



Issuing Department: Internal Audit, Compliance, and Enterprise Risk Management

Effective Date: 5/31/2007
Reissue Date: 8/1/2022

Preventing Fraud, Waste, and Abuse: Federal and State False Claims and False Statements

I. Summary of Policy

NYU Langone Health recognizes the seriousness of health care fraud, waste, and abuse and the importance of the federal and state authorities' efforts in identifying such instances. This Policy provides the NYU Langone Health Community with information relating to preventing and detecting any fraud, waste, or abuse, as it relates to federal and state health care programs.

II. Policy Purpose

The purpose of this Policy is to disseminate information about the following:

- The Federal False Claims Act;
- Federal administrative remedies for false claims and statements;
- New York State laws pertaining to civil or criminal penalties for false statements; and
- Whistleblower protections under such laws and regulations relating to preventing and detecting health care fraud, waste, and abuse.

III. Applicability of the Policy

This Policy applies to employees, trustees, officers, faculty, medical staff, residents, fellows, students, volunteers, trainees, vendors, contractors, consultants, sponsored individuals, and agents of NYU Langone Health.

IV. Definitions

Claim means any request or demand, whether under contract or otherwise, for money or property and whether or not the United States has title to the money or property that is presented to an officer, employee, or agent of the United States, or made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the government's behalf or to advance a government program or interest, and if the United States government provided or has provided any portion of the money or property request or demanded, or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded, and does not include requests or demands for money or property that the government has paid to an individual as compensation for federal employment or as an income subsidy with no restrictions on that individual's use of the money or property.

Knowing and *Knowingly* means any person, with respect to information 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. Proof of specific intent to defraud is not required.

Material means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

NYU Langone Health includes NYU Langone Health System, NYU Langone Hospitals (including all inpatient and ambulatory facilities), NYU School of Medicine, NYU Grossman Long Island School of Medicine, and all entities that are controlled by any of them, except where specifically excluded. This Policy has also been adopted by the Family Health Centers at NYU Langone (the “FHC”); therefore, for the purposes of this Policy, “NYU Langone Health” also includes the FHC and any entity controlled by it, except where specifically excluded.

Obligation means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

V. Policy

NYU Langone Health is committed to preventing and detecting any fraud, waste, or abuse, especially as it relates to federal and state health care programs. The Office of Internal Audit, Compliance, and Enterprise Risk Management (“IACERM”) maintains a Corporate Compliance Program, which details NYU Langone Health’s fundamental principles, values, and operational framework for compliance, a Code of Conduct, and other policies which articulate NYU Langone Health’s commitment to compliance and strives to educate every member of the NYU Langone Health community on health care fraud, waste, and abuse and reporting concerns of such.

All members of the NYU Langone Health community are responsible for adhering to the Corporate Compliance Program, Code of Conduct, and other related NYU Langone Health policies, as well as all federal and state regulations.

All members of the NYU Langone Health community are required to report any violations or potential violations of these laws or any of NYU Langone Health’s policies. Concerns can be reported via several avenues, as described further in the *Compliance Concerns: Reporting, Investigating, and Protection from Retaliation* policy, but includes contacting IACERM directly at 212-404-4079 or compliancehelp@nyulangone.org or to the Compliance Helpline at 866-NYU-1212 or <https://complianceyulmc.alertline.com/gcs/welcome> (which can be made anonymously).

Individuals who in good faith report, including to NYU Langone Health or a government agency, actual or suspected suspicions of fraud, waste, and abuse, are protected from retaliation.

VI. Key Regulations

The following are key federal and state regulations governing fraud, waste, and abuse. These laws stress the importance of submitting accurate claims and reports to the federal and state governments.

A. The Federal False Claims Act (31 U.S.C. §§3729-3733)

The False Claims Act has two main liability provisions. The false claims provision creates liability for knowingly presenting, or causing to be presented, a false or fraudulent claim for payment. For example, a physician submits a bill to Medicare for services she knows she did not provide. The false statement provision creates liability for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.

For example, a physician creates a backdated medical record note to support a claim that was already submitted without documentation at the time. A person or entity may also be liable under the False Claims Act for a reverse false claim, which involves improper conduct to avoid paying the government or improper retention of an overpayment by the government. For example, a hospital discovers a mistake in coding that resulted in additional reimbursement on every claim of a certain type and fixes the problem going forward, but does not refund the overpayment.

Other provisions of the False Claims Act impose liability for:

- knowingly and improperly withholding part or all of the government's money or property
- intending to defraud the government by making or delivering (with the authority to do so) a document certifying receipt of property used, or to be used, by the government without completely knowing if the information on the receipt is true
- knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who is not permitted to sell or pledge the property

Additionally, a person or entity may be liable under the False Claims Act for conspiring to commit a violation of the liability provisions.

The False Claims Act imposes civil penalties of not less than \$5,000 and not more than \$10,000, plus three times the amount of damages the government sustains due to the actions of any person liable under the above-mentioned provisions.

The U.S. Attorney General, as well as private persons, can bring a civil action under the False Claims Act. An action commenced by a private person, known as the relator or *qui tam* plaintiff, is in the name of the government. The government uses the information provided by the *qui tam* plaintiff to investigate the claims and can decide to intervene in the case, usually within 60 days of receiving the complaint. A *qui tam* plaintiff can recover a percentage of any judgment or settlement regardless of whether the government intervenes in the action.

The False Claims Act protects a *qui tam* plaintiff, also known as a “whistleblower” from retaliation by his or her employer. If a *qui tam* plaintiff employee is discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment as a result of bringing a civil action under the False Claims Act, that *qui tam* plaintiff employee can bring an action in federal court seeking reinstatement, two times the amount of back pay plus interest, and other costs, damages, and fees, including litigation costs and reasonable attorneys' fees.

B. The Federal Program Fraud Civil Remedies Act (31 U.S.C. §§3801-3812)

The Program Fraud Civil Remedies Act allows for administrative recoveries by federal agencies for false claims. The act provides that any person who makes, presents, or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to \$5,000 per false claim and up to twice the amount claimed in lieu of damages sustained by the government.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid, and the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

C. New York State Civil and Criminal Laws

1) The New York False Claims Act (State Finance Law §§187-194)

The New York False Claims Act is similar to the federal False Claims Act. It imposes fines and penalties 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. Specifically, the New York False Claims Act provides that any person who knowingly presents, or causes to be presented, to any employee, officer, or agent of the state or a local government a false or fraudulent claim for payment or approval, knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government, conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid, 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 or transmit money or property to the State or local government is liable to the State of New York for a civil penalty of not less than \$6,000 dollars and not more than \$12,000, as adjusted to be equal to the civil penalty allowed under the federal False Claims Act, plus three times the amount of all damages, including consequential damages, which the state or local government sustains because of the act of that person. While proof of specific intent to defraud is not required, acts occurring by mistake or due to mere negligence are not covered by the New York False Claims Act.

The New York False Claims Act also provides that private parties, also known as *qui tam* plaintiffs, can bring an action on behalf of the state or a local government, subject to some limitations imposed by the State Attorney General or a local government. If the suit concludes with payments back to the government, the *qui tam* plaintiff can recover a percentage of the proceeds, amounts of which are dependent upon whether the government did or did not participate in the suit.

The New York False Claims Act provides protection to an employee of any private or public employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by his or her employer because of lawful acts taken by the employee in furtherance of an action under the New York False Claims Act. Remedies include reinstatement, 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.

2) False Statements (Social Services Law §145-b)

Under 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. Violations of this law are subject to damages equal to three times the amount by which any figure is falsely overstated or in the case of non-monetary false statements or representations, three times the amount of damages which the state, political subdivision of the state, or entity performing services under contract to the state or political subdivision of the state sustain as a result of the violation or \$5,000, whichever is greater.

Additionally, under Social Services Law §145-b, the New York State Department of Health (“NYS DOH”) can impose a monetary penalty on any person who causes Medicaid payment 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. For each claim, the NYS DOH may recover any overpayment, unauthorized payment, or otherwise inappropriate payment and if 25% or more of those claims which were the subject of an audit by the NYS DOH result in overpayments, unauthorized payments or otherwise inappropriate payments and for which the claims were submitted by a person for payment under the medical assistance program, the department may also impose a monetary penalty against any person, or persons, who received the overpayment, unauthorized payment, or otherwise inappropriate payment for such claim. If less than 25% of identified claims result in overpayments, unauthorized payments or otherwise inappropriate payments, then the NYS DOH may recover such monies or may impose a monetary penalty, but not both. In addition, the NYS DOH is also authorized to recover any overpayment, unauthorized payment, or otherwise inappropriate payment and impose a monetary penalty against any person, or persons, other than a recipient of an item or service under the medical assistance program, who caused the overpayment, unauthorized payment, or otherwise inappropriate payment to be received by the other person or persons.

The NYS DOH cannot recover overpayments, unauthorized payments, or otherwise inappropriate payments from any person, or persons, for a single claim, in an amount that exceeds the amount paid for such claim. Additionally, the NYS DOH cannot impose a monetary penalty that exceeds \$10,000 for each item or service. However, if a penalty has been imposed on the person within the previous five years, the penalty shall not exceed \$30,000 for each item or service.

3) Sanctions (Social Services Law §145-c)

Under Social Services Law §145-c, if a 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 needs or the person’s family’s needs shall not be taken into account for six months if a first offense, twelve months if a second offense (or if benefits wrongfully

received are at least \$1,000 but not more than \$3,900), eighteen months if a third offense, and five years for four or more offenses.

4) Penalties (Social Services Law §145)

Under Social Services Law §145, any person who by means of a false statement or representation, or by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain, or aids or abets any person to obtain public assistance or care to which he is not entitled, or does any willful act designed to interfere with the proper administration of public assistance and care, shall be guilty of a misdemeanor.

5) Voluntary Self-Disclosure (Social Services Law §363-d)

Under Social Services Law §363-d, providers within the medical assistance program are to develop and implement a compliance program to resolve payment discrepancies and detect inaccurate billing, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. Eligible participants of the self-disclosure program are to report, return and explain in writing to the Office of the Medicaid Inspector General (“OMIG”) Medicaid overpayment and shall pay the overpayment amount determined by the OMIG within fifteen days of the OMIG notification of the amount due or OMIG permitted installment repayments.

6) Penalties for Fraudulent Practices (Social Services Law §366-b)

Under Social Services Law §366-b, any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain medical assistance to which he is not entitled, shall be guilty of a class A misdemeanor. Additionally, any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise, shall be guilty of a class A misdemeanor.

7) Larceny (Penal Law Article 155)

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. Larceny has been applied to Medicaid fraud cases. Larceny includes four levels of severity, dependent on the amount of property stolen.

- a. Fourth degree grand larceny involves property valued over \$1,000. This is a Class E felony. (§155.30)

- b. Third degree grand larceny involves property valued over \$3,000. This is a Class D felony. (§155.35)
- c. Second degree grand larceny involves property valued over \$50,000. This is a Class C felony. (§155.40)
- d. First degree grand larceny involves property valued over \$1 million. This is a Class B felony. (§155.42)

8) False Written Statements (Penal Law Article 175)

Several sections in Penal Law Article 175 relate to filing false information or claims and have been applied in Medicaid fraud prosecutions.

- a. Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intended to defraud. This is a Class A misdemeanor. (§175.05)
- b. Falsifying business records in the first degree includes the elements of the §175.05 offense plus the additional element of the intent to commit another crime or conceal its commission. This is a Class E felony. (§175.10)
- c. 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. This is a Class A misdemeanor. (§175.30)
- d. Offering a false instrument for filing in the first degree includes the elements of the second degree offense plus the additional element of the intent to defraud the state or one of its political subdivision. This is a Class E felony. (§175.35)

9) Insurance Fraud (Penal Law Article 176)

Penal Law Article 176 applies to claims for insurance payments, including Medicaid or other health insurance. Insurance fraud contains six crimes that range from a misdemeanor to a felony depending on the amount of the insurance claim.

- a. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor. (§176.10)
- b. Insurance fraud in the fourth degree is filing a false insurance claim for over \$1,000. This is a Class E felony. (§176.15)
- c. Insurance fraud in the third degree is filing a false insurance claim for over \$3,000. This is a Class D felony. (§176.20)
- d. Insurance fraud in the second degree is filing a false insurance claim for over \$50,000. This is a Class C felony. (§176.25)
- e. Insurance Fraud in the first degree is filing a false insurance claim for over \$1 million. This is a Class B felony. (§176.30)
- f. Aggravated insurance fraud is committing insurance fraud on more than one occasion. This is a Class D felony. (§176.35)

10) Health Care Fraud (Penal Law Article 177)

Penal Law Article 177 applies to health care fraud crimes and primarily applies to claims by providers for health insurance payment, including Medicaid payment.

- 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 omission. This is a Class A misdemeanor. (§177.05)
- b. Health care fraud in the fourth degree is filing false claims and annually receiving over \$3,000 in aggregate. This is a Class E felony. (§177.10)
- c. Health care fraud in the third degree is filing false claims and annually receiving over \$10,000 in the aggregate. This is a Class D felony. (§177.15)
- d. Health care fraud in the second degree is filing false claims and annually receiving over \$50,000 in the aggregate. This is a Class C felony. (§177.20)
- e. Health care fraud in the first degree is filing false claims and annually receiving over \$1 million in the aggregate. This is a Class B felony. (§177.25)

11) Whistleblower Protections

Under New York 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 of 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 any retaliatory action against the employee, the employee may institute a civil action 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.

Under New York 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 institute a civil action 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.

VII. Policy Enforcement

The Office of Internal Audit, Compliance, and Enterprise Risk Management has general responsibility for implementation and enforcement of this Policy. Individuals who are found to be non-compliant with applicable federal, state and local laws and regulations, professional standards, and institutional policies may be subject to disciplinary action up to and including

termination of employment or association with NYU Langone Health. Such institutional policies include, but are limited to, the Code of Conduct, Corporate Compliance Program, and the policies set forth in the Faculty Handbook, Residency Training Program Contract, GME House Staff manual, Postdoctoral Handbook, Student Handbook, By-laws of the Medical Staff, and Patient Care and Safety Standards This Policy shall remain in effect unless terminated or superseded by a revised and/or updated policy issued by IACERM.

VIII. Related Policies and Documents

By-laws of the Medical Staff

Code of Conduct

Compliance Concerns: Reporting, Investigating, and Protection from Retaliation

Corporate Compliance Program

Faculty Handbook

GME House Staff Manual

Notice to Employees Concerning Rights and Remedies Under the Pilot Program for Enhancement of Employee Whistleblower Protection (41 U.S.C. 4712)

Postdoctoral Handbook

Residency Training Program Contract

Staff Handbook

Student Handbook

IX. Legal Authority/References

Deficit Reduction Act of 2005 §6032

The Social Security Act, 42 U.S.C. §1396a(a)(68)

The False Claims Act (FCA), 31 U.S.C. §§3729 - 3733

Program Fraud Civil Remedies Act, 31 U.S.C. §§3801-3812

NY State Finance Law §§187-194 (2012)

NY Social Services Law §145

NY Social Services Law §366-b

NY Penal Law Article 155

NY Penal Law Article 175-177

NY Labor Law §740-741

XIII. Version History

May 31, 2007	Original Policy
October 20, 2010	Reviewed and Revised
October 8, 2018	Reviewed and Revised
August 1, 2019	Reviewed and Revised

This version supersedes all NYU Langone Health (as defined in this Policy) previous policies, including but not limited to NYU Hospitals Center, New York University School of Medicine, Lutheran Medical Center, and Winthrop University Hospital.