Health Care Compliance Policy
Program and Operating Standards
Emergency Medical Services

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I. Introduction

The New York City Fire Department ("FDNY") has established a health care compliance program to ensure that its workforce members and "affected individuals"[1], comply with all applicable laws, regulations, and program requirements when providing medical services and submitting claims for payment and reimbursement of medical services. This document demonstrates FDNY's commitment to complying with applicable legal, regulatory and other requirements, appropriate guidance, and our contractual commitments.

FDNY is committed to consistently and fully complying with all laws and regulations and to performing in accordance with the highest professional and business standards. In support of this commitment, the Department has established a compliance program to ensure that all affected individuals comply with all applicable laws, regulations, and program requirements. All Compliance Program standards and operating procedures are posted on the FDNY Intranet and Internet at https://www.nyc.gov/site/fdny/about/resources/resources.page.

FDNY's mission is to save lives and improve the quality of life within New York City by rapidly responding to emergency situations, by providing emergency medical, fire suppression and rescue services, by code enforcement, investigation, and education activities and by staff, administrative and operational support functions. All affected individuals are expected to promote organization-wide integrity, preserve public trust, promote confidence in government, protect the integrity of government decision-making, and enhance government efficiency and FDNY's ability to achieve our mission. All affected individuals have a responsibility to ensure that their conduct does not violate the public trust placed in them. Their actions in all relationships, not just with the public, but also with coworkers, colleagues and vendors, must be governed at all times by the highest standards of honesty. Each affected individual shall make a personal commitment to adhere to the guiding principles set forth in the applicable policies and procedures by:

- Fostering leadership at all levels to sustain a culture where ethical conduct is recognized, exemplified and valued by all employees and others doing business with FDNY;
- Obeying the laws and regulations governing our organization and your professions;
- Being honest, fair, and trustworthy in all activities and relationships;
- Avoiding all conflicts of interest between work and personal affairs;
- Fostering an atmosphere in which equal opportunity extends to every member of our diverse community;
- Striving to create a safe workplace and protecting the environment; and
- Establishing accountability for compliance at all times.

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers." FDNY does not have the same corporate structure, therefore, FDNY defines affected individuals as employees, the Fire Commissioner, Chief of EMS, other senior leaders, contractors, agents, subcontractors, and independent contractors.

This Health Care Compliance Program contains the necessary seven (7) core elements required by the New York State Office of the Medicaid Inspector General ("OMIG")[2]outlined below and follows the U.S. Department of Health and Human Services Office of Inspector General ("OIG") General Compliance Program Guidance (November 2023)[3] as well as the for Ambulance Suppliers Guidance[4] and adopts the principles set forth by the United States Sentencing Commission[5] pertaining to effective compliance and ethics programs.

(1) Written Policies and procedures that describe compliance expectations;
(2) A designated compliance officer and compliance committee;
(3) Education and training of all affected individuals;
(4) Communication lines and processes for the reporting of compliance concerns;
(5) Enforcement and disciplinary policies and procedures to encourage good faith participation in the compliance program;
(6) Monitoring and auditing systems to aid in the routine identification of compliance risk areas; and
(7) A system for responding to, investigating, correcting and reporting compliance issues as they are raised.

This program is intended to provide a comprehensive statement of the responsibilities and obligations of FDNY in submitting claims for medical services provided by FDNY's Emergency Medical Services Bureau ("EMS") to patients, and claims submissions to private insurance companies, Medicare fee-for-service, Medicaid fee-for-service and both Medicaid and Medicare Managed Care Plans. The Program applies to key compliance areas including, without limitation: (1) billings; (2) payments; (3) medical necessity; (4) quality of care; (5) governance; (6) mandatory reporting; (7) credentialing; (8) contractor, subcontractor, agent or independent contract oversight; (9) other risk areas identified through FDNY's compliance activities and risk assessments.[6] In addition, this program is intended to apply to business arrangements with vendors, hospitals, and other persons or entities, which may be impacted by federal or state laws relating to fraud, waste and abuse (FWA).

[2] *See* 18 NYCRR § 521.3, *see also* Office of the Medicaid Inspector General Compliance Program at https://www.omig.ny.gov/compliance.
[3] HHS-OIG General Compliance Program Guidance | November 2023
[4] Compliance Program Guidance for Ambulance Suppliers at 68 Fed. Reg. 14245; March 24, 2003 at https://oig.hhs.gov/fraud/docs/complianceguidance/032403ambulancecpgfr.pdf.
[5] See United States Sentencing Commission 2022 Guidelines. Effective Compliance and Ethics Programs - The Organizational Sentencing Guidelines: Thirty Years of Innovation and Influence (ussc.gov). March 2023 Update - Microsoft Word - 2023.03.03 - Revised ECCP (revised3) (justice.gov).
[6] Although "ordered services" was also an identified risk by OMIG, it was determined that it does not apply to FDNY.

II. Element I - Written Policies and Procedures

FDNY Compliance standards and procedures have been developed to provide guidance to affected individuals regarding how they must conduct themselves to protect and promote integrity in the healthcare operations. All affected individuals are responsible to ensure that their behavior and activity are consistent with these guidelines and applicable program requirements. All standards and procedures are reviewed at least annually and revised as appropriate to ensure they are current and relevant. The current standards and procedures are easily accessible on the FDNY Intranet and internet.

A. Principles and Standards Regarding the Submission of Claims for Emergency Medical Services

All affected individuals are responsible to ensure that their behavior and activity is consistent with the Code of Conduct, which is available for review on the FDNY Intranet and Internet at https://www.nyc.gov/site/fdny/about/resources/resources.page and the following principles and standards regarding the submission of claims for ambulance services.

B. Conflicts of Interest

All Employees shall not violate the Conflicts of Interest provisions of the New York City Charter Section 68 or any law, rule, or regulation of the City of New York pertaining to the proper conduct of employees.

As an example, no employee shall engage in any business transaction, or private employment, or have any financial or other private interest, direct or indirect, which is in conflict with the proper discharge of official duties, unless a waiver is obtained from the New York City Conflicts of Interest Board[7].

Moreover, no employee shall accept any valuable gift, as defined by the New York City Conflicts of Interest Board, from any person or firm that such employee knows is, or intends to become, engaged in business dealings with FDNY.

In addition, no employee shall receive compensation, except from FDNY, for performing any official duty or accept or receive any gratuity from any person whose interests may be affected by the employee's official action.

Affected individuals, other than employees, shall not violate the contract provisions addressing their requirements to avoid conflicts. Failure to comply with that requirement could lead to termination of the relationship.

C. Legal Compliance

Affected individuals shall comply with all laws, regulations, and program requirements when

[7]NYC Conflicts of Interest Board at https://www1.nyc.gov/site/coib/about/about-coib.page.

submitting claims for payment and reimbursement of ambulance services.

FDNY expects all affected individuals to refrain from conduct, which may violate the fraud, waste and abuse laws. In general, these laws prohibit: (i) the submission of false, fraudulent, or misleading claims to any government entity or third-party payer, including misrepresenting services rendered, billing for services not rendered, or filing claims which do not otherwise comply with applicable program or contractual requirements; (ii) direct, indirect, or disguised payments in exchange for the referral of patients; and (iii) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

D. Claims Development and Submission Process – Ambulance Transports

(1) General Documentation

An electronic Pre-hospital Care Report ("ePCR") must be completed by FDNY personnel whenever an ambulance FDNY EMS provider makes patient contact.

Ambulance staff must document the provision of ambulance services in full by the end of the call, but no later than end of the shift during which the services were provided. All information should be documented with clarity and accuracy to facilitate appropriate billing.[8]

Additional business rules are established and maintained by the Bureau of Revenue Management.

(2) Documentation of Medical Condition to Support the Services Billed

Ambulance crews must clearly and accurately document the patient's symptoms and/or injuries at the time of transport.[9]

(3) Obtaining Insurance Information

Ambulance crews are expected to attempt to obtain insurance information from the patient or a representative at the time of service.

(4) Obtaining Patient Signature

The ambulance crews are required to obtain the signature, or properly document why they were not able to obtain it. The patient signature authorizes billing Medicare, Medicaid and other insurers, the assignment of benefits, and the release of medical information. Medicare

[8] Medicare Benefit Policy Manual – Ambulance, Chapter 10, §10.2.4 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf.

[9] Medicare Benefit Policy Manual – Ambulance, Chapter 10, §10.2.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf and 18 NYCRR 540.7(a) at https://regs.health.ny.gov/content/section-5407-requirements-billing#:~:text=(a)%20All%20bills%20for%20medical,drugs%2C%20the%20prescription%20filled)%3B

requires either 1) a signature of the patient, or 2) if the patient is physically or mentally unable to sign, the signature of the patient's authorized representative, or 3) if the patient is physically or mentally unable to sign, and the patient does not have an authorized representative who is willing and able to sign, Medicare requires the signatures of both the ambulance crew and hospital representative. In addition, appropriate documentation must support the claim and must be sufficiently legible so it can be audited and reviewed. In the medical record, the names of the signatory will be automatically populated into the field corresponding with the signature.[10] If signature of authorized representative is obtained, the name of the signatory typed in to the available data field.

(5) Signature of Hospital Receiving Agent

Ambulance crews transporting a patient to the hospital must obtain the signature of the receiving agent at the hospital. The crew must type in the full name of the receiving agent into the field corresponding with the signature.

(6) Mileage

Milage must accurately reflect the location of pick up and location of transport. This is automatically calculated.

(7) Claim Processing

Billing staff or billing vendor must ensure that claims are submitted to Medicare only when Medicare signature requirements are met. Medicare requires either 1) a signature of the patient, or 2) if the patient is physically or mentally unable to sign, the signature of the patient's authorized representative, or 3) if the patient is physically or mentally unable to sign, and the patient does not have an authorized representative who is willing and able to sign, Medicare requires the signatures of both the ambulance crew and hospital representative. In addition, appropriate documentation must support the claim and must be sufficiently legible so it can be audited and reviewed.

(8) Medicaid

The payment FDNY-EMS currently receives for Medicaid Fee for Service (FFS) patients is a variable percentage of the amount the Health and Hospitals Corporation (H+H) receives from NYSDOH for Medicaid in-patient discharges. The costs of providing EMS are considered part of the hospital's operating costs. As a result, FDNY-EMS does not directly bill transported patients if they are Medicaid Fee for Service (non-HMO) insured, and there is no direct relationship between the specific patients transported and the payment passed through to FDNY by H+H. However, FDNY is authorized to bill for ambulance services where the insurer is a Medicaid HMO. Based on regulations issued by the New York State Department of Health, effective January 1, 2013, all transports where the primary insurer is a Medicaid HMO are no longer to be billed to the HMO but will be billed to and paid by the State. FDNY submits claims to the State for patients covered by

[10] Medicare Benefit Policy Manual – Ambulance, Chapter 10, §20.1.2 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf.

Medicaid HMOs. Claims for patients covered by Medicaid (non-HMO) Fee for Service will not be submitted and will continue to be reimbursed as a variable percentage from H+H as per paragraph above.

In addition, claims paid by Medicare as primary payer, will automatically be crossed over to New York State by Medicare, if the patient is covered by Medicaid fee for service (FFS) as a secondary payer. FDNY will be reimbursed by Medicaid FFS in these cases.

(9) Medical Necessity

Medical necessity determination must comply with Medicare guidelines.[11] All claims submitted to Medicare must be first reviewed to ensure that medical necessity has been met per Medicare guidance. This is performed by the third-party vendor that is submitting claims on behalf of FDNY. The information shall accurately and completely reflect the patient's condition at the time of incident. Upon request of the carrier, billing staff must provide documentation to support the medical necessity of a service. The billing staff and or vendor will review claims to determine medical necessity.

(10) Coding

The ICD-10-CM codes must reflect the patient's condition at the time of treatment and should reflect the date on which the service was delivered. It must comply with Medicare and AHIMA coding guidelines.

(11) Billing

Billing and claim information must be consistent with the information contained in the source records. Therefore, the medical record should reflect the condition of the patient at the time of the contact with medical staff.

(12) Collection of Co-Payments and Deductibles

Reasonable efforts must be made to collect co-payments and deductibles from patients. However, a lesser amount may be accepted in discharge of a patient's liability, or liability may be waived, if the decision is based on FDNY's determination of a particular patient's indigence.

E. Record Retention

The Chief Health Care Compliance Officer and/or appropriate department heads, supervisors and managers, shall appropriately document and file the following information:

1. The Office of Health Care Compliance or IT department will retain the evidence of completion of Compliance and Privacy training (orientation/annual) on the e-Learning system.

[11] Medicare Benefit Policy Manual – Ambulance, Chapter 10, §10.2.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf

2. Documentation pertaining to compliance training programs, including the date of the training program, the presenter(s), a brief description of the presentation, presentation materials and sign-in sheets. In addition, should maintain the annual Training Plan.
3. Evidence of the appointment of the Chief Health Care Compliance Officer and quarterly reports to the Executive Cabinet by the Officer.
4. Office of Health Care Compliance and Human Resources will retain documentation relating to background checks of new employees and results of monthly sanction screenings, and
5. Office of Medical Affairs will maintain information regarding credential screening of professional staff.
6. Bureau of Investigations and Trials will retain documentation relating to disciplinary actions taken against affected individuals resulting from violations of the Compliance Program.
7. Office of Health Care Compliance will maintain the Code of Conduct, Compliance Committee Charter and Compliance policies and procedures, indicating dates approved, reviewed, revised and effective. Maintaining evidence of annual reviews and annual distribution to staff.
8. Office of Health Care Compliance will maintain the Compliance Committee agendas and minutes.
9. Office of Health Care Compliance will maintain documentation of audit findings, reports or complaints made to the Chief Health Care Compliance Officer.
10. Office of Health Care Compliance will maintain reports to management and corrective action plans prepared as a result of audit findings, reports or complaints made to the Chief Health Care Compliance Officer also should be maintained in the files.
11. Office of Health Care Compliance will maintain documentation of annual compliance work plans and auditing and monitoring conducted in furtherance of the Compliance Program.
12. Office of Health Care Compliance will maintain documentation of reports made to the Compliance Committee and to the Executive Cabinet.
13. Office of Health Care Compliance and Office of Revenue Management will maintain documents related to self-disclosures and/or overpayment reports to federal health care programs or oversight agencies (*e.g.,* OIG, OMIG, Medicare contractor).
14. Office of Health Care Compliance and Office of Revenue Management will maintain copies of annual certifications made to the NYS Office of Medicaid Inspector General or the NYS Department of Health regarding Compliance and Ethics Program Effectiveness and compliance with the Deficit Reduction Act of 2005.
15. Office of Revenue Management will maintain the following documents: supporting information relating to filed claims; records relating to reimbursement from the federal health care programs; and eligibility information (i.e., Medicare number) for patients served.
16. EMS Operations or other relevant departments will maintain information relating to the qualifications of crew and vehicles.

These records should be retained as outlined in the Record Retention schedule.

F. Bad Debt

All internal and external write-off procedures should be followed, including any subsequent disposal (sale) of debt as per Comptroller's and Department's guidelines.

It shall be the responsibility of the Chief Health Compliance Officer to ensure that the standards and procedures remain current and are updated as necessary.

In addition, the designated manager and/or supervisor in each affected area shall be responsible for ensuring that the compliance standards and procedures are adhered to, assessing particular compliance risks that relate to their area, and making recommendations to the Compliance Officer for changes to address those risks.

G. Contracting with Outside Billing Agents

Any vendor that is used for claims and billing services must comply with all applicable federal and New York state laws related to submission of claims. The vendor will be required to follow FDNY's compliance program as noted in this policy.

III. Element II - Compliance Committee and Compliance Officer

The Fire Commissioner has created an FDNY Emergency Medical Service Compliance Committee (hereinafter "Compliance Committee") for the purpose of establishing and implementing the integrity in the health care operations. The responsibilities of the Compliance Committee are outlined below and in the Compliance Committee Charter.

In addition, the Fire Commissioner has designated the Chief Health Care Compliance Officer as the individual within FDNY with day-to-day responsibility for overseeing and monitoring the implementation and operation of the compliance program. The Chief Health Care Compliance Officer shall report directly to the Fire Commissioner.

A. Composition of the FDNY Emergency Medical Service Compliance Committee

The members of Compliance Committee include the following members or appointed designees of such positions:

(1) Chief Health Care Compliance Officer/Chief Privacy Officer (chair);
(2) Chief Medical Officer;
(3) Chief Medical Director;
(4) Deputy General Counsel, Health Care Law;
(5) Chief of Emergency Medical Services;
(6) Assistant Commissioner for Investigations and Trials;
(7) Deputy Commissioner, Management and Budget;
(8) Chief Information Security Officer/HIPAA Security Officer;
(9) Executive Director for Internal Audit;
(10) Director of Revenue Management; and
(11) Deputy Commissioner, Human Resources.

B. Duties of FDNY Emergency Medical Service Medical Compliance Committee

The Compliance Committee shall be responsible for coordinating with the Chief Health Care Compliance Officer to ensure FDNY is conducting its business in an ethical and responsible manner, consistent with its compliance program and ensuring that FDNY has an effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues. Duties of the Compliance Committee are defined in its Charter.

Compliance Committee shall meet no less frequently than quarterly and shall, no less frequently than annually, review and update the compliance committee charter.

C. Periodic Reporting to Fire Commissioner Executive Cabinet

The FDNY Emergency Medical Service Compliance Committee shall report on a quarterly basis to the Executive Cabinet on the status of the compliance program. These reports shall include a summary of findings and recommendations, ongoing investigations, and any other information requested by the Fire Commissioner. In addition, the Compliance Officer shall

submit the Work Plan (which is a result of the Risk Assessment and ongoing work of the Committee) audit results, to all parties affected by the findings. FDNY shall maintain all information, including supporting documentation relating to the Risk on its premises, arranged by report year, so that it will be readily available for a minimum of six (6) years.

D. Compliance Officer

FDNY shall employ a Chief Health Care Compliance Officer who shall have sufficient education, training, funding, resources and authority to ensure implementation of the Program, be a member of senior management; report directly to the Executive Cabinet on compliance matters while being accountable to and reporting administratively and operationally to the Commissioner and/or their designee and have direct access to senior management and legal counsel. FDNY shall ensure that the Chief Health Care Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program. FDNY shall ensure that the Chief Health Care Compliance Officer and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their compliance program responsibilities.

The Chief Health Care Compliance Officer shall make regular reports to the Commissioner and the Executive Cabinet.

The Chief Health Care Compliance Officer's full scope of responsibilities are:

(1) overseeing and monitoring the implementation and operation of the compliance program including overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness;
(2) advising the Commissioner, Executive Cabinet, and other senior leaders on compliance risks facing the entity, compliance risks related to strategic and operational decisions of the entity, and the operation of the entity's compliance program;
(3) chairing the Compliance Committee(s);
(4) drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance work plan which shall outline the required provider's proposed strategy for meeting the requirements of 18 NYCRR Part 521;
(5) reporting to the Executive Cabinet on the implementation, operation, and needs of the compliance program, the compliance risks the entity faces, and the methods through which the entity is addressing or can address those risks on a quarterly basis;
(6) revising the compliance program periodically in light of changes in the needs of the organization, applicable law, and policies and procedures of third-party payors;
(7) coordinating with Human Resources to ensure that all directors, officers, employees, contractors, and medical staff, if applicable, are screened before appointment or engagement and monthly thereafter against the List of Excluded Individuals and Entities ("LEIE") and Medicaid program exclusion lists;
(8) assisting FDNY in establishing methods to improve efficiency, quality of services, and reducing the required provider's vulnerability to fraud, waste and abuse;
(9) coordinating with other relevant entity components (e.g., as applicable, Legal Affairs,

Internal Audit, Revenue, EMS Operations, IT) to develop work plans for reviewing, monitoring, and auditing compliance risks;

(10) independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports involving, for example, compliance concerns or suspected legal violations) and to make recommendations for process and policy changes and corrective action; and

(11) developing policies and programs that encourage personnel to report suspected fraud and other improprieties without fear of retaliation.

IV. Element III - Training and Education Programs

A. Department wide training

FDNY provides an ongoing program for the training of affected individuals on matters related to the compliance program, fraud, waste and abuse, ethical practices and compliance with Federal and State regulations. In addition, FDNY's policy to educate executives and the members of the Executive Cabinet with respect to compliance and privacy obligations, expectations and the compliance program by providing such training to assure a meaningful understanding of such compliance efforts on an annual basis (or if a new member joins the Executive Cabinet at the time of appointment). The training information and program requirements are outlined in the Training Plan.

The Chief Health Care Compliance Officer, in conjunction with other FDNY personnel and consultants, shall be responsible to ensure affected individual's education and training. Such education and training may consist of lectures, workshops, case studies, videos, and classes as outlined by the Training Plan.

All employees involved in the development and submission of claims shall receive initial training, which they must attend and successfully complete. Likewise, all new hires for these functions will be trained as part of the orientation program provided to new employees. Thereafter, those employees directly involved in billing will receive annual retraining. Similarly, EMTs and Paramedics shall receive training at the time of appointment and annually. Compliance Committee members and Executive Cabinet members will also receive initial training and annual retraining.

The Chief Health Care Compliance Officer shall also ensure that all education and training provided to employees is documented. The documentation shall include the names and positions, including the bureau, division and/or unit, of the individuals conducting and receiving the training, the date and duration of the educational activity or training program, and a brief description of the subject matter. The information will be maintained in the Learning Management System and the employee will be required to review the policies within the same system and attest, if necessary.

In addition to the training related to FDNY's Compliance program, all employees in the covered component must receive training related to HIPAA privacy and security rules and HITECH regulations relating to patient privacy and breach notification.

Please reference the annual Training Plan for details related to the annual training.

B. Deficit Reduction Act Training

It is FDNY's policy to provide health care services in a manner that complies with applicable federal and state law. To further this and to comply with Section 6032 of the Deficit Reduction Act of 2005 and Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York with regard to FDNY's contractors, agents, subcontractors, independent contractors with compliance responsibilities.

FDNY requires designated contractors, agents, subcontractors, independent contractors to acknowledge receipt of and compliance with FDNY's policies and procedures to prevent and detect fraud, waste, and abuse in health care systems. Such acknowledgement will be accomplished by executing an attestation.

FDNY's contracts and/or agreements with contractors, agents, subcontractors, independent contractors should contain a provision enforcing execution of the attestation and continued adherence to FDNY's compliance policies. To comply with the Employee Education Provision of the Deficit Reduction Act of 2005, contractors, agents, subcontractors, independent contractors must execute an attestation of receipt of information regarding fraud, waste, and abuse, and adhere to the compliance policies received from FDNY, as updated annually. Contractors, agents, subcontractors, independent contractors must educate their employees and agents, on at least an annual basis, about FDNY's Compliance Program as well as fraud, waste and abuse issues including the False Claims Act and whistleblower protections provided thereunder, if such employees do not complete FDNY's new employee orientation and annual training. See relevant laws as **Addendum A**.

V. Element IV - Communication of Compliance Issues

A. Notices Concerning Compliance Reporting

FDNY has established and implemented effective lines of communication, ensuring confidentiality, between the Chief Health Care Compliance Officer, members of the Compliance Committees and work force members, managers and senior staff. The lines of communication are accessible to all affected individuals and Medicaid recipients, allow for questions regarding compliance issues and report of compliance issues and potential fraud, waste and abuse as they are identified and include methods for anonymous and confidential good faith reporting of potential compliance issues.

FDNY encourages open lines of communication and reporting by all affected individuals and Medicaid recipients by:

(1) Taking each report seriously;
(2) Investigating each report to every extent possible given the information received and taking any necessary action needed to correct problem identified in the report;
(3) Not retaliating against an employee or taking any action adverse to the terms and conditions of their employment for reporting a violation in good faith; and
(4) Honoring any requests for anonymity consistent with FDNY's obligations to investigate reported violations and to take corrective action.
(5) Compliance reports may be made anonymously, if a person chooses and investigations will be handled in such a manner as to maintain confidentiality. All reports made will be kept confidential, whether requested or not unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding. Compliance files shall maintain appropriate confidentiality of reported information.

FDNY is committed to the timely identification and resolution of all compliance issues. Affected individuals who are aware of or suspect acts of fraud, waste and abuse, or violations of the Code of Conduct or FDNY policies are required to report them. Several independent reporting paths are available:

(1) Affected individuals may report to their supervisor or managers. Supervisors and managers will refer the report to the Chief Health Care Compliance Officer as soon as the report is made.
(2) Affected individuals may report directly to the FDNY's Health Care Compliance Committee or to the Chief Health Care Compliance Officer at **(718) 999-0691**.
(3) FDNY operates the Compliance & Privacy Hotline at **1-(877) FDNY-NYC [877-336-9692]**. The Hotline is available 24 hours a day, seven days a week. Individuals may use this line anonymously.

B. Responsibility of Affected Individuals

It is the responsibility of all affected individuals to abide by applicable laws, regulations, and

program requirements and to support FDNY's compliance efforts.

All affected individuals are required to report any violation of the compliance program or applicable law, if they have a good faith belief that a violation has occurred. For employees, Violations shall be reported, either orally or in writing, to the employee's manager or supervisor, or if the employee prefers, directly to the Chief Health Care Compliance Officer.

Work force members wishing to report violations may also use the twenty-four-hour, seven day-a-week, telephone hotline or via regular mail. These number(s), and addresses are disseminated to all employees, posted online, prominently posted at central locations, and at all ambulance stations. In addition, each manager and supervisor shall: ensure that all billing activities in their area of responsibility are conducted in accordance with this Compliance program; inform the Chief Health Care Compliance Officer of any problems he or she observes, or becomes aware of, that could have a detrimental effect on FDNY's compliance efforts; identify training and compliance needs; and actively promote compliance.

For other affected individuals, the information is shared via contracts, annual training and online via FDNY Intranet and Internet at https://www.nyc.gov/site/fdny/about/resources/resources.page.

Affected individuals are required to exercise diligence in documenting, handling, and submitting claims for payment or reimbursement. In addition, it is the obligation of every employee to immediately report to their manager, supervisor, the Chief Health Care Compliance Officer, or the hotline, any known or suspected submission of false, fictitious, fraudulent, or improper claims. Examples of such claims may include the following:

(1) Misrepresenting Services Rendered – Overcharging
Claims must accurately reflect the service provided. No bill shall be submitted without full documentation of the service that was provided.

(2) Billing for Services that are Not Rendered
Claims shall only be submitted for payment for services rendered.

(3) Services that are Not Medically Necessary
Medical necessity must be determined as per regulations and submitted in accordance with such regulations.

(4) Upcoding and/or Inaccurate Coding
Claims must be accurately coded to reflect the service provided and the patient's condition at the time of transport.

(5) False Statements
No affected individual should ever knowingly or willfully make false statements or representations, or conceal or fail to disclose information, to any governmental entity or third-party payer.

(6) Duplicate Billing

No affected individual may submit bills for any service to more than one payer at the same time, except for purposes of coordinating benefits.

(7) Multiple Coverage and Secondary Payers

No affected individual shall bill Medicare as the primary payer if he or she knows that another payer is, or is likely to be, the primary insurer. Examples of such insurance are worker's compensation, automobile no fault, and employer group health plans. Medicare makes certain specific exceptions to these rules, but in all cases Medicare regulations must be adhered to.

(8) Failure to Report Credit Balances

Credit balances may occur when overpayments are made or when claims for which a payment has been made are ultimately denied. In such cases, affected individuals shall report the existence of the balance to Medicare or other payers. This may result in requests for refunds or adjustments to current payments. Employees should not permit any continuing failure to report such credit balances.

(9) Refund Process

Refunds should be processed and submitted to the respective recipient as soon as possible, but within a reasonable timeframe. All refund timelines set forth by regulation must adhered to. See self-disclosure section below for timing and for requirements.

(10) Protection Against Retaliation - Whistleblower Protection

FDNY policy strictly prohibits retaliation, in any form, against individuals making a report, complaint or inquiry in good faith, concerned suspected fraud, waste and abuse or other suspected violation of law. Employees shall be assured that they should feel free to make such reports without fear of retaliation or other adverse action, and that all such reports will be investigated by FDNY or other appropriate authority in accordance with the following:

- The Federal False Claims Act (31 U.S.C. Section 3730(h));
- New York False Claim Act (State Finance Law Section 191[12]);
- New York Labor Law (Sections 740 and 741) and
- The City's Whistleblower Law under section 12.113 of the City Administrative.

C. Non-Retaliation/Non-Intimidation

All employee reports will be handled in a manner that protects the confidentiality of the reporter, if requested. However, there may be circumstances in which confidentiality cannot be maintained. In all cases, however, FDNY is determined that the reporting employee will not suffer from retaliation or intimidation for their good faith actions.

It is the responsibility of FDNY to ensure that those reporting and/or investigating in good faith do not suffer retaliation for doing so. Employees who believe that they have been retaliated against because they have reported a possible instance of misconduct or fraud should

[12] The New York State False Claims Act does not generally apply to claims made by New York City agencies; claims made by City agencies are usually covered under the Federal False Claims Act.

notify the Chief Health Care Compliance Officer. The Chief Health Care Compliance Officer and/or BIT will investigate all good faith complaints of retaliation or direct them to the appropriate entity for the investigation and/or follow up.

Good faith participation in the Compliance and Ethics Program includes, but is not limited to:
(1) reporting actual or potential issues or concerns, including but not limited to, any action or suspected action taken by or within FDNY that is illegal, fraudulent or in violation of any adopted FDNY Compliance and Privacy Policies;
(2) cooperating with or participating in the investigation of compliance and privacy matters;
(3) assisting with or participating in self-evaluations, audits, and/or resolving compliance issues (remedial actions);
(4) reporting instances of intimidation or retaliation;
(5) reporting potential fraud, waste or abuse to appropriate State of Federal Entities; or reporting to appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.

Individuals reporting suspected violations in good faith will be protected from any intimidation, harassment, discrimination, retaliation or adverse employment consequences. Acts of retaliation or intimidation should be immediately reported to a Chief Health Care Compliance Officer or to the Compliance Hotline. If the Chief Health Care Compliance Officer determines that an individual was improperly intimidated or retaliated against for good faith participation in the Compliance Program, FDNY will promptly take all appropriate corrective action as to the individual who was intimidated or retaliated against. In addition, if the Chief Compliance Officer determines that an individual was intimidated or retaliated against for good faith participation in the Compliance, the matter will be referred to BITs for appropriate disciplinary action against the offending party, in accordance with FDNY's policies.

All affected individuals are expected and required to participate in and comply with the Compliance Program, including the reporting of any potential misconduct, illegal conduct or other compliance-related concerns. Retaliation or intimidation in any form against an individual who in good faith reports possible misconduct or illegal conduct or for other good faith participation in the Health Care Compliance Program is strictly prohibited and is itself a violation of the Health Care Compliance Program. Acts of retaliation or intimidation should be immediately reported to the Chief Health Care Compliance Officer and, if substantiated, will be disciplined appropriately. Lastly, FDNY may terminate contracts and affiliations based on retaliation or intimidation for good faith participation in the Compliance Program.

FDNY may take appropriate disciplinary or legal action if a report of wrongdoing was fabricated or distorted to injure someone else or benefit the reporting individual or was otherwise knowingly or recklessly inaccurate. Moreover, although FDNY may consider "self-reporting" favorably when determining appropriate disciplinary action, the individual remains subject to disciplinary actions for his or her improper acts.

This Policy will be distributed to all affected individuals. This may be done by posting on the internet to https://www.nyc.gov/site/fdny/index.page.

VI. Element V - Enforcement and Discipline

Affected individuals who fail to adhere to FDNY's compliance efforts shall be subject to appropriate discipline. FDNY shall ensure that there are uniform practices for enforcement and discipline for individuals who fail to comply with applicable laws, regulations, guidelines and policies. Chief Health Care Compliance Officer in collaboration with Bureau of Investigations and Trials and/or Human Resources and/or shall ensure disciplinary standards fairly and consistently, and the same disciplinary action should apply to all levels of personnel. Violating conduct may include, but shall not be limited to:

(1) conduct that leads to the filing of a false claim or that is otherwise responsible for the filing of a claim in violation of state or federal law, or conduct that results in violation of any other law relating to participation in the Medicare or other federal health care programs;
(2) the failure to comply with all laws, regulations, and program requirements regarding the development and submission of claims, including encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
(3) the failure to perform any obligation required by this compliance program; or
(4) the failure to report suspected violations of this compliance program or applicable laws, regulations, or program requirements to the appropriate person.

Discipline shall be initiated and imposed in accordance with established laws, rules and regulations and FDNY policies and procedures applicable, collective bargaining agreements and Section 75[13].

In addition to any actions which may be taken by FDNY, some violations may be subject to review by appropriate local, state, or federal authorities.

Disciplinary investigations will be conducted consistent with the process outlined in the Civilian Code of Conduct which references Mayoral Executive Orders 16, 72, 78 and 105.

[13] https://www.nysenate.gov/legislation/laws/CVS/75

VII. Element VI - Monitoring and Auditing

FDNY has established a system for the routine identification and assessment of compliance risk areas relevant to its operations. This process includes internal, and as appropriate, external reviews, audits, and other practices to evaluate FDNY's compliance with federal health care program requirements (e.g., the Medicare and Medicaid Programs) and the overall effectiveness of the Compliance Program. Monitoring and auditing provide early identification of program or operational weaknesses and substantially reduce exposure to regulatory risk and government-related lawsuits. FDNY's Compliance Committee will annually develop a Risk Assessment. Using the results of the risk assessment, the Committee will develop an annual compliance monitoring and auditing work plan. The Work Plan will be approved by the Commissioner and the Executive Cabinet.

A. Risk Assessments

The annual compliance monitoring and auditing work plans will be created based on a compliance risk assessment. A risk is an event that, if it were to occur, would have a material consequence on an organization's ability to achieve objectives. A compliance risk assessment is the identification, measurement, and prioritization of compliance risks. Compliance means adhering to a standard, policy, or law. Compliance risk is the likelihood an applicable law or regulation may be violated. The compliance risk assessment's focus is solely on the risks affecting the organization as a result of its healthcare operations (e.g., HIPAA, billing and coding processes, etc.) as opposed to those risks that exist in any business (e.g., financial fraud, emergency preparedness, etc.) Conducting a compliance risk assessment enables compliance resources to be used most efficiently and effectively.

The Office of Health Care Compliance will take the lead in creating, organizing, and overseeing the compliance risk assessment steps of risk identification, risk measurement, and risk control.

The Office of Health Care Compliance will identify key employees (risk assessment group) who will provide insight into the issues they face and the degree to which established controls will mitigate risk as they arise. This should include front-line staff who can provide information on how processes actually work, as opposed to how the policy and procedure state they are supposed to work. Through facilitated sessions, in a group, if possible, the following three open-ended questions should be included:

(1) What can go wrong?
(2) Where is our organization most vulnerable?
(3) What are the issues that concern you the most?

B. Risk Identification

The Office of Health Care Compliance will take the first step in identifying the compliance risks to each division. These lists can be added to by the key employees. The list should include:

(1) Specific compliance risk areas identified in 18 N.Y.C.R.R. §521 (i.e., billing; payments; ordered services; medical necessity; quality of care; governance;

mandatory reporting; credentialing; contractor, subcontractor, agent or independent contract oversight, or that are identified by specific compliance protocols or through other means).

(2) Issues gleaned from the OIG Work Plan and the OMIG Work Plan
(3) Government enforcement trends
(4) FDNY's own history of government enforcement
(5) Results of prior internal monitoring reviews or ongoing audits

C. Risk Measurement

The purpose of the measurement step is to determine:

(1) The impact and extent of each risk
(2) The degree of vulnerability that the organization faces with respect to each risk
(3) The strength of the controls currently in place to mitigate each risk

For each identified risk, the risk assessment group will measure the degree of risk impact and the legal, financial and reputational impact. When compliance risks have been identified and measured, they will be prioritized. High risk items will be those that people raise repeatedly, are hard to detect, have a high likelihood of occurrence, or will have a significant impact if they were to occur. Moderate risk items might be those that are frequently mentioned but have high or moderate detectability scores. Lower risk categories are unlikely or those that could be likely but would have a low impact upon occurrence. The high-risk items will take precedence in the development of the annual compliance monitoring and auditing work plan. Some reserve time should be built in to address urgent issues as they arise during the year. To validate the existing identified controls, the monitoring and auditing work plans should include testing some identified controls that allegedly mitigate or detect the designated compliance risks.[14]

D. Monitoring and Auditing Work Plans

The draft monitoring and auditing work plans shall be approved by the Compliance Committee. The work plan shall be submitted to the Commissioner, but no formal approval from the Executive Board is required. The results of the monitoring and auditing reviews shall be provided to the Compliance Committee and the Commissioner several times during each year. Any deficiencies noted require the submission, for the Department of Compliance's approval, of a Corrective Action Plan which shall explain how the deficiency will be addressed timely and brought to resolution. Ongoing monitoring of the progress of any corrective action plan implementation shall be monitored by the Chief Compliance Officer. Timely updates of progress made and/or challenges to bringing deficiencies to a resolution are provided to the Compliance Committee and the Commissioner as needed and on a periodic basis.

E. Credentialing

All professional staff employed or engaged by FDNY will be properly licensed (and/or certified) and registered as required by applicable law, rules and regulations. FDNY will take steps on a regular basis to monitor and ensure such compliance.

[14] Some items which on their fact present a high risk will not be scored but added to the Work Plan.

F. Sanction Screening

FDNY is committed to maintaining high quality care and service as well as integrity in its financial and business operations. As such, it is FDNY policy to inquire into the background of any potential employee or independent contractor.

It is the policy of FDNY to ensure that no Medicare or Medicaid reimbursement is sought for ambulance services by an individual or entity excluded from participation in federally sponsored healthcare programs ("Ineligible Person").

Additionally, FDNY shall not knowingly allow, or cause to be allowed, any person convicted in any local, state, or Federal court of any felony involving health care matters to hold a management position within FDNY's billing operation or a similar capacity with any of FDNY's agents, either through an employment or contractual relationship.

As part of this process, the Compliance Officer, Bureau of Human Resources and Bureau of Fiscal Services shall ensure that mechanisms are in place to effectively screen those potential employees and independent contractors whose job functions or activities impact the claims development or submission process.

FDNY requires all personnel and vendors to disclose immediately to their supervisor, Compliance Officer, or other individual as designated in this Compliance Policy or in the relevant contract, any debarment, exclusion, suspension, or other event that makes that person or entity an Ineligible Person.

All FDNY personnel and vendors shall disclose if they are an Ineligible Person at the time of the initial hiring, credentialing, or contracting process, or at any point thereafter. Failure to do so may result in disciplinary action or contract termination.

(1) Screening FDNY Personnel:

The Bureau of Human Resources shall screen and review all applicants selected for hire as part of the pre-employment process to determine whether they are an Ineligible Person or have been sanctioned by a Federal or state law enforcement, regulatory or licensing Agency. Such applicants will be screened at the time of hire and subsequently screened as set forth below. If FDNY has actual notice that any FDNY personnel is an Ineligible Person or is proposed for exclusion during their FDNY employment, FDNY shall take all appropriate action to ensure that the responsibilities of the FDNY personnel have not and shall not adversely affect the quality of care rendered to any beneficiary, or the accuracy of any claims submitted retrospectively or prospectively to any Federally funded healthcare program.

As required by the New York State Office of the Medicaid Inspector General and OIG, FDNY shall monthly review the updated list of Excluded individuals on the Exclusion Lists and compare it to the current list of active service

providers in order to verify that existing employees have not been excluded from the federal programs since the last review. The Compliance Officer will be notified of any matches found during any of the above screening processes and will conduct additional verifications as necessary.

(2) Screening of Vendors:

FDNY Bureau of Fiscal Services and the Compliance Officer shall screen and review all prospective vendors as part of the pre-contract investigation screening process to determine whether the entity is an Ineligible Person or have been sanctioned by a Federal or state law enforcement, regulatory or licensing Agency. Additionally, contracts with FDNY vendors shall contain a certification that the vendor has performed its own exclusion screening against the Exclusion Lists and neither the vendor, nor any individuals it employs or retains, are Ineligible Persons. Such certification must include a requirement that the entity or individual will notify FDNY of any change in the exclusion or ineligibility of any screened persons. If FDNY has actual notice that any FDNY vendor is an Ineligible Person or is proposed for exclusion during its contract term, FDNY shall take all appropriate action to ensure that the responsibilities of the FDNY vendor have not and shall not adversely affect the quality of care rendered to any beneficiary, or the accuracy of any claims submitted retrospectively or prospectively to any Federally funded healthcare program. This may include suspension of contract, termination of contract, reporting, disclosure or other actions necessary to ensure compliance with exclusion mandates. As required by the New York State Office of the Medicaid Inspector General and OIG, FDNY shall monthly review the updated list of Excluded individuals on the Exclusion Lists and compare it to the current list of active service providers in order to verify that existing employees have not been excluded from the federal programs since the last review. The Compliance Officer will be notified of any matches found during any of the above screening processes and will conduct additional verifications as necessary.

(3) Screening Databases:

FDNY will conduct exclusion checks to verify that any individual or entity has not been excluded from federal and state healthcare programs. An exclusion check is a search of the following databases ("Exclusion Lists") to determine whether the individual or entity's name appears on any list:

- System for Award Management ("SAM"), list of parties excluded from federal programs. The URL address is https://www.sam.gov.
- Department of Health and Human Services Office of the Inspector General ("HHS OIG") excluded providers list. The URL address is http://exclusions.oig.hhs.gov/.

- New York State Office of the Medicaid Inspector General ("NYSOMIG") list of restricted, terminated or excluded individuals or entities. The URL address is http://www.omig.ny.gov/search-exclusions.

- In addition, FDNY reserved the right to screen other states lists including but not limited to: New Jersey, Connecticut, Massachusetts, Pennsylvania and Florida.

G. Monitoring

The Compliance Officer shall arrange for monitoring of the compliance program, including periodic review and testing of coding and billing. Where deemed necessary and appropriate, independent firms may be retained to carry out this function.

In addition, the Compliance Officer shall oversee ongoing quality assurance reviews by managers and supervisors to ensure that:

(1) there is proper completion and transmission by ambulance staff of all required information;
(2) appropriate decisions are being made regarding issues of medical necessity and coding;
(3) all billing information (including pre-billing, paid claims and claims denials) is accurate, complete, and reflects the appropriate sources of information; and
(4) all computer software used in billing is consistent with the compliance program and meets minimum data requirements.

H. Auditing

On an annual basis, FDNY shall conduct, or arrange to have conducted, a review and audit of the billing policies, procedures, and practices of FDNY to verify that its submissions for reimbursement comply with all applicable federal and NY state health care program statutes, regulations, program and carrier directives relating to medical necessity and diagnostic coding, and to identify all instances where claims fail to meet these standards. The annual reviews and audits shall be aimed at ensuring that these programs are billed appropriately for services rendered. To the extent that other irregularities are uncovered during the review, the annual audit shall identify the nature and cost of the irregularity and shall take the necessary steps to end the irregularity and prevent recurrences. External audits shall be conducted as appropriate.

The audits shall be conducted in accordance with professionally accepted standards. Where billing deficiencies are identified, FDNY shall give timely notification, as appropriate, to payers and authorities, make necessary refunds, and take timely steps to correct problems and prevent recurrences.

VIII. Element VII - System for Promptly Responding to Compliance Issues:

Investigating and Correcting Compliance Problems

A. Investigation

(1) Conducting an Investigation

A compliance problem may be uncovered as the result of a report to the Chief Health Care Compliance Officer, Compliance Hotline, an internal compliance review, the review of a new regulation or governmental fraud alert, or from another source.

In each instance where a report is received, either the Chief Health Care Compliance Officer or the Bureau of Investigations and Trials ("BIT") shall conduct a preliminary inquiry into the nature of the compliance issue, gather and/or preserve all relevant information and determine the appropriate unit to complete the investigation of the allegations. The investigation will be conducted by the Chief Health Care Compliance Officer with assistance from BIT, Internal Audit and Control, Bureau of Legal Affairs ("BLA"), and if necessary, referred to the Department of Investigation of the City of New York "("DOI").

An internal review shall be conducted for any report that is sufficiently specific so that it (i) permits a determination of the appropriateness of the billing practice alleged to be involved; and (ii) reasonably permits corrective action to be taken and ensures that proper follow-up is conducted.

FDNY shall document such complaints, investigations and corrective actions.

(2) Purpose of Investigation

The purpose of the investigation shall be to:

(1) identify those situations in which the laws, rules, and standards relating to the development and submission of claims may not have been followed;
(2) identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violated laws, regulations, or standards;
(3) contribute to the development of procedures necessary to ensure future compliance;
(4) protect FDNY in the event of civil or criminal enforcement actions; and
(5) initiate appropriate disciplinary action.

(3) Investigative Findings and FDNY Response

Upon the conclusion of the Investigation, FDNY shall:

(1) refer evidence of criminal activity to DOI or other appropriate authority;
(2) ensure that ongoing billing conforms fully to all applicable laws, procedures, and program requirements, including making any necessary and appropriate notifications to Federal or state regulatory agencies;
(3) refer the case to BIT to initiate appropriate disciplinary action up to and including termination of employment against the person or persons whose conduct is considered a breach of this Compliance Policy;
(4) revise or clarify procedures or provide additional training or other corrective actions to address any violations arising from failure to comply with applicable standards or procedures; and

(5) any other measures calculated to eliminate illegal or inappropriate behavior.

All affected individuals are expected to cooperate in all compliance investigations. Failure to cooperate can result in referral to BITs for discipline up to and including termination.

When appropriate, corrective action plans will be created and tailored to the particular conduct and will provide a structure with time frames to attempt to ensure non-compliant activity does not recur. Corrective action will be implemented promptly and thoroughly and may include (but is not necessarily limited to): conducting training and education; revising or creating appropriate forms; modifying or creating new compliance policies and procedures; conducting additional internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate; refunds to appropriate payers and/or self-disclosing to appropriate government agencies (e.g., the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services, Office of Inspector General or the Centers for Medicare and Medicaid Services) or other appropriate parties as is further detailed in FDNY's policy Responding to Compliance Reports, Investigations, and Corrective Action Protocol. Corrective action plans and other corrective actions will continue to be monitored after they are implemented to ensure that they are effective.

4. Communicating with Reporters

If the reporter is not anonymous, after the issue has been investigated, if applicable, and the non-compliance has been remedied or a corrective action plan has been created, the Chief Health Care Compliance Officer will report to the reporter that the investigation is completed and will report the findings and explain how the problem has been remedied, if appropriate.

5. Investigations – Actionable Reports

The Compliance Office is authorized full, free and unrestricted access to FDNY's records, facilities, and staff pertinent to carrying out any investigation.

The purpose of the investigation is to determine if there has been an occurrence or course of fraud, abuse or other systemic noncompliance, and if so:

(1) To determinate the nature, scope, frequency, duration and financial magnitude of the fraud, abuse or other noncompliance;
(2) To identify the individuals who may have knowingly or inadvertently been responsible for the fraud, abuse or other noncompliance;
(3) To Cease the problematic activity;
(4) Determine whether it has a repayment obligation;
(5) Determine whether it has a self-disclosure obligation;
(6) Develop and implement a corrective action plan;
(7) Take appropriate disciplinary steps against the persons responsible including referrals to BIT or DOI;

(8) Make required or appropriate reports or referrals concerning the persons responsible, such as reports to licensing authorities as well as MFCU, OMIG or law enforcement; and
(9) Take other appropriate corrective action.

Actionable reports typically will be investigated by the Chief Health Care Compliance Officer and other individuals selected by the Chief Health Care Compliance Officer. Interim measures may be taken to prevent retaliation or to facilitate effective investigation. The investigation process shall include, as applicable, but need not be limited to:

(1) Interviewing the complainant and other persons who may have knowledge of the alleged fraud, abuse or other noncompliance;
(2) Reviewing medical records, bills and other documents relevant to the alleged fraud, abuse or other noncompliance;
(3) Reviewing other representative bills or claims submitted to the relevant payor; and
(4) reviewing the applicable laws, regulations, and other documents regarding program requirements.

B. No Findings of Fraud, Abuse or other Noncompliance

If at any time the Chief Health Care Compliance Officer in consultation with relevant subject matter experts concludes, based on the investigation, that the reported conduct does not constitute fraud, waste, abuse or other noncompliance, the Chief Health Care Compliance Officer shall document the finding in the Compliance records.

C. Findings of Fraud, Abuse or other Noncompliance

At the conclusion of the investigation, if the Chief Compliance Officer in consultation with relevant subject matter experts concludes that there has been fraud, abuse or other systemic noncompliance, the Compliance Officer shall prepare a report of findings that shall include, as applicable:

(1) the reason for commencing the investigation;
(2) the investigation process;
(3) a description of the evidence of fraud, abuse or other systemic noncompliance;
(4) facts ascertained regarding the nature, scope, frequency, duration and financial magnitude of the fraud, abuse or other systemic noncompliance;
(5) the identity of person or persons who appear to have been responsible for the fraud, abuse or other systemic noncompliance, and a description of the evidence of their responsibility and intent; and
(6) recommended responses.

D. Report of Investigation, Findings and Documentation

Investigations and findings must be concluded within a reasonable time period after the potential offense was detected. What is considered reasonable will depend upon the circumstances of the particular instance of FWA. Such investigations and findings must be reported to the Compliance Committee and Executive Cabinet, no less than quarterly.

The Compliance Office will maintain a log of all reports, tracking their receipt, investigation and resolution. Sufficient documentation should be maintained by the Compliance Officer to describe the nature, scope and outcome of any internal investigation that is undertaken.

E. Corrective Actions

Whenever a compliance matter is uncovered, regardless of the source, FDNY will ensure that prompt, thorough, appropriate and effective corrective action is implemented. All affected individuals are expected to assist in the resolution of compliance issues. Failure to cooperate could lead to referral to BITs for discipline. Any corrective action and response implemented must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

Corrective actions may include, but are not limited to:

(1) Informing and discussing with the offending employee/vendor both the violation and how it may be avoided in the future;
(2) Providing remedial education (formal or informal) to ensure that there is an understanding of the applicable laws, rules, regulations and/or requirements;
(3) Conducting a follow-up review to ensure that the problem is not recurring;
(4) Suspending billing, in whole or in part, of the services provided by an EMT/paramedic;
(5) Refunding any past payments that resulted from any improper bills to the extent required or otherwise appropriate;
(6) Promptly self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS' Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS) or the New York State Department of Health, Office of the Medicaid Inspector General (OMIG);
(7) Modifying or improving FDNY's business practices; and/or
(8) Modifying or improving the Compliance Program to better ensure continuing compliance with applicable federal and state laws, rules, regulations, federal health care program requirements and/or other contractual requirements.
(9) If Chief Health Care Compliance Officer discovers credible evidence that criminal conduct may have occurred, FDNY shall promptly investigate the matter to determine if specific corrective action and/or notification of appropriate governmental authorities is warranted under the circumstances. All instances in which credible evidence of a potential violation of any law (whether criminal, civil or administrative) is discovered will be promptly referred to legal counsel to evaluate the seriousness of the allegations and the necessity and timing of any disclosure to appropriate New York and/or federal authorities such as CMS, OIG or New York State Department of Health ("DOH") or MFCU, OMIG or NYC DOI.

F. Report and Return of Overpayment

All reports or other information indicating that an overpayment may have been received during the lookback period must be immediately brought to the attention of the Chief Health Care Compliance Officer.

Overpayment is defined as any funds that a person receives or retains under title XVIII (Medicare) or title XIX (Medicaid) to which the person, after applicable reconciliation, is not entitled. Overpayments include, but are not limited to, reimbursement received due to: upcoding, incorrect coding resulting in a higher level of reimbursement, insufficient or lack of documentation to support billed services, lack of medical necessity, duplicate payments, payments to the incorrect payee, or any other finding that reflects an overpayment was received by FDNY as a result of inaccurate or improper coding or reporting of health care items or services.

An identified overpayment means the entity person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. That is, the person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the entity has received an overpayment and quantified the amount of the overpayment. An entity should have determined that an over payment was received and quantified if the entity fails to exercise reasonable diligence and the entity in fact received an overpayment.

The Chief Health Care Compliance Officer must ensure that the entity exercises reasonable diligence to quantify any potential overpayments.

a. Deadline for Reporting and Returning Identified Overpayments
Medicare Part B. For identified overpayments received from Medicare Part B, the deadline for reporting and returning the overpayment is the later of either: 60 days from the date the overpayment is identified or the date any corresponding cost report is due, if applicable.

Medicare Advantage (Part C). For identified overpayments received from Medicare Part C, the deadline for reporting and returning the overpayment is no later than 60 days after the date the overpayment is identified, unless otherwise directed by CMS for purposes of risk adjustment data validation audit.[15]

Medicaid. The same deadline as defined above in 2.a is applicable to identified Medicaid overpayments. In addition, please refer to NYS OMIG Guidance of Self-Disclosure. OMIG's Self-Disclosure Program includes two pathways for Medicaid Entities/Providers to report, return and explain self-identified overpayments. Both the Full Self-Disclosure Process and the Abbreviated Self-Disclosure Process begin with the same steps. A Medicaid Entity/Provider discovers that they are in receipt of a Medicaid overpayment and investigates to

[15] In 2018, the regulation governing Medicare Part C overpayments was found to be invalid by a Federal District Court. That ruling was overturned by the U.S. Court of Appeals for the District of Columbia Circuit on August 13, 2021 (See United Healthcare Insurance Company v. Becerra, 2021 WL 3573766).

identify and explain it. Chief Health Care Compliance Officer must be consulted to investigate and prepare the OMIG Self-Disclosure.

Other Third-party Payers. In the case of overpayments by commercial/other third-party payers, overpayments shall be reported and returned in accordance with the payer's requirements, the overpayment must be returned with 60 days from the date the overpayment is identified by the payer or FDNY.

b. Lookback period. An overpayment must be reported and returned if a provider identifies the overpayment within six (6) years of the date the overpayment was received. Reasonable diligence includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining credible information about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances.

c. Process to Report and Return Identified Overpayments
Medicare Part B. With the limited exception described below, Medicare overpayments shall be returned to the Medicare Contractor that paid the claim, at the address provided by the Medicare Contractor using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process as set forth by the Medicare Contractor.
Medicare Part C. The MA organization must notify CMS of the amount and reason for the overpayment, using a notification process determined by CMS and return identified overpayments in a manner specified by CMS.
Exception for Fraud. Identified Medicare overpayments that resulted from fraud shall be disclosed using the OIG's Self–Disclosure Protocol or the CMS Voluntary Self–Referral Disclosure Protocol, as applicable.
Medicaid. Medicaid overpayments shall be reported and returned to the NYS Department of Health; a written explanation of the reason for the overpayment shall be provided to the OMIG through its Self-Disclosure Program. Information regarding OMIG's Self-Disclosure Program is available here: https://omig.ny.gov/provider-resources/self-disclosure. A Self-Disclosure submission related to a Medicaid program overpayment requires completion of a Self-Disclosure Statement, Certification, and a Claims Data File of affected Medicaid claims, or Mixed Payer Calculation (MPC) form for Excluded provider disclosures. If the Medicaid program overpayment is not related to claim data or an excluded or non-enrolled provider, additional explanation to allow for the verification of the overpayment is required. Please refer to OMIG Self disclosure guidance.

G. Disclosing Damaged, Lost or Destroyed Records

If FDNY staff becomes aware that medical records have been damaged, lost or destroyed, they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.[16] OMIG requires a submission for lost, destroyed, or damaged records by completing a Statement of Lost or Destroyed Records

[16] 18 NYCRR §504.3, requires providers to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request.

form and submission of any accompanying documentation to support the report of loss or damaged records. Affected individuals are required to contact Chief Health Care Compliance Officer to assist with the preparation of this self-disclosure.

IX. Conclusion

FDNY is committed to a culture that promotes prevention, detection and remediation of fraud waste and abuse. Accordingly, FDNY maintains a robust Health Care Compliance Program to prevent, detect and remediate fraud, waste and abuse for all its affiliated entities. If you have reason to believe that someone acting on FDNY's behalf has committed an act of fraud, waste, or abuse, or if you have other compliance-related concerns, it is your duty to report the matter.

Revision History

Date	Change/Note
9/1/2024	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
4/2014	Revised and updated to reflect changes in process.
9/2009	Initial Policy

APPENDIX A

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS/WHISTLEBLOWER PROTECTIONS

FEDERAL LAWS

False Claims Act [**Title 31 United States Code §§ 3729 to 3733]**

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

> Any person who (1) knowingly presents, or causes to be presented, to an office 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 of not less than $5,000 and not more than $10,000,[4] plus 3 times the amount of damages which the Government sustains because of the act of that person….
> For purposes of this section:
>
> (a) the term "claim"— means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
> provides or has provided any portion of the money or property requested or demanded; or
>
> will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
>
> does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;
> (b) The terms "knowing" and "knowingly mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
>
> (c) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or

from the retention of any overpayment; and

(d) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

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 under the Act.

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 form the government. An example of this may include a government contractor who submits records that he knows (or should know) is 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 who 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. 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.

Administrative Remedies for False Claims [**Title 31 United States Code §§ 3801 to 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.[5] The agency may also recover twice the amount of 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.

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.

Civil and Administrative Laws

NY False Claims Act [State Finance Law §§187–194]

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. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. 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. If the suit eventually concludes with payments back to the government, the person who started the case can recover up to 25-30% of the proceeds.

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 5 years, a penalty up to $ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

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 person's, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

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

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.

Any person, who with intent to defraud, presents for payment and 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.

Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

First degree grand larceny involves property valued over $1 million. It is a Class B felony.

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:

§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.

§175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

§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. It is a Class A misdemeanor.

§175.35, Offering a false instrument for filing in the first degree includes the elements of the second-degree offense and must include an 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.

Insurance fraud in the 5gh degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is

a Class D felony.

Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

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:

Health care fraud in the 5th 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.

Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

WHISTLEBLOWER PROTECTIONS

Federal False Claims Act (31 U.S.C. §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 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.

NY False Claim Act **[State Finance Law § 191—Remedies]**

The New York 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 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 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.
New York Labor Law §741

Certain health care employers 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, to a news media outlet or to a social media forum available to the public at large. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care or improper quality of workplace safety. 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, a specific patient or a specific employee 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.