CHILDREN'S DENTAL HOSPITAL

MEDICAID BILLING COMPLIANCE PROGRAM

INTRODUCTION

This Program is an integral part of the Children's Dental Hospital's (Hereinafter referred to as the Hospital) ongoing efforts to achieve compliance with federal and state laws relating to Medicaid billing for dental and medical services. The Program creates a comprehensive system of oversight for Medicaid billing, reporting and practices. The goal of this Program is to ensure that Medicaid eligible services are properly documented and accurately billed and that services rendered, but not properly documented are not billed. Moreover, the program establishes systematic checks and balances to detect and prevent inaccurate billings and inappropriate practices in the Medicaid Program.

The Program shall be overseen by the Hospital's Medicaid Compliance Officer who shall report directly to the Chief Executive Officer of the Hospital. It remains, however, the responsibility of each individual involved in the provision of services and the billing process, to comply with the provisions of the law.

MEDICAID COMPLIANCE OFFICER

The Hospital shall designate annually a Medicaid Compliance Officer. The Compliance officer shall be responsible for:

1. Day to day operations of the Compliance Program.
2. Providing guidance to Hospital employees to ensure Medicaid billing compliance;
3. Development and delivery of Hospital in-service training on compliance issues, expectations, and maintenance of documentation for the same;
4. The coordination of system-wide and/or department-specific audits of records on an ongoing basis;
5. Communications to Hospital employees and to service providers on any changes to the laws and regulations regarding Medicaid billing and this Program;
6. The investigation of allegations of improper billing practices and the reporting of the same.

The Compliance Officer shall report directly to the CEO of the Hospital and shall periodically report if needed to the appropriate Medicaid personnel in charge of the compliance program.

COMPLIANCE

Billing for Medicaid eligible patients will be done in compliance with all applicable state and federal laws and regulations. Specifically, no bill for reimbursement shall be submitted unless it was actually performed and documented by the service provider.

The Hospital is committed to maintaining the accuracy of every claim it processes and submits. Any false, inaccurate, or questionable claims should be reported immediately to the Hospital's Medicaid Compliance Officer. False billing is a serious offense. Federal and State rules prohibit knowingly and willfully making or causing to be made any false statement or representation of a material fact in an application for benefits or payment. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. In addition to criminal penalties, the Federal False Claims Act permits substantial civil monetary penalties against any person who submits false claims. The Act provides a penalty of triple damages as well as fines up to $10,000 for each false claim submitted. The persons involved in submitting false claims (as well as the Hospital) may be excluded from participating in the Medicaid programs.

Numerous other federal laws prohibit false statements or inadequate disclosure to the government and mandate exclusion from Medicaid programs. It is illegal to make any false statement to the federal government, including

statements on Medicaid claim forms. It is illegal to use the U.S. mail to scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government.
The Hospital promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity, and accuracy in all its financial dealings. Each employee and professional, including outside consultants, who is involved in submitting charges, preparing claims, billing, and documenting services is expected to maintain the highest standards of personal, professional, and institutional responsibility. Individuals who fail to report suspected problems, participate in non-compliance behavior and/or encourage, direct or facilitate non-compliance behavior may be subject to disciplinary action in accordance with the provisions of New York law and any applicable collective bargaining agreement.

EDUCATION AND TRAINING

It is the Compliance Officer's responsibility is to ensure that every employee involved with the Medicaid service and billing process is educated about the applicable laws and regulations governing provider billing and documentation. Moreover, the Hospital's Compliance Program shall be shared with all Hospital employees, be available for inspection and shall be published on the Hospital's website.
The Compliance Officer shall also develop, oversee and/or provide in-service training on Medicaid billing and documentation requirements for all staff involved in providing and/or billing for Medicaid services periodically and at other times, including initial employment or assignment. Such training shall be mandatory and the Hospital shall maintain records of all trainings.

REPORTING AND INVESTIGATION

Reporting

Every employee in the Hospital has the responsibility not only to comply with the laws and regulations, but to ensure that others do as well. Employees must report non-compliance to their immediate supervisors, or the Hospital's Compliance Officer. Supervisors are required to report these issues through established channels or directly to the Hospital's Medicaid Compliance Officer at 718-645-1588 ext. 207. Calls may be made anonymously, although the Hospital encourages employees to provide their name and telephone number so that reports may be more effectively investigated. Every attempt will be made to preserve the confidentiality of reports of non-compliance. All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases, disclosures will be on a "need to know" basis only.

Investigation

The Compliance Officer will, personally or through his/her designee, investigate every report of non-compliance as soon as practicable. Investigations may include interviewing employees and/or reviewing documentation. Each employee must cooperate with such investigations.
Once the Compliance Officer completes an investigation, he/she will make a report to the CEO of the Hospital. The report will be the basis for the Compliance Officer's Program or recommendation of corrective action and/or discipline. Reports will be retained for a period of six years.

Non-Retaliation

It is the policy of the Hospital that no person shall retaliate, in any form, against a person who reports in good faith, an act or suspected act of non-compliance (although employees may be disciplined for making intentionally false reports of non-compliance). Any person who is found to have retaliated for such a report shall be subject to discipline. In addition, the Federal False Claims Act and New York State Law provide certain protections to individuals who are discharged, demoted, suspended or threatened, harassed or discriminated against by their employer in retaliation for assisting in the investigation, initiation or prosecution of a False Claims Act violation or which constitutes health care fraud under the New York State Penal Law.

Corrective Action/Sanctions

In order to make this Compliance Program effective, the Compliance Officer will have authority to impose corrective action.
If a service provider or employee is found to be non-compliant in a single instance or relatively insignificant percentage of cases over a short period, the Compliance Officer may require that person to undergo a session of education or training.
If a provider or other employee fails to comply with billing or documentation requirements repeatedly, sanctions may be more severe.
Plans of correction and discipline may include, but are not limited to:
1. A requirement to undergo training;
2. A period of required supervision or approval of documentation before bills can be issued;
3. Expanded auditing, internal or external, for some period of time until compliance improves;
4. Self-reporting of violations; and
5. Insufficiently egregious cases, discipline.

In addition, the Compliance Officer may recommend some other appropriate course of action to correct non-compliance.

AUDITING/REVIEW

Monitoring of compliance with billing rules is essential. The Compliance Officer must be able to ensure compliance through an understanding of current regulations and overall levels of compliance throughout the District at any given time.
Under this Plan, there will be both internal and external (i.e. by an independent consultant or other professional) auditing of Medicaid billing documentation. Internal auditing is done by the professional staff of the Compliance Officer, who will conduct periodic reviews.
The Compliance Officer may engage an external auditing firm as deemed necessary to assess the Hospital's overall compliance. All employees must cooperate fully with this effort by making themselves and/or any pertinent documents available.
The external auditor will report to the Compliance Officer concerning the results of its investigation. The Compliance Officer will report, in turn, to the CEO of the Hospital.

ONGOING ASSESSMENTS

The Compliance Officer will make an annual assessment of the success of this Compliance Program. That assessment will be based on the examination of results of internal audits and investigations, reports of any outside audits that may have been conducted, and or his/her own personal experience with the functioning of the Program over the previous year.
A summary of this assessment shall be provided to the Chief Executive Officer of the Children's Dental Hospital.