Kaleida Health POLICY	**Title: Fraud, Waste, and Abuse Compliance including Federal and New York State False Claims Act Information** **Owner:** Internal Audit and Corporate Compliance	**# IAC.18** **Issued:** 6/1/07
Keywords: fraud, waste, abuse, whistleblower		

I. Statement of Purpose

It is the policy of Kaleida Health to comply with all applicable federal and state laws pertaining to fraud, waste and abuse in Federal health care programs including Section 6032 of the Deficit Reduction Act of 2005 and disseminate information to all covered persons regarding:

A. Federal laws and administrative remedies and State laws related to false claims and statements, and whistleblower protections under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, and

B. Kaleida Health's policies of detecting and preventing fraud, waste, and abuse.

C. The Patient Protection and Affordable Care Act (Public Law 111-148) requires providers to have a compliance program as a condition of participation in the Medicare and Medicaid programs.

II. Audience

All workforce members. For the purposes of this policy, the term "workforce member" means Medical Staff members, hospital, home care, clinic and nursing home staff, including employees, students, interns, residents and volunteers. This policy also applies to members of the Board of Directors, consultants, contractors and vendors of Kaleida Health, as applicable.

III. Instructions – (Outline necessary steps for consistent completion of process/ procedure)

Detecting fraud, waste and abuse (FWA) is the responsibility of everyone. Kaleida Health has written policies on Corporate Compliance Program (IAC.20) and the Code of Conduct and Business Ethics (IAC.19). These policies outline expected behaviors of all Kaleida Health employees and those doing business with Kaleida Health. This policy provides additional guidance in federal and state laws, recognizing fraud, waste, and abuse as well as preventive and detective measures in place.

A. **Federal Legislation**

1. **False Claims Act (31 U.S.C. § 3729 et seq)**

a. Key Provisions

1) Applies to any demand or claim to federal monies other than tax refunds.

2) Knowingly presenting a false claim is actionable.

3) Deliberate ignorance or reckless disregard for the accuracy of a claim is actionable.

4) "Whistleblower" or "relator" role defined in False Claims Act to encourage private citizens to bring false claims actions to the attention of the government with the filing of a civil lawsuit.

5) Penalties may be reduced if an entity detects and reports false claims activity to the government.

b. Penalties

1) Fines of $10,781 to $21,563 per claim plus damages and costs.

2) Corporate Integrity Agreement may be imposed.

3) Exclusion from participation in Medicare, Medicaid and other federal programs.

c. Amendments to the False Claims Act (31 U.S.C. § 3729 et seq) in the Fraud Enforcement Recovery Act of 2009
   1) Applicable to claims submitted to government contractors and subcontractors when there is a connection to government funds.
   2) Improperly retaining any overpayment of government funds is a False Claims Act violation even if the original claim was appropriate.
   3) Expands whistleblower protections to contractors and agents.

2. **Program Fraud Civil Remedies Act (31 U.S.C. §§3801 – 3812)**
   a. Key Provisions
      1) Applies specifically to Medicare and Medicaid programs.
      2) Knowingly or has reason to know a claim or statement is false, fictitious or fraudulent is actionable.
      3) Omission of material facts that the entity has a duty to include is actionable.
      4) Claim is for items or services that a person or entity has not provided.
   b. Penalties
      1) Fines up to $5,000 or each false claim with an additional penalty up to $5,000 if entity claimed original material was truthful, plus damages.
      2) Exclusion from participation in Medicare and Medicaid programs.

3. **Patient Protection and Affordable Care Act (Public Law 111 – 148)**
   a. Section 1313
      Payments made by, though, or in connection with health exchanges fall within the scope of the Federal False Claims Act should such payments include federal funds.
   b. Section 6402
      1) Requires providers that have received an overpayment from Medicare, Medicaid and CHIP to return it appropriately with a written notification done within 60 days.
      2) Any claim resulting from a violation of the Antikickback Statute (42 USC § 1320a - 7b) is a false claim.
      3) Exclusion for providers making false statements or misrepresenting material facts in an application.
      4) New civil monetary penalties for false statements in applications, failure to report and return an overpayment.
   c. Section 6408
      1) Civil monetary penalty applied for knowingly making a false record or statement material to a false claim.
      2) Civil monetary penalty applied for failing to grant timely access to the OIG for audits or investigations.
      3) Permissive exclusion of a provider for conviction of obstruction of an audit.
   d. Section 10606
      Increases potential penalties for health care fraud under the Federal Sentencing Guidelines

B. **New York State Legislation**

1. **New York State False Claims Act (NY State Fin § 187 – 194)**
   a. Key Provisions
      1) Applies to any demand or claim to state and local monies.
      2) Knowingly presenting a false claim is actionable.
      3) Deliberate ignorance or reckless disregard for the accuracy of a claim is actionable.
      4) "Whistleblower" or "qui tam plaintiff" role encourages private citizens to bring false claims actions to the attention of the government with the filing of a civil lawsuit.
      5) Penalties may be reduced if the entity detects and reports false claims activity to the government.
   b. Penalties
      1) Civil penalties of $6,000 to $12,000 per false claim plus damages and costs.
      2) Exclusion from the NYS Medicaid program.

2. **New York State Social Services Law § 145-b**
   a. Key Provisions
      1) Applies specifically to NYS Medicaid program.
      2) Knowingly submitting a false statement, deliberately concealing a material fact, or any other fraudulent scheme or device is actionable.
   b. Penalties
      1) Three times the amount of damages sustained by the Medicaid program or $5,000 whichever is greater.
      2) Civil penalties up to $2,000 for each claim submitted.

3. **New York State Social Services Law §145-c**
   a. Key Provisions
      1) Applies to any person applying for or receiving public assistance including Medicaid.
      2) Intentionally making a false or misleading statement or intending to do so is actionable.
   b. Penalties
      1) The person and/or the person's family's needs are sanctioned for 6 months for a first offense.
      2) The person and/or the person's family's needs are sanctioned for 12 months (or once if benefits received are over $3,900) for a second offense.
      3) The person and/or the person's family's needs are sanctioned for 5 years for 4 or more offenses.

4. **New York State Social Services Law § 145**
   a. Key Provisions
      1) Applies to a person who submits false statements in order to receive public assistance including Medicaid.
      2) Applies to any person who deliberately conceals material information in order to receive public assistance including Medicaid.
   b. Penalties
      Guilty of misdemeanor

5. **New York State Social Services Law §366-b**
   a. Key Provisions
      1) With intent to defraud presents any false or fraudulent claim.
      2) Knowingly submits false information for the purpose of obtaining greater compensation than otherwise permitted.
      3) Knowingly submits false information for the purpose of obtaining authorization under the Medicaid program.
   b. Penalties
      1) Considered a Class "A" misdemeanor.
      2) Up to a one-year jail sentence.

6. **New York Penal Law Article 155**
   a. Key Provisions
      1) Defines crime of larceny and has been applied to Medicaid fraud cases.
      2) Applies to person who, with the 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.
   b. 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.

7. **New York Penal Law Article 176**
   a. Key Provisions
      1) Defines insurance fraud.
      2) Applies to claims for insurance payments including Medicaid.
   b. Penalties
      1) Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing it is false. This is a Class A misdemeanor.
      2) Insurance fraud in the 4th degree if filing a false insurance claim for over $1,000. This is a Class E felony,
      3) Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. This is a Class D felony.
      4) Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. This is a Class C felony.
      5) Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. This is a Class B felony.
      6) Aggravated insurance fraud is committing insurance fraud more than once. This is a Class D felony.

8. **New York Penal Law Article 177**
   a. Key Provisions
      a. Intent to defraud public and private health plans.

b. Knowingly and willfully provides materially false information or omits material information for purpose of receiving payment to which individual or entity is not entitled.

b. Penalties
   a. Amount of payments wrongfully received in one year.
   b. Corresponding jail time.
   c. Health care fraud penalties correspond to penalties defined under Penal Article 176.

C. **"Whistleblower" Protections**

1. **Federal and New York State protections under False Claims Acts**
   a. Reinstatement with seniority if terminated
   b. Double back pay
   c. Interest
   d. Special damages sustained as a result of discriminatory treatment
   e. Attorneys' fees and costs
   f. In New York, no discrimination in hiring an individual who is or was a whistleblower
   g. In New York State, a lawful act includes obtaining or transmitting information to the state or other parties to investigate, potentially file, or file a cause of action even though such act may violate a contract, employment term, or duty owed to an employer or contractor

2. **New York Protections under NY Labor Law §740**
   a. Prohibits retaliatory action by employers.
   b. Protection for employees reporting health care fraud to a supervisor or public body.

3. **New York Protections under NY Labor Law §741**
   a. Prohibits retaliatory action by health care employers.
   b. Protections for employees reporting health care fraud to a supervisor or externally.

4. **Kaleida Health Code of Conduct and Business Ethics (IAC.19)**
   a. Zero tolerance for any form of retribution or retaliation against a whistleblower.
   b. Violator subject to discipline up to and including termination.

D. **Definitions of fraud, waste, and abuse (FWA)**

1. **Fraud** – An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable state or federal law.

2. **Waste and Abuse** – Incidents or practices that are inconsistent with legal, ethical, accepted and sound business, fiscal or medical practices that result in unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It includes Medicare and Medicaid practices that result in unnecessary costs to a health program.

3. Examples of potential FWA (this list is not exhaustive)
   a. Falsifying claims
   b. Alteration of claims
   c. Incorrect coding
   d. Double billing
   e. Misrepresentation of medical condition
   f. Failure to report third party liability
   g. Billing for services not provided
   h. Misrepresentation of services or supplies
   i. Providing substandard care
   j. Fraudulent credentials
   k. Underutilization and over utilization
   l. Failure to refer for needed services
   m. Kickback/Stark violations

E. **Kaleida Health FWA prevention and detection measures**

1. **Prevention Measures**

   a. **Compliance Program** – The Kaleida Health Compliance Program contains the following aspects which pertain to the prevention and detection of false claims and statements and impermissible financial transactions which result in health care fraud and abuse: Code of Conduct and Business Ethics (IAC.19), Corporate Compliance Program (IAC.20), Conflict of Interest (HR.16), and Laboratory Compliance Plan (LB-CM.2).

   b. **Education** - Kaleida Health is committed to on-going education of its workforce. The on-line Talent Management system offers a central location for enrollment in both instructor-led and on-line educational opportunities. Departments regularly provide in-services. The on-line Annual Review includes modules on corporate compliance, False Claims Act, Red Flag regulations, and HIPAA. The Health Information Management department regularly attends local and regional coding clinics to maintain their coding proficiency. On request, Internal Audit and Corporate Compliance provides training to any department.

   c. **Reporting Mechanisms** - Kaleida Health employees are obligated to report suspected non-compliant activities pursuant to both the Code of Conduct and Business Ethics (IAC.19) and Standards of Personal Conduct (HR.15). Different options have been established to contact Internal Audit and Corporate Compliance including anonymous reporting through the STARS system, the Corporate Compliance hotline (716-859-8559), or in a written report. Employees may also arrange a personal meeting with the Kaleida Health compliance officer, request a meeting with the Office of General Counsel or request a meeting with an Audit and Corporate Compliance committee member as well as contacting outside governmental and accrediting organizations.

   d. **Background Checks** - Kaleida Health Corporate Employment 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 Sales Representative Access policy (FI.2) that includes a criminal background check. Kaleida Health regularly checks all employees, vendors, volunteers, and members of the medical staff 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.

e. **Legal Review of Contracts** - Kaleida Health Office of General Counsel reviews contracts with attention to compliance with fraud and abuse laws.

2. **Detection Measures**

a. **Billing and Coding Edits** – as one means of detecting billing and coding that is not compliant with rules associated with federal and state health care programs, Kaleida Health has implemented various billing and coding edit software packages.

b. **Audits** – All Kaleida 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, Internal Audit and 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.

c. **Internal Controls** - Kaleida Health 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.

d. **Investigations** – Internal Audit and Corporate Compliance performs both informal and formal investigations based upon reports of possible fraud, waste, or abuse associated with federal and state health care programs. If errors or wrongdoing are found, Kaleida Health reports and returns any overpayments to the appropriate payer.

IV. Approved by - **(Include date)**

Office of General Counsel	7/07, 2/11, 9/13, 8/15, 7/16, 9/17
Corporate Policy Approval Committee	1/13/12, 10/11/13, 8/14/15

V. References **(Include evidence based research, Kaleida Health policy, and regulation as applicable)**

IAC.20 - Corporate Compliance Program
IAC.19 - Code of Conduct and Business Ethics
HR.16 - Conflict of Interest

LB-CM.2 - Laboratory Compliance Plan
FI.2 - Vendor Sales Representative Access

NYS False Claims Act (State Finance Law §§ 187 – 194), New York State Finance Law, S 39, Article XIII

False Claims Act (31 U.S.C. §§3729-3733), Deficit Reduction Act of 2005 Section 6032, Fraud Enforcement Recovery Act of 2009, Patient Protection and Affordable Care Act (Public Law 111-148), Health Care Education and Affordability Reconciliation Act (2010)

Version History:

Effective Date:	Reviewed/ Revised
9/18/17	Reviewed no changes
8/15/16	Revised
8/31/15	Revised
9/13	Revised
12/11	Revised