COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

JAMES L. TOMARKEN, MD, MPH, MBA, MSW
Commissioner

SUBJECT: **DEPARTMENTAL MANDATORY PROVIDER COMPLIANCE/ FALSE CLAIMS POLICY**

BACKGROUND: Section 6032 of the Federal Deficit Reduction Act of 2005 (DRA) amended the Social Security Act, Title 42, United States Code, Section 1396a(a), by inserting an additional relevant paragraph, (68); and, the New York State (NYS) Laws of 2006 amended
§ 363-d of the NYS Social Services Law to require a compliance program. Both of these provisions are directed towards combating and preventing Medicaid fraud, waste, and abuse. Medicaid providers are required to disseminate to covered staff education policies that are aimed at detecting and preventing fraud, waste, and abuse in the Medicaid program, as well as informing covered staff regarding the listed anti-fraud, false claim, and "whistle blower" protection statutes.

As a governmental agency which receives Medicaid payments in excess of $5 million per year, Suffolk County Department of Health Services (SCDHS) qualifies as an entity under these rules.

<u>The Federal False Claims Act (31 USC §§3729-3733) (FCA), and Federal whistleblower protections:</u>

The FCA permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the entity that committed the fraud. If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Any person who knowingly presents a false or fraudulent claim for payment, knowingly makes, uses, or causes to be made or used, a false record to get a false or fraudulent claim paid or approved by the Government; conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the government, or knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay money to the Government … is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages which the Government sustains because of the act of that person. In summary, the FCA imposes liability on any person who submits a claim to the government that he or she knows (or should know) is false. Detailed information is provided in Appendix A of this policy.

OFFICE OF THE COMMISSIONER
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New York State False Claims Act (NYS FCA),and other applicable State civil or criminal laws and State whistleblower protections:

New York State's false claims laws fall into two categories: civil and administrative; and, criminal. Some apply to recipient false claims, and some apply to provider false claims. Detailed information is provided in Appendix B of this policy.

SCOPE: This policy applies to all SCDHS employees, contractors, and agents. It outlines a compliance program, including the delineation of information regarding detecting and preventing fraud, waste and abuse (FWA), and informs staff regarding listed anti-fraud, false claim, and "whistle blower" protection status.

POLICY: It is the policy of SCDHS to detect and prevent fraud, waste, and abuse in Federal health care programs.

The Commissioner of Health Services shall have the authority and responsibility for the implementation of a Departmental Compliance Policy/Plan. Specifically, the Commissioner and/or designee shall have the authority and responsibility for compliance with governmental laws and regulations pertinent to SCDHS, including taking all the required and needed actions to assure accurate billing for services provided to persons; to direct repayment when necessary; and, to report misconduct to enforcement authorities.

The appointment of employees, contractors, and agents of SCDHS is contingent in part on acceptance of and compliance with this Policy.

This policy is not intended to replace other compliance practices or rules and regulations as defined elsewhere in any Suffolk County Policies and Procedures Manuals, Standard Operating Procedures, Administrative Codes, Local Laws, etc.

PROCEDURES: The following procedures are in place to detect and prevent fraud, waste, and abuse:

Education

DHS shall provide education to its employees, contractors and agents regarding the FCA, Federal and State whistleblower protections, NYS FCA, and other applicable State civil or criminal laws. This will include all pertinent Governing Bodies within the SCDHS, as well as the Board of Health.

Compliance Officer

The Commissioner of Health Services shall appoint a Compliance Officer, whose responsibilities shall include the implementation and maintenance of this policy. The Officer shall report jointly to the Commissioner of Health Services and the Compliance Committee. The Suffolk County Board of Health will receive reports at the first meeting of each calendar year from the Compliance Officer regarding the status of the Departmental Compliance Policy/Plan and any material compliance issues that have arisen since the previous Board meeting. Any one with questions regarding this Policy's interpretation or any one with suggestions should contact the Compliance Officer directly.

The Commissioner of Health Services has designated Kimberly Gierasch as its Compliance Officer. The Compliance Officer will seek advice from the Commissioner when necessary to ensure compliance with the law and SCDHS policies. The Compliance Officer may be reached by calling 631-854-0066 or in writing at the Compliance Officer's office.

SCDHS has appointed a Compliance Committee. The committee is chaired by the Commissioner, and members include:

- Commissioner of Health Services
- Director of Health Administrative Services
- Compliance Officer
- Director, Risk Management Unit
- Director, Division of Patient Care Services
- Director, Division of Mental Hygiene Services
- Assistant to the Commissioner

The Committee is empowered to assist the Compliance Officer in evaluating compliance issues, and in making policy and procedure changes to ensure that SCDHS remains in compliance with all applicable laws and regulations.

Responsibility for Compliance

All employees have the obligation to report any actual or suspected violations of this Departmental Compliance Plan. An employee who: fails to report any such activity; participates in non-compliant behavior; or, encourages, directs, facilitates or permits non-compliant behavior will be subject to appropriate disciplinary action. SCDHS also has established a hotline number – 631-854-0066 – for employees and others, to report all suspected violations.

Duty to Report:
It is the duty of every employee, contractor, and agent to report any actual or suspected violations of the Policy, including any conduct which is believed in good faith to be a violation of this Policy. This shall immediately be reported through the SCDHS hotline or in writing. Employees, contractors, and agents should report or discuss suspected violations with their immediate supervisor or administrator. Additionally, supervisors and administrators should promptly report confirmed violations, via phone as well as in writing to the Compliance Officer. Anyone has the right to confidentially and anonymously discuss or inquire about compliance issues or report suspected violations directly to the Compliance Officer. This can be done by either calling the Hotline at 631-854-0066 or in writing.

SCDHS will protect the identity, to the fullest extend allowed by law, of anyone reporting violations, as well as the individual that is the subject of such reporting. It is a serous violation of this policy to falsely report a violation or to retaliate or attempt to retaliate against anyone who makes a good faith report of a suspected or known violation.

Non-Retaliation:
There will be no reprisals for inquiries or good faith reporting of actual or possible violations of this policy. SCDHS will not retaliate against any employee, contractor, or agent for taking any lawful action under the covered laws and regulations. Any report will provide information that will either uncover an actual or potential problem, and/or provide SCDHS an opportunity to correct something. Moreover, SCDHS will not retaliate for reporting any potential compliance concern, as described in the whistleblower protection provisions located in the Appendices of this document, or any other pertinent whistleblower protection provisions.

Retaliation against any employee for participating in good faith in an investigation of suspected misconduct is prohibited. Acts of retaliation should be reported immediately, and will not be tolerated.

Code of Conduct:
All employees, contractors, and agents of SCDHS shall adhere to the Department's Code of Conduct. This Code shall be provided to said persons and entities upon employment, appointment, or execution of a contractual agreement, and is attached (Appendix C).

Billing Documentation and Reporting
Billing documentation and reporting activities are to be performed in a manner consistent with payor regulations and requirements, and in accordance with SCDHS documentation and billing practices.

Audit and Monitoring Procedures
To assist in its efforts to detect and prevent fraud, waste, and abuse, SCDHS conducts regular audit and monitoring procedures, both internally, and externally when appropriate. Said audits will be utilized to: identify compliance problems, correct such problems promptly and thoroughly, identifying potential compliance problems and instituting preventive measures, implementing procedures, policies and systems as necessary to reduce the potential for recurrence.

Corrective Action:
If billing errors or billing requirements violations are discovered, SCDHS will take steps to prevent any further similar violations. To the extent possible, SCDHS shall take the necessary steps to ensure that any necessary refunds of any overpayments from third party payers are promptly completed. Corrective actions may include enhancing systems, providing feedback and education, and, if warranted, imposing disciplinary measures.

Actions that Violate the Policy
Any employee who engages in actions that violate the False Claims Act, NYS FCA, and/or other applicable State civil or criminal laws, as well as any employee who has knowledge of any other employee who is engaging in actions that violate these, will face disciplinary action consistent with current disciplinary processes.

Contractor or Agent Agreements
All agreements executed between SCDHS and contractors and agents will include provisions that ensure compliance with this policy.

Investigating Violations
SCDHS management will promptly and thoroughly investigate reports of suspected violations. Investigations will be done in coordination and cooperation with the Compliance Officer, Compliance Committee, and any other persons or agencies designated by the Officer. When indicated, compliance issues will be reported to the NYS Department of Health, the Office of Medicaid Inspector General, additional governmental and/or other agencies.

Investigations Conducted by Governmental and/or Other Agencies

SCDHS and all those working on its behalf will cooperate fully and promptly with investigations conducted by governmental and other regulatory agencies. Information provided to these agencies, whether in writing or through personal interview, will always be truthful, complete and unambiguous. Alteration or destruction of documents in anticipation of a government request for them is prohibited.

SCDHS requires that all non-routine requests received from outside agencies, whether for written documentation and/or personal interviews, be reviewed and approved by an administrator before any information is sent or an interview is scheduled.

Disciplinary Action for Violations

Disciplinary action for violations will be consistent with current County disciplinary rules, and in addition can include reporting for possible civil or criminal prosecution.

Certification of Compliance

SCDHS will submit to NYS Office of Medicaid Inspector General (OMIG) prior to January 1st of each year a certification of compliance with OMIG requirements. This should include: confirmation of maintenance of a written policy; and, that said policy has been published by SCDHS and disseminated among employees, contractors, and agents. This certificate is available on www.omig.state.ny.us, and should be mailed to New York State OMIG, Riverview Center, 150 Broadway, Albany, NY 12204. (Appendix D).

Availability of Policy

SCDHS is making this written policy available in an electronic and print format. A printed copy will be available in the Compliance Officer's office, as well as in the Commissioner of Health's Office. It will be posted on the Department's intranet and internet site.

Signature on File

James L. Tomarken, MD, MPH, MBA, MSW
Commissioner

July 31, 2013

Date

Distribution:
Administration, All Division Directors, Compliance Officer, All Department of Health Services Staff

The Federal False Claims Act (31 USC §§ 3729-3733):

One of the requirements of this Policy is that employees, contractors, and agents of SCDHS be educated regarding the Federal False Claims Act and associated whistleblower protections.

The Federal False Claims Act (FCA) imposes liability on any person who submits a Medicaid claim that he or she knows (or should know) is false. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. The third area of liability includes those instances in which someone may obtain Medicaid money from the Federal government to which he or she may not be entitled, and then uses false statements or records in order to retain the money.

FCA permits any person who knows of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud. The person who files the lawsuit is known as a "qui tam plaintiff," and is a private party. If the action is successful the qui tam plaintiff is rewarded with a percentage of the recovery.

The qui tam plaintiff must notify the U.S Department of Justice (DOJ) of their lawsuit and provide the DOJ with all information about the fraud. The DOJ then has the option of intervening and taking over prosecution of the lawsuit from the qui tam plaintiff. If the Justice Department decides not to intervene, the qui tam plaintiff may pursue the lawsuit on behalf of the Government.

If the DOJ takes over, the qui tam plaintiff is entitled to between 15% and 25% of the recovery. If the DOJ does not intervene, and the qui tam plaintiff pursues the action individually, the qui tam plaintiff is entitled to between 25% and 30% of the recovery.

If the fraud is proven, the defendant is generally liable for three times the damages sustained by the Government because of the fraud. In addition, the defendant is liable for an additional $5,000 to $10,000 for each false claim it made to the Government.

Whistleblower "Qui Tam" Plaintiff

Any person may bring a qui tam action regardless of whether he or she has "direct" or first-hand knowledge of the fraud, conditioned that the fraud has not already been publicly disclosed. Thus an employee that learns from a colleague of fraud by his or her employer at work may bring a qui tam action, even if the qui tam plaintiff personally has no first-hand knowledge.

If the fraud has already been publicly disclosed, a person may still bring a qui tam action if he or she has direct knowledge of the fraud, independent of the publicly disclosed information. Thus, if an employee personally observes or uncovers fraud by his or her employer, or another person or company, the employee may bring a qui tam action even if the information has already been publicly disclosed.

Anyone who has knowledge of fraud against the Government should seek legal advice to de whether he or she qualifies to bring a qui tam action.

Applies to Fraud, Waste, and Abuse

Under the False Claims Act, fraud has a very wide and inclusive meaning. Under the Act, the defendant does not need to have known that the information it provided to the Government was false. It is sufficient that the defendant supplied the information to the Government either: (i) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information.

Thus, the Act is not limited solely to those who intentionally misrepresent facts, it also covers reckless conduct.

Whether the reported act is intentional fraud, waste, or abuse, the same penalties may be assessed against the wrongdoer and the same reward is payable to the qui tam plaintiff.

The Act permits recovery from those who "cause" misrepresentations to be made to the federal Government by others. In other words, a person may violate the law even if he or she does not actually submit the false information to the Government, but instead creates or provides false information that is then submitted to the Government by another.

Whistle Blower Protection (31 USC § 3730(h))

The Act provides protection to employees who are retaliated against by an employer because of the employee's participation in a qui tam action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee investigates, files, or participates in a qui tam action.

This "whistleblower" protection includes reinstatement with comparable seniority as the employee would have had but for the discrimination, and damages of double the amount of lost wages if the employee is fired, interest on any back pay, and compensation for any other damages sustained if the employee is otherwise discriminated against (including litigation costs and reasonable attorneys' fees).

New York State False Claims Laws

One of the requirements of this Policy is that employees, contractors, and agents of SCDHS be educated regarding the New York State False Claims Act, associated State Laws and whistleblower protections.

A. Civil and Administrative Laws

NY False Claims Act (State Finance Law, §§ 187-194) (NY FCA)

The NYS FCA closely tracts 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 $5,000 to $12,000 per claim, and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

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

Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

Labor Law § 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result

in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

Social Services Law § 145-b False Statements

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

Social Services Law § 145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are more than $3,900) and five years for four or more offenses.

B. Criminal Laws

Social Services Law § 145 Penalties

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

Social Services Law § 366-b Penalties for Fraudulent Practices

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

Penal Law Article 155, Larceny

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

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

Penal Law Article 175, False Written Statements

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

a. § 175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
b. § 175.10, Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
c. § 175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
d. § 175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud

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 that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. it is a Class E felony.
c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. it is a Class D felony.
d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. it is a Class C felony.
e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. it is a Class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th 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 4th degree is filing false claims and annually receiving over $3,000 in the aggregate. It is a Class E felony.
c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class E felony.
d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class E felony.
e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class E felony.

Suffolk County Department of Health Services (SCDHS) Code of Conduct

One of the requirements of this Policy is that employees, contractors, and agents of SCDHS adhere to a Code of Conduct. To this end, SCDHS has developed a Code of Conduct for its employees, contractors, and agents.

The mission of SCDHS is to assure the well-being of the community by preventing disease, promoting healthy behavior and preserving the health of our residents.

The purpose of this Code is not intended to replace any other policies or Standard Operating Procedures that are in effect, but rather to clearly define SCDHS's position regarding issues related to integrity and ethics, and to provide information that will assist employees, contractors, and agents in utilizing good judgment when dealing with integrity and ethics issues that may arise in the course of their duties. It is expected that all will adhere to the Code of Conduct and to the policies, standards, and procedures outlined in this program when they act on behalf of SCDHS.

SCDHS requires that all employees, contractors, and agents conform to the highest ethical standards, and takes pride in its long tradition since its founding in 1929 of ethical and responsible conduct in its programs and services. All employees, contractors, and agents are expected to adhere to the current Suffolk County Administrative Standard Operating Procedure A-06 (Code of Ethics).

SCDHS's employees, contractors, and agents will:

- Be fair and honest in all matters, with no attempt made to misinform or mislead. Any errors occurring with patients, other agencies, members of the public or others will be rectified as soon as possible;
- Take responsibility to resolve any uncertainty they may have relating to ethical questions that arise in the course of their duties. SCDHS will assist by providing access to supervisors and administrators as well as a confidential Compliance Helpline;
- Adhere to both the letter and spirit of all applicable Federal, State, and Local Laws and regulations.
- Keep accurate records. All records must be truthful, prepared accurately and retained in accordance with SCDHS and other requirements.
- Behave ethically and adhere to high ethical standards when he or she acts on behalf of SCDHS.
- Avoid conflicts of interest. He or she will not use a position for personal gain, and will not engaging in activities that may conflict with the mission, business or operations of SCDHS.
- Report possible violations. Everyone is expected to report any possible violations of law or ethical standards in accordance with the procedures set forth in this document. The Code of Conduct provides resources for reporting without fear of reprisals.

Quality of Care:
The SCDHS works as a team to insure the satisfaction of patients, employees, contractors, agents, and the community, believing in maximizing people's potential and creating an environment where citizens are provided with quality care and their rights are respected and protected. SCDHS is committed to providing the care and services necessary to attain or maintain a person's highest practical physical, mental and psychosocial well being. All citizens receive the same high standard of care quality of care. SCDHS recognizes that citizens have the right to comment about care and services without fear of reprisal. SCDHS recognizes all concerns, promptly and appropriately investigating and resolving all complaints as soon as possible. Professional staff conduct their practice within the scope of their license and the privileges accorded them by their appointment and credentialing process (when applicable).

Compliance with all Laws:
Guided by the SCDHS mission and the highest standards, SCDHS exercises sound judgment, care and diligence in all matters relating to duties and responsibilities. Business is conducted consistent with all applicable Federal, State and Local Laws and regulations.

Policies:
SCDHS and its programs maintain policies and procedures that guide in carrying out duties in compliance with legal and ethical requirements.

Honesty:
Representatives of SCDHS do not make statements that are known to be false, inaccurate or misleading. Proper steps are taken to learn the facts, when necessary, before information is provided.

Confidential Information:
Confidentiality is protected for all persons receiving care from SCDHS, as well as confidentiality for SCDHS business records and processes. Information is only provided to those authorized to receive it. Unauthorized disclosures are prevented. Confidential SCDHS business or financial information is only provided in a manner consistent with HIPAA and other pertinent regulations.

Billing and Coding Integrity:
Billing, coding and reimbursement procedures are performed in compliance with all applicable contracts, regulatory, and legal requirements. Services are billed, using billing codes that accurately describe the services that were provided, and supported by accurate documentation in the medical record. Those who perform billing and/or coding of claims will take every reasonable precaution to ensure their work is accurate, timely, and in compliance with Federal, State, and Local laws/regulations.

Actual and Medically Necessary Services:
Only necessary services that were actually performed by appropriate practitioners are billed.

Documentation of Services:
All patient services are documented in a proper, accurate, legible and timely manner, and all billing is supported by this documentation.

Coding:
Payment claims for services are prepared using only billing codes that reflect the services provided and supported by appropriate documentation. SCDHS or its contractors do not use billing codes that provide a higher payment rate than the billing code that actually reflects the service furnished (upcoding). SCDHS or its contractors will not improperly bill services separately that are required to be billed together (unbundling).

No Duplication of Billing:
SCDHS does not submit duplicate bills, and does not bill for items or services that are covered by another primary payor.

Communication to Assure Correct Billing:
Effective and accurate communication between the clinical and billing staff ensures correct billing of services. SCDHS does not knowingly bill for inadequate or substandard care.

Accurate Cost Reporting:
Departmental cost reports are prepared in compliance with third-party payers', legal, and regulatory requirements.

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

CERTIFICATION OF COMPLIANCE WITH 42 USC § 139 a(a)(68) EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

STATE OF NEW YORK)
)ss:
COUNTY OF SUFFOLK)

I, _____ , as the _____
(Name) (Title)

of _____ , with offices located at _____
(Name of Entity)

_____ , do hereby certify that the above entity:
(Address)

1. Maintains the written policies, and any employee handbook, required under 42 USC § 1396a(a)(68) and that they have been properly adopted and published by the provider entity, and disseminated among employees, contractors and agents, and that the written policies and any employee handbook shall be retained for a period of six years from the latter of the due date or the actual date of submission of the certification.

2. Understands that the Office of the Medicaid Inspector General (OMIG) may review the certification(s) of the entity, and also that OMIG, or its designee may review the written policies and any employee handbook maintained by the entity during audits, for compliance with the Social Security Act, and any additional requirements of which entities are notified and that any failure to timely submit the required certifications, or maintain the written policies and any employee handbook may be considered an unacceptable practice and subject the entity to sanctions and/or penalties; and that the Center for Medicare and Medicaid services may, at its discretion, independently determine compliance through audits of entities or other means.

_____
Signature

Sworn to before me this _____

day of _____, 20 _____ .

_____
Notary Public