

SEPTEMBER 27, 2007

**NOTICE TO CONTRACTORS, AGENTS & VENDORS
OF MONTEFIORE MEDICAL CENTER**

False Claims Laws & Whistleblower Protections

Montefiore Medical Center (“MMC”) holds all contractors, agents and vendors responsible for compliance with federal and state laws that prohibit the making of false claims and for otherwise conducting our affairs lawfully. MMC is mandated by the federal Deficit Reduction Act of 2005, and the New York State Office of the Medicaid Inspector General to specifically require that such contractors, agents and vendors comply with the MMC policy and procedure on the detection and prevention of fraud, waste and abuse, a copy of which is attached. Also attached is the MMC policy summarizing state and federal laws intended to prevent submission of false claims.

We are providing you with this notice and attachments as one of our contractors, agents and vendors, in order to comply with our obligations under the law. Subsequent to receipt of this notice, you are required to communicate this information to your own employees, contractors or agents. You must also sign and return a copy of this notice as acknowledgement of receipt of and compliance with these requirements to the MMC Accounts Payable Department.

The information in this Notice and attachments is intended to highlight certain wrongful “false claims” activity that federal and state governments have specifically targeted in the healthcare profession and the laws that govern such wrongful activity. The attached policies are not intended to outline every law that concerns healthcare providers and you are encouraged to be aware of the laws, rules and regulations that may apply to your activities and to ensure compliance with such laws. Unlawful activity, such as false claims, could jeopardize MMC’ ability to continue to serve our patients, customers and the community.

MMC contractors, agents and vendors are responsible for reporting to MMC any suspected violations of the false claims laws, fraud, waste or abuse, or any other suspected unlawful conduct or violations described in the attached policies. MMC encourages direct reporting of suspected violations to the MMC Compliance Department, at **(718) 920-6351**. Concerns also can be reported anonymously to the **MMC Compliance Hotline at 1-800-662-8595**.

PLEASE SIGN AND RETURN THIS ACKNOWLEDGEMENT OF RECEIPT AND COMPLIANCE TO:

Montefiore Medical Center
Attention: Accounts Payable, Fordham 6th fl.
111 East 210th st.
Bronx, NY 10467

Name: _____

Title: _____

Name of Contractor,
Vendor or Agent: _____

Date: _____



MONTEFIORE MEDICAL CENTER
The University Hospital for the
Albert Einstein College of Medicine

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	SUMMARY OF FEDERAL AND STATE FALSE CLAIMS LAWS	NUMBER: JC31.1
OWNER:	COMPLIANCE OFFICE	
EFFECTIVE DATE: 2/07	REVIEW/REVISED DATE: 9/07	SUPERSEDES:
REFERENCE: 31 USC § 3729 <i>et seq.</i> ; 42 USC § 1320a-7a(a); 31 USC § 3730 <i>et seq.</i> ; 31 USC §§ 3801, 3802; NY Finance Law § 39 Article 13 187-194; 2007-2008 NY State Legislature S. 2108-C; NY Social Services Law § 145-b; NY Social Services Law § 366-b; NY Penal Law Article 177; NY Labor Law § 740 <i>et seq.</i>		
<i>Cross-Reference: Administrative Policy and Procedures, JC30.1, Detection and Prevention of Fraud, Waste and Abuse</i>		

Policy:

Montefiore Medical Center (MMC) is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005 and to preventing and detecting any fraud, waste, or abuse in its organization. It is the policy of Montefiore Medical Center (“MMC”) that all associates, including management, physicians, consultants and vendors/agents who provide services, shall comply with all applicable Federal and New York State False Claims Laws and regulations.

In compliance with the federal and state False Claims provisions, MMC prohibits any associates (or contractors or agents acting on its behalf) from knowingly submitting to any federally or state funded program a claim for payment approval that includes fraudulent information or is based on fraudulent documentation. MMC strives to educate our work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments, to assist MMC in preventing fraud, waste and abuse in health care programs. As part of MMC’s Compliance Program, associates shall receive training on these laws, which are summarized below. MMC’s compliance policies and procedures are set forth in detail in our compliance plan, which is available at [MMC Compliance Program Intranet site](#) and is provided to each employee.

All persons covered by this policy have a duty to notify the MMC Department of Compliance of any suspected fraud, waste, or abuse, including giving MMC reasonable time to investigate and to respond to such allegations. Additionally, persons should consult with the Department of Compliance if they have questions related to how these laws apply to their job. The Office of Compliance maintains an anonymous Hotline (1-800-662-8595), which can also be called to report any suspected violations.

This policy is intended to comply with the requirements of the Deficit Reduction Act and will be modified as necessary to do so. Please see more information about these Federal and New York State laws below.

MMC's POLICIES AND PROCEDURES

To assist MMC in meeting its legal and ethical obligations, any employee who reasonably suspects or is aware of the preparation or submission of a false claim or report, or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is required to report such information to his/her supervisor or MMC's compliance officer. Any employee of MMC who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under MMC's internal compliance policies and procedures and Federal and State law. However, MMC retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or hospital policy.

As an organization, MMC commits itself to investigate any suspicions of fraud, waste, or abuse swiftly and thoroughly and requires all employees to assist in such investigations. If an employee believes that MMC is not responding to his or her report within a reasonable period of time, the employee shall bring these concerns about MMC's perceived inaction to the MMC Department of Compliance. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the employee's obligations to MMC and may result in disciplinary action.

FEDERAL AND STATE STATUTES

The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act and certain relevant State laws.

FEDERAL LAWS/STATUTES

Federal False Claims Act

The Federal False Claims Act, 31 USC §3279, *et seq*, establishes liability for any person who engages in certain acts, including:

- knowingly presenting or causing to be presented a false or fraudulent claim to the Federal government for payment;
- knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal government; or
- conspiring to defraud the Federal government by getting a false or fraudulent claim allowed or paid.

Under the Federal False Claims Act, a person acts "knowingly" if s/he:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

There is no requirement that the person specifically intended to defraud the government through his or her actions.

Under the Federal False Claims Act, a "claim" is any request or demand for money or property if the Federal government provides any portion of the money or property in question. This includes requests or demands submitted to a contractor of the Government and includes Medicaid and Medicare claims.

A violation of the Federal False Claims Act results in a civil penalty between \$5,500 and \$11,000 for each false claim submitted, plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in Federal health care programs.

Qui Tam/Whistleblower Protections

The False Claims Act allows a private person to file a *qui tam* lawsuit on behalf of the Federal government. This person, also called a relator or whistleblower, must file his or her lawsuit under seal in a federal district court. The government may decide to intervene with the lawsuit, in which case the United States Department of Justice will direct the prosecution. If the government does not decide to intervene, the relator may still continue the lawsuit independently.

If a *qui tam* lawsuit is successful, the relator may receive between 15% to 30% of the recovery, depending on the level of the government's participation and other factors, as well as reasonable attorney's fees and costs. In addition, there can be no retaliation against the relator for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

Federal Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986, 31 USC §§3801, *et seq*, is similar to the False Claims Act, establishing an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent to certain Federal agencies, including HHS, and again, includes Medicaid and Medicare claims.

Similar to the False Claims Act, a person who "knows or has reason to know" is defined as one whom:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

Once again, there is no necessary proof of specific intent to defraud the government.

A violation of the Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to \$5,500 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing after investigation by HHS and approval by the United States Attorney General.

NEW YORK STATE LAWS/STATUTES

New York False Claims Act

The New York False Claims Act closely follows the Federal False Claims Act. Under New York False Claims Act (State Finance Law) §145-194, penalties and fines are imposed on individuals and entities which 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 ranges from \$6,000 to \$12,000 per claim, plus 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.

Qui Tam/Whistleblower Protections

Like the Federal False Claims Act, the New York State Act allows a private person to file a *qui tam* lawsuit on behalf of the state or local government. Also similar to the Federal law, if a *qui tam* lawsuit is successful, the relator may receive between 15% to 30% of the recovery, depending on the level of the state/local government's participation and other factors, as well as reasonable attorney's fees and costs.

The New York State 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 bringing an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had in absence of action, 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. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

New York Social Services Law

Under New York Social Services Law §145-b, it is unlawful to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. For a violation of this law, the local Social services district or the State has a right to recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Service district or State may recover three times the damages (or \$5,000, whichever is greater) sustained by the government due to the violation.

The law also empowers the New York State Department of Health to impose a monetary penalty on any person who, among other actions, causes Medicaid payments to be made if the person knew or had reason to know that:

- the payment involved care, services, or supplies that were medically improper, unnecessary, or excessive;
- the care, services or supplies were not provided as claimed;
- the person who ordered or prescribed the improper, unnecessary, or excessive care, services, or supplies was suspended or excluded from the Medicaid program at the time the care, services, or supplies were furnished; or
- the services or supplies were not in fact provided.

The monetary penalty shall not exceed \$2,000 for each item or service in question, unless a penalty under the section has been imposed within the previous five years, in which case the penalty shall not exceed \$7500 per item or service.

Under New York Social Services Law §366-b (2), any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining compensation greater than that to which s/he is legally entitled for furnishing services or merchandise shall be guilty of a class A misdemeanor. If such an act constitutes a violation of a provision of the penal law of the state of New York, the person committing the act shall be punished in accordance with the penalties fixed by such law.

New York Penal Law

Under New York Penal Law §155, Larceny, a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trickery, embezzlement, false pretense, false promise, including a scheme to defraud or other similar behavior. It has been applied to Medicaid fraud cases.

Under New York Penal Law §175-177, Health Care Fraud is established as a crime, inclusive of, but not limited to, production of false written statements and insurance fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), s/he knowingly and willfully provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which s/he is not entitled.

Under the New York State Penal Law, Health Care Fraud is punished with fines and jail time, based on the amount of payment inappropriately received due to the commission of the crime. The higher the payments in a one year period, the more severe the punishments, which may include up to 25 years of imprisonment if more than \$1 million in improper payments are involved.

New York Labor Law

New York law also affords protections to employees who may notice and report inappropriate activities. Under New York Labor Law §740, an employer shall not take any retaliatory personnel action against an employee because the employee:

- discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;
- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or
- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

According to §741 of the New York Labor Law, to bring an action under this article, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice. Furthermore, the relator is afforded certain protections under the law and may not be retaliated against for any good-faith disclosure of information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency/official. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation; reinstatement, back-pay and compensation of reasonable costs. At the same time, however, employees who bring an action without basis in law or fact may be held liable to the employer for its attorneys' fees and costs.



MONTEFIORE MEDICAL CENTER
The University Hospital for the
Albert Einstein College of Medicine

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	DETECTION AND PREVENTION OF FRAUD, WASTE AND ABUSE	NUMBER: JC30.1
OWNER:	COMPLIANCE OFFICE	
EFFECTIVE DATE: 2/07	REVIEW/REVISED DATE:	SUPERSEDES:
REFERENCE: S. 1932, Deficit Reduction Act of 2005		
CROSS-REFERENCE: Administrative Policy and Procedures, JF11.1, Provider Billing Compliance, JF03.1 Billing by Teaching Physicians, JE16.1, Ethical Conduct, Legal Compliance, Fraud and Misconduct, MMC Code of Conduct		

Policy:

It is the policy of Montefiore Medical Center ("MMC") that all associates (employees), physicians, vendors, consultants and agents who provide health care services shall comply with all pertinent Federal and New York State false laws and regulations including federal and state fraud and abuse and false claims laws. It is incumbent upon MMC to develop systems to detect, correct and prevent fraud, waste and abuse, especially in the areas that have been identified by the Office of the Inspector General of the Department of Health and Human Services to be "high risk" for fraud and abuse.

Scope:

This policy applies to all associates and physicians of MMC, whether assigned to perform duties in a division or unit of MMC or a corporate affiliate of the MMC, or at another institution under a contract between the MMC and such institution, and to all MMC clinical chairpersons regardless of MMC that is their employer. It is also applicable to all vendors, consultants and agents who perform services under contracts with MMC, with respect to their activities while performing those services or otherwise on behalf or purportedly on behalf of MMC.

Definitions:

Fraud - Fraud is the intentional deception or misrepresentation that an individual (1) knows to be false or does not believe to be true and (2) makes knowing the deception could result in some unauthorized benefit to himself/herself or some other person.

Abuse - Abuse involves incidents or practices that are inconsistent with accepted sound medical, business, or fiscal practices. These actions may result in unnecessary program costs and improper payment for services not meeting professionally recognized standards of care or

medical necessity.

Application:

Montefiore Medical Center has adopted an extensive set of programs in for detecting and preventing fraud. The Compliance Office oversees these programs and depending on the nature of the allegations works collaboratively with the Department of Audit Services, Risk Management, Legal Affairs and other departments to conduct investigations in these areas.

As part of the commitment to ethical and legal conduct, associates are required to bring immediately to the attention of their immediate supervisor, department supervisor, or the Compliance Officer, information regarding suspected improper conduct. Associates may also call the Compliance Hotline at 1-800-MMC-8595 (1-800-662-8595) to discuss concerns about possible violations of the law or institutional policy. MMC is committed to investigating any such allegation of fraud, waste, or abuse swiftly and thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, MMC requires that all associates fully cooperate in the investigation.

MMC devotes substantial resources to investigate allegations of fraud and abuse and therefore, expects that all associates will bring their concerns to MMC first in order to address and correct any fraudulent activity. Any associate of MMC who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under MMC's internal compliance policies and procedures and federal and state law. However, MMC retains the right to take appropriate action against an employee who has participated in a violation of federal or state laws, regulations, requirements of regulatory, licensing or accrediting agencies or hospital policy.

Certain state and federal laws provide that any private citizen may bring their concerns of fraud and abuse directly to the government; however, MMC strongly encourages its associates bring their concerns to MMC and to give MMC reasonable time to investigate and respond to the allegations. Failure to do so will be considered a breach of the associate's duty of loyalty to MMC.

Procedures:

Work Plans – Each year, the Compliance Office prepares work plans for the following year for each of the following areas: Corporate Compliance, HIPAA Privacy and Security, and Billing Compliance. The work plans set for the auditing and monitoring activities that will be undertaken in the calendar year. All work plans are approved by the Executive Compliance Committee and presented to the Compliance Committee of the Board of Trustees.

Auditing and Monitoring – The AVP of Billing Compliance, along with the billing compliance staff, performs routine and periodic reviews of claims submitted to Medicare, Medicaid and other health care plans. Reviews of the claims development and submission process are also conducted, and may include reviewing the work of coders, billers, admitting and registration clerks, physicians and ancillary departments. Reviews may also be scheduled as a result of a complaint made directly to the Compliance Office.

For HIPAA compliance, routine reviews of the clinical information system designed to identify unauthorized and/or inappropriate access to medical information are performed.

Risk Assessment – Certain laws and regulations require that a health care provider perform a periodic risk assessment. Risk assessment activities may be accomplished via the administration of questionnaires, departmental reviews, or using computer-based tools.

Education and Training – Depending upon the results of the reviews and other ongoing monitoring activities, the Compliance Office will design department-specific training sessions to address the issues of potential non-compliance. In addition, some training sessions are mandatory for specific groups, such as the teaching physician guidelines training session, HIPAA privacy and security training, and training involving billing for research-related services.

Corrective Action/Re-Review – In accordance with policy JF11.1, Provider Billing Compliance, departments or any and all other providers that are performing below the threshold for error will be put on a corrective action plan that may include 100% audit of claims, and may be subject to disciplinary action. Violations of HIPAA privacy and security will result in written disciplinary action, and in some cases, termination.

Responsibility:

Compliance Office

Regulatory Reference(s):

Deficit Reduction Act of 2005, S.1932 Sect. 6032 and Social Security Act, 42 U.S.C. 1396a(a)(68); Federal False Claims Act 31 U.S.C. 3729-3733; and New York State False Claims Provisions, Social Services Law Article 5 Title 1 §145-b; OIG Model Compliance Program Guidance for Hospitals, 63 FR 8987-8988 (2/23/98); OIG Supplemental Compliance Program Guidance for Hospitals, 70 FR 4858-4875 (01/31/05),