1) **ANTI-KICKBACK**

**Social Services Law § 366-d, “Medical assistance provider; prohibited practices”**

The statute applies to all providers in the New York Medicaid program and prohibits medical assistance providers from soliciting, receiving, accepting, or agreeing to receive or accept or offer, agreeing to give, or giving any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (1) for the referral of services for which payment is made under Title 11 of article five of this chapter; or (2) to purchase, lease, or order any good, facility, service, or item for which payment is made under the Medicaid program. While the statute does not enumerate any "safe harbors," subsection 2(d) specifically states that the prohibition "shall not apply to any activity specifically exempt by federal statute or federal regulations promulgated thereunder." This language appears to incorporate all of the statutory exceptions and safe harbors available under 42 U.S.C. § 1320a-7b and 42 C.F.R § 1001.952 (federal Anti-Kickback safe harbors). However, there is no case law construing subsection (d), and it is therefore uncertain how it would be applied in the event of a challenge. A violation of the statute is either a misdemeanor or felony depending upon whether the defendant obtains money and/or property in violation of the statute and, if so, the amount obtained.

**Social Services Law § 366-f, “Persons acting in concert with a medical assistance provider; prohibited practices”**

The statute provides that no person acting in concert with a Medicaid provider and with the intent to defraud may solicit, receive, accept, or agree to receive or accept or offer, agree to give, or give any payment or other consideration in any form to/from another person to the extent such payment or other consideration is given: (1) for the referral of services for which payment is made under this title; or (2) to purchase, lease, or order
any good, facility, service, or item for which payment is made under the Medicaid program. Subsection (1)(c) of the statute specifically exempts from the prohibition any activity exempt by federal statute or regulation. A violation of the statute is a misdemeanor punishable by imprisonment or a fine of $10,000 or double the amount of gain attributable to the violation. If the violation results in the individual obtaining money or funds in excess of $7,500, such violation is a class E felony.

18 N.Y.C.R.R. § 515.2, “Unacceptable practices under the medical assistance program”
This regulation lists unacceptable practices as fraud or abuse under the medical assistance program, including: (1) directly or indirectly soliciting or receiving any payment, or offering or paying any payment, in cash or in kind, in return for referring a client for medical care, services, or supplies for which payment is claimed under the medical assistance program; (2) purchasing, leasing, ordering, or recommending any medical care, services, or supplies for which payment is claimed under the medical assistance program; and (3) seeking or receiving any gift, money, donation or other consideration in addition to the amount paid or payable under the medical assistance program for any medical care, services, or supplies for which a claim is made. However, if the discount or reduction is disclosed to the client and the Department of Health and reflected in a claim, or a payment is made pursuant to a valid employer-employee relationship, it may be considered an acceptable practice.

Section 587 of the Public Health Law, and the accompanying regulations, prohibit health care providers from soliciting, receiving, accepting, or agreeing to receive or accept any payment or consideration in exchange for the referral of clinical laboratory services. The statute and regulations also make clear that no clinical laboratory employees, agents, or fiduciaries shall make, offer, give, or agree to make, offer or give any payment or consideration in any form for the referral of services. Any transaction excluded from the prohibition under Public Health Law § 586 is similarly excluded (this includes payment by a relative of the recipient of the services, an insurance carrier, a hospital on behalf of a patient who was the recipient of the services, a purveyor to another purveyor for services actually rendered, an industrial firm for its own employees, a trade union health facility, and government agencies on behalf of recipients). A violation of this statute is a misdemeanor punishable by imprisonment, a fine of $500 to $10,000, and/or, if property was gained as a result of the violation, a fine not to exceed double the amount gained, or both imprisonment and a fine. However, this prohibition does not apply to any hospital group purchasing program or arrangement between a clinical laboratory and health maintenance organization operating in accordance with Articles 43 and 44 of this chapter.

Notable Case Law
Quality Health Care Mgt. v. Kobakhidze, 977 N.Y.S. 2d 568 (N.Y. Supp. Ct. 2013) – Even supposing that two former workers were independent contractors and their agency agreements with a clinical laboratory violated § 587, their status as non-employees
would not render the agreements unenforceable or preclude the laboratory from recovering under them because § 588(2) provides statutory sanctions to address violations of this § 587. Upon finding that a statute has been violated, a court does not need to invalidate an agreement if the statute does not expressly state that violation would nullify a contract. In this case, precluding the plaintiff from recovery because a *malum prohibitum* statutory violation would be out of proportion to the requirements of the public policy.

*For more information on Public Health Law §§ 587 and 588, please follow this link and select “Laws” > “Laws of New York” > “PBH” > “Article 5 – Laboratories” > “Title 6 - (585 - 588) Laboratory Business Practices.”*

**Education Law § 6530, “Definitions of professional misconduct”**
Section 6530 defines professional misconduct of physicians and physician assistants under the Education Law. The list of practices or activities which constitute professional misconduct includes the direct or indirect "offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services." *Id.* at Section 6530(18). Additionally, a physician or a physician’s assistant may “not compensate or give anything of value to representatives of the press, radio, television or other communications media in anticipation of or in return for professional publicity in a news item.” *Id.* at Section 6530(27)(c)(ii). Any physician or physician assistant in violation of this statute shall be subject to the penalties set forth under Section 230-a of the Public Health Law, which may include: (1) censure or reprimand; (2) suspension of license; (3) limitation of the licensee’s license; (4) revocation of licensee’s license; (5) annulment of a license or registration; (6) limitation on registration or issuance of a further license; (7) a fine not to exceed $10,000 for each charge of professional misconduct; (8) a requirement that the licensee obtain further education or training; and (9) a requirement that the licensee perform public service for up to 500 hours.

**8 N.Y.C.R.R. § 29.1, “General provisions”**
Section 29.1 of the Education Regulations defines professional misconduct of licensed professionals other than physicians and physician assistants, such as chiropractors, dentists, dental hygienists, physical therapists and assistants, pharmacists, nurses, and optometrists, among others. Like Education Law Section 6530(18), Section 29.1(b)(3) prohibits “directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services.”

**2) REFERRAL/SELF-REFERRAL**

**Public Health Law § 238-a “Prohibition of financial arrangements and referrals” and “Definitions”**
The statute applies to practitioner self-referrals for certain enumerated services without regard to the type of payer. The statute prohibits self-referrals to health care providers
where a "practitioner or immediate family member of such practitioner has a financial
relationship with such healthcare provider" and the referral is for one of the specified
services. It also prohibits the presentment of any claim, bill, or demand for payment for
specified services. Specifically, the statute applies to referrals for clinical laboratory,
pharmacy, radiation therapy, physical therapy, X-ray, and imaging services. Included in
the definition of "healthcare provider" are individual practitioners, professional
corporations, hospitals, and home health agencies. "Practitioner" is defined to include
"licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife,
physician assistant or specialist assistant, physical therapist, or optometrist." There are
a number of carve-outs to which the prohibition does not apply such as in-office
ancillary services and referrals for inpatient hospital services. The referring practitioner
and the health care provider furnishing the services in violation of this statute are jointly
and severally liable to the payer for any amounts billed and collected in violation of this
statute. Additionally, a violation by a health care provider may result in the imposition of
civil fines up to $2,000 dollars for each violation, pursuant to N.Y. Pub. Health Law
Section 12.

Public Health Law § 238-b, “Provider requests for payment”
This statute requires that each provider submitting a bill for a clinical laboratory,
pharmacy, radiation therapy, physical therapy, X-ray, or imaging service for which the
provider knows or has reason to believe that there has been a referral from a
practitioner who is an interested investor in the provider, identify the referring
practitioner by name and professional license number or any appropriate program
provider number. Bills for services regulated solely by federal law and regulations are
exempted from the self-referral prohibition set forth in N.Y. Pub. Health Law Section
238-a.

10 N.Y.C.R.R. § 34-1 et seq., “Health Care Practitioner Referrals and Laboratory
Business Practices”
These regulations are established under the authority of the Public Health Law
provisions described above. The regulations and exceptions mirror the self-referral
prohibition set forth in Section 238-a of the Public Health Law and are applicable to
clinical laboratory, pharmacy, radiation therapy, X-ray, imaging, and physical therapy
services. Provided that the ownership or investment interest and the patient’s right to
utilize a specifically identified alternative health care provider if reasonably available are
disclosed by the referring practitioner to the patient, the following referrals are exempt
from the prohibition: (1) referrals in rural areas; (2) referrals to a general hospital when
the investment is in the general hospital and not a subdivision; and (3) referrals to
ambulatory surgery centers when the services are in conjunction with a surgical
procedure performed by the referring practitioner at the ambulatory surgery center. In
addition, disclosure is required by the practitioner of his or her ownership or investment
interest when the referring practitioner has an ownership or investment interest in the
health care provided to which the patient is being referred. A form for disclosing
ownership or investment interests is included in the regulations. The regulations also
specify certain relationships that are not considered compensation arrangements
implicated by the statutory or regulatory prohibition, including the rental of equipment,
bona fide employment relationships, personal services arrangements, payment for items and services, and certain other remuneration when the conditions set forth in the regulation are met.

Public Health Law § 4501 et seq., “Medical referral service businesses prohibited”
This statute prohibits all persons, firms, partnerships, associations, corporations, and their agents and employees from engaging in any for-profit business or service that includes the referral or recommendation of persons to a physician, dentist, hospital, health-related facility, or dispensary for any medical or dental care. It provides that the imposition of a charge for any such referral or recommendation creates a presumption that the business or service is operating for profit. This statute further precludes physicians, dentists, hospitals, health-related facilities, and dispensaries from entering into any agreement to accept for care any person referred or recommended by a referral service doing business in another state, if the service would be prohibited by this statute if it were operating in New York. Nonprofit and federally tax-exempt entities are exempt from this statute. A violation of this statute constitutes a misdemeanor punishable by imprisonment up to one year, a fine up to $5,000, or both.

3) FALSE CLAIMS/FRAUD & ABUSE

State Finance Law § 187 et seq., “New York False Claims Act”
This series of statutes that comprise Article XIII of the New York State Finance Law is referred to as the New York False Claims Act, and it is modeled after the federal False Claims Act. Among the actions that constitute a violation of the New York False Claims Act are: (1) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment to the New York state or local government; (2) knowingly making or using a false record or statement in order to obtain approval or payment of a false or fraudulent claim from the state or local government; and (3) conspiring to defraud the state or local government in connection with a false or fraudulent claim. A person in violation of the New York False Claims Act is liable: (1) to the state government for a penalty between $6,000 and $12,000, plus three times the amount of damages sustained by the state government; and (2) to any local government for three times the amount of damages sustained by such local government. However, a court may not assess more than two times the amount of damages sustained by the government, if the court finds that certain cooperation factors were met such as bringing all information to the government within thirty days and fully cooperating with the investigation. The New York False Claims Act permits private citizens to bring enforcement actions as qui tam plaintiffs, and to collect damages ranging from 15% to 25% of the proceeds recovered in the action or the settlement between the defendant and the state government.

13 N.Y.C.R.R. § 400.1 et seq.
These regulations provide definitions and procedural clarification and guidelines as to enforcement actions brought under the New York False Claims Act.
**Social Services Law § 145-b, “False statements; actions for treble damages”**

It is unlawful for a person, firm, or corporation to knowingly make a false statement or representation, including by deliberate concealment of fact, to attempt to obtain payment from public funds for services or supplies covered under the New York Medicaid program. The prohibition broadly applies to information submitted on a cost report in addition to fee-for-service claims for reimbursement. Each violation is subject to civil damages of the greater of $5,000 or three times the amount claimed or the damage to the state. The statute also empowers the New York State Department of Health to impose a monetary penalty in the case where goods or services paid for under the Medicaid program failed to meet the standards of the Medicaid program or deviate from generally accepted medical practice. This power applies, among others, in cases where there are orders for unnecessary care, care provided in a manner different than claimed, and care or services provided by a provider excluded from the Medicaid program.

**Social Services Law § 366-b, “Penalties for fraudulent practices”**

False claims in the New York Medicaid program are prohibited by the New York Social Service Law. The statute makes it a crime for any person who: (1) with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise; (2) knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise; or (3) knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under the Medicaid program. A violation of the statute is a Class A misdemeanor for which imprisonment from 15 days to one year may apply. N.Y. Penal Law § 70.15. If the underlying act constitutes a violation of another section of the New York Penal Law, however, "the penalties fixed by such law" apply.

**18 N.Y.C.R.R. § 515.2, “Unacceptable practices under the medical assistance program”**

This regulation prohibits certain "unacceptable practices" in connection with the New York Medicaid program. An "unacceptable practice" is generally defined as conduct that is contrary to: (1) the official rules and regulations of the Department of Health; (2) the published fees, rates, claiming instructions, or procedures of the Department of Health; (3) the official rules and regulations of the Departments of Health, Education, and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or (4) the regulations of the federal U.S. Department of Health & Human Services promulgated under Title XIX of the federal Social Security Act.

The regulation further provides that an "unacceptable practice" is conduct that constitutes fraud or abuse and includes certain specifically enumerated practices. Unacceptable practices relating to false claims and false statements, kickbacks, unacceptable recordkeeping, and failure to meet standards include: (1) false claims; (2) false statements; (3) failure to disclose any event affecting the right to payment with the intention that a payment be made when not authorized or in a greater amount than due; (4) converting a medical assistance payment to a use or
benefit other than the use and benefit for which it was intended by the medical assistance program; (5) bribes and kickbacks; (6) unacceptable recordkeeping; (7) employment of sanctioned persons; (8) seeking or receiving payment in addition to the amount payable under the program for services rendered; (9) client deception; (10) conspiracy to defraud the Medicaid program; (11) excessive services; (12) failure to meet recognized standards; (13) unlawful discrimination; (14) factoring; (15) solicitation of clients; (16) failure to verify Medicaid eligibility; and (17) denial of services based on inability to pay the copayment.

Note that the statute pursuant to which this regulation was promulgated (N.Y. Soc. Serv. Law § 366-d) appears to provide that the federal statutory exceptions safe harbors are applicable (as discussed above). The regulation itself, however, expressly excepts only properly disclosed discounts and bona fide employer-employee relationships from its kickback prohibitions.

The penalties for violations of any of these various provisions include exclusion from the Medicaid program, censure, conditional or limited participation in the program, and/or recoupment of overpayments made in connection with a violation.

18 N.Y.C.R.R. § 516.1, et seq. “Policy, scope and definitions”
This regulation empowers the Department of Health to impose a monetary penalty on any person who fails to comply with the standards of the Medicaid program or generally accepted medical practice, or who grossly violates such standards, and who receives or causes to be received by another person payment from the Medicaid program when the person knew or had reason to know that: (1) the payment was a result of the provision or ordering of medically improper, unnecessary, or excessive care; (2) the care, services, or supplies were not provided as claimed; (3) the person who ordered or prescribed the care, services, or supplies was suspended or excluded from the Medicaid program; or (4) the care, services or supplies for which payment was received was not provided.

18 N.Y.C.R.R. § 516.2, et seq. “Amount of Penalty”
If a penalty has not been imposed upon the person within the past five years, the penalty can be up to $10,000 for each item of care, service, or supply that is the subject of a determination under this part. If a penalty has been imposed upon the person within the past five years, the penalty can be up to $30,000 for each item of care, service, or supply that is the subject of a determination under this part.

NY CLS Penal Law § 177.00 et seq.
Article 177 of the Penal Law contains provisions defining varying levels of health care fraud.

A person (including an individual or entity) commits health care fraud in the fifth degree when he or she, with intent to defraud a health plan (including Medicaid or a private health plan), knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for a
health care item or service and, as a result, receives payment that he or she is not entitled to under the circumstances. Health care fraud in the fifth degree is a Class A misdemeanor.

Health care fraud in the fourth degree occurs when the amount involved from a single health plan exceeds $3,000 in one year and is a Class E felony.

Health care fraud in the third degree occurs when the amount involved from a single health plan exceeds $10,000 in a year and is a Class D felony.

Second degree health care fraud occurs when the amount involved exceeds $50,000 in one year and is a Class C felony.

First degree health care fraud occurs when the amount involved from a single health plan exceeds $1 million in one year and is a Class B felony.

**Notable Case Law**

*People v. Khan*, 942 N.Y.S. 2d 399 (N.Y. 2012) – Where defendant provided an undercover officer with pills that were not consistent with the prescriptions, but billed Medicaid in accordance with the prescriptions, he was properly convicted of fourth-degree healthcare fraud under Penal Law §§ 177.05, and 177.10 because the defendant knowingly and willfully provided materially false information to Medicaid as to the dispensed medications.

4) **COMPLIANCE PROGRAMS/SELF-DISCLOSURE**

**N.Y. CLS Social Services Law §363-d, “Provider Compliance Program”**

This statute mandates that covered Medicaid providers adopt and implement a compliance program addressing, at a minimum, Medicaid billing and payments. The compliance program must include the following elements:

- written policies and procedures;
- designation of an *employee* vested with responsibility for day-to-day operation of the program;
- training and education of affected employees, executives, and members of the governing body;
- accessible lines of communication to the compliance officer, including a method for anonymous and confidential reporting of potential compliance issues;
- disciplinary policies to encourage good-faith participation in the compliance program;
- a system for routing identification of compliance risk areas, self-evaluation and internal audits, external audits, and evaluation of actual or potential non-compliance;
- a system for responding to compliance issues, promptly correcting problems, and refunding overpayments; and
• a policy of non-intimidation and non-retaliation.

The requirements of Section 363-d are applicable to licensed health care providers (i.e., under Articles 28 and 36 of the Public Health Law, Articles 16 and 31 of the Mental Hygiene Law), and other Medicaid providers and suppliers “for which the medical assistance program is a substantial portion of their business operations.”

It is the position of the Office of the Medicaid Inspector General (OMIG) that Section 363-d imposes an affirmative duty to “self-disclose, explain and identify overpayments.” OMIG has developed its own self-disclosure protocol and specified disclosure form for these purposes, which are posted on the OMIG website.

**18 N.Y.C.R.R. § 521 et seq., Provider Compliance Programs**

The implementing regulations under Social Services Law Section 363-d are contained in Part 521 of the Social Services regulations, 18 N.Y.C.R.R. § 521 et seq. The regulations interpret the statute so as to subject to the mandatory compliance program requirements, in addition to licensed providers under Article 28 or 36 of the Public Health Law and Article 16 or 31 of the Mental Hygiene Law, any “other persons, providers or affiliates who provide care, services or supplies under the medical assistance program, or persons who submit claims for care, services or supplies for or on behalf of another person for which the medical assistance program is or should be reasonably expected by a provider to be a substantial portion of their business operations.” The term “substantial portion” is defined as receipt or expected receipt of, or submission of claims involving, at least $500,000 in Medicaid payments in any consecutive 12-month period.

Covered persons and entities must implement an effective compliance program applicable to billing, payment, medical necessity and quality of care, governance, mandatory reporting, credentialing, and other risk areas identified by the provider. The compliance program must also include written policies and procedures, a designated employee(s) with responsibility for operation of the program, training and education of all affected persons, communication lines for reporting compliance issues, disciplinary policies, a system for routine identification and evaluation of compliance risk areas specific to the provider type, a system for responding to compliance issues as they are raised, and a non-intimidation and non-retaliation policy.

Every party required to adopt and maintain a compliance program must certify the sufficiency of its compliance program to OMIG (using a form on its website) upon applying for enrollment in the Medical Assistance Program and during each December thereafter. OMIG has also made available on its website a Provider Self-Assessment Tool for use in reviewing compliance program effectiveness.

In the event that the Commissioner of Health or OMIG find that a required party does not have a satisfactory compliance program, the party may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in Medicaid. More information on compliance.
5) UNFAIR BUSINESS PRACTICES


This statute prohibits deceptive acts or practices in the conduct of any business, trade, or commerce or in the furnishing of any service within the state of New York, but provides as a defense that such act or practice is subject to and complies with the rules and regulations of, and the statutes administered by, the Federal Trade Commission or any official department, division, commission, or agency of the United States. In addition to the right of the Attorney General to seek an order pursuant to this section, any injured party may bring an action to enjoin such acts and to recover actual damages or $50, whichever is greater. A court may, in its discretion, award additional damages up to three times the actual damages up to $1,000 and attorneys’ fees, if the court finds the defendant willfully or knowingly violated this section.

**Notable Case Law**

- **Batas v. Prudential Ins. Co. of Am., 724 N.Y.S.2d 3 (N.Y. App. div. 1st Dep’t 2001)** – In class action on behalf of all subscribers to health care plans offered by insurer and related defendants, the defendant’s argument that Public Health Law § 4406 designated the responsibility for regulating the contracts of HMO’s to the Commissioner of the Department of health, did not preclude plaintiffs’ causes of action for breach of contract, fraud and violations of General Business Law § 349(a) and §350. Public Health Law §4406 does not contain clear legislative intent to preempt common law or other rights and remedies. Plaintiffs sufficiently stated cause of action for fraud where defendants misrepresented facts in materials used to induce potential subscribers to obtain defendants’ health insurance policies was not duplicative of plaintiffs’ breach of contract claim, which was based on defendants’ alleged failure to conduct promised utilization review procedures, and plaintiffs adequately pleaded reliance, it being unnecessary at pleading stage to set forth with particularity materials relied on.

- **Sergeants Benevolent Ass’n Health & Welfare Fund v. Sanofi-Aventis U.S. LLP, 20 F. Supp. 3d 305 (E.D.N.Y. May 9, 2014), aff’d, 806 F.3d 71 (2d. Cir. N.Y. 2015)** – In a suit by health benefit providers and third party insurance payers alleging deceptive acts and practices by a pharmaceutical company’s misrepresentation of the safety and efficacy of a particular prescription antibiotic, plaintiffs successfully met the consumer oriented requirement under § 349 because it adequately demonstrated that the unlawful acts and practices of the pharmaceutical company had a broader impact on consumers at large.

**N.Y. CLS General Business Law § 350-b, “Disclosures Required in Advertisements Using the Title “Doctor”**

Any person using the title "doctor" in making representations for the purpose of inducing, or which are likely to induce, the purchase of: (1) drugs, devices, or cosmetics; or (2) other goods or services intended to diagnose, treat, or prevent any disease, injury, nutritional deficiency, or physical condition, must conspicuously disclose the profession in which he or she is licensed.

For the purposes of this section, “conspicuously” shall mean equally in size, type or prominence and positioned adjacent to the title “doctor.”
6) FEE SPLITTING

**10 N.Y.C.R.R. § 600.9, “Governing Authority or Operator”**

This fee-splitting prohibition applies to hospitals, nursing homes, and other health care facilities licensed under Article 28 of the Public Health Law and provides that “[a]n individual, partnership or corporation which has not received establishment approval may not participate in the total gross income or net revenue of a medical facility." It is commonly interpreted to prevent the splitting of fees between an Article 28-established facility and any entity that is not established under Article 28. Penalties for a violation of this regulation include potential revocation of the facility’s operating certificate and/or fines.

**N.Y. CLS Public Health Law § 587, “Prohibited Practices”**

No medical professional, including but not limited to, a physician, dentist, podiatrist, or chiropractor, nor any group, association, corporation, partnership, firm, or other entity that employs such medical professionals shall participate in the division, transference, assignment, rebating, or splitting of fees with any clinical laboratory or any other medical professional in relation to clinical laboratory services.

**Notable Case Law**

*Magidson v. Dowling*, 608 N.Y.S.2d 598 (N.Y. Sup. Ct. 1993) – Physicians were convicted of crimes related to the furnishing of, or billing for medical care and services where they referred patients to laboratory for laboratory work and laboratory paid physicians percentage of fees it received from physicians’ patients in violation of N.Y. CLS. Pub Health § 587(1).

**N.Y. CLS Education Law § 6509-a, & N.Y. CLS Education Law § 6531, “Additional Definition of Professional Misconduct”**

The statute prohibits the professionals governed by the enumerated articles of the Education Law, including chiropractors, dentists, dental hygienists, physical therapists and assistants, pharmacists, physician assistants, nurses, and optometrists, among others, from directly or indirectly requesting, receiving, or participating in the division, transference, assignment, rebating splitting, or refunding of a fee for, or directly requesting, receiving, or profiting by means of a credit or other good and valuable consideration as a commission, discount, or gratuity in connection with the furnishing of professional care or services. The statute set forth a list of services and supplies included within the scope of the statute, such as X-ray examination, clinical laboratory services or supplies, ambulance services, hospital medical supplies, artificial limbs, hearing aids, and others.

Penalties for violation of the statutory provisions above include the revocation, suspension, or annulment of the professional’s license as well as any other penalty provided for in: (1) Education Law Section 6531 with respect to physician assistants; or (2) Education Law Section 6511 with respect to any professional to which Education Law Section 6509-a applies.

**N.Y. CLS Education Law § 6530, “Definitions of Professional Misconduct”**

Section 6530(19) defines professional misconduct of physicians and physician assistants under the Education Law. Included in the specific listing of practices or
activities constituting professional misconduct is the sharing of fees for professional services with another person other than the licensee’s partner, employee, associate in a professional corporation or firm, a professional subcontractor or consultant authorized to practice medicine, or a legally authorized trainee practicing under the supervision of a licensee. The prohibition on fee splitting also applies to any arrangement where the amount received in payment for furnishing space, facilities, equipment, or personnel services used by a licensee is dependent upon, or is a percentage of, the income earned by the licensee in the course of performing the professional services.

Any physician or physician assistant in violation of this statute shall be subject to the penalties set forth under N.Y. CLS Pub. Health § 230-a, which may include:

(1) censure or reprimand;
(2) suspension of license;
(3) limitation of the licensee’s license;
(4) revocation of licensee’s license;
(5) annulment of a license or registration;
(6) limitation on registration or issuance of an additional or further license;
(7) a fine not to exceed $10,000 for each charge of professional misconduct;
(8) a requirement that the licensee obtain further education or training; and
(9) a requirement that the licensee perform public service for up to 500 hours.

The New York State Education Department regulations, at Section 29.1(b)(4), define "unprofessional conduct" by licensed professionals to include a licensee sharing "fees for professional services, [with someone] other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner." This regulation makes clear that the fee-splitting prohibition applies to arrangements in which the amount is received as payment for "furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee."

7) WHISTLEBLOWER PROTECTIONS

N.Y. CLS State Finance Law § 191, “Remedies” (as part of the New York False Claims Act"
This statute, which is part of the New York False Claims Act, provides protection to employees who are fired, demoted, suspended, threatened, harassed, or discriminated against in any manner in connection with their employment because of such employee’s participation or involvement in an action brought under the New York False Claims Act. Such employee shall be entitled to the relief necessary to make the employee whole, which may include:
(1) injunctive relief;
(2) reinstatement of the employee to the same or equivalent position he or she would have had but for the discrimination;
(3) reinstatement of full fringe benefits and seniority rights;
(4) payment of two times back pay, plus interest; or
(5) compensation for any special damages, including litigation costs and attorneys’ fees.

**N.Y. CLS Labor Law § 740, “Retaliatory Personnel Action by Employers; Prohibition”**

Employers are prohibited from taking personnel action against an employee in retaliation for the employee disclosing, or threatening "to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes healthcare fraud." In addition, employees are protected from retaliatory personnel actions for providing information to or testifying before any public body conducting an investigation into such violation by the employer, or for objecting to or refusing to participate in the underlying violating activity, policy, or practice. A violation of this statute may subject the employer to various civil penalties, in addition to reasonable costs, disbursements, and attorneys' fees.

Accordingly, in its discretion, the court may "order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee under this section was without basis in law or fact."

**Notable Case Law**

*Bordell v. General Elec. Co.*, 622 N.Y.S.2d 1001 (N.Y. App. Div. 1st Dep’t) –CLS Labor § 740 requires proof of an actual violation of a law, rule, or regulation; it does not protect an employee from retaliation where the employee has only a good-faith reasonable belief that activity, policy, or practice of employer is in violation of law, rule, or regulation.

**N.Y. CLS Labor § 741, “Prohibition; health care employer who penalizes employees because of complaints of employer violations”**

Health care employers, including facilities authorized under Article 28 or Article 36 of the Public Health Law, are prohibited from taking retaliatory personnel action against any employee who "discloses or threatens to disclose to a supervisor, or to a public body an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care;" or "objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care." This statute protects persons who "perform[] healthcare services" and who disclose violations of "improper quality of patient care" from retaliatory discharge. The statute does not identify the class of "healthcare services" or employees protected by the statute.
"Improper quality of patient care" is defined as "any practice, procedure, action or failure to act . . . which violates any law, rule, regulation or declaratory ruling, where such violation relates to matters that may present a substantial and specific danger to public health or safety or a significant threat to the health or safety of a specific patient."

The protection afforded by this section only applies if the employee has brought the improper quality of care to the attention of a supervisor and has afforded the employer reasonable opportunity to correct such activity, policy, or practice, unless the improper quality of care presents an imminent threat to public health or to the health of a patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action. A health care employee may seek enforcement of this section in the same way as under Section 740.

New York City Laws
As required by New York City Charter and law, the New York City Department of Health and Mental Hygiene ("DOHMH") Compliance Program works with the New York City Department of Investigation ("DOI") to address potential and actual cases of fraud. DOI plays an important role in fraud reporting, investigation, penalties, and whistleblower protection.

DOI's major functions include investigating and referring for prosecution cases of fraud, corruption and unethical conduct by NYC employees, contractors and others who do business with NYC. DOI is also charged with studying agency procedures to identify systemic failures and recommending improvements in order to reduce the City’s vulnerability to corruption, fraud, waste and abuse. In addition, DOI investigates the backgrounds of persons selected to work in decision-making or sensitivity NYC jobs, conduct checks on those who are awarded contracts with the City, and acts as the investigative arm of the Conflict of Interest Board ("COIB").

Criminal Penalties (NYC Charter Ch. 49, § 1116)
Any City employee or officer who willfully violates the law in relation to his or her job, defrauds the City, converts public property for personal use, allows another to convert public property to personal use, or knowingly files false or deceptive reports or statements can be found guilty of a misdemeanor. In all instances, the employee or officer will lose his or her job upon conviction and in some instances will be barred from City employment in the future. The full text of the NYC Charter is available here.

New York City False Claims Act (NYC Adm. Code § 7-801 et. seq.)
The New York City False Claims Act authorizes the citizens to bring lawsuits to recover treble damages for fraudulent claims submitted to the City. The New York City False Claims Act is patterned after the federal qui tam statute. Successful plaintiffs, under circumstances, may keep as much as 30% of funds they help recover.

Whistleblower Protections (NYC Adm. Code § 12-113)
The New York city Whistleblower Law and Mayoral Executive Order # 16 protect City employees from retaliation for reporting to DOI allegations of misconduct, corruption, criminal activity, and conflicts of interest. The Law and Mayoral Order protect
employees from retaliation in the form of dismissal, demotion, suspension, or negative performance evaluations. To be protected, however, an employee must have reported the fraud or abuse to certain elected officials before he or she suffers adverse personnel action.

8) HELPFUL LINKS
- New York State Department of Health
- New York State Attorney General
- New York Medicaid Program
- OMIG