

False Claims Recoveries – Medicaid Fraud and Abuse

1. Deficit Reduction Act of 2005 § 6032

The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities receiving or making \$5 million or more in Medicaid payments during a federal fiscal year to establish written policies and procedures informing their **employees, contractors and agents** about federal and state false claim acts and whistleblower protections. The policies must be available to the entity's employees as well as employees of its agents and contractors. For purposes of Section 6032 compliance, CMS' (Centers for Medicare and Medicaid Services) guidance is as follows:

CMS defines the term "Contractors and Agents" as any contractor, subcontractor, agent, or other person that, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

*Contractors furnishing Medicaid health care items or services include, but are not limited to, all contract therapists, physicians (including, but not limited to, house staff, hospitalists, and independent contractors), and pharmacies. Contractors **not associated with the provision of Medicaid health care items or services**, such as copy or shredding services, grounds maintenance, or hospital cafeteria or gift shop services, are excluded from the definition of "contractor".*

OPWDD's (Office for People With Developmental Disabilities) contractors meeting the criteria in the above definition are required to participate in the review and audits described in OPWDD's policies, and to abide by these policies with respect to funding for OPWDD services. Such contractors are also required to make this information available to all of their employees and contractors involved in performing work under their contracts with OPWDD.

2. Understanding False Medicaid Claims

OPWDD is committed to identifying inappropriate Medicaid claims to maintain the integrity of the Medicaid program. This involves not only educating our employees, agents, and contractors about the potential risks involved with Medicaid billing, but also safeguarding our system against Medicaid abuse and the submission of fraudulent Medicaid claims through monitoring and detection efforts.

A "false claim" occurs when someone submits a bill to Medicaid for services that they know were not provided or causes another person to submit a false claim to the government or knowingly makes a false record or statement to get a false claim paid by the government.

Federal and State laws impose liabilities on an individual who knowingly submits a false record in order to obtain payment from the government.

3. OPWDD Deficit Reduction Act § 6032 Policy

It is the policy of OPWDD to assist in ensuring the integrity of the Medicaid program by safeguarding against Medicaid abuse and the submission of fraudulent Medicaid claims. OPWDD

acts under the direction of the New York State Office of the Medicaid Inspector General (OMIG) to maintain Medicaid program integrity. The OMIG has been established by statute as an independent entity within the New York State Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. In carrying out its mission, the OMIG conducts and supervises all prevention, detection, audit and investigation efforts with OPWDD and other State agencies. OPWDD performs various internal reviews and monitoring of its Medicaid claims.

4. OPWDD Policies

OPWDD acts under the direction of the New York State Office of the Medicaid Inspector General (OMIG) to identify inappropriate Medicaid claims and to maintain Medicaid program integrity.

OPWDD currently performs reviews of Medicaid claims as follows:

- For the OPWDD state services sector, OPWDD conducts routine reviews of documentation supporting Medicaid claims. OPWDD Central Operations also utilizes several separate review procedures relative to Medicaid claims. Based on these reviews OPWDD, in conjunction with the New York State Department of Health and the OMIG, carries out or oversees Medicaid voids or adjustments for inappropriate claims.
- The Field audit function, in relation to the Medicaid paid claims by voluntary agencies, is the responsibility of the Office of Medicaid Inspector General (OMIG). OMIG, in consultation with OPWDD, develops audit protocols which it uses to conduct detailed field audits and recover funds when in its determination, claims have been improperly reimbursed to the voluntary agency. OMIG also conducts investigation into alleged improper Medicaid practices, including the employment of unqualified providers of Medicaid eligible services by the voluntary agencies and takes further legal steps necessary to properly address the underlying conditions. Responding to allegations of Medicaid irregularities by staff and the public, OPWDD auditors, as warranted, make referrals to the OMIG.
- OPWDD issues Administrative Memoranda that specify the billing standards and service documentation requirements for each Medicaid service and program operated or certified by OPWDD. Additionally, OPWDD has established compliance liaisons in each of our State Operations District Offices throughout the State to act as point persons for field staff on compliance issues.

Under the direction of the OMIG, OPWDD will further strengthen its efforts to prevent and detect fraud and abuse in the Medicaid program.

5. OPWDD Medicaid Compliance Program (State Operations)

To comply with the requirements of New York Social Services Law § 363-d, NYCRR Title 18 Part 521, and the Deficit Reduction Act (DRA) obligations in 42 USC § 1396a (a) (68), OPWDD has implemented a Medicaid Compliance Program applicable to the umbrella of State Operations (OPWDD as a provider of Medicaid services). The purpose of the program is to assist in enhancing the integrity of the Medicaid program including efforts to detect and prevent fraudulent, abusive, and wasteful practices within OPWDD and to correct improper Medicaid billings or payment

mistakes. OPWDD seeks to provide uniform guidance for its State Operations Offices for billing and accounting activities, as well as program integrity areas including quality of care, governance, credentialing and other risk areas that may be identified.

A. Duty to Report Misconduct, Fraud, Waste and Abuse

Employees, contractors, and others who have knowledge of violations of law or OPWDD policy or operating procedures or conduct which could be characterized as Medicaid fraud, waste or abuse have a “duty to report” what they know, as soon as possible. Employees and others should understand that they may be subject to disciplinary or other corrective administrative action, if they commit misconduct, fraud, waste and abuse.

B. Reporting Medicaid Misconduct

OPWDD evaluates, and investigates or refers to appropriate parties for further action, all complaints of Medicaid misconduct, fraud, waste, and abuse.

If one suspects or sees Medicaid wrongdoing, we need to know. This includes:

- Giving or receiving bribes or kickbacks;
- Using unacceptable medical and/or billing practices;
- Misusing or abusing Medicaid services;
- Falsifying records or giving false information.

C. How do you report Medicaid misconduct or fraud?

Contractors, agents, employees of such, and others, may report suspected Medicaid misconduct, fraud or abuse in the ways listed below. As much information as possible on the issue should be reported, which includes:

- what wrongdoing occurred;
- who is involved;
- when it occurred;
- whether there are witnesses to the misconduct;
- how the issue was discovered or any other relevant information or detail to support how Medicaid Fraud is being committed.

Several communication lines are available for receiving Medicaid allegations.

To OPWDD’s Central Office Info Line:

1-866-946-9733 or 1-866-933-4889 (TTY)

The OPWDD Information Line manages all complaints. All calls are logged and forwarded to the appropriate personnel. Callers may report **anonymously** via the online form on the OPWDD Internet www.opwdd.ny.gov under “Contacts” and “Information Line.” http://www.opwdd.ny.gov/opwdd_contacts/information_line/home

In Writing:

Helene DeSanto
OPWDD Compliance Officer
44 Holland Avenue, 4th floor
Albany, NY 12229
Medicaid.Compliance@opwdd.ny.gov

Office of the Medicaid Inspector General:

The Office of Medicaid Inspector General (OMIG) has been established by statute as an independent entity within the NYS Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. In carrying out its mission, the Office conducts and supervises all prevention, detection, audit and investigation efforts and coordinates such activities with OPWDD. The OMIG may be reached at 1-877-87FRAUD (1-877-873-7283) or via their website at www.omig.ny.gov.

Federal & New York Statutes Relating to Filing False Claims

1. Federal Statutes

A. False Claims Act

The False Claims Act (FCA) 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 records that he knows (or should know) are false and that indicate 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 or Medicaid 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 or Medicaid program.

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 also can be found liable. In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 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 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d) (2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

The current FCA can be found in the United States Code, Title 31, Sections 3729 through 3733:

[US Code Title 31 Chapter 37](#)

Background

The FCA dates back to the Civil War. During the Civil War, some defense contractors defrauded the Union government, and Congress enacted the FCA in response to these scandals.

Who is Liable?

The FCA makes anyone who submits (or causes someone else to submit) a false or misleading claim liable for penalties and fines.

What is a claim?

A claim is simply some demand for money or property, where the federal government provides any portion of the money or property requested. Because the federal government funds part of New York's Medicaid program, the FCA covers claims or bills to Medicaid in New York, including claims or bills for Medicaid-funded services or goods provided by OPWDD or provided by OPWDD-funded agencies or persons.

How Does This Work?

If a Medicaid claim or bill is untrue (or "false"), it will bring liability upon the person who said it was true. The penalties and fines under the FCA will vary for each claim and can include the government's costs in pursuing a lawsuit against the person. Some of the things included in the FCA are falsifying billing records, billing for services not rendered, billing for goods not provided, billing for a more expensive service than the one actually provided (often called "upcoding") and duplicating billing to obtain double payment. No proof of specific intent to defraud the government is required to be held liable under the FCA. All that is required is that the person has actual knowledge, or has acted with deliberate ignorance or reckless disregard of the truth or falsity of his or her claim. Basically, the defense of "I didn't know it was illegal" does not work.

The FCA also has incentives for employees to come forward and report misconduct. Generally, a person who knows about the false claims (the whistleblower) may sue on behalf of the government for a violation of the FCA. After the whistleblower files a lawsuit, the government can pursue the suit on its own, or decline and allow the whistleblower to continue. The government may elect to move forward with the suit as is, change it to a criminal or administrative case, settle it, or request a dismissal. The whistleblower can participate in the lawsuit along with the government, but the judge can limit who the whistleblower calls as witnesses, how long they testify and how much the whistleblower can cross examine witnesses if the whistleblower is just harassing the defendant or is interfering with or duplicating the government's case.

Depending on the outcome of the case and the whistleblower's involvement in the prosecution of the case, the whistleblower can receive a percent of the proceeds of the action or settlement. The whistleblower only gets this money if the government recovers money from the defendant as a result of the FCA lawsuit. The whistleblower's award may be reduced if the judge decides that the whistleblower planned and initiated the violation. A

whistleblower who files a frivolous lawsuit can be forced to reimburse the defendant for all the costs of defending the lawsuit, including attorneys' fees.

Is there a Statute of Limitations?

Yes. A lawsuit to enforce the FCA must be brought within six years of the violation, or, if the government brings the suit, within three years of when the government knew or should have known the facts about the violation. A suit can never be brought later than ten years after the date the violation was committed.

B. Administrative Remedies for False Claims

This federal 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 and additional amounts for the claim.

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.

For reference purposes, the full code may be accessed in the United States Code, Title 31 Chapter 38 Sections 3801-3812: Administrative Remedies for False Claims and Statements.

[US Code Title 31 Chapter 38](#)

2. New York State Statutes

The New York False Claims Act and other state laws address false claims. These 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 are also applicable.

A. Civil and Administrative Laws

New York False Claims Act

The NY 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. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

There are penalties of at least \$6,000 per claim and damages of three times the loss the government sustains because of the false claim. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to some limitations imposed by the State Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover a percentage of the proceeds, amounts of which are dependent upon whether the government did or did not participate in the suit. (25% - 30% if the government did not participate in the suit, and 15% - 25% if the government did participate in the suit). For reference purposes, the full state law may be found in Article XIII: New York False Claims Act, Sections 187-194: [New York False Claims Act](#)

Social Services Law §145-b, False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local social services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. If repeat violations occur within five years, a penalty of up to \$30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services. [Social Services Law](#)

Social Services Law § 145-c, Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least \$1,000 but not more than \$3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of \$3,900), and for five years for any subsequent occasion of any such offense. [Social Services Law](#)

B. Criminal Laws

Social Services Law § 145, Penalties

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

Social Services Law § 366-b, Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain, for himself or others, Medicaid by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment 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. This statute has been applied to Medicaid fraud cases. [NYS PENAL LAW Articles 155, 175, 176, 177](#)

- a. Fourth degree grand larceny involves property valued over \$1,000. This is a class E felony.
- b. Third degree grand larceny involves property valued over \$3,000. This is a class D felony.
- c. Second degree grand larceny involves property valued over \$50,000. This is a class C felony.
- d. First degree grand larceny involves property valued over \$1 million. This is a class B felony.

Penal Law Article 175, False Written Statements.

Several sections in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions: [NYS PENAL LAW Articles 155, 175, 176, 177](#)

- a. § 175.05 – Falsifying business records - involves entering false information, omitting material information or altering an enterprise’s business records with the intent to defraud. This is a class A misdemeanor.
- b. § 175.10 – Falsifying business records in the first degree - includes the elements of § 175.05 and the intent to commit another crime or conceal its commission. This is a class E felony.
- c. § 175.30 - Offering a false instrument for filing in the second degree - involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. This is a class A misdemeanor.
- d. § 175.35 – Offering a false instrument for filing in the first degree – includes the elements of § 175.30 and an intent to defraud the state or a political subdivision. This 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 involving filing false insurance claims and committing insurance fraud. [NYS PENAL LAW Articles 155, 175, 176, 177](#)

- a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. This is a class A misdemeanor.

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

Penal Law Article 177, Health Care Fraud.

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute. This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes five crimes. [NYS PENAL LAW Articles 155, 175, 176, 177](#)

- a. Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.
- b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
- c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
- d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
- e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

3. Whistleblower Protections

A. Federal False Claims Act (31 U.S.C. § 3730(h))

The Federal False Claims Act (FCA) provides protection to *qui tam* relators (individuals who commence a False Claims action) 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 U.S.C. § 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.

B. New York State False Claims Act (State Finance Law § 191)

The New York State False Claims Act also provides protection to *qui tam* relators (individuals who commence a False Claims action) 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 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.

C. New York State Labor Law § 740

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

D. New York State Labor Law § 741

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

reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.
[Consolidated Laws of the State of New York, Labor \(LAB\)](#)