

False Claims / Federal Deficit Reduction Act Notice

Help Stop Healthcare Fraud, Waste and Abuse:

Report to the Firelands' Corporate Compliance Officer

Firelands Regional Medical Center (Firelands) is committed and takes pride in complying with federal and state laws and regulations that govern the delivery of health care to its patients and the prevention of fraud, waste and abuse. Firelands relies on all of its employees, contractors, and agents to support this effort. This notice contains important compliance information for our employees, contractors and agents regarding the Federal False Claims Act, administrative remedies for false claims and statements, various section of the Ohio Revised Code promulgated to address false claims and Medicaid fraud; and whistleblower protections under state and federal law. Attachment A to this Policy provides an overview of the applicable federal and state laws.

What is the False Claims Act?

The Federal False Claims Act (FCA) prohibits any person from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval of government funds. Under the Federal False Claims Act, any person who knowingly submits a false or fraudulent claim to a Medicare, Medicaid or other federal healthcare program is liable to the Federal Government for three times the amount of the Federal Government's damages plus penalties of \$5,000 to \$11,000 per false or fraudulent claim.

What are examples of a false claim?

Under the Federal False Claims Act, the Federal Government prosecutes, criminally or civilly, individuals or entities who submit or cause to be submitted, claims for payment by the government, when the claims are false. In the healthcare industry this includes Medicare, Medicaid and other federal healthcare programs. Examples that may create a false claim include but are not limited to:

- Billing twice for the same service;
- Billing for services not rendered;
- Prescribing unnecessary drugs
- Intentionally using improper codes on claims to receive a higher rate of reimbursement;
- Billing for medically unnecessary services or falsifying certificates of medical necessity;
- Unbundling or billing separately for services that should be billed as one;
- Creating false medical records or treatment plans to increase payments;
- Failing to report and refund overpayments or credit balances;
- Physician billing without personal involvement for services rendered by medical students, interns, residents or fellows in teaching hospitals; and
- Giving and/or receiving unlawful inducements to healthcare providers for referrals for services.

What and how do I report?

If you suspect instances of fraud, submission of false medical billing claims or other non-compliance with federal, state, local laws, or regulations, you should report it. If you suspect any activity that violates any state or federal law or regulation (e.g. corruption, malfeasance, bribery, theft or misuse of property, fraud, coercion, or conversation); or wastes money, or involves gross misconduct, gross incompetence, or gross inefficiency you should report it.

You can report fraud, waste or abuse to Firelands by:

- Call the Firelands' Hotline at 1-888-556-4984
- Call the Corporate Compliance Officer at 1-419-557-5510
- Sending an email to: Compliance@Firelands.com
- Sending a fax to 419-557-6977
- Writing a letter or memo to Firelands Regional Medical Center, attention Corporate Compliance Officer, 1111 Hayes Ave., Sandusky OH 44870
- When reporting fraud, waste or abuse please provide the Corporate Compliance Officer with as many details as possible, including the name, address and telephone number of the individual or company involved in the suspected fraud, waste or abuse. You may remain anonymous; however, if you do not provide your name and contact information, the Corporate Compliance Officer will not be able to contact you for additional information. Your report will be confidential to the extent allowed by law.

Whistleblower Protections:

A whistleblower (or relator as he/she are referred to in the law) must be the original source of the allegation, thus the whistleblower cannot use published accounts of fraud allegations or information that has already come to the attention of the Centers for Medicare and Medicaid Services (CMS) or other government agencies. False Claims Act whistleblowers are protected by federal and state laws from retaliation in any form as the result of their whistle blowing. If you believe you have been retaliated against for whistleblowing, you may seek redress by contacting Firelands' Corporate Compliance Officer.

Attachment A

Federal False Claims Act. 31 USC section 3729

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program including Medicare and Medicaid. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment, conspires to defraud the government, or knowingly makes or uses a false record to conceal an obligation to refund monies.

The term “knowingly” is defined to mean that a person:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Health care providers can be prosecuted for a variety of conduct that leads to submission of a false claim such as falsifying records, double-billing for items or services, or submitting bills for services never performed. Persons and organizations violating the False Claims Act can be subject to civil monetary penalties ranging from \$5,000 to \$11,000 for each false claim submitted. If a provider is convicted of a False Claims Act violation, the Office of the Inspector General may seek to exclude the provider or supplier from participation in federal health care programs.

Section 3730 in the False Claims Act is a qui tam provision allowing any person with actual knowledge of allegedly false claims being made to the government to file a lawsuit on behalf of the U.S. government, to participate in any resulting settlement, and to make such claim without fear of retribution from the employer.

Administrative Remedies for False Claims and Statements, 31 USC Chapter 38 / Program Fraud Civil Remedies Act of 1986 (PFCRA)

The PFCRA authorizes federal agencies such as the Department of Health and Human Services (“HHS”) to investigate and assess penalties for the submission of false claims or statements to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. A person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim or statement that the person knows or has reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that :
 - Omits a material fact;
 - Is false, fictitious, or fraudulent as a result of such omission; and
 - Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
 - Is for payment for the provision of property or services, which the person has not provided as claimed.

The government agency may assess twice the amount of its damages and a civil penalty of up to \$5,500 for each false or fictitious claim. The United States Attorney General has exclusive authority to enforce such assessments and penalties in federal court.

Deficit Reduction Act (DRA) of 2005, Section 6032

The DRA establishes section 1902(a)(68) of the Social Security Act and relates to “Employee education about false claims recovery.” Ohio has promulgated a series of sections of the Ohio Revised Code in response to the DRA. These sections are outlined below.

ORC §5111.101 – Fraud, Waste and Abuse Prevention and Detection

Requires each person that receives Medicaid payments in a calendar year of \$5,000,000 or more to, *as a condition of receiving Medicaid payments*, do all of the following:

- Provide each employee, contractor, and agent detailed, written information about the role of all of the following in preventing and detecting fraud, waste, and abuse in federal health care programs:
 - Federal false claims law, 31 USC 3729-3733
 - Federal administrative remedies for false claims and statements, 31 USC 3801-3812
 - ORC 2913.40, 2913.401, and 2921.13 and any other state laws pertaining to civil or criminal penalties for false claims and statements

ORC §5111.03 – Offenses by Medicaid Providers

The Medical Provider Offenses Statute prohibits Medicaid providers from acting “by deception” to obtain or receive or attempt to obtain or receive payments to which the provider is not entitled or to falsify any report or document relating to Medicaid.

- “Deception” includes acting with reckless disregard or deliberate ignorance of the truth or falsity of information or withholding information.
- Penalties for violation of the Medicaid Provider Offenses Statute include interest on excess payments, three times the amount of excess payments, civil penalties of \$5,000 to \$10,000 per claim, recovery of the costs of enforcement and termination of the Medicaid provider agreement
- The Ohio Attorney General may enforce the provisions of this statute in state court
 - Whistleblower protections under the above laws.

ORC §2913.40 – Medicaid Fraud

The Medicaid Fraud Act imposes criminal penalties for, among other things:

- Knowingly making or cause to be made a false or misleading statement or representation for use in obtaining Medicaid reimbursement.
- Doing either of the following with the purpose to commit fraud or knowingly facilitating a fraud:
 - Charging, soliciting, accepting or receiving any amount in addition to the amount of reimbursement due from Medicaid and any authorized deductibles or co-payments;
 - Soliciting, offering or receiving any remuneration other than authorized deductibles and co-payments in cash or in kind, including kickbacks or rebates, in connection with the furnishing of goods or services for which payment may be made under the Medicaid program.
- Knowingly altering, destroying, concealing or removing any records necessary to support a Medicaid claim or cost report
- The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

ORC §2913.401 – Medicaid Eligibility Fraud

The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

ORC §2921.13 – Falsification

Ohio criminal law prohibits persons from knowingly making false statements or swearing or affirming the truth of a false statement for the purpose of securing payment of benefits administered by a governmental agency or paid out of a public treasury, for the purpose of securing a provider agreement with the government or in connection with any report that is required or authorized by law, such as the Medicaid cost report.

ORC §4113.52 – Right of Employee to Report Violation of Law by Employer

Provides whistleblower protection for non-state employees who report violations of state or federal law that the employer has authority to correct and the employee reasonably believes is a criminal offense or likely to cause an imminent risk of physical harm or hazard to public health. Government may award employee back pay, interest, reinstatement, attorney fees, and court costs.