



Policy ID & Revision: 2112.4
Title: Education Concerning False Claims Liability, Anti-Retaliation Protections, and Detecting and Responding to Fraud, Waste and Abuse
Latest Eff. Date: 1/1/07
Responsible Party: Barbara A. Kuhl, Chief Compliance Officer
Approved By: Corporate Compliance Committee

1. **Scope**
System Wide
2. **Purpose**

This policy applies to all physicians, employees, contractors, and agents of Marshfield Clinic and Family Health Center of Marshfield, Inc. References to Marshfield Clinic below shall include Family Health Center.

The purpose of this Policy is to provide information about certain federal and state laws concerning the submission of false and fraudulent claims for payment to the government. These laws play a central role in the government's efforts to prevent and detect fraud, waste, and abuse in federal health care programs.

3. **Definitions**

“Knowingly” means:

- Having 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.

4. **Policy Body**

It is the policy of Marshfield Clinic to provide health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. To further this policy, and to comply with Section 6032 of the Deficit Reduction Act of 2005, Marshfield Clinic provides the following information about its policies and procedures and the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

I. Summary of Federal and State Laws

The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act, and Wisconsin's Medicaid Fraud Statute, and their role in preventing and detecting fraud waste, and abuse in federal health care programs.

A. Federal False Claims Laws:

1. False Claims Act; 31 U.S.C. §§ 3729 – 3733

The federal False Claims Act imposes 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.

A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties of between \$5,500 and \$11,000 per claim plus three times the amount of damages that the government sustained because of the illegal act.

Anyone may bring a qui tam action under the False Claims Act in the name of the United States. The case is initiated by filing the complaint and all available material evidence under seal with a 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 often 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 may receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case and other factors. If the government does not proceed with the case, the person who filed the action may be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys' fees and costs.

2. Program Fraud Civil Remedies Act; 31 U.S.C. §§ 3801 – 3812

