Policy and Procedure

Policy Name: False Claims Acts	**Policy#:** CMP-212	**Version#: 17**
Author Department: Compliance	**Origination Date:** 7/30/2008	
Business Units Impacted: All	**Date Last Reviewed:** 12/4/2024	
Products/LOBs: All	**Date Approved by CPT: 12/05/2024**	

DEFINITIONS:

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary cost to Medicaid programs.

False Claim: A claim knowingly submitted for services or supplies that were not provided as presented or for which the entity is otherwise not entitled to payment.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.

Knowingly: Includes having actual knowledge, acting in deliberate ignorance, or demonstrating reckless disregard for the truth or falsity of information.

Waste: Incurring unnecessary costs as a result of deficient management, practices, systems or controls; the over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Whistleblower: An individual who reports suspected or actual violations of law in good faith and is protected from retaliation.

Workforce Member(s): Means individuals who are employed by, or affiliated with, Colorado Access (COA or organization), including full-time and part-time employees, temporary staff, contractors, volunteers, interns, and other personnel who perform work on behalf of the organization.

SCOPE:

This policy applies to all Colorado Access (COA) Workforce Members, contractors, and business partners across all business units and lines of business. It encompasses any conduct related to state and federal healthcare program reimbursements, including activities addressing fraud, waste, and abuse prevention and detection.

PURPOSE:

The purpose of this policy is to ensure compliance with federal and state False Claims Acts, including the Colorado Medicaid False Claims Act, and to promote ethical behavior in the prevention and detection of fraud, waste, and abuse. This policy sets forth expectations for COA workforce members, contractors, and vendors to safeguard the integrity of public healthcare programs and maintain transparency and accountability.

STATEMENT OF POLICY:

Colorado Access (COA) is committed to compliance with state and federal laws addressing fraud, waste and abuse prevention, detection and resolution. COA prohibits knowingly submitting or facilitating false claims or statements to any government program. All Workforce Members must adhere to the principles outlined in COA's Compliance Plan, Code of Conduct, and this policy. COA implements a Compliance

Policy and Procedure

Policy Name: False Claims Acts	**Policy#:** CMP-212	**Version#: 17**
Author Department: Compliance	**Origination Date:** 7/30/2008	
Business Units Impacted: All	**Date Last Reviewed:** 12/4/2024	
Products/LOBs: All	**Date Approved by CPT: 12/05/2024**	

Program to promote integrity and ensure workforce members understand the standards of conduct related to the False Claims Act. Key statutes include:

Federal False Claims Act:[1]
- Prohibits Knowingly submitting fraudulent claims to the federal government.
- Violations may result in civil penalties of $5,000-$11,000 per claim and treble damages.

Colorado Medicaid False Claims Act:[2]
- Prohibits Knowingly submitting fraudulent claims to the Colorado Medicaid program.
- Civil penalties range from $5,000-$10,000 per claim plus treble damages.

Colorado Fraudulent Acts Statute:[3]
- States that a person commits theft when they knowingly obtain, or willfully aid or abet another to obtain, public assistance, vendor payments, or medical assistance through false statements, impersonation, or other fraudulent devices.
- Violations may result in disqualification from public assistance programs.
- Criminal penalties for violations may include felony or misdemeanor charges, depending on the damages.

Whistleblower Provisions:[4]
- Allows individuals to bring civil actions on behalf of the government.
- Protects employees who report violations in good faith from retaliation.

PROCEDURES:

A. Identifying Potential Violations

1. Recognizing potential violations requires an understanding of fraud, waste, and abuse indicators. Below are examples and warning signs that may suggest non-compliance**:**

    a. Examples of Common Violations Under the False Claims Act:
        - **Billing for services not provided:** Submitting claims for patient care, procedures, or services that never occurred.
        - **Upcoding:** Claiming reimbursement for a more expensive service or procedure than what was actually performed.
        - **Unbundling:** Separating services that should be billed together as a single procedure into multiple claims to increase reimbursement.
        - **Misrepresentation of medical necessity:** Submitting claims for services, treatments, or supplies that are not medically necessary according to standard care guidelines.

[1] 31 U.S.C. §§ 3729–3733
[2] C.R.S. §§ 25.5-4-303.5 to 25.5-4-310
[3] C.R.S. § 26-1-127
[4] 31 U.S.C. § 3730(h), C.R.S. § 25.5-4-306

Policy Name: False Claims Acts	**Policy#:** CMP-212	**Version#: 17**
Author Department: Compliance	**Origination Date:** 7/30/2008	
Business Units Impacted: All	**Date Last Reviewed:** 12/4/2024	
Products/LOBs: All	**Date Approved by CPT: 12/05/2024**	

- **False certification:** Certifying compliance with Medicaid or Medicare program rules (e.g., quality standards or qualifications) when the provider knows they are not in compliance.
- **Kickbacks:** Offering or receiving compensation in exchange for referrals or preferential use of products or services, which indirectly causes the submission of false claims.
- **Improper coding or documentation:** Submitting claims with incorrect diagnosis or procedure codes that result in higher reimbursement, even if unintentional.
- **Duplicate billing:** Submitting claims multiple times for the same service, either to the same or different payers.
- **Failure to return overpayments:** Retaining known overpayments for services instead of promptly refunding the amount to the government payer.
- **Improper cost-shifting:** Billing Medicaid for services that should have been paid by another program or payer.
- **Identity fraud:** Using someone else's Medicaid or Medicare ID to access healthcare services, which causes false claims to be submitted.
- **Falsified eligibility:** Providing false information during application processes to qualify for Medicaid benefits improperly.
- **Prescription fraud:** Selling prescription medications obtained through Medicaid or altering prescriptions for personal gain.

B. Reporting Potential Violations

1. Workforce Members must report potential violations through the following channels:

   - Their direct supervisor
   - **In-person** at the main COA facility.
   - **Email** at compliance@coaccess.com.
   - **Confidential Hotline** at (877) 363-3065 (anonymous reporting available).

2. Supervisors receiving reports must forward the concern to the Compliance email within one (1) business day of receipt.

3. Reports will be investigated and treated confidentially to the extent possible. COA enforces a non-retaliation policy for good-faith reporting. For more details refer to CMP-201 Compliance Problem Reporting and Non-retaliation policy.

C. Training and Education

1. All Workforce Members will complete mandatory compliance training upon hire and annually thereafter. For more details refer to CMP-204 Compliance Education and Training policy.

Policy Name: False Claims Acts	**Policy#:** CMP-212	**Version#: 17**
Author Department: Compliance	**Origination Date:** 7/30/2008	
Business Units Impacted: All	**Date Last Reviewed:** 12/4/2024	
Products/LOBs: All	**Date Approved by CPT: 12/05/2024**	

2. COA will include information about the False Claims Act, in the provider manual, on the company website, in provider bulletins, company policies and procedures, vendor contracts, and in other communications.

D. Review and Updates

1. This policy will be reviewed annually and updated as necessary to ensure compliance with applicable laws and regulations.

E. Record Retention

1. COA will retain records in accordance with CMP-210 Record Retention and Destruction policy.

REFERENCES:
31 USC §§3729-3733
CRS §25.5-4-303.5 to §25.5-4-310
CRS § 26-1-127
31 U.S.C. § 3730(h)
C.R.S. § 25.5-4-306
CMP-201 Compliance Problem Reporting and Non-retaliation policy.
CMP-204 Compliance Education and Training policy
CMP-210 Record Retention and Destruction policy

ATTACHMENTS:
None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 7/30/2008, Version 2: 9/24/2009, Version 3: 8/5/2010, Version 4: 7/8/2011, Version 5: 9/18/2012, Version 6: 9/18/2013, Version 7: 8/20/2014, Version 8: 3/1/2016, Version 9: 3/1/2017, Version 10: 3/1/2018, Version 11: 3/1/2018, Version 12: 3/1/2019, Version 13: 2/15/2020, Version 14: 7/12/2021, Version 15: 7/6/2022, Version 16: 12/1/2023, Version 17: 12/5/2024

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE: 12/05/2024**