicaid Claims Act, provide protections for individuals reporting fraud and abuse in good faith.

D. **GUIDELINE/PROCESS/PROCEDURE**

1. **Commitment to Charging, Coding and Billing Compliance**
   a. Maintain honest and accurate records of all charging, coding, and billing activities.
   b. We are committed to both accurate billing and submission of claims only for services that are actually rendered and medically necessary.
   c. We will not file a claim for services that were not rendered or were not rendered as described on the claim form.
   d. We will ensure that diagnoses are properly coded and that they are supported by medical necessity requirements.
   e. We will not use diagnostic information provided by a physician from earlier dates of services, unless conforming to approved standing orders.
   f. We are committed to ensuring that bills submitted for payment are properly coded, documented and billed in accordance with all applicable laws, regulations, guidelines and policies.
   g. We will research all credit balances and refund any money received that is not due to us in a timely manner.
   h. We will promote and adhere to the goal of full and accurate compliance with all laws and regulations.
   i. We will not submit any claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, incomplete or fictitious.
i. We will bill for services using only charge codes that accurately describe the services that were provided. If inaccuracies are discovered in bills that have already been sent, we will take immediate steps to alert the payer and correct the bill in accordance with the payer’s guidelines and requirements.

j. We will submit claims only for services and supplies ordered by a physician or other authorized person and provided to the patient.

k. Insufficient documentation to support the services provided is perhaps the most common reason for Medicare to deny or delay reimbursement. Physicians, nurses, and other practitioners must complete medical records and other documentation to prove that they provided items or services.

l. We will take particular care to avoid improper or illegal billing and coding practices such as upcoding, unbundling, or inappropriate use of modifiers.

2. Processes to Ensure Accurate Charging, Coding and Billing

a. The GHS Billing and Coding Compliance Committee monitors coder education and qualifications, and reviews documentation practices to assure that claims are based on complete medical records and that the medical records support the levels of service claimed.

b. GHS departments/subsidiaries assigned responsibility for charging, billing or coding will regularly review and become familiar with the Medicare Administrative Contractor (MAC)s, local coverage determinations (LCD) and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs). LCDs and NCDs are incorporated into GHS coding and billing operations.

c. The Revenue Management Department has responsibility for assuring the GHS coding software includes up-to-date NCCI edit files.

d. The Revenue Management Department and applicable departments are responsible for ensuring the charge description master is up-to-date, that the modifiers are appropriately used, and that the correct associations between procedure codes and revenue codes exist.

e. Departments/subsidiaries that provide outpatient services are responsible for ensuring that services provided are medically necessary and sufficiently documented to accurately reflect the intensity of resources utilized. Managers are responsible for reviewing and ensuring compliance with the CMS Outpatient Prospective Payment System (OPPS) rule, including evaluation and management coding guidelines.

f. GHS maintains a Utilization Management Plan developed by the Coordinated Care Department and approved by the Board of Directors. The Coordinated Care Department continually monitors the appropriateness of resource utilization.

g. GHS maintains admission and discharge policies to reflect current CMS rules.

h. GHS thoroughly assesses all new computer systems and software that impact coding, billing or the generation or transmission of information related to the Federal health care programs or their beneficiaries.

3. Policies and Procedures

GHS maintains detailed policies and procedures and documents that outline processes for complying with applicable statutes or regulations related to charging, coding and billing for services. The GHS Corporate Compliance Program (Policy #9510-01-01) and Code of Conduct address the following compliance elements:

• Leadership Responsibilities
• Setting Standards
• Compliance Training and Education
• Request for Guidance and Reporting Concerns
• Personal Obligation to Report
• Non-Retaliation Policy
• Internal Investigations and Corrective Action
• Measuring Program Effectiveness

The GHS Corporate Compliance Manual contains numerous policies and procedures that support our commitment to maintaining the accuracy of charging, coding and billing. These documents are available on the GHS intranet, Gwinnettwork, and include but are not limited to:

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<tr>
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<td>Correct Coding Initiative Edits</td>
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<td>Charge Master and Order Item Master</td>
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<td>Indigent &amp; Charity Care</td>
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**ATTACHMENTS**
None

**FOR MORE INFORMATION CONTACT**
Revenue Management
Chief Compliance Officer
Chief Financial Officer

**APPROVAL BODIES**
Corporate Compliance Committee

**KEYWORDS**
Fraud, abuse, associate handbook, code of conduct, whistleblower, Deficit Reduction Act (DRA)