Fraud Laws, Overpayment Reporting and Deficit Reduction Act Notice Policy

Policy Number:	M111103166
Effective Date:	1/1/2007
Sponsoring Department:	SIU, Compliance, Legal
Impacted Department(s):	All Independent Health, and its affiliated organizations (Nova, Reliance Rx, PBD, WNY Collaborative Management Services LLC)

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☒ Corporate (All)
☐ State Products, if yes which plan(s): ☐MediSource; ☐MediSource Connect; ☐Child Health Plus; ☐Essential Plan
☐ Medicare, if yes, which plan(s): ☐MAPD; ☐PDP; ☐ISNP;☐CSNP
☐ Commercial, if yes, which type: ☐Large Group; ☐Small Group; ☐Individual
☐ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☒ No☐

Purpose and Applicability:

The purpose of this policy is to educate and ensure compliance with federal and state fraud, waste, and abuse (FWA) laws regarding false claims, statements, or any other type of fraudulent activity. These laws are put in place to combat FWA.

Policy:

Independent Health has a comprehensive **fraud, waste,** and **abuse** program which is led by its Special Investigations Unit (SIU) and is designed to detect, correct, prevent and report potentially illegal and fraudulent practices. Independent Health provides workforce members, contingent workers, and their employees with detailed educational information related to fraud, waste, and abuse laws as outlined in the Fraud Prevention Plan. Providing this education and information allows Independent Health to be compliant with Section 6032 of the Deficit Reduction Act (DRA) of 2005, which requires health care entities receiving $5 million or more in Medicaid reimbursement during a federal fiscal year to establish written policies and procedures informing their employees, workforce members, and contingent workers about federal and state false claim acts and whistleblower protections. Additional information can be obtained by contacting the Legal Department or Special Investigations Unit. Independent Health's fraud, waste and abuse related policies and business processes are posted on SharePoint on InsideIH. Workforce members who believe they have encountered fraud, waste, abuse, or a violation of law or any questionable activity are required to report it to the Special Investigations Unit at 1-800-665-1182. See the Fraud Prevention and Reporting Policy (#A990901029).

In addition, Independent Health has contracted with a third party (Report It) to facilitate our compliance, ethics and fraud, waste, and abuse hotline. This service allows for any concerned party (workforce members, members, business partners, vendors, first tier related entities) to report actual or suspected issues or concerns of fraud, waste and abuse, noncompliance, misconduct, retaliation, intimidation, wrong-doing and ethical concerns confidentially and anonymously. The confidential and anonymous helpline may be accessed 24/7/365 by calling 1-877-229-4916 or via web access at http://reportit.net with the username IHA and password redshirt. See the Mechanisms for Reporting Noncompliance and Corrective Action Policy (#A990801007).

Federal Laws:

A. The Federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who:
   1.) Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

a. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

2.) 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 Government;

3.) Conspires to commit a violation of any of the provisions of the False Claims Act as outlined under Standard II.B.: 1., 2., 4., 5., 6., or 7. in this policy.

4.) Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

5.) Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

6.) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

7.) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

B. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information:

1.) Has actual knowledge of the information;

2.) Acts deliberate ignorance of the truth or falsity of the information; or

3.) Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.

C. For purposes of the False Claims Act, the term claim includes any request or demand for money that is submitted to the Federal government or its contractors and subcontractors. A claim also:

1.) Means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that:

a. Is presented to an officer, employee, or agent of the United States; or

b. Is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a government program or interest, and if the United States Government;

i. Provides or has provided any portion of the money or property requested or demanded;

ii. Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded and;

c. The term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

d. The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

D. Examples of false claims and false statements include, but are not limited to the following:

1.) Knowingly falsifying records that are then used to get a false claim paid.
2.) Double billing.
3.) Submitting bills for services that were never performed.
4.) Retention of an overpayment where there is an obligation to repay.
5.) Inaccurately reporting or certifying data in bids and rate proposals.
6.) Using inaccurate data to support reported claims experience and loss ratios.
7.) Failing to correctly report rating or discounts for similarly sized subscriber groups under Federal Employee Health Benefits (FEHB).
8.) Falsely certifying compliance with Medicaid Managed Care marketing or other program requirements.
9.) Manipulating provider or vendor dealings to distort reported claims experience in our government programs.
10.) Making any false statement, omission or misrepresentation in any application, bid or contract to participate in Medicare Advantage, Medicare Part D plan or Medicaid Managed Care (please note, the potential penalty for this type of violation is $50,000 for each false statement or misrepresentation and not more than three times the total amount claimed for each item or service for which payments were received and was based on the application which contained the false statement).

E. In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

1.) When the Government has intervened in the lawsuit, it shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.
2.) The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions

of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Anti-Kickback Statute and Safe Harbors:

The Anti-Kickback Statute is a criminal law that prohibits the knowing and willful offer, payment or solicitation of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Both the recipient of the remuneration and the individual or entity who offers the remuneration is subject to the Anti-Kickback Statute.

- **Remuneration:** Remuneration means any kickback, bribe, discount, rebate made in cash or in kind, regardless of whether it was paid directly, indirectly, overtly or covertly. The Government defines the word remuneration very broadly. Remuneration that is intended to induce referrals is banned and so is remuneration that is intended to induce the purchasing, leasing, ordering or arranging for any good, facility, service or item paid for by a federal health care program. Besides the Anti-Kickback Statute, the beneficiary inducement statute also imposes civil monetary penalties on insurers who offer renumeration to Medicare and Medicaid beneficiaries to influence them to enroll.
- **Exceptions:** Because of the broad reach of the statue the Government has issued regulations that create a list of practices that do not violate the Anti-Kickback Statute, these practices are commonly referred to as "safe harbors." Safe harbors are narrow exceptions to the Anti-Kickback Statute's prohibited practices which specify various payment and business practices are not subject to sanctions under the statute. If you would like more information about the Anti-Kickback Statute's safe harbors, please contact an attorney in the Legal Department. If you are a **contractor/vendor** of Independent Health, please consult with your attorney. For additional information on safe harbors, see "OIG's Safe Harbor Regulations." The safe harbors cover a small number of payment practices such as:
    - The waiver of coinsurance and deductible amounts under certain specific conditions.
    - Giving incentives to individuals to promote the delivery of preventive care.
    - Remuneration which promotes access to care and which poses a low risk of harm to patients and Federal health care programs.
    - Offering or transferring coupons and rebates or other retailer rewards for free or less than fair market value if certain conditions are met,
    - Offering or transferring items or services for free or less than market value if: (a) they are not offered through an advertisement, (b) they are not tied to an item or service that is

reimbursable under a federal or state health care program, (c) there is a reasonable connection between the items or services offered and the individual's medical care, (d) the individual receiving the item or service is in financial need,

- As of January 1, 2011, the waiver of any copayment for the first prescription fill of a generic drug that is covered by Medicare Part D.

- **Damages:** Kickbacks in health care can lead to Overutilization, increased program costs, corruption of medical decision making, patient steering, and unfair competition, to name a few. The Government does not need to prove harm or financial loss to the programs to show a violation of the AKS occurred. The AKS is a criminal statute with both civil and criminal penalties. On the civil side, AKS violators risk penalties up to $100,000 per violation and triple the value of any illegal kickbacks, and they may also be excluded from participating in federal healthcare programs. On the criminal side, an AKS conviction is a felony that can lead to a $100,000 fine per violation and up to ten years in prison. In addition, AKS violations can give rise to FCA liability because, by statute, claims tainted by AKS violations are deemed false for purposes of the FCA.
- **Stark Law**: The Stark Law prevents the practice of a physician referring a patient to a medical facility (e.g., hospital, lab, etc.) in which the physician or the physician's immediate family member may have a financial interest, be it ownership, investment, or a structured compensation arrangement. This type of arrangement may encourage over-utilization of services which in turn drives up health care costs.
- **Conspiracy:** A lawsuit can also be brought against any person who conspires with another person or entity to commit any of the acts just described in this section.

Overpayment Provisions Applicable to Providers:

Title 42, Chapter 4, Subchapter A, Section 401.305 requires that a person in receipt of an overpayment must report and return the overpayment within 60 days of identifying such overpayment.

An Independent Health contracted provider/person must submit a claims adjustment, advise Independent Health to apply a credit balance, or self-report with a refund payable to Independent Health to report an overpayment. They must also supply in writing to Independent Health the date on which the overpayment was identified and the reason for the overpayment. The reporting obligations can be satisfied if the provider makes a disclosure under the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol resulting in a settlement agreement using the process described in the respective protocol with a corresponding report to Independent Health. Independent Health will in turn report such overpayment to the applicable regulatory agencies following their reporting protocols.

An overpayment must be reported and returned if identified within 6 years of the date the overpayment was received.

Title 18 of the New York Code of Rules and Regulations (NYCRR) §521- 3.3(b)(5) states that, for an overpayment made by Independent Health to a Network Provider, a Network Provider satisfies its obligation for self-disclosure by reporting, returning and explaining the overpayment to Independent Health, provided that it is reported and returned within sixty (60) days of identification.

Affordable Care Act (ACA) of 2010 §6402 states that Medicaid and Medicare overpayments must be returned within 60 days of identification, or by the date any correspondence cost report was due, whichever is later.

Social Services Law (SOS) §363-d(6) & (7) requires a person to report and return overpayments under the medical assistance program to OMIG within 60 days of identification, or by the date any corresponding cost report is due, if applicable. It also outlines eligibility criteria for participation in the self-disclosure program and overpayment report processing timeframes.

Social Services Law (SOS) §145-b(4)(D)(iii) states that payment of monetary penalties may be required in restitution to the medical assistance program for any person who knew or should have known that an overpayment was identified and was not reported, returned and explained in accordance with SOS §363-d.

Title 18 of the New York Code of Rules and Regulations (NYCRR) §521-3 establishes the requirements that persons shall report, return and explain overpayments to the OMIG, and explains the requirements of the self-disclosure program administered by OMIG.

Independent Health is bound by the terms in Model Contract 3/1/2019 section 18.5(a)(viii)(G), which states that the Medicaid Managed Care Organization (MMCO) shall report to the Department of Health (SDOH) and OMIG within sixty (60) days of identification of any capitation payments in excess of amounts specified in the Model Contract Agreement .

For overpayments identified by Independent Health, see the Reporting and Returning Overpayment Policy #A20150512027.

Self-Reporting Violations:

As a contractor of the United States Department of Health and Human Services ("HHS") Centers for Medicare and Medicaid Services ("CMS") for various Medicare products, Independent Health is obligated to report to the HHS Office of the Inspector General in writing and send a carbon copy to the CMS official in charge of Independent Health's contract with CMS when it has credible evidence that one of its workforce members or Medicare-related subcontractors has violated:

- Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations in Title 18 of the United States Code; or
- The Federal False Claims Act.

When making such reports to the Government, Independent Health shall mark each page of its written report as "Confidential."

Federal Audits:

Federal law permits the HHS to audit Independent Health for potential violations of a variety of Federal fraud laws, regulations, and rules. If Independent Health does not grant the Government timely access to our facilities, records, and systems so they can perform their audits, investigations and evaluations, Independent Health can be subject to a penalty in the amount of $15,000 per day.

New York State Law

New York False Claims Act

1.) A civil lawsuit can be brought by the New York State Attorney General and or any local Government against any person who does any of the following activities:
   a. Knowingly presenting a false claim to the State or a local Government or a Medicaid Managed Care plan.
   b. Knowingly making use of a false record to receive payment from the State or a local Government or a Medicaid Managed Care plan.
   c. Conspiring to defraud the State or a local Government by getting a claim paid.
   d. Delivering, or causing to be delivered, to the State or a local Government less property or money than the amount for which a person receives a Certificate of Receipt, with an intent to defraud or willfully to conceal the property or money.
   e. Making or delivering, with intent to defraud, a certifying receipt to the State or local Government without completely knowing that the information on the receipt is true.
   f. Knowingly buying or receiving as a pledge of an obligation or debt, public property from a State officer or employee knowing that the property may not be lawfully sold or pledged.
   g. Knowingly making, using, or causing to be used a false record or statement to conceal, avoid or decrease an obligation of money or property to the State or a local Government.

2.) **Damages:** The person can be held responsible for damages for: (1) a civil penalty of $6,000 to $12,000 paid to the State, (2) three times the amount of damages the State suffers ("treble damages"), (3) three times the amount of damages any local Government suffers; and (4) the cost of any civil lawsuits and attorney's fees brought to recover any such penalties and damages. A court may reduce treble damages to double damages if: (1) the violator furnishes all information to the officials who are investigating the violation within 30 days of the violator

obtaining that information; (2) the violator fully cooperates with the Government's investigation; and (3) at the time the violator provides the information, no criminal, civil or administrative action had begun and the violator did not have actual knowledge of any investigation.

3.) **New York False Claims Act Qui Tam Lawsuits:**
Similar to the Federal False Claims Act, the State False Claims also allows "qui tam" actions. These lawsuits are brought by an individual who knows about the fraud. This individual is called a "whistleblower" or a "qui tam relator." The Government works with the individual and decides whether to get involved in the lawsuit.

a. **How this works:** The individual files a lawsuit in New York State Supreme Court, a trial level court of law. The individual's complaint is "sealed" and kept confidential for at least 60 days. During that period of time, the Government will investigate the complaint and decide whether to get involved in the case. The Government may either: (1) take over the case completely and re-file the lawsuit in the name of the State of New York; (2) join in the lawsuit and help the individual who filed the lawsuit; or (3) decide not to participate at all. If the Government joins in the case, the Government will try the case to its completion or settle the case. The court will determine if a settlement is fair before it is finalized.

b. **When:** Qui tam lawsuits must be filed by the individual within six years of the violation or three years after the date facts that are material to the case are known or reasonably should have been known to the Government official charged with the responsibility to act in the circumstances, whichever occurs last. In no event may the lawsuit be brought later than 10 years after the violation was committed.

c. **Awards:** If the Government gets involved in the lawsuit and the lawsuit is successful, the individual is entitled to 15%-25% of the total recovery or the settlement. If the Government does not get involved in the lawsuit and the lawsuit is successful, the individual is entitled to 25%–30% of the total recovery or the settlement. The court may also award reasonable costs and expenses, including attorney's fees. An individual's recovery may be reduced to 10% of the proceeds of the lawsuit or a settlement if the court finds that the lawsuit was based mainly on disclosures from someone other than the individual who started the lawsuit which are connected to allegations in a criminal, civil or administrative hearing or in a legislative or administrative report, hearing audit, or investigation or from the news media.

d. **Anti-retaliation Protections:** If an employer discharges, demotes, suspends, threatens, harasses or is otherwise discriminated against one of its employees for filing a State False Claims Act lawsuit, the employee is entitled to all relief necessary to put the person in the position he or she was in before the discrimination. For example, the employee may be entitled to reinstatement to a position he or she would have had if the discrimination did

not occur or two times the amount of back-pay. An employee may file another lawsuit to get the relief needed to make him or her whole. See the Non-retaliation and Non-intimidation Whistleblower Protection Policy (#A030414073) for additional information.

Unacceptable Practices Under Medicaid:

New York State law makes knowingly submitting a false statement and claim a Class A misdemeanor under the New York State criminal law. New York law also lists certain prohibited practices for companies and individuals involved in providing benefits or services to Medicaid recipients. The unacceptable practices include, but are not limited to:

- Making false claims for medical care or services
- Making false statements relating to claims for payment for medical services or supplies
- Failing to disclose information about the right to payment.
- Taking a medical assistance payment and using it for something other than medical assistance
- Taking bribes and kickbacks and inappropriate referrals
- Unacceptable recordkeeping practices
- Submitting claims or accepting payments for medical care, services or supplies offered by a person who is not qualified to participate in the Medicaid program.
- Receiving additional payments for services or supplies for which a Medicaid claim has been made.
- Deceiving a Medicaid recipient in any way
- Furnishing excessive medical care, services or supplies to a Medicaid recipient.
- Any conspiracy to do any the activities listed above; and
- Unlawful discrimination against a Medicaid recipient.

Fraud Against a Health Plan:

New York State criminal law contains specific provisions about fraud against health plans. To be guilty of healthcare fraud against a health plan, a person must do the following:

- Act with intent to defraud a health plan.
- Knowingly and willfully provide materially false information or omit information to request payments from a health plan for a healthcare item or service; and
- Actually receive a payment he or she or another person is not entitled to receive.

NON-RETALIATION AND NON-INTIMIDATION

Independent Health will not retaliate or engage in intimidation tactics against any workforce members who reasonably believe and in good faith make reports of known or suspected wrong-doing, non-compliance, violations of any corporate policy or any illegal or fraudulent action or participates in/with an organizational investigation pertaining to alleged wrong-doing or non-compliance, or who assists

appropriate authorities in investigating possible wrong-doing or non-compliance, will not suffer intimidation, harassment, discrimination or other retaliation, including any adverse employment consequences. All workforce members are provided with a copy of this information within 90 days of hire and annually thereafter. See the Non-Retaliation and Non-intimidation Whistleblower Protection Policy (#A030414073) for additional information.

Definitions

Abuse is any incident or practice of a provider, physician or supplier which, although not usually considered fraudulent, is inconsistent with accepted and sound medical, business or fiscal practices and directly or indirectly results in services that fail to meet professionally recognized standards of care or, in some cases, may be medically unnecessary.

Contingent workers: are external resources, not employed by Independent Health Association, its subsidiaries or affiliated organizations which include: Temporaries (including interns), Consultants, independent Contractors, Vendors and Board Members.

Fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity, or to some other party.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system.

Workforce Member means Independent Health's employees, officers, directors, board members, contingent workers, and volunteers who provide substantial services, who perform services on behalf of Independent Health and its subsidiaries and affiliates.

References

Related Policies, Processes and Other Documents

- Fraud Prevention and Reporting Policy # A99090129
- Fraud Prevention Plan
- Non-Retaliation and Non-Intimidation Whistleblower Protection Policy # A030414073
- Reporting and Returning Overpayment Policy # A20150512027
- Mechanisms for Reporting/Disclosing Noncompliance and Corrective Action Policy #A990801007
- Corporate Code of Conduct and Ethics
- Corporate Compliance Plan
- Independent Health Associate Handbook

Regulatory References

- Deficit Reduction Act of 2005, Pub. L. No. 109-171, §6032, 120 Stat. 4 (2006) (codified as 42 U.S.C. §1396a(a)(68)(2006))
- Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, § 4, 123 Stat. 1617 (2009) (codified as 31 U.S.C. §§ 3729, 3730(h), 3732(c), 3733 (2009))
- Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§§6402, 6408, and 10606, 124 Stat. 119 (2010) (codified as 42 U.S.C.§1320a-7K(d), 42 U.S.C. §1320a-7(b)(16) (g) and (h), 42 U.S.C. §1320a-7a(a)(8) and (9), (i)(6)(F)-(I), 18 U.S.C. §1347(b)).
- Section 14 of the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93
- 28 C.F.R. § 85.3
- 31 U.S.C. § 3729, et. seq.
- 31 U.S.C. § 3730, et. seq.
- 31 U.S.C. § 3801, et. seq.
- 42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7a(a)(5), 1320a-7a(a)(7), 1320a-7b(b), 1320a-7b(f)
- 42 U.S.C. §§1395 nn
- 42 C.F.R. §411.350 - §411.389
- 42 C.F.R. § 422.326 and 423.360
- 42 C.F.R. § 422.503(b)(4)(vi)
- 42 C.F.R. § 423.504(b)(4)(vi)
- 42 C.F.R. § 1001.952, et. seq.
- 48 C.F.R. §52.203-13(b)(3)
- N.Y. State Fin. Law § 187-194
- N.Y. Soc. Serv. Law § 366-b and 145-b(4)
- 18 NYCRR § 515.2
- N.Y. Penal Law §§ 177.00 – 177.30
- N.Y. Lab. Law § 740
- NPCL § 715-b

Version Control

Sponsored By:
Name sponsor: Jared Gross
Title of sponsor: Executive Vice President, Chief Financial Officer
Signature of sponsor: Click here to enter text.

Revision Date	Owner	Notes
12/16/2008	Compliance	N/A
1/1/2012	Compliance	N/A
1/1/2012	Compliance	N/A
8/13/2013	D. Odrzywolski	Reviewed, no changes
3/3/2015	D. Odrzywolski	Updated per NPCL 715-b and ACA Overpayment Provisions
3/1/2016	D. Odrzywolski	Revised, minor changes
11/17/2016	D. Odrzywolski	Revised, added anonymous hotline
1/1/2017	D. Odrzywolski	Reviewed, minor changes
1/1/2018	D. Odrzywolski	TBD
1/1/2019	N. Britton	Reviewed, formatting changes
1/1/2020	N. Britton	Reviewed, no changes
1/1/2021	N. Britton	Reviewed, notation of impacted departments
1/1/2022	N. Britton	Reviewed, updated impacted departments
1/1/2023	N. Britton / S. Caulfield	Reviewed, updated references, consolidated non-retaliation and overpayment content, updated AKS section and safe harbor reference
2/29/2024	K. Jurkas	Changed verbiage to align for False Claims Act and added Stark Law. Combined reporting into introduction and reworded purpose of the policy.
10/15/2024	K. Jurkas	Reviewed, No Changes
3/1/2025	K. Jurkas	Reviewed, minor updates
3/14/2025	K. Jurkas	Updated Overpayment Language for Providers