FOR VENDORS AND CONTRACTORS

East Orange General Hospital is committed to the highest levels of quality and ethical standards and to ensuring that all its business is conducted in compliance with Federal, State and local laws and within applicable regulatory guidelines. These policies describe our compliance with certain requirements set forth in the Deficit Reduction Act of 2005. We are committed to complying with Section 6032 of the Federal Deficit Reduction Act, as well as with all other federal, state, local laws and regulations; and ensuring that our billing to the Medicare program, the New Jersey State Medicaid program and other federal and state sponsored programs is accurate and conforms to applicable law.

The Deficit Reduction Act of 2005 requires all Medicaid recipients develop and distribute policies outlining federal and state false claims acts, as well as information regarding whistleblower protections and the entities' policies to reduce fraud and abuse. Please view EOGH's policies below….

POLICY ON FRAUD AND ABUSE PREVENTION

PURPOSE

The Office of Inspector General ("OIG") and the Centers for Medicare & Medicaid Services ("CMS") of the United States Department of Health and Human Services ("HHS") and other government agencies charged with enforcement of federal health care laws have emphasized the importance of compliance programs such as the East Orange General Hospital (the "Hospital") Compliance Program.

The OIG and other regulatory agencies recognize that compliance programs can be a significant factor in reducing and preventing instances of fraud, abuse and waste under government health care programs such as the Medicare and Medicaid programs, particularly in connection with reimbursement matters where claims and billing operations are subject to extensive governmental regulation.

The Compliance Program is intended to assist the Hospital in improving overall quality and preventing instances of non-compliance with applicable health care laws, while developing a central coordinating source for information and guidance on applicable laws, regulations, standards of conduct and conditions of participation in governmental health care programs.

Although a primary impetus behind the Compliance Program is to prevent and detect instances of non-compliance in connection with applicable health care laws and particularly those involving the Medicare and Medicaid programs, the Hospital is committed to full compliance with all pertinent federal, state and local laws and regulatory guidelines, whether they relate to health care matters or not. Accordingly, the responsibilities and obligations established under the Compliance Program, such as the duty to report to the Compliance Officer any instance of suspected non-compliance or wrongdoing, apply to all laws and regulations applicable to the Hospital and all areas and aspects of the Hospital's operations.

There are numerous federal and state health care laws that are applicable to different aspects of the Hospital's operations. Some of the more relevant health care laws, for which persons and entities found to violate them may be subject to substantial criminal and civil penalties, include the following:

- *Anti-Kickback Law (also referred to as the Medicare and Medicaid Anti-Kickback Statute).* This federal law prohibits anyone from knowingly and willfully offering, paying, soliciting or receiving anything of value in return for, or to induce, recommend or arrange, the referral of an individual or the purchase or lease of a product or service covered under Medicare, Medicaid or another governmental health care program. A similar law also applicable to Medicare, Medicaid and other governmental health care programs prohibits anyone from offering or paying anything of value to a patient that the person knows or should know is likely to influence the patient to receive a medical item or service from the person or entity making the offer or payment instead of from another provider.

- *Federal and State False Claims Acts*. These laws prohibit anyone from knowingly presenting or causing to be presented any claim for payment under Medicare, Medicaid, other governmental, state and private third-party health care programs for a medical item or service that the person knows or should know was not provided as claimed, was false or fraudulent, or was for a pattern of medical items or services that were not medically necessary.

- *False Statements Law*. This law prohibits anyone from knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in any application for benefits or payment or in determining rights to benefits or payment under Medicare, Medicaid or another governmental health care program. Similar laws prohibit false statements made to other third party payors including private insurance companies.

- *Anti-Referral Laws (also referred to as the Stark and Codey Physician Self-Referral Laws).* Among other things, at the federal level, the Stark Law prohibits a physician from referring a Medicare or Medicaid patient to a health care provider for a "designated health service", if the physician or an immediate family member of the physician has an ownership or investment interest in, or financial or compensation arrangement with, the health care provider, unless one of certain limited exceptions applies. The state "Codey Law" includes similar restrictions, but applies to all patients and virtually all health care services, unless an exception applies.

- *Health Care Fraud.* It a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud any health care benefit program, or to obtain money or property from a health care benefit program through false representations. This applies not only to federal health care programs, but also to most other types of health care benefit programs.

- *Theft or Embezzlement in Connection with Health Care.* It a crime to knowingly and willfully embezzle, steal or intentionally misapply any of the assets of a health care benefit program. This prohibition applies not only to federal health care programs, but also to most other types of health care benefit programs.

- *False Statements Relating to Health Care Matters.* It a crime to knowingly and willfully falsify or conceal a material fact, or make any materially false statement or use any materially false writing or document in connection with the delivery of or payment for health care benefits, items or services. This prohibition applies not only to federal health care programs, but also to most other types of health care benefit programs.

- *Obstruction of Criminal Investigations of Health Care Offenses.* It is a crime to willfully prevent, obstruct, mislead, delay or attempt to prevent, obstruct, mislead or delay the communication of records relating to a federal health care offense to a criminal investigator. This prohibition applies not only to federal health care programs, but also to most other types of health care benefit programs.

- *Civil Monetary Penalties.* This law is a comprehensive statute that covers an array of fraudulent and abusive activities and is very similar to the False Claims Act. The statute prohibits a health care provider from presenting or causing to be presented, claims for services that the provider "knows or should know" were:

    - Not provided as indicated by the coding on the claim.

    - Not medically necessary.

    - Furnished by a person who is not licensed as a physician (or who was not properly supervised by a licensed physician).

    - Furnished by a licensed physician who obtained his or her license through misrepresentation of a material fact (such as cheating on a licensing examination).

    - Furnished by a physician who was not certified in the medical specialty that he or she claimed to be certified in.

    - Furnished by a physician who was excluded from participation in a federal health care program to which the claim was submitted.

  Under this law, it is also unlawful to:

    - Offer remuneration to a Medicare or Medicaid beneficiary that the person knows or should know is likely to influence the beneficiary to obtain items or services billed to Medicare or Medicaid from a particular provider.

- Employ or contract with an individual or entity that the person knows or should know is excluded from participation in a federal health care program.

POLICY

It is the Hospital's policy to operate in compliance with the above laws and their accompanying regulations. Any of the Hospital's personnel who believe or have reason to believe that the Hospital or any of the Hospital's employees, agents or staff have violated (or are about to violate) any of the above-described health care laws must immediately report such information to the Compliance Officer.

Examples of fraud include the following actions: (i) billing for services that were not furnished or supplies not provided; (ii) altering claim forms or receipts in order to receive a higher payment amount; (iii) duplicating billings to the Medicare program and the beneficiary; (iv) billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage; (v) completing certificates of medical necessity for patients not personally and professionally known by the provider; and (vi) billing procedures over a period of days when all treatment was completed during one visit.

Examples of abuse may include, but are not limited to, (i) charging in excess of services or supplies; (ii) providing medically unnecessary services or services that do not meet professionally recognized standards; (iii) billing Medicare based on a higher fee schedule than for non-Medicare patients; and (iv) submitting bills to Medicare that are the responsibility of other insurers under the Medicare secondary payer regulations. Abusive acts may develop into fraudulent acts if there is evidence that the party acted knowingly, willfully and intentionally.

REFERENCES

Federal Anti-Kickback Law, 42 U.S.C. §1320a-7b; Federal False Claims Act, 31 U.S.C. 3729-3733; New Jersey False Claims Act, N.J.S.A. 2A:32C-1 through 17; Program Fraud Civil Remedies Act, 31 U.S.C. 3801 et seq.; Stark Law, 42 U.S.C. §1395nn; New Jersey Codey Law, N.J.S.A. 45:9-22.5; Health Care Claims Fraud, N.J.S.A. 2C:21-4.2-4.3, N.J.S.A. 2C:51-5; 31 U.S.C. § 669; 47 U.S.C. § 1035; 47 U.S.C. § 1518; Civil Monetary Penalties, 42 U.S.C. 1320a–7a; New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq.

If you have any questions, please contact the Compliance and Risk Officer at East Orange General Hospital at (973) 414-6867.