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Owner	Lindy Nesbitt: Assistant VP Compliance & Senior Counsel
Area	Corporate Compliance
Applicability	Erie County Medical Center
References	CORP-018

Fraud, Waste and Abuse Compliance

I. Statement of Purpose

It is the policy of Erie County Medical Center Corporation ("ECMCC") to comply with all applicable federal and state laws pertaining to fraud, waste and abuse in Federal health care programs, and to disseminate information to all workforce members 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. ECMCC's policies of detecting and preventing fraud, waste, and abuse.

II. Statement of Policy

Detecting fraud, waste and abuse (FWA) is the responsibility of all workforce members, including members of the Board of Directors, contractors, agents, subcontractors, and independent contractors of ECMCC. This policy provides additional guidance in federal and state laws, recognizing fraud, waste, and abuse as well as preventive and detective measures in place.

III. 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 some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable state or federal law.

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. 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. Kickback/Stark violations

IV. Procedure

To assist ECMCC in meeting its legal and ethical obligations, ECMCC expects and encourages any employee, contractor or agent who is aware of or reasonably suspects conduct that is illegal, against ECMCC policy or in furtherance of 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 the individual's supervisor, the Compliance Office (716-898-6439), or to call the confidential Compliance & HIPAA Hotline at 855-222-0758, which is available 24 hours a day, 7 days a week.

Where appropriate, the Corporate Compliance Officer will report the issue to the Board Audit and Corporate Compliance Committee. A record will be kept of all whistleblower interactions. 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.*)

A good faith report is a report that a whistleblower reasonably believes to be true regarding conduct that the individual reasonably 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. Reports will be kept confidential to the extent permitted by law.

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

ECMCC has the right to take appropriate action against an employee who has participated in a violation of law or hospital or ECMCC 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 ECMCC and for any affiliated individual who fails to comply or report a suspected violation. As a ECMCC 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.

V. Key Fraud, Waste and Abuse Laws and Regulations

The following sections detail the various key laws and regulations that address fraud, waste and abuse in healthcare.

FEDERAL LAWS

a. **Federal False Claims Act (31 U.S.C. § 3729-3733)**
    i. Applies to any demand or claim to federal monies other than tax refunds.
    ii. Knowingly presenting a false claim is actionable.
    iii. Improperly retaining any overpayment of government funds is a False Claims Act violation even if the original claim was appropriate.
    iv. Deliberate ignorance or reckless disregard for the accuracy of a claim is actionable.
    v. Applicable to claims submitted to government contractors and subcontractors when there is a connection to government funds.
    vi. Penalties
        1. Civil penalty of not less than $5,000 to $10,000, plus 3 times the amount of damages which the government sustains.
        2. Corporate Integrity Agreement may be imposed.
        3. Exclusion from participation in Medicare, Medicaid and other federal programs.
        4. Penalties may be reduced if an entity detects and reports false claims activity to the government.
    vii. "Whistleblower" or "relator" role defined in False Claims Act to encourage private citizens (including contractors and agents) to bring false claims actions to the attention of the government with the filing of a civil lawsuit.

b. **Program Fraud Civil Remedies Act (31 U.S.C. §§3801 – 3812)**
    i. Applies specifically to Medicare and Medicaid programs.

ii. Submission of a claim one knows or has reason to know is false, fictitious or fraudulent is actionable.

iii. Omission of material facts that the entity has a duty to include is actionable.

iv. Claim is for items or services that a person or entity has not provided.

v. Penalties

1. A civil penalty of not more than $5,000 for each claim.
2. Exclusion from participation in Medicare and Medicaid programs.

NEW YORK STATE LAWS

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

i. Applies to any demand or claim to state and local monies.

ii. Knowingly presenting a false claim is actionable.

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

iv. Penalties

1. 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.
2. Potential exclusion from the NYS Medicaid program.
3. Penalties may be reduced if the entity detects and reports false claims activity to the government.

v. "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.

b. **New York State Social Services Law § 145-b False Statements**

i. Applies specifically to NYS Medicaid program.

ii. Knowingly submitting a false statement, deliberately concealing a material fact, or any other fraudulent scheme or device is actionable.

iii. Penalties

1. 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.
2. 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. Applies to any person applying for or receiving public assistance including Medicaid.

ii. Intentionally making a false of misleading statement or intending to do so is actionable.

iii. 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 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,
3. The person and/or the person's family's needs are sanctioned 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,
4. The person and/or the person's family's needs are sanctioned for a period of fifive 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

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 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

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 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.

VI. ECMCC Code of Conduct

a. ECMCC expects all workforce members will act in accordance with our Code of Conduct. All workforce members must refuse to participate in unethical or illegal conduct, and must report any unethical or illegal conduct to the Compliance Officer. It is the responsibility of all workforce members in carrying out the functions of the compliance program.

b. Zero tolerance for any form of intimidation or retaliation against a whistleblower. *See Non-Retaliation, Non-Intimidation Policy.*

c. Violators are subject to discipline up to and including termination. *See Discipline Policy.*

VII. ECMC FWA prevention and detection measures

a. **Corporate Compliance Program** – ECMCC 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 the Code of Conduct, Corporate Compliance Coding and Billing policy, and Conflict of Interest policy. All workforce members are responsible for carrying out the functions of the Compliance Program.

b. **Education** - ECMCC is committed to on-going education of its workforce. The on-line training system offers an annual mandatory on-line education of our entire workforce. In addition, all new employees are required to attend orientation containing Fraud, Waste and Abuse Compliance training.
    i. On request, Corporate Compliance provides training to any department.
    ii. High risk areas will receive additional training. (e.g. Billing)

c. **Reporting Mechanisms** – ECMCC workforce members are obligated to report suspected non-compliant activities pursuant to both the Code of Conduct and our Compliance Program. Different options have been established to contact Corporate Compliance including anonymous reporting COMPLIANCE & HIPAA HOTLINE 1-855-222-0758, the AVP of Corporate Compliance directly at 716-898-6439, email, Case Call Reporting or in a written report.

d. **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 employees, contractors, 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** – ECMCC's Legal Department reviews contracts and specifies within that contractors are subject to ECMCC's Compliance Program to the extent that they are affected by our risk areas and only within the scope of the contracted authority and risk areas.

VIII. 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, ECMCC has implemented various billing and coding edit software packages.

b. **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.

c. **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.

d. **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 returns any overpayments to the appropriate payer. If a self-disclosure is required, ECMCC will self-disclosure within 60 days.

    1. An investigation of the reasoning and/or how the error or wrongdoing occurred will be completed. Internal Controls will be put into place to identify and to preventive any future issues.

References:

New York State Finance Law §§ 187 – 194
New York State Social Services Law §§ 145 and 363
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

CORP-012 NON-RETALIATION AND NON-INTIMIDATION

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

Sam Cloud: Chief Medical Officer	09/2023
Lindy Nesbitt: Assistant VP Compliance & Senior Counsel	08/2023
Lindy Nesbitt: Assistant VP Compliance & Senior Counsel	08/2023