Departments:	Policy OR Procedure Name:	Policy OR Procedure Number:
All Supports	False Claims Act	MPM – Policies - 130
Funding Source Policy:	**Effective Date:**	**Revised Date:**
N/A		11/15/2023; 2/12/2025
Implemented By:	**Monitored By:**	**Policy Considerations:**
All Departments	Quality Assurance	acknowledges/incorporates inclusivity and diversity; no identified barriers

Purpose: It is the policy of Arion Care Solutions (ACS) to detect and prevent fraud, waste and abuse in the delivery of services.

Many federal and state laws are designed to prevent healthcare fraud. Some of these laws are intended to prevent any kickback or payment for referring patients, particularly in federally or state funded programs.

A violation of the False Claims Act ("FCA") can entail any employee knowingly presenting (or causing to be presented) false or fraudulent claim for payment. The False Claims Act covers fraud involving any federally-funded contract or program, except for tax fraud.

This policy is established to facilitate development of controls that aid in the detection and prevention of fraud, waste, and abuse. It is the intent of ACS to promote consistent organizational behavior by providing guidelines and assigning responsibility for the development of controls and conducting of investigations.

This policy applies to any irregularity, or suspected irregularity, involving employees, persons receiving services, guardians, consultants, vendors, contractors, outside agencies doing business with employees of such agencies, and/or any other parties with a business relationshipwith ACS.

Definitions:

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or other persons. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

Waste: Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program

Abuse of the Program: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Division or any AHCCCS funded program. 42 CFR 455.2.

Any irregularity that is detected or suspected must be reported immediately to the Quality Assurance Department.

Penalties for violating anti-fraud laws include fines, criminal or civil actions or exclusion from the Medicare and AHCCCS programs or other federal programs and termination from employment. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $11,665 to $23,331 (adjusted from time to time for inflation) for each false claim.

Arion Care employees acknowledge the following to comply with ACS policy.

Actions Constituting Fraud

An employee who knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Federal Government can constitute a violation of the FCA.

Conspiring with others to get a false or fraudulent claim paid by the Federal Government can constitute a violation of the FCA.

Employees also shall comply with all Arizona statutes regarding civil or criminal penalties for false claims and statements.

Examples of fraud Include, but are not limited to:

- Any dishonest or fraudulent act
- Submitting claims (known incorrect timecards) for services that were not provided, including the inflation of the hours actually expended.
- Unbundling of service codes, upcoding for services
- Falsely documenting and coding claims to reflect the services that were not provided
- Impropriety in the handling or reporting of money or financial transactions
- Making or offering payments or any other benefits to physicians or others for referrals of patients or the ordering of services
- Accepting payments or any other benefits from vendors or suppliers in return for additional business
- Participating in the destruction, removal, or inappropriate use of records, furniture, fixtures, and equipment
- Disclosing confidential and proprietary information to outside parties.

If there is any question as to whether an action constitutes fraud, waste or abuse, Quality Assurance should be contacted, immediately.

If fraudulent activity is identified, ACS is responsible for the following:

- Correcting an inaccurate bill
- Notifying payors of overpayments for services and refunding overpayments, as applicable
- Cooperating with authorized investigators seeking information about potential billing or fraud concerns
- ACS is prohibited from and will not retaliate against someone who, in good faith, makes a complaint or participates in the investigation of a complaint concerning false or fraudulent statement or claims of payment. Any ACS team member who reports allegations of fraudulent activity will not be held liable unless these allegations are made with malicious intent. No sanctions will be placed on team members who report these allegations. An individual can share in a percentage of a government recovery in an FCA action or settlement if they bring an action on behalf of the United States as a "qui tam relator." Qui tam relator is a private citizen who successfully brings a suit against those who have defrauded the government. ACS employees are covered by the Whistleblower Act, which prohibits employers from taking any sanctions (i.e., discharge, demotion, harassment, or other discrimination) against an employee for filing a complaint under the False Claims Act.

If an investigation establishes that fraudulent activity has been conducted by an employee, the employee will be terminated. If an investigation establishes fraudulent activity on the part of a contractor, agent or business associate, the relationship will be terminated.

Prevention of Fraud, Waste and Abuse:

- ACS reviews timesheets for accuracy prior to submittal for billing
- ACS utilizes an Electronic Visit Verification system (EVV) that verifies date, time, and place of service provision
- Member hours are utilized only in accordance with authorizations received from funding sources and tracked in the EVV system

How to Report a Compliance Concern:

If you have compliance concerns or questions regarding ACS, you may:

- Call the Quality Assurance Department at 480-722-1300. The Quality Assurance Department is located at 3200 N Dobson Rd Suite F2 Chandler AZ 85224.
- Alternatively, you may present a compliance concern to the Quality Assurance Department by written communication (qualityassurance@arioncare.com). The Quality Assurance Department will respond promptly to all compliance calls and reports. Compliance calls and reports will be treated confidentially, to the extent permitted by law, unless you agree otherwise. You can make an anonymous call or report, although it is sometimes harder for the Compliance Department to investigate concerns without being able to contact you for follow-up information.

REFERENCES: Public Law 101-12 (Whistleblower Protection Act), Public Law 109-171 (Deficit Reduction Act of 2005); 31 U.S.C. 3729-3733 (False Claims Act)