

North Shore – LIJ Health System, Inc.

POLICY TITLE: Detecting and Preventing Fraud, Waste and Abuse	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL Section: Compliance and Ethics
POLICY #: 800.09	DEPARTMENT: Corporate Compliance
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Prepared by: Corporate Compliance	

GENERAL STATEMENT of PURPOSE

It is the obligation of the North Shore-Long Island Jewish Health System and its affiliated entities (“Health System”) to prevent and detect any fraud, waste and abuse in its organization related to federal and state health care programs (Medicare, Medicaid and other governmental payer programs).

To this end, the Health System maintains a vigorous Compliance Program and strives to educate our work force regarding the importance of submitting accurate claims and reports to federal and state governments, as well as regarding the requirements, rights and remedies of Federal and state laws governing the submission of false claims, including the rights of employees to be protected as whistleblowers under such laws.

POLICY

The Health System prohibits the knowing submission of a false claim for payment in relation to a federal or state-funded health care program. Such a submission violates the federal False Claims Act as well as various state laws, and may result in significant civil and/or criminal penalties.

SCOPE

This policy applies to all members of the North Shore – LIJ Health System workforce including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at North Shore – LIJ Health System.

DEFINITIONS

None.

PROCEDURE/GUIDELINES

A. **Health System Fraud and Abuse Detection, Prevention and Employee Protection**

To assist the Health System in meeting its legal and ethical obligations, the Health System expects and encourages any employee, contractor or agent who is aware of or reasonably suspects the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a federal or state-funded health care program, to report such information to his/her supervisor, the Compliance Director of the Health System facility where he/she is employed, the Chief Corporate Compliance Officer of the Health System (516-465-8097), or to call the confidential Compliance Help-Line at (800) 894-3226 which is available 24 hours a day, 7 days a week or by visiting www.northshore-lij.ethicspoint.com where individuals can make reports about compliance issues online.

Any individual who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for making the report. The Health System also prohibits anyone from intimidating an individual from disclosing compliance concern. The Health System will immediately investigate and take appropriate action with respect to all suspected acts of retaliation or intimidation.

The Health System obligates itself to swiftly and thoroughly investigate any reasonable credible report of fraud, waste, or abuse or any reasonable suspicion thereof through the Health System's Compliance Program.

The Health System has the right to take appropriate action against an employee who has participated in a violation of law or hospital or Health System policy. The failure to comply with the laws and/or to report suspected violations of state or federal law can have very serious consequences for the Health System and for any affiliated individual who fails to comply or report. As a Health System employee or affiliated individual, you have an obligation to report concerns using the internal methods listed above and to understand the options available should your concerns not be resolved.

The Health System educates its employees, contractors and agents on the importance of this policy on a periodic basis.

B. **State and Federal Fraud and Abuse Detection, Prevention and Employee Protection**

I. **FEDERAL LAWS**

False Claims Act (31 U.S.C. §§ 3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

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; (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 defraud the Government by getting a false or fraudulent claim paid or approved by the Government; ...or (7) knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person...

- (a) 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 in 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.

While the FCA 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.

In sum, the FCA imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled and then uses the false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital that obtains interim payments from Medicare throughout the year and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

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 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, 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 not be less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims (31 U.S.C. §§ 3801-3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the FCA, a violation of this law occurs when it is submitted, not when it is paid. Also, unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties are made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York False Claims Act (State Finance Law, §§ 187-194)

The New York False Claims Act closely tracks the Federal FCA. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000-\$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit or 15-25% if the government did participate in the suit.

Social Services Law § 145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$2,000 per violation. If repeat violations occur within 5 years, a penalty of up to \$7,500 per violation may be imposed for more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law § 145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, and is found to have intentionally made a false or misleading statement for the purpose of establishing or maintaining the eligibility of the individual or of the individual's family for aid or of increasing (or preventing a reduction in) the amount of such aid, then the needs of such individual shall not be taken into account in determining his or her need or that of his or her family (i) for a period of six months upon the first occasion of any such offense, (ii) for a

period of twelve months upon the second occasion of any such offense or upon an offense which resulted in the wrongful receipt of benefits in an amount of between at least one thousand dollars and no more than three thousand nine hundred dollars, (iii) for a period of eighteen months upon the third occasion of any such offense or upon an offense which results in the wrongful receipt of benefits in an amount in excess of three thousand nine hundred dollars, and (iv) five years for any subsequent occasion of any such offense.

CRIMINAL LAWS

Social Services Law § 145 Penalties

Any person, who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b Penalties for Fraudulent Practices

- a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
- b. Any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155 Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This crime has been applied to Medicaid fraud cases.

- a. Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.
- b. Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.
- c. Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.
- d. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

Penal Law Article 175 False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- a. § 175.05, Falsifying business records, involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
- b. § 175.10, Falsifying business records in the first degree, includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It

is a Class E felony.

- c. § 175.30, Offering a false instrument for filing in the second degree, involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
- d. § 175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176 Insurance Fraud

This statute applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes.

- a. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
- b. Insurance fraud in the fourth degree is filing a false insurance claim for over \$1,000. It is a Class E felony.
- c. Insurance fraud in the third degree is filing a false insurance claim for over \$3,000. It is a Class D felony.
- d. Insurance fraud in the second degree is filing a false insurance claim for over \$50,000. It is a Class C felony.
- e. Insurance fraud in the first degree is filing a false insurance claim for over \$1 million. It is a Class B felony.
- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177 Health Care Fraud

This statute applies to claims for health insurance payment, including Medicaid, and contains five crimes.

- a. Health care fraud in the fifth degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
- b. Health care fraud in the fourth degree is filing false claims and annually receiving over \$3,000 in aggregate. It is a Class E felony.
- c. Health care fraud in the third degree is filing false claims and annually receiving over \$10,000 in aggregate. It is a Class D felony.
- d. Health care fraud in the second degree is filing false claims and annually receiving over

\$50,000 in aggregate. It is a Class C felony.

- e. Health care fraud in the first degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. § 3730(h))

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. 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.

New York False Claims Act (State Finance Law § 191)

The New York False Claims Act also 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 Act. 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.

New York Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or similar agency or public official. Protected disclosures are those that assert that the employer's policy, practice or activity violates the law and creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions).

The employee's disclosure is protected only if (a) the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, and (b) the policy, practice or activity actually violates the law. If an employer takes a retaliatory action against the employee, the employee may sue for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

New York Labor Law § 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures

are those that are asserted by employees in good faith and with the reasonable belief that the policy, practice or activity constitutes improper quality of patient care.

The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue for reinstatement to the same or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

42 U.S.C. §1396a(a)(68)

CLINICAL REFERENCES

APPROVAL: To Include Committee Name / Approval Date	
System P&P Committee	5/12/09; 11/9/10; 4/12/11
System PICG Committee	5/28/09; 11/18/10; 4/28/11