Mather Hospital
Northwell Health

Compliance Program

Employee Handbook

Code of Conduct

and

Brief Summary of the Compliance Program
MESSAGE FROM THE PRESIDENT

Mather Hospital Northwell Health (the “Hospital”) is dedicated to improving the health and well-being of our patients through patient care, research and advocacy through our core values of:

➤ Excellence in everything we do

➤ Compassion in the care and services we provide to our patients

➤ Innovation in finding better approaches to improve the quality and responsiveness of care

➤ Team work as a defining characteristic of our Hospital, treating each other with respect

The Hospital is also committed to providing patients with high quality and caring medical services in keeping with the highest ethical and legal standards.

Our Code of Conduct was approved by our governing board and was designed to be consistent with the principles set forth in our Mission Statement. It is a sign of our commitment to assuring that our actions consistently reflect our words. In this spirit, we expect all personnel to adhere, without exception, to the standards set forth herein. This document, in addition to setting forth the Hospital’s Code of Conduct standards that personnel are required to follow, highlights some of the key procedures that are at the core of the Hospital’s Compliance Program. The Hospital’s Compliance Manual is available on the Hospital’s intranet, and may also be obtained directly from the Compliance Officer or your supervisor.

Our Compliance Program will continue to operate effectively only if everyone takes the time to be aware of what our Code of Conduct states, abides by its requirements, and works to support our commitment to “doing the right thing.”

Sincerely,

Kenneth Roberts
I. CODE OF CONDUCT

All Hospital personnel -- including members of the Board of Directors, senior management, administrators, managers, supervisors, employees, physicians, voluntary attendings, volunteers, vendors and contractors associated with the Hospital -- are expected to adhere to the following Code of Conduct.

A. General Standards

1. Be Honest and Truthful: All personnel are expected to adhere to high ethical standards when acting on behalf of the Hospital; to be honest and truthful in all of their work for and dealings related to the Hospital; and to responsibly use and control all of the Hospital’s assets and resources. Particular care should be taken to ensure that all communications within the Hospital and to outside agencies (including government representatives) are truthful, accurate and complete.

2. Obey the Law. There are many laws and regulations that govern the activities of the Hospital and its operations. The Hospital has developed many different Policies and Procedures to explain many of these legal requirements. All personnel must obey the law. If you are not certain about what the law requires, you should ask for help. Guidance can be obtained by asking your Supervisor, Manager, Administrator or by contacting the Compliance Officer at one of the contact numbers listed in Section III below.

3. Treat Others with Respect, Courtesy and Dignity. All personnel — including members of the medical staff — must conduct themselves in a professional and cooperative manner. Verbal outbursts, physical threats or assaults, intimidating behaviors, uncooperative attitudes, sexual harassment, profane language, and other abusive behavior towards patients or staff are considered to be disruptive and inappropriate behaviors that are not tolerated by the Hospital and may subject the employee, officer or medical staff member to disciplinary action.

4. Report Concerns and Cooperate With the Compliance Program. All personnel must assist the Hospital in promoting and ensuring compliance with applicable laws, and to assist and cooperate with the Hospital in any compliance investigation. You are expected to report concerns or questions to your immediate Supervisor, Manager or Administrator or by calling the Compliance Officer at one of the contact numbers listed in Section III below. Personnel may, if they so choose, report anonymously by using the Compliance Hotline or other appropriate means of communication.

5. No Retaliation or Intimidation. Retaliation against, or intimidation of, any personnel for making a good-faith report, requesting clarification about applicable laws or policies, or participating in any investigation is strictly prohibited. It is also forbidden for any personnel to punish or conduct reprisals against anyone who has participated or cooperated in an investigation of such matters. Retaliatory actions violate this Code and will not be tolerated.

6. Discipline. Discipline may be imposed on personnel, including up to and including possible termination of employment, for violating the Code of Conduct, participating
in non-compliant behavior, encouraging or allowing non-compliant behavior, or failing to report suspected compliance problems.

B. Standards Relating to Quality of Care

The Hospital is fully committed to providing quality care that is medically necessary to our patients. To achieve this goal, the hospital will continually measure its performance against comprehensive standards through our Quality Assurance process.

1. Quality of Care Principles.
   - All patients will receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
   - All patients and their families will receive information that is necessary to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
   - The Hospital will protect and promote the rights of each patient.
   - The Hospital will conduct background checks pursuant to federal and state law (which includes, but is not limited to, exclusion from participation in any federal health care program) on all personnel.
   - The Hospital will conduct routine checks to ensure that all practitioners employed by, on contracted on behalf of, the Hospital will have the proper credentials, licensure, experience and expertise required to discharge their responsibilities.
   - The Hospital will provide patient care that conforms to acceptable clinical and safety standards.
   - The Hospital will continuously strive toward a culture of patient safety and providing quality medical care to its patients.

2. Credentialing. The Hospital will comply with all applicable federal and state laws, rules and regulations governing the credentialing process. The Hospital conducts on-going and continuous credentialing, competency and licensure reviews of clinical and non-clinical staff. Complying with credentialing and licensure requirements is a necessary component of the Hospital’s commitment to providing appropriate quality of care to its patients.

3. Mandatory Reporting. The Hospital will comply with all applicable federal and state mandatory reporting laws, rules and regulations, and will conduct periodic reviews to ensure that all incidents and events that are required to be reported are done so in timely manner.
C. Standards Relating to Billing and Providing Services

1. Billing and Coding. All billing by the Hospital may be submitted to third-party payors only for medical services actually rendered, and all personnel must take the necessary steps to prevent the submission of claims for reimbursement that are fraudulent, abusive, inaccurate or medically unnecessary. Only billing codes that accurately represent the service rendered will be selected.

2. Documentation. Medical record documentation must comport with all applicable laws and regulations and be consistent with professional and industry standards that support the diagnosis and justification for treatment and shows the course of treatment and results.

3. Claim Submission. Personnel must comply with all applicable Federal and State laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) New York State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in the Appendix at the end of this document.

4. Honor Patient Confidences and Privacy. Our patients rightfully expect that their private medical information will be handled appropriately and confidentially. Confidential information relating to Hospital patients must be protected.

D. Standards Relating to Business and Related Practices

1. Conduct Business Practices Ethically and Legally. All personnel must be law-abiding, honest, trustworthy, and fair in all of their business dealings. Honesty will be our guide.

2. Business Records Must be Accurate and Truthful. All business records must be accurate, truthful and complete, with no material omissions. Such records include tax and financial reports, institutional documents, and reports submitted to government agencies.

3. Business Transactions. The Hospital will forgo any business transaction or opportunity that can only be obtained by improper or illegal means. We will conduct business transactions free from offers of improper inducements. The Hospital will also conform to all applicable anti-trust laws and regulations.

4. The Hospital Will not Pay for Referrals. The Hospital will not pay for the referral of patients to the Hospital, and will comply with all federal and state health care fraud and abuse laws in its dealings with health care providers, vendors or other referral sources.

5. Protect Confidential Hospital Information. Confidential information relating to the Hospital must be protected.
6. **Avoid Conflicts of Interests.** All personnel must avoid any situation in which their responsibility to the Hospital might be or appears to be compromised by an outside interest that they or their family may have. If you have any questions regarding a particular situation, contact the Compliance Officer.

7. **Adhere to the Hospital’s Gifts and Hospitality Policy.** Personnel may not accept gifts and hospitality from patients, patient family members, vendors or contractors doing business with the Hospital if doing so would create an appearance that the gift or hospitality is being provided to induce the personnel to act in his or her own benefit (over the Hospital’s). *Cash or cash equivalents may not be given or accepted under any circumstance.* Personnel may accept business entertainment consistent with what is reasonable under the circumstances, as long as the offered entertainment is not for the purpose of improperly influencing the personnel’s business behavior. Items of nominal value, such as holiday cookies or candy that are tokens of appreciation, may be accepted.

II. **COMPLIANCE PROCEDURES**

1. **Investigation and Corrective Action.** A Compliance Officer has been appointed to run the day-to-day operations of the Compliance Program and will investigate all reports received. If a compliance problem is found to exist, the Compliance Officer will ensure that appropriate and effective corrective action is implemented.

2. **Compliance Monitoring and Auditing.** The Compliance Officer will have a system in place for conducting an on-going assessment of the compliance risks that potentially face the Hospital, including a system of monitoring and auditing various Hospital operations on a regular, periodic basis to ensure compliance with all legal requirements.

3. **Compliance Training.** All personnel will receive a copy of the Code of Conduct and Compliance Program Standards and receive periodic training regarding the Compliance Program and the legal requirements most relevant to their particular jobs.

4. **Reporting.** The Compliance Officer will report to the Hospital’s CEO and Board of Directors (or Corporate Compliance and Audit Committee of the Board), which will exercise oversight of the Compliance Program.

III. **COMPLIANCE CONTACTS AND NUMBERS**

Hospital personnel may contact the Compliance Officer with any compliance question or issue.

➢ The Compliance Officer is Kevin J. Murray, who can be reached at (631) 476-2816. You may also contact James Danowski, Chairman of the Corporate Compliance and Audit Committee, at (631) 473-3400.

➢ Compliance issues can also be reported directly to Northwell Health, via their 24 hour Helpline 800-894-3226 or reported on their website at Northwell.ethicspoint.com
APPENDIX

Compliance with Applicable Federal and State False Claims Acts: Overview of the Laws Regarding False Claims And Whistleblower Protections

POLICY:

It is Mather Hospital Northwell Health’s policy that all personnel (including employees, management, physicians, consultants and other agents) shall comply with all applicable Federal and New York State false claims laws and regulations. We have instituted procedures, as are set forth in the Compliance Manual and other compliance protocols, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal and State health care programs.

RELEVANT LAWS:

I. FEDERAL LAWS

A. The Federal False Claims Act (31 USC §§3729-3733)

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

1) any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit [the above violations]; . . . or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

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is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000,1 plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

(b) For purposes of this section,

1 Although the statutory provisions of the False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation and increased by regulation to not less than $5,500 and not more than $11,000. 28 CFR §85.3(a)(9).
(1) the terms "knowing" and "knowingly" (A) 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 (B) require no proof of specific intent to defraud; and

(2) the term "claim" (A) 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 (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(3) 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

(4) 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. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government or a contractor of the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false
statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital 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. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 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.

B. Administrative Remedies for False Claims (31 USC Chapter 38, §§ 3801 – 3812)

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

II. NEW YORK STATE LAWS

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

A. Civil And Administrative Laws

1. 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 $6,000 - $12,000 per claim 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 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

2. 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 $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

3. 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 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five years for 4 or more offenses.

B. Criminal Laws

1. 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.

2. Social Services Law § 366-b -- Penalties for Fraudulent Practices

(a) 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.

(b) 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.

3. 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.
(a) Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

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

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

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

4. 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:

(a) §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise’s business records with the intent to defraud. It is a Class A misdemeanor.

(b) § 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.

(c) §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

(d) §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.

5. Penal Law Article 176 -- Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

(a) Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

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

(c) Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
(d) Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

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

(f) Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

6. Penal Law Article 177 -- Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

(a) 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

III. WHISTLEBLOWER PROTECTION

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

The FCA provides protection to any employee, contractor, or agent who is 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 lawful acts in furtherance of other efforts to stop violations of the FCA. Remedies include reinstatement with comparable seniority as the employee, contractor, or agent would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

B. NY False Claim Act (State Finance Law §191)

The New York State 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.

C. 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.

D. New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee
discloses certain information about the employer’s policies, practices or activities to a regulatory,
law enforcement or other similar agency or public official. Protected disclosures are those that
assert that, in good faith, the employee believes constitute improper quality of patient care. The
employee’s disclosure is protected only if the employee first brought up the matter with a
supervisor and gave the employer a reasonable opportunity to correct the alleged violation,
unless the danger is imminent to the public or patient and the employee believes in good faith
that reporting to a supervisor would not result in corrective action. If an employer takes a
retaliatory action against the employee, the employee may sue in state court for reinstatement to
the same, or an equivalent position, any lost back wages and benefits and attorneys’ fees. If the
employer is a health provider and the court finds that the employer’s retaliatory action was in bad
faith, it may impose a civil penalty of $10,000 on the employer.
ACKNOWLEDGEMENT OF RECEIPT OF CODE OF CONDUCT DURING ANNUAL EVALUATION

I acknowledge that I have received a copy of the “Code of Conduct and Brief Summary of the Compliance Program” for Mather Hospital Northwell Health (“Hospital”).

I agree to read it, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the brief summary of the Code of Conduct, and to cooperate with management in carrying out the objectives of the Compliance Program.

I further certify that I know of no conduct by any Hospital personnel that may constitute a violation of any law, rule, or regulation applicable to the Hospital and its business or medical practices.

I am aware that this manual is also available on the Hospital’s Intranet. I know that Jonathan Dreyfuss is the Compliance Officer for Mather Hospital Northwell Health, and I may call him at any time on his office phone at (516) 266-5001, or his cell phone at (516) 242-6383.

ACKNOWLEDGEMENT OF RECEIPT OF APPROPRIATE USE OF COMPUTER HARDWARE, SOFTWARE AND MEDIA POLICY DURING ANNUAL EVALUATION

I acknowledge that I have received a copy of the “Appropriate Use of Computer Hardware, Software and Media Policy” for Mather Hospital Northwell Health (“Hospital”).

I agree to read it, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the Appropriate Use of Computer Hardware, Software and Media Policy, and to cooperate with management in carrying out its objectives.

I am aware that this Policy is also available on the Hospital’s Intranet. I know that Thomas Heiman is the Information Security Officer for Mather Hospital Northwell Health, and I may call him at any time through the Information Services Help Desk at (631) 473-1320 x4700.

Acknowledged and agreed:

__________________________________________  _________________________________________
Print Name                                                   Signature

__________________________________________  _________________________________________
Job Title or Description                                       Today’s Date