

Subject: **Compliance Education**

Applies to: All Faculty and Staff

I. Policy: As set forth in its Code of Conduct, the University is committed to the highest standards of ethical and professional conduct. The Board of Trustees and the University leadership expect that each individual conducting business on behalf of the University will adhere to those standards in the performance of her or his duties. It is the responsibility of each individual – faculty or staff member, acting on behalf of the University to comply with legal and regulatory requirements, policies and procedures that apply to his or her position. To help meet this expectation, Medical Center employees shall become familiar with the Medical Center’s Compliance Program and policies by reading the Compliance Education section below.

II. Guidelines:

- A. Overview: This policy provides Medical Center employees with education and information about the Medical Center Compliance Program, certain laws that relate to the submission of claims to Medicare and Medicaid and protections for individuals who report potential billing problems.
- B. Expectation: All employees of the University’s healthcare divisions should read part III of this policy. Any questions they have about the policy should be referred to the Medical Center’s Compliance Office at 275-1609.

III. Compliance Education:

- A. The University’s health care divisions such as Strong Memorial Hospital participate in the Medicare and Medicaid programs. These programs pay hospitals and health care providers who care for people who are older than 65, disabled or financially needy.
- B. Medicare and Medicaid are very complex. Hospitals and professionals must follow the rules of these programs carefully. If they do not, they may be paid too much or too little for the services they provide.
- C. Medical Center employees who care for patients or who help bill Medicare or Medicaid are expected to understand the rules that apply to their jobs. This includes rules that relate to the proper documentation and billing for services. Employees should bring their questions about these rules to their supervisors.
- D. The Medical Center Compliance Program is also available to answer billing questions. The Medical Center Compliance Office may be reached by calling 275-1609. The Medical Center Compliance Office may also be contacted anonymously by calling the Integrity Hotline at 756-8888.
- E. The Medical Center Compliance Office has a detailed program for finding and fixing more serious billing problems. The program is described at the Compliance Office website www.urmc.rochester.edu/compliance-office/plans-policies . Employees are encouraged to consult this website and ask their supervisors or the Compliance Office if they have any questions about this program.

- F. Employees are also expected to promptly report billing problems to their supervisors. They must also report serious billing problems promptly to the Compliance Office at 275-1609 or the Medical Center Legal Counsel's Office at 758-7600. Anonymous reports may be made by calling the Integrity Hotline at 756-8888. (The Compliance and Counsel's Offices will take all appropriate steps to ensure the level of confidentiality desired, but sometimes the institution's legal obligations to investigate or address a violation will override the individual's wish for confidentiality.) Failure to report serious billing problems may subject an employee to discipline up to and including discharge from employment. Failing to repay an overpayment may also constitute a violation of the False Claims Act discussed below.
- G. Serious billing problems include those that result from knowing or intentional misconduct (such as billing for services that were not provided), that may affect a large number of claims, or that may have produced a large overpayment to the Medical Center. Simple mistakes or problems that relate to a single bill usually do not have to be reported to Compliance but should be promptly corrected.
- H. It is critically important that employees report serious billing problems as soon as they discover them. Fraudulent billing (billing that was done with a bad intent or purpose) is a serious crime. Keeping money that should be returned may also be fraudulent. People who commit billing fraud may be guilty of one or more crimes that may be punishable by fines or imprisonment. These crimes include the following:
- i. State Health Care Fraud (Penal Law Article 177), which makes it a crime to intentionally file false claims for health care payment;
 - ii. Insurance Fraud (Penal Law Article 176), which makes it a crime to submit a false insurance claim with intent to defraud;
 - iii. Larceny (Penal Law Article 155), which makes it a crime to obtain property by means of a trick, false statement or scheme to defraud;
 - iv. Falsifying Business Records (Penal Law Sections 175.05 and 175.10), which makes it a crime to falsify a business record with intent to defraud;
 - v. Offering a False Instrument (Penal Law Sections 175.30 and 175.35), which makes it a crime to knowingly present a written document, including a claim for payment, to a public office;
 - vi. Fraudulent Practices under the Medical Assistance Program (Social Services Law Section 366-b), which makes it a crime to submit false information to the Medicaid Program with the intent to obtain greater Medicaid compensation or a Medicaid authorization;
 - vii. Federal Health Care Fraud (18 USC 1347) which makes it a crime to defraud any commercial or government health care benefit program;
 - viii. Federal Health Care Theft of Embezzlement (18 USC 669) which makes it a crime to embezzle or steal property from a health care benefit program;
 - ix. Obstruction of Criminal Investigation (18 USC 1518) which makes it a crime to obstruct, delay or mislead the communication of information to a criminal investigator relating to a health care benefit program;

- x. False Statements (18 USC 1035) which makes it a crime to knowingly falsify or conceal a material fact, or to make any materially false, fictitious or fraudulent statement in connect with a health care benefit program;
- xi. False, Fictitious or Fraudulent Claims (18 USC 387) which makes it a crime to present a false, fictitious or fraudulent claim to the federal government;
- xii. Fraud and False Statements (18 USC 1001) which makes it a crime to submit false statements or documents to the federal government;
- xiii. Mail and Wire Fraud (18 USC 1341) makes it a crime to use the US mails or wires to commit fraud.

Many of the crimes described above are felonies. They are punishable by fines and imprisonment. A person convicted of these crimes would lose any professional license and be excluded from (not allowed to participate in) the Medicare or Medicaid programs.

IV. Billing fraud can also have very serious consequences for the Medical Center.

- A. Under State and Federal False Claims Acts (31 USC Sections 3729-3733, New York State Finance Law Sections 187-194), persons and organizations who “knowingly” submit false claims for payment to Medicare or Medicaid are subject to stiff penalties. They may have to repay three times the amount of the overpayment (treble damages) and fines of up to \$21,500 for each false claim submitted. They may also be excluded from Medicare or Medicaid.
- B. State and Federal agencies may also impose certain financial sanctions (penalties) upon health care providers who submit false claims for payment to government payors. These administrative sanctions are imposed without a trial. They include the following:
 - i. The Administrative Remedies for False Claims (31 USC Sections 3801-3812) which grants the United States Department of Health and Human Services (HHS) the power to impose double damages and a penalty of up to \$5,000 for each false or fraudulent Medicare or Medicaid claim;
 - ii. The Federal Civil Monetary Penalties Act (42 USC Section 1320a-7a) which grants HHS the power to impose treble damages and a fine of up to \$10,000 for each such claim;
 - iii. Section 145-b of New York’s Social Services Law which authorizes the New York State Department of Health to impose treble damages and civil penalties of \$2,000 to \$7,500 per violation against providers who use a false statement or fraudulent scheme to obtain Medicaid payments or who provide excessive services to Medicaid patients.
- C. Fortunately, organizations that report their billing problems to the government and return any overpayments usually do not have to pay any fines or penalties.
- D. The Medical Center Compliance Office and the Medical Center Counsel’s Office are experts in resolving serious Medicare and Medicaid billing problems with the State and Federal Government. Employees who discover problems are expected to work with those offices to investigate and resolve the problems. The State and Federal False Claims Acts also provide a way for persons to bring a lawsuit on behalf of the government for violations of the False Claims Act and to share in a percentage of the proceeds the government receives from the False Claims Act action or settlement.

- E. The University and Medical Center policy, the False Claims Act and State law prohibit retaliation against employees and professional staff who report or try to stop billing problems or violations of this policy in good faith. See the Compliance Office website for more information. Please note that some protections require the employee to bring the concerns to a supervisor and to give the employer a reasonable opportunity to correct the problem.