MADISON COUNTY POLICY AND PROCEDURES

Subject: **Compliance Policy:**
Health Services Code of Conduct

Issued: September 24, 2012
Approved: August 26, 2014
Revised: August 26, 2014

Purpose:

Madison County is committed to providing services with compassion and integrity. For that reason, **Madison County** has developed this Code of Conduct, which establishes the legal and ethical standards that govern our expectations for all Covered Persons as it particularly relates to health services, including mental hygiene, public health and medical services.

Please take the time to carefully read through this Code of Conduct. If you have any questions about any of the information contained in the Code of Conduct, contact the Corporate Compliance Officer at (315) 366-2361. We believe that our commitment to these standards will enable all staff to effectively work together to provide the highest standard of care to our community.

Madison County's goal is to communicate to all staff its expectations of ethical and professional conduct and to ensure that every staff member understands these expectations. By signing the Health Services Code of Conduct, each Covered Person agrees to the following:

Quality of Care:

- Treat every client with consideration, courtesy, dignity and respect.
- Provide the highest quality of service by meeting the needs of our clients/patients/residents with the utmost care and courtesy.
- Perform our duties in a responsible, reliable, appropriate and cost-effective manner.

Compliance with Laws and Regulations:

- Operate strictly in accordance with all applicable laws, regulations and standards.
- Ensure that all reports or other information required by any federal, state, or local government agency are filed timely, accurately and in conformance with the applicable laws and regulations.
- Promptly report any violations or suspected violations of any law, regulations, policies, or procedures to a supervisor, director or the applicable Compliance Officer (CO).
- Not pay other healthcare professionals, directly or indirectly, to refer clients to any department.
- Not tolerate false or misleading statements, written or oral, by Covered Persons to a government agency or other payer.
- Not engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks, or payoffs, intended to induce, influence, or reward favorable decisions of any customer, contractor, vendor, governmental personnel or anyone in a position to benefit any

department.
- Not engage in retaliation or reprisal against anyone who reports violations of law, regulations or agency policies.
- Limit the use and disclosure of confidential patient health information to the extent necessary to treat the patient/client/resident and to meet legal requirements under HIPAA Laws and regulations and related State and Federal laws.
- Maintain all required professional licenses, certifications, or other credentials and comply at all times with federal and state requirements applicable to these professions.

Conflicts of Interest:

- A Covered Person shall not accept personal gratuities or gifts from patients, clients, suppliers or vendors in accordance with Madison County Code of Ethics.
- Not become involved for personal gain with a client, vendor or supplier.
- Not engage in outside employment or activity, which conflicts with Madison County's interests or which reduces our effectiveness in performing our duties.
- Act in the best interest of Madison County whenever dealing with vendors, suppliers or governmental agencies.
- Provide full disclosure and obtain clearance from the Corporate Compliance Committee and the Madison County Ethics Board, if necessary, before engaging in any transaction involving the department where the Covered Person or the Covered Person's family member(s) receive any benefit, directly or indirectly.

Billing and Coding:

- Only bill for eligible services that are actually rendered, appropriately documented, and consistent with medical necessity guidelines.
- Take every precaution to ensure that our billing and coding work is accurate, timely and in compliance with our policies and federal and state laws and regulations.
- Not tolerate the submission of any claims which contain any false, fraudulent or inaccurate statements.
- Follow all established internal billing and coding protocols that may include establishing adequate separation of duties between care providers and fiscal staff; and comply with all internal controls that pertain to the functions of billing, collecting, recording, depositing, and reconciling funds.
- Ensure that the diagnosis and procedure codes reported on reimbursement claims are based on clients'/patients'/resident's medical records, as well as comply with applicable coding rules and guidelines.
- Promptly report any concerns regarding potentially erroneous billing or coding practices to your supervisor or the CO.
- Do not misrepresent the type of level of service rendered, bill for non-covered services, inappropriately unbundle services, bill for services rendered by other providers, or misrepresent a diagnosis in order to obtain higher payment.
- Not routinely waive deductibles or copayments without appropriate permission.

Business and Financial:

- Should represent the highest standards of business excellence.
- Handle all business and financial documents with integrity and accuracy.
- Retain all medical and business documents as required by law.
- Comply with financial accounting standards.
- Maintain computer passwords and access codes in a confidential and responsible manner.
- Keep accurate, true and complete records, including business expense accounts, vouchers, bills, payrolls, service records, petty cash and reports, whether electronic or on paper.
- Establish, maintain, support and follow internal controls designed to provide reasonable assurance that transactions are authorized, and that transactions and other data are recorded and presented in a manner that is accurate, complete, current and not misleading.

Policy:

FEDERAL AND NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAW

False Claims Act (31 USC, sections 3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) 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 Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; … or (7) 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 Government,

Is liable to the United States Government for a civil penalty or not less than $5,000 and not more than $10,000, plus three (3) times the amount of damages which the Government sustains because of the act of that person…

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required (31 USC section 3729).

While the False Claims Act imposes liability only when the claimant acts "knowingly", it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the

information, can also be found under the Act (31 USC 3729[b]).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits a record that he knows (or should know) is false and that indicates compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States (31 USC 3730[b]). These private parties, known as "qui tam relators", may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least fifteen (15) percent, but not more than twenty-five (25) percent of the proceeds of the FCA action, depending upon the extent to which the realtor substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the realtor shall receive an amount that the court decides is reasonable and shall not be less than twenty-five (25) percent and not more than thirty (30) percent.

Administrative Remedies for False Claims (31 USC Chapter 38, sections 3801-3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claims.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, 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.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative, and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

New York False Claims Act (State Finance Law, sections 187-194)
The New York False Claims Act closely tracks the federal False Claims Act. 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 $6,000 - $12,000 per claim and the recoverable damages are between two (2) and three (3) times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

Social Services Law, section 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 and the person's family's needs are not taken into account for six (6) months if a first offense, twelve (12) months if a second (or once if benefits received are over $3,900) and five years for four (4) or more offenses.

B. CRIMINAL LAWS

Social Services Law, section 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, section 366(b) – Penalties for Fraudulent Practices
1. 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.
2. Any person who, with intent to defraud, presents for payment a 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.

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:

1. Section 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.

2. Section 175.10: Falsifying business records in the first degree includes the elements of the section 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
3. Section 175.30: Offering a false instrument for filing in the second degree involved 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.
4. Section 175.35: Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include 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:

1. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim, knowing that it is false. It is a Class A misdemeanor.
2. Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000. It is a Class E felony.
3. Insurance fraud in the third degree is filing a false insurance claim for over $3,000. It is a Class D felony.
4. Insurance fraud in the second degree is filing a false insurance claim for over $50,000. It is a Class C felony.
5. Insurance fraud in the first degree is filing a false insurance claim for over $1 million. It is a Class B felony.
6. 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:

1. Health care fraud in the fifth 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.
2. Health care fraud in the fourth degree is filing false claims and annually receiving over $3,000 in the aggregate. It is a Class E felony.
3. Health care fraud in the third degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.
4. Health care fraud in the second degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.
5. Health care fraud in the first degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act – 31 USC, section 3730(h)

The FCA 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 FCA (31 USC 3730[h]). Remedies include reinstatement with comparable seniority as the qui tam relator 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.

New York False Claim Act – State Finance Law, section 191

The False Claim Act also provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies included reinstatement with comparable seniority as the qui tam relator 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.

New York Labor Law, section 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 constitutes health care fraud under Penal Law, section 177. 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.

New York Labor Law, section 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.

IV. ANTI-KICKBACK LAW

Federal Anti-Kickback Statute (42 USC, sections 41320a-7b)

The Medicare/Medicaid Anti-Kickback Statute makes it a felony for any person or entity to

knowingly and willfully solicit, receive, offer or pay any remuneration in exchange for referring, furnishing, purchasing, leasing or ordering (or recommending the furnishing, purchasing, leasing, or ordering of) any good, facility, service or item that is paid in whole or in part by the Medicare or Medicaid programs, or other federal health care programs. Both the recipient and the offeror of the remuneration are subject to the Anti-Kickback Statute. Violators are subject to fines up to $25,000 per violation, up to five (5) years in prison, as well as administrative penalties, including exclusion from participation in the Medicare and/or Medicaid programs.

Remuneration. The term "remuneration" is broadly defined and includes any kickback, bribe, discount, rebate, in case or in kind, whether paid directly or indirectly. The government has taken the position that conferring of any benefit by one party on another constitutes "remuneration" for the purpose of the Anti-Kickback Statute. Because the prohibition applies to direct as well as indirect remuneration, the entire chain of financial transactions must be analyzed under this law, where at least one of the parties receives reimbursement from federal health programs and at least one other party is in a position to make referrals, order goods or services, or generate businesses for the first. Such common business practices as the provision of discounts for volume, or the offer of preferential pricing on prepackaged or bundled goods and services, are subject to the scrutiny as unlawful remuneration.

One Purpose Rule. The Anti-Kickback Statute has been construed by court decision to prohibit any otherwise legitimate remuneration for goods or services rendered if "one purpose" of the payment is to induce the referral, furnishing, leasing, etc., of goods or services paid by the Medicare or Medicaid programs.

Fair Market Value. When the remuneration between the parties is not fair market value, the government suspects that one purpose of the reimbursement is to compensate referrals between the parties.

Fair market value under the Anti-Kickback Statute is generally defined as that remuneration in the arms' length transaction that is not determined in a manner that takes into account the volume or value of Medicare or Medicaid services generated between the parties. Although no compensation methodology is per se prohibited, the government in various public statements has indicated that it views per procedure, per order, per purchase and percentage of revenue compensation methodologies as susceptible to abuse under the Anti-Kickback Statute because they inherently vary with volume or value.

Safe Harbors. The government has promulgated by regulation certain "safe harbors", which are payment practices that are excluded from the definition of "remuneration". However, the failure of an activity to comply with a safe harbor does not mean it violates the law, only that it is subject to case-by-case scrutiny under the Anti-Kickback Statute. The safe harbors cover a limited number of payment practices and are narrowly drawn. In addition, the safe harbors generally require that the entire transaction be "commercially reasonable" and have a reasonable commercial purpose other than the exchange of referrals. The risk of an enforcement action is mitigated the closer a transaction comes to meeting the various standards of a safe harbor.

Fraud Alerts. The Office of Inspector General (OIG) of the Department of Health and Human Services in fraud alerts, Advisory Opinions and other public statements has identified practices and arrangements that it considers potentially violative of the Anti-Kickback Statute. These fraud alerts should be regarded as the government's enforcement position with respect to a particular subject matter. The fraud alerts are examples and the naming of specific types of providers in a fraud alert does not limit the application of its meaning.

The OIG considers improper under the Anti-Kickback Statute any payment, prize, reward, including any gift, or any offer of free goods or services if it is:

- Made to a person in a position to generate business for the paying party related to the volume of business generated for the paying party;
- More than nominal in value and/or exceeds fair market value of any legitimate service rendered to the paying party, or is unrelated to any service at all, other than generation for business for the paying party.

Because of the central role of physicians under Medicare reimbursement rules, the OIG has also issued fraud alerts on the paying of incentives to physicians, and has identified several arrangements it considers potentially improper, such as providing physicians with:

- Free or significantly discounted office space, equipment or staff;
- Free training for physician's office staff;
- Discounted loans or loan forgiveness tied to patient referrals;
- Conference and/or continuing education expense reimbursement;
- Insurance coverage at a below-standard cost;
- Payment for services requiring few actual duties;
- A discounted price or a gift, coupon, bonus or cash payment to physicians in exchange for or based on prescribing or ordering specific products;
- Cash or other benefits in exchange for performing sales-oriented, education or patient outreach marketing; and in-office technicians, computers and/or fax machines at no charge, unless it can be shown that the staff or equipment is integral to the service being provided by the supplier, and limits are placed and monitored to assure staff and equipment are used by physicians only for the purposes of using or ordering the supplier's product.

V. FEDERAL STARK LAW, 42 USC, SECTION 1395nn

Under the federal physician self-referral prohibition (known as the Stark Law), a physician is prohibited from referring to an entity for certain "designated health services" if he or she has an ownership interest or a compensation arrangement with the entity. In addition, the referral recipient is prohibited from submitting a claim or receiving services provided pursuant to a prohibited referral. Because a "compensation arrangement" is defined as one which involves any form of remuneration, direct and indirect, the Stark Law will apply to every financial relationship between an entity and a physician, and likely, such intermediaries and Internet-based service providers who facilitate transactions between the physician and the provider of designated health services. "Designated health services" include outpatient prescriptions and

radiology services.

The Stark Law differs from the federal Anti-Kickback Statute in that where the Anti-Kickback Statute is intent-based (i.e., it requires knowing and willful behavior); the Stark Law creates an absolute prohibition on referral regardless of intent, unless the financial relationship or the referral falls within a stated exception. Hence, the failure to find an exception to the Stark Law is general fatal to a transaction. One of the exceptions provided under Stark is for the purchase of services (other than designated health services) by a physician at fair market value. This exception would apply to the financial relationship between an Internet-based services provider and a physician.

All covered persons must fill out the acknowledgement form on the following page. This form will be signed once only, during the new employee orientation process.

MADISON COUNTY
ACKNOWLEDGEMENT

I certify that I have received the Health Services Code of Conduct that was approved and adopted on December 27, 2012. I understand that it is a mandatory policy and I agree to abide by it.

_____
Signature

_____
Printed Name

_____
Date