FRAUD AND ABUSE

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This chapter includes information on identifying and preventing fraudulent claims.

FRAUD AND ABUSE OVERVIEW

Unscrupulous medical professionals, small-time criminals and even members of organized crime siphon as much as $100 billion a year from the nation's health care system. Although fewer than five percent of practitioners in the U.S. commit such violations, health care fraud remains a powerful contributor to the skyrocketing cost of medical care. Federal lawmakers have passed numerous important acts, including The Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996, to address issues of fraud and abuse.

EmblemHealth's Special Investigations Unit (SIU) was established to meet regulatory requirements while addressing concerns about the cost of fraud and abuse to members and practitioners. The SIU monitors, reviews and investigates potential cases involving fraud, abuse or improper billing. Additionally, the SIU ensures proper payment has been requested and reimbursed. Our SIU respects the partnership we have with our network providers and works with our providers to curb fraud and abuse.

We ask each of our medical professionals to be a part of our fraud fighting team by working together to prevent and identify inappropriate and potentially fraudulent billings through the following procedures:

- Monitoring of claims submitted for compliance with billing and CPT coding guidelines
- Adherence by providers and facilities to Standard Medical Record Guidelines
- Education of all staff members responsible for dealing with medical records and/or billings
- Referral of suspected fraud and abuse cases to EmblemHealth's Special Investigations Unit

The SIU conducts audits by any of the following methods:

- Data analysis of filed claims
- Review of medical records and filed claims
- On-site visits

If improper or fraudulent billings are identified, the SIU will send written documentation to the provider outlining its findings. If and when necessary, the SIU will hold meetings to address providers' concerns and arrange repayment of amounts paid on identified fraudulent claims.

Fraud is defined as obtaining, or attempting to obtain, services or payments by dishonest means with knowledge, willingness or intent. The Federal False Claims Act (accessed at **http://www.cms.hhs.gov/smdl/downloads/SMD032207Att2.pdf**) widens the definition to also include reckless conduct, "deliberate ignorance" of the truth or falsification of information, and "reckless disregard" of the truth or falsity of the information.

Examples of Fraud

- False or fabricated filings of claims.
- Billing for goods and services that were never delivered or rendered. This includes billing for

no shows or cancelled appointments.

- Billing for more services than were actually provided. This includes, but is not limited to, billing for new or premium durable medical equipment, prosthetics/orthotics or supplies while substituting substandard or inexpensive DME.
- Billing at doctor rates for work that was actually conducted by a nurse, resident intern or physician assistant (i.e., up-coding), unless permitted by your contract agreement, state laws and regulations, and/or CMS guidelines.
- Billing for services performed by a lesser-qualified person, unless permitted by your contract agreement, state laws and regulations, and/or CMS guidelines.
- Billing for services under a provider's name for services actually rendered by another provider.
- Misrepresentation of services rendered (CPT codes), diagnosis, place of services, date of services and/or providers of services in order to justify reimbursement.
- Billing for non-covered services as covered services.
- Medical documentation that does not support, or is inconsistent with, the service being billed.
- Falsifying certificates of medical necessity, plans of treatment and medical records to justify payment. This includes fabrication and recreation of medical records to justify the billing and payment.
- Double billing in an attempt to gain duplicate payment (i.e., billing multiple claims to EmblemHealth and/or another insurer without proper disclosure of any COB or payment information, or EOB from another carrier).
- Altering of claim form to obtain higher payment amount.
- Billing separately for a panel of tests when a single panel test was requested (i.e., unbundling).
- Billing procedures over a period of days or weeks when the actual treatment occurred during a single visit (i.e., split billing).
- Improper coding practices (misuse of CPT codes).
- The acceptance of, or failure to return, monies paid on claims known to be false, fabricated or received in error.
- Kickbacks or participating in schemes that involve collusion between a provider and a member.
- Members providing false information for potential gain.
- Billing a planned hospital admission service as if it were an emergency admission and/or urgent care admission.

Abuse or improper billing is defined as any provider or member practice that is inconsistent with sound or established fiscal, business, insurance or medical practices and results in an unnecessary cost to any EmblemHealth benefit program, including, but not limited to, reimbursement for services that are not medically necessary or treatments that fail to meet professionally recognized standards. Each incident need not be intentional to be considered abuse. Consistent patterns of abuse may be indicative of fraud.

Examples of Abuse or Improper Billing

- Inappropriate balance billing
- Inadequate resolution of overpayment
- Failure to collect deductibles, coinsurances and copays

- High utilization of procedures or tests that are not medically necessary
- Providing services that are experimental or services that do not meet professionally recognized standards
- Coding a service at a higher level than warranted (i.e., up-coding)
- Inappropriate documentation of services rendered
- Unbundling of services or charges
- Requesting prior approval under a network location and billing under an out-of-network location

An entity performing such acts may include a provider, a hospital, an agency, an organization, another institutional provider, an employee or employees of a provider or group of providers, a billing service, a member or any person in a position to file a claim for health benefits.

To report suspicious activity, please contact EmblemHealth's Special Investigations Unit in one of the following ways:

- E-mail: **KOfraud@emblemhealth.com**
- Toll-free hotline: **1-888-4KO-FRAUD** (1-888-456-3728)
- Mail:
  EmblemHealth
  Attention: Special Investigations Unit
  441 Ninth Avenue
  New York, NY 10001

A trained investigator will discuss the nature of the concern. The informant may remain anonymous.

FALSE CLAIMS ACT AND MEDICAID FRAUD PROGRAMS

The Deficit Reduction Act of 2005 requires health care entities to educate contractors and agents, including providers, about the False Claims Act. In addition, New York State requires Medicaid providers to develop and implement compliance programs aimed at detecting fraud, waste and abuse in the Medicaid program. Providers should ensure that their personnel are familiar with the requirements below.

False Claims Act

Neither EmblemHealth nor our providers may submit false or fraudulent claims to the Federal government. The Federal False Claims Act makes it illegal to:

1. Knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government.
2. Knowingly make, use or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
3. Conspire to defraud the government by getting a false or fraudulent claim allowed or paid.
4. Have possession, custody or control of property or money used or to be used by the

government and, intending to defraud the government, either willfully conceal the property or deliver or cause to be delivered less property than the amount for which the person receives a certificate or receipt.

5. Authorize the making or delivering of a document which certifies receipt of property used or to be used by the government and, intending to defraud the government, make or deliver the receipt without completely knowing that the information on the receipt is true.

6. Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government or member of the Armed Forces who may not lawfully sell or pledge the property.

7. Knowingly make, use or cause 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 government.

"Knowingly" includes acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the facts. To impose liability, it is not necessary for the court to find a specific intent to defraud. Simply presenting a false claim is a violation, even if the claim has not been paid and no money has been expended.

The federal government may impose fines of up to $10,000 per claim and treble damages (i.e., three times the amount of actual damages) for False Claims Act violations.

In addition to the Federal False Claims Act, New York State (NYS) and New York City (NYC) have each enacted a False Claims Act. All three prohibit the items set forth above and all three can impose treble damages for each violation. A civil penalty of between $6,000 and $12,000 may be imposed for each violation of the NYS False Claims Act and a penalty of between $5,000 and $15,000 may be imposed for each violation of the NYC False Claims Act. In each instance, the court is authorized to reduce the fine to two times the amount of damages if the alleged violator (i) provided full information to the Commissioner of Investigation, or the investigating agency or official(s), within 30 days of receiving the information; (ii) cooperated with any subsequent government investigation; and (iii) at the time the individual provided information about the violation, no action had commenced with respect to the violation and the individual did not have any actual knowledge that an investigation was underway. It should be noted that the NYS False Claims Act does not apply to claims, records or statements made under the tax law.

Whistleblower Protections under the False Claims Act

The Federal False Claims Act provides that private parties, known as "qui tam relators," may bring an action on behalf of the United States. The Act provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Federal False Claims Act. Remedies include reinstatement with seniority comparable with what the individual would have had but for the discrimination, two times the amount of any back pay, interest on any back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Under New York's Labor Law, employers are prevented from taking any retaliatory actions (i.e. discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment) against an employee who discloses or threatens to disclose to a supervisor or a public body an activity, policy or practice of the employer that is in violation of a law, rule or regulation the violation of which creates and presents a substantial and specific danger to public health or safety or which constitutes health care fraud. An employee who has been the subject of a retaliatory personnel action may institute a civil action for relief within one year after the alleged retaliatory personnel action was taken.

New York State Medicaid Fraud Detection

Chapter 442 of the Laws of 2006, which established the New York State Office of the Medicaid Inspector General (OMIG), also created a new Social Services Law § 363-d which requires that Medicaid providers develop and implement compliance programs aimed at detecting fraud, waste and abuse in the Medicaid program. Each provider covered by the requirements must develop and adopt an effective compliance program based on a set of minimum core requirements. Provider compliance programs shall, at a minimum, be applicable to billings to and payments from the medical assistance program, but need not be confined to such matters. The law contains only the minimum requirements for such plans and, effective January 1, 2007, the OMIG, in consultation with the DOH, is authorized to impose additional requirements for compliance plans beyond the basic statutory requirements.

Additional requirements, minimum standards, etc., may be found at the Office of the Medicaid Inspector General Web site at **www.omig.state.ny.us**. In addition, a new Part 521, entitled "Provider Compliance Programs," is added to Title 18 of the Codes, Rules and Regulations of the State of New York.

From the New York State Office of the Medicaid Inspector General Web site at www.omig.ny.gov/data/content/view/261/53, last accessed on January 27, 2012

Mandatory Provider Compliance Programs

Frequently Asked Questions

THE MANDATORY COMPLIANCE LAW

Chapter 442 of the Laws of 2006, which established the New York State Office of the Medicaid Inspector General (OMIG), also created a new Social Services Law § 363-d which requires that Medicaid providers develop, adopt and implement effective compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program.

WHAT IS THE PURPOSE AND INTENT OF THE MANDATORY COMPLIANCE LAW?

The purpose of directing Medicaid providers to implement a compliance program is to ensure providers establish systemic checks and balances to detect and prevent inaccurate billing and inappropriate practices in the Medicaid program.

ARE THE MANDATORY COMPLIANCE PROVISIONS RELATED TO THE DRA REQUIREMENTS?

While the mandatory compliance requirements contained in Social Services Law § 363-d and 18 NYCRR Part 521, and the Deficit Reduction Act (DRA) obligations found in 42 USC § 1396a (a)(68) address similar areas and each has a certification requirement, there are significant differences in which providers are covered and the scope of provider responsibilities.

Providers required to meet both provisions typically include the DRA requirements in their more comprehensive mandatory compliance programs.

WHO MUST HAVE A COMPLIANCE PROGRAM?

The Mandatory Compliance Law applies to Medicaid providers operating under Articles 28 or 36 of the Public Health Law, Articles 16 or 31 of the Mental Hygiene Law and those providers of care, services and supplies for which the Medicaid program "constitutes a substantial portion of their business operations," which the Office of the Medicaid Inspector General has defined under 18 NYCRR § 521.2 (b) as ordering, providing, billing or claiming $500,000 or more from Medicaid in a 12-month period. The $500,000 threshold applies if a provider receives the reimbursement directly or indirectly from Medicaid funds. If the provider meets either the statutory provisions or monetary thresholds, there are no exemptions. For example, the law is applicable to early intervention, school supportive, state and county-run providers, etc.

IN MULTIPLE PROVIDER SYSTEMS, WHO IS RESPONSIBLE FOR DEVELOPING PROVIDER COMPLIANCE PROGRAMS?

Each covered provider must develop, adopt and implement an effective compliance program that is appropriate to its characteristics. Affiliated providers may operate under the umbrella compliance program of its parent organization, as long as the compliance program address the core requirements as provided by the regulation and is specific enough to address the structure, operations and risk areas of each affiliate.

IS THERE AN EQUIVALENT "MULTIPLE PROVIDER SYSTEM" APPROACH FOR NON-PUBLIC EI, PRE-SCHOOL AND SCHOOL AGE SPECIAL EDUCATION PROGRAMS?

The OMIG has had several discussions with non-public providers of EI and special education services including §4410 and "853" schools and with county officials and school districts. Given the nature of the referral and billing relationship between/with counties, districts and these types of providers, to avoid unnecessary duplication of effort and costs to contracted providers of services, the OMIG supports an approach where the county/district incorporates (covers) early intervention, pre-school,

and school-age special education providers under the county's or district's compliance program (including, for example, the sharing of resources - - such as a toll free hot line). In such cases, the OMIG would expect an appropriate written agreement detailing the respective responsibilities of the parties. Such agreements may include, be incorporated in, or be ancillary to, the contract for the provision of such services executed by the county/district and provider which includes provision for Medicaid payments and reimbursement including statements of reassignment, record maintenance, quality assurance review and liability of providers for failure to support the county/district relative to special services and programs paid by or reimbursed through Medicaid.

Notwithstanding the other compliance related functions performed by the County and/or District, the OMIG assumes that early intervention, preschool and school age special education providers will ensure an internal compliance presence by designating an employee who has an understanding of the culture and operations of the provider, to address issues raised by provider staff and to coordinate those compliance initiatives handled by the provider in satisfaction of Part 521 requirements governing compliance officers.

DO ALL PROVIDERS THAT ARE COVERED BY THE LAW, REGARDLESS OF SIZE, HAVE TO MEET THE SAME REQUIREMENTS?

The law contains a set of minimum core requirements that are applicable to all providers, regardless of size. However, the OMIG recognizes that there is no "one size fits all" approach to compliance and an effective compliance program must be tailored to a provider's size, scope of items or services provided, complexity, resources and culture.

AT A MINIMUM, WHAT MUST A COMPLIANCE PROGRAM CONTAIN?

Provider compliance programs should apply to, at a minimum, billings to and payments from the medical assistance program. The law contains only the minimum requirements, including the following eight core requirements:

1. Write policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel, and describe how potential compliance problems are investigated and resolved.
2. Designate an employee vested with responsibility for the day-to-day operation of the compliance program; the designated employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; the employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program.
3. Train and educate all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation. Training shall occur periodically and be made a part of the orientation for a new employee, appointee or associate, executive and governing body member.
4. Establish communication lines to the designated compliance person, accessible to all employees, persons associated with the provider, executives and governing body members, allowing compliance issues to be reported. Communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.
5. Establish disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:
    1. failing to report suspected problems;
    2. participating in non-compliant behavior; and/or
    3. encouraging, directing, facilitating or permitting non-compliant behavior.

    Disciplinary policies shall be fairly and firmly enforced.

6. Create a system for routine identification of compliance risk areas specific to the provider type for self-evaluation, including internal audits, and, when appropriate, external audits for evaluation of potential or identified non-compliance.
7. Establish systems for responding to compliance issues as they are raised; investigating potential compliance

problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting identified problems promptly and thoroughly; implementing policies, procedures and systems to reduce the potential for recurrence; identifying and reporting compliance issues to the OMIG or the DOH; and refunding overpayments.

8. Establish a policy of non-intimidation and non-retaliation for good-faith participation in the compliance program, including but not limited to: reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law (new whistleblower provisions for health care fraud).

WILL THE OMIG PROVIDE GUIDELINES OR MODEL COMPLIANCE PLANS ON ITS WEBSITE TO ASSIST PROVIDERS?

The OMIG is in the process of drafting industry-specific guidelines that reflect the requirements of the Mandatory Compliance Law and will make them available on its web site. The OMIG does not anticipate issuing model compliance plans or templates.

WILL THE OMIG PROVIDE TECHNICAL ASSISTANCE TO PROVIDERS UPON REQUEST?

The OMIG will offer guidelines on its web site. Additionally, OMIG representatives speak frequently at various provider and representative association events. Providers are encouraged to monitor OMIG Corporate Integrity Agreements (CIAs) for compliance-related provisions. Copies of all executed OMIG CIAs will be published on the OMIG web site.

HOW WILL THE MANDATORY COMPLIANCE LAW IMPACT PROVIDERS?

The OMIG has the authority to determine, at any time, if Medicaid providers covered by the Mandatory Compliance Law have established effective compliance programs. Upon enrollment in the Medicaid program, new providers must satisfactorily meet the requirements of the Mandatory Compliance Law.

WHAT ARE THE POSSIBLE CONSEQUENCES FOR FAILING TO ADOPT AN EFFECTIVE COMPLIANCE PROGRAM?

As of October 1, 2009, the OMIG is authorized to impose sanctions or penalties, including, but not limited to, the revocation of the provider's agreement to participate in the Medicaid program against providers who fail to develop, adopt and implement an effective compliance program.

IS THERE AN EXCEPTION TO THE MANDATORY COMPLIANCE LAW?

The Mandatory Compliance Law provides that "a compliance program that is accepted by the United States Department of Health and Human Services Office of Inspector General and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provision of this law." However, the US HHS OIG does not review and "accept" provider compliance plans. A compliance program may be a part of more comprehensive compliance activities so long as the minimum requirements of the law and implementing regulations are met.

WHAT IS THE PROCESS FOR CERTIFICATION UNDER THE MANDATORY COMPLIANCE LAW?

The OMIG has developed an on-line certification form through its web site. Covered providers who apply for enrollment into the MA program will be required to certify upon enrollment and on or before December 31 annually. Participating providers who fall under the requirements of the regulations and who are currently enrolled in the MA program will be required to certify on or before December 31, 2009 and on or before December 31 each year thereafter. The OMIG has modified the Certification form, and the updated version will be posted at www.omig.state.ny.us by Friday, November 20, 2009. Providers who have previously submitted an electronic certification have the option of submitting a new certification form but will not be required to do so.

CAN PROVIDERS SUBMIT PAPER CERTIFICATIONS?

No. Only on-line certifications will be accepted.

WILL PROVIDERS RECEIVE A CONFIRMATION OF RECEIPT?

An electronic confirmation will be generated upon submission of the certification. This electronic confirmation will be in the form of a printable page with a confirmation number on it. The provider should print this confirmation page for their records and retain it as proof of certification. The confirmation page will only be available at the time of the form submission.

NOTE: There will be no confirmation email sent regarding the compliance certification.

WHO SHOULD SIGN THE CERTIFICATION?

The OMIG strongly encourages that someone from senior management (other than the compliance officer) or a member of the governing authority sign the certification as an indication that the provider's compliance efforts and responsibilities extend beyond the compliance officer.

DOES A PROVIDER HAVE TO SUBMIT A SEPARATE CERTIFICATION FOR EACH LOCATION OR PROVIDER NUMBER?

Good news as of December 2010 no longer will the certifying person need to type in all the providers identification numbers only the parent FEIN/SSN or if there are more than one FEIN for the organization then each FEIN will need to certify as to having an effective compliance program even if it is the same program over all the entities when no parent FEIN exists.

Providers with multiple locations, affiliates or provider numbers may submit a single certification and list the relevant provider numbers associated FEIN/SSN with that certification. However, there are separate certification forms for mandatory compliance and DRA requirements.

WHAT IS THE CONSEQUENCE OF A PROVIDER'S FAILURE TO CERTIFY?

The OMIG is authorized to impose administrative sanctions, up to and including exclusion from the program, against providers who fail to certify to the existence of an effective compliance program.

SHOULD PROVIDERS SUBMIT A COPY OF THEIR COMPLIANCE PLAN ALONG WITH THE CERTIFICATION?

No, OMIG will specifically request a copy of a provider's compliance program when the OMIG is interested in evaluating a particular provider's compliance with the Mandatory Compliance Law.

SSL FORM INSTRUCTIONS

Enrolled Provider - A person or entity which has gone through the enrollment process to participate in the medical assistance program and has been assigned an unique identification number referred to as their Medicaid Provider Identification Number (PIN).

Enrolling Provider- A person or entity applying to participate in the medical assistance program and must certify to having an effective compliance program if required under the Social Services Law 363-d and 18NYCRR Part 521.

FAQ

Question: What if I am applying as a enrolling provider and cannot certify to having a compliance program?

Answer: If you are enrolling and cannot certify that you have an effective compliance program according to Social Services

Law 363-d and 18NYCRR Part 521 the form will not allow you to proceed and therefore you will not be able to obtain the certification confirmation page required on application for participation in the medical assistance program and you will not be assigned a Medicaid Provider Identification Number (PIN).

Question: Who do I call if I have questions about the Social Services Law 363-d and 18NYCRR Part 521 requirements of a compliance program?

Answer: Please address your questions to compliance @omig.ny.gov and please state in the subject line that you are an enrolling provider.

A new Part 521, entitled "Provider Compliance Programs," is added to Title 18 of the Codes, Rules and Regulations of the State of New York to read as follows:

PART 521
PROVIDER COMPLIANCE PROGRAMS

§521.1 General requirements and scope.

To be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, the following persons shall adopt and implement effective compliance programs:

(a) persons subject to the provisions of articles twenty-eight or thirty-six of the public health law;

(b) persons subject to the provisions of articles sixteen or thirty-one of the mental hygiene law; or

(c) other persons, providers or affiliates who provide care, services or supplies under the medical assistance program or persons who submit claims for care, services, or supplies for or on behalf of another person for which the medical assistance program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

§521.2 Definitions.

For purposes of this Part, the definitions contained in Parts 504 and 515 of this Title shall apply. In addition, the following terms, as used in this Part, shall have the following meanings:

(a) "Required provider" means a provider meeting any of the criteria listed in subpart 521.1 of this Part.

(b) "Substantial portion" of business operations means any of the following:

(1) when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period from the medical assistance program;

(2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period directly or indirectly from the medical assistance program; or

(3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least five hundred thousand dollars ($500,000) in any consecutive twelve-month period.

§521.3 Compliance Program Required Provider Duties.

(a) Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers' compliance programs shall be applicable to:

(1) billings;

(2) payments;

(3) medical necessity and quality of care;

(4) governance;

(5) mandatory reporting;

(6) credentialing; and

(7) other risk areas that are or should with due diligence be identified by the provider.

(b) Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its website, that a compliance program meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

(c) A required provider's compliance program shall include the following elements:

(1) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(4) communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

(i) failing to report suspected problems;

(ii) participating in non-compliant behavior; or

(iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;

such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence;

identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

521.4 Determination of Adequacy of Compliance Program.

(a) The commissioner of health and the Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that is effective and appropriate to its characteristics and satisfactorily meets the requirements of this Part.

(b) A provider whose compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this Part, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the required provider does not have a satisfactory program, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.