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Detecting and Preventing Fraud, Waste, Abuse and Misconduct

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I. Statement of Purpose

It is the obligation of Erie County Medical Center Corporation ("ECMCC") to prevent and detect any actions within the organization that are considered to be fraudulent, wasteful, or abusive of federally funded programs. These actions, commonly known as "fraud, waste, and abuse", and as further defined within this policy, include actions that are illegal, violative of federal and state health care programs (Medicare, Medicaid and other governmental payer programs), or in violation of any applicable ECMCC policy, including policies that are designed to prevent financial wrongdoing; policies prohibiting fraud, theft, embezzlement, bribery, kickbacks and abuse or misuse of corporate assets; conflict of interest policies; policies addressing unethical conduct; and harassment and discrimination policies.

The purpose of this policy is to educate our work force regarding the fraud, waste and abuse laws, including the requirements, rights and remedies of federal and state laws governing the submission of false claims. This policy also addresses the rights of employees to be protected as whistleblowers under such laws and the importance of submitting accurate claims and reports to federal and state governments.

II. Definitions of fraud, waste and abuse ("FWA")

a. **Fraud** is an intentional deception or misrepresentation made by a person with knowledge that the deception could result in financial or personal gain. It includes any act that constitutes fraud under applicable state or federal law.

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b. **Waste** includes practices that, directly or indirectly, result in unnecessary costs to federally funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

c. **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to federally funded programs. Abuse involves paying for items or services when there is no legal entitlement to that payment.

d. **Affected Individuals** are individuals who are covered by ECMCC's Compliance program requirements. This includes employees, senior administrators, managers, contractors, governing body and corporate officers.

e. Examples of potential FWA (this list is not exhaustive):

    i. Falsifying claims

    ii. Alteration of claims

    iii. Incorrect coding

    iv. Double billing

    v. Misrepresentation of medical condition

    vi. Failure to report third party liability

    vii. Billing for services not provided

    viii. Misrepresentation of services or supplies

    ix. Providing substandard care

    x. Fraudulent credentials

    xi. Under utilization and over utilization

    xii. Failure to refer for needed services

    xiii. Antikickback/Stark law violations

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III. Procedure

To assist ECMCC in meeting its legal and ethical obligations, ECMCC requires affected individuals who is aware of or in good faith suspects conduct that is illegal, against ECMCC policy, or in furtherance of the preparation or submission of a false claim or report, or conduct that includes any other potential fraud, waste, or abuse related to a federal or state-funded health care program, to report such information to the individual’s supervisor and/or the Compliance Officer (716-898-6439), or to call the confidential Compliance & HIPAA Anonymous Hotline at 855-222-0758, which is available 24 hours a day, 7 days a week. A good faith report is a report that a whistleblower reasonably believes to be true, and believes to constitute illegal conduct, fraud or a violation of ECMCC policy.

ECMCC will immediately investigate and take appropriate action with respect to all suspected acts of retaliation or intimidation. Such actions may include self-disclosures to appropriate governmental regulatory bodies and/or paybacks to appropriate payers. Actions may also be taken against an Individual who has participated in a violation of law or hospital or ECMCC policy or who had knowledge of such violations and failed to in good faith report them.

All whistleblower reports will be kept confidential to the extent permitted by law. Where appropriate, the Compliance Officer will report issues reported or identified to the ECMCC Board's Audit and Compliance Committee, though anonymity of the whistleblower will be retained whenever possible. Any individual who reports such information in good faith will have the right and opportunity to do so anonymously and will be protected against intimidation, harassment, discrimination or other retaliation or, in the case of employees, adverse employment consequences. ECMCC also prohibits anyone from intimidating an individual into not disclosing compliance concerns. (*For further details, see ECMCC's Non-Retaliation Policy.*)

IV. Relevant FWA Laws & Regulations

The below is a non-exhaustive list of applicable FWA laws and regulations that apply to ECMCC, as well as further details on the protections available to Individuals who in good faith report violations of them.

FEDERAL LAWS

a. **Federal False Claims Act ("FCA") (31 U.S.C. § 3729-3733)**
    i. 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) knowingly conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; and/or (4) 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 $11,803 and not more than $26,607, plus three 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.
    ii. Further specifics of this law are as follows:
        a. 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.
            i. *Example:* a physician who submits a bill to Medicare for medical services she knows she has not provided.
        b. The FCA also imposes liability on an individual who knowingly submits a false record in order to obtain payment from the government.
            i. *Example:* a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

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c. The FCA imposes liability on an individual who obtains 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.

    i. *Example:* 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.

d. In addition, 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.

    i. Section(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.

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b. **Program Fraud Civil Remedies Act (31 U.S.C. §§3801 – 3812)**

    i. This law applies specifically to Medicare and Medicaid programs and 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 $11,803 for each claim. The agency may also recover twice the amount of the claim. Congress may make additional periodic adjustments to the penalties set forth in this section.

    ii. 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.

NEW YORK STATE LAWS

a. **New York State False Claims Act (NY State Fin § 187 – 194)**

    i. The New York False Claims Act closely resembles 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 $11,803-$26, 607 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.

    ii. 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.

b. **New York State Social Services Law § 145-b False Statements**
    i. This law applies specifically to NYS Medicaid program. It makes it 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 $10,000 per violation for more serious violations of Medicaid rules, including billing for services not rendered, providing excessive services and failing to report and return a Medicaid overpayment. If repeat violations occur within 5 years, a penalty of up to $30,000 per violation may be imposed.

c. **New York State Social Services Law §145-c Sanctions**
    i. This law applies to any person applying for or receiving public assistance including Medicaid. Under this law, 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.

d. **New York State Social Services Law § 363-d**
    i. This statute requires all providers who obtain payment for items or services furnished under any Social Services program, including Medicaid, to adopt and implement a compliance program which satisfies the statute's requirements.
    ii. A provider who fails to implement a compliance program which adheres to the statute's requirements will be subject to a penalty of up to $5,000 per month, as well as additional sanctions, including potential exclusion from the Medicaid program. If repeat violations occur, a penalty of up to $10,000 per month may be imposed.
    iii. The statute also requires providers to report, return and explain in writing to the Office of the Medicaid Inspector General any Medicaid overpayments within 60 days of receipt of the overpayment, and specifies when this 60-day time period may be tolled. Providers who fail to comply with this requirement are subject to penalties and sanctions under Social Services Law § 145-b.

CRIMINAL LAWS

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In addition to civil/monetary penalties, violation of many laws also constitutes criminal activity, as follows:

a. **Social Services Law § 145 Penalties**
    1. Any person, who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

b. **New York State Social Services Law §366-b Penalties for Fraudulent Practices**
    i. 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.
    ii. 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.

c. **New York Penal Law Article 155 (Larceny)**
    i. 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.
    ii. Penalties
        1. Class E felony: fourth degree grand larceny involving property valued over $1,000.
        2. Class D felony: third degree grand larceny involving property valued over $3,000.
        3. Class C felony: second degree grand larceny involving property valued over $50,000.
        4. Class B felony: first degree grand larceny involving property valued over $1 million.

d. **New York Penal Law Article 175 (False Written Statements)**
    i. 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

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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.

e. **New York Penal Law Article 176 (Insurance Fraud)**

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

a. Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing it is false. This is a Class A misdemeanor.

b. Insurance fraud in the 4th degree if filing a false insurance claim for over $1,000. This is a Class E felony,

c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. This is a Class D felony.

d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. This is a Class C felony.

e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. This is a Class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. This is a Class D felony.

f. **New York Penal Law Article 177**

i. 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.

WHISTLEBLOWER PROTECTION LAWS

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

i. 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

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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.

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

   i. 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.

c. **New York Protections under NY Labor Law §740**

   i. An employer may not take any retaliatory action against an employee if the employee discloses or threatens to disclose 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 an employee reasonably believes; (i) violates a law, rule or regulation; or (ii) poses a substantial and specific danger to the public health and safety.

   ii. The law further requires that before disclosing information about the employer's policies, practices or activities to a regulatory, law enforcement or similar agency or public official, the employee first make a good-faith effort to raise the matter with a supervisor and give the employer a reasonable opportunity to correct the alleged violation. Employees are not required to take those steps if they reasonably believe: (i) there is imminent and serious danger to public health or safety, (ii) the supervisor is already aware of and will not correct the unlawful activity; (iii) the activity would endanger the welfare of a minor; (iv) physical harm will result to the employee or another person; or (v) the reporting of such would lead to the destruction of evidence or other concealment of the activity.

d. **New York Protections under NY Labor Law §741**

   i. A health care employer may not take any retaliatory action against an employee if the employee discloses, or threatens to disclose, certain information about the employer's policies, practices or activities to a supervisor, regulatory, law enforcement, other similar agency, public official, news media outlet or social media forum. 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 or improper quality of workplace safety.

   ii. The employee's disclosure is protected only if the employee first brought up the improper quality of patient care to the attention of a supervisor and gave the employer a reasonable opportunity to correct the alleged activity, policy or practice, unless the danger is imminent to the public health or safety to the health of a specific patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action.

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V. ECMCC FWA prevention and detection measures

ECMCC has implemented a number of measures designed to both detect and prevent fraud, waste, and abuse at ECMCC, including the following:

a. **Corporate Compliance Program.** ECMCC's Corporate Compliance Program is structured to prevent and to detect non-compliance, false claims and impermissible financial transactions which result in health care fraud, waste or abuse. The core of ECMCC's Compliance program are ECMCC's Code of Conduct and Compliance Plan, and Conflict of Interest Policy. Affected Individuals are required to have familiarity with ECMCC's Compliance Program and these documents. Individuals involved in any medical documentation, claims submission, or related areas are expected to have familiarity as well with ECMCC's Coding and Billing policies.

b. **Education.** ECMCC is committed to on-going education of its workforce. ECMCC's on-line training system offers an annual mandatory on-line re-education of its entire workforce. In addition, all new employees are required to attend orientation containing Fraud, Waste and Abuse Compliance training. The Corporate Compliance department provides additional training to all affected individuals and any departments both upon request and as additional education is identified, particularly in high risk areas such as components of ECMCC's Revenue Cycle. Additional details on ECMCC's education efforts are set forth in ECMCC's Compliance Training and Education policy.

c. **Reporting Mechanisms.** As earlier described, Affected Individuals are obligated to report suspected non-compliant activities. Different options have been established to contact Corporate Compliance including anonymous reporting via our hotline at 1-855-222-0758, contacting Compliance directly at 716-898-6439 or by e-mail at dlnesbitt@ecmc.edu, supervisor reporting or Case Call Reporting.

d. **Audits.** All ECMCC departments are responsible for the accuracy of operating expenses and revenue capture. This includes correct charging for services and/or supplies as well as accurate record keeping and retention. Patient Financial Services, Revenue Integrity, Corporate Compliance, and Health Information Management all perform audits of medical record documentation to ensure compliance with the billing requirements of federal and state health care programs. In addition, compliance risk areas identified in the HHS Office of the Inspector General's annual work plan and the New York State Office of the Medicaid Inspector General's annual work plan are reviewed by Internal Audit and Corporate Compliance to assess vulnerabilities, and notify affected operating areas accordingly.

e. **Billing and Coding Edits**. ECMCC has implemented various billing and coding edit software packages to further detect billing and coding that is not compliant with rules associated with federal and state health care programs

f. **Internal Controls.** ECMCC has instituted an internal set of checks and balances to detect and deter fraud, waste and abuse in all business practices. These include but are not limited to written policies and procedures, segregation of duties, security, and regular monitoring.

g. **Investigations.** Corporate Compliance performs both informal and formal investigations based upon proactive auditing and reports of possible fraud, waste and abuse associated with federal and state health care programs. If errors or wrongdoing are found, ECMCC reports and

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returns any overpayments to the appropriate payer. If a self-disclosure is required, ECMCC will self-disclosure within 60 days. Additionally, an investigation of the reasoning and/or how the error or wrongdoing occurred will be completed and internal controls will be put into place to identify and to preventive any future issues.

h. **Background Checks.** ECMCC Human Resources Department conducts criminal background checks on individuals following an offer and acceptance of employment. Based on the results of the background check, an individual's offer of employment may be rescinded or, if an employee has started at work and the background check is unacceptable, employment will be terminated. Potential vendors are required to undergo the process outlined in the Vendor Access Policy (PUR-001) that includes a criminal background check through VCS. In addition, ECMCC regularly checks all affected individuals against exclusion lists published by the Federal government and the New York State government. These lists identify individuals and entities that have been convicted of health care fraud and have been excluded from participation with Medicare, Medicaid, and other governmental programs. Appropriate steps are taken with regard to individuals and entities appearing on one or more of these exclusion lists.

i. **Legal Review of Contracts.** ECMCC's Legal Department reviews contracts and works closely with the Compliance Department to identify potential compliance risks prior to contract execution. The Legal Department additionally specifies within applicable contracts that contractors are subject to ECMCC's Compliance Program to the extent that they are affected by our risk areas and within the scope of the contracted authority and risk areas.

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References:

New York State Finance Law §§ 187 – 194
New York State Social Services Law §§ 145 and 363
Federal False Claims Act (31 U.S.C. §§3729-3733)
OMIG Deficit Reduction Act of 2005
Penal Law Article 175
New York State Labor Law §§740- 741
Health Care Education and Affordability Reconciliation Act (2010)
31 U.S.C.§ 3730(h)
42 U.S.C. §1396a(a)(68)
ECMCC Code of Conduct
ECMCC Corporate Compliance Program

ECMCC has developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations from these policies and procedures may be warranted in actual practice based upon individual patient characteristics and clinical judgment in unique care circumstances.

Approval Signatures

Step Description	Approver	Date
	Lindy Nesbitt: Assistant VP Compliance & Senior Counsel	Pending

Applicability

Erie County Medical Center

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