

To: All Vendors, Agents and Contractors of Hutchinson Regional Medical Center

From: Corporate Compliance Department

Re: Deficit Reduction Act of 2005

Dear Vendor/Agent/Contractor:

Under the Deficit Reduction Act of 2005, Hutchinson Regional Medical Center, formerly Promise Regional Medical Center-Hutchinson, is required to provide information to all employees and contractors regarding (1) the Federal False Claims Act and similar Kansas laws, (2) the rights of employees and others protected under the laws for providing information regarding any suspected violations of the laws, and (3) the policies and procedures for detecting and preventing fraud, waste and abuse.

We have enclosed a copy of the Notice Pursuant to the Deficit Reduction Act of 2005 (Notice), and have also posted the Notice and the 2005 Deficit Reduction Act (DRA) Section 6032 Compliance Policy (Policy) on the internet at [www.hutchregional.com](http://www.hutchregional.com). Please review the attached Notice and the Policy, and distribute this letter to all of your employees and agents who provide services to, for, or on behalf of Hutchinson Regional Medical Center.

If you have any questions or concerns regarding the Notice or the Policy, or any compliance issue, please contact the Compliance Department at 620-665-2447. You may also call the compliance hotline to leave an anonymous message at 620-665-3939. Thank you for your time and attention.

Sincerely,

Melissa A. Moodie  
Interim Compliance Officer

**Hutchinson Regional Medical Center, Inc.**  
**Notice**  
**Pursuant to Deficit Reduction Act of 2005**

Hutchinson Regional Medical Center strives to comply with all state and federal laws and regulations prohibiting the submission of false claims to the state or federal government to obtain payment for health care services. To assist in that effort, Hutchinson Regional Medical Center has rewritten its Corporate Compliance materials. Hutchinson Regional Medical Center requires that its employees, contractors, and agents also comply with those laws. Contractors and agents include those who (a) furnish or authorize the furnishing of Medicaid health care items or services on behalf of Hutchinson Regional Medical Center, (b) perform billing or coding functions on behalf of Hutchinson Regional Medical Center, or (c) are involved in monitoring the health care provided by Hutchinson Regional Medical Center.

The Hutchinson Regional Healthcare System's Corporate Compliance Program mandates compliance with federal and state laws including: (a) the False Claims Act, 31 U.S.C. §§ 3729-3733, (b) the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812, (c) The Anti-kickback Statute, 42 U.S.C. 1320a-7b(b), (d) Stark Laws, 42 U.S.C. § 1395 et al. (e) the Kansas False Claims Act, K.S.A. §§75-7501-7511; and (f) Kansas Medicaid Fraud Control Act, K.S.A. §§ 21-3844-3856. Hutchinson Regional Medical Center has also established a new policy for compliance with the provisions of Section 6032 of the Deficit Reduction Act. Hutchinson Regional Medical Center expects that employees, contractors and agents will comply with all State and Federal laws, regulations and guidances in performing their duties, including the Federal and State False Claims Act and that all employees will recognize that they are subject to criminal and civil penalties and disciplinary action for the failure to comply with the Corporate Compliance Program and with Federal and State laws.

Hutchinson Regional Medical Center will not take retaliatory action against any individual who in good faith reports conduct which violates federal or state laws. Protections afforded those employees and contractors who provide assistance to the government by investigating and reporting fraud, waste, or abuse are addressed in the Corporate Compliance Program, the DRA Compliance Policy and the Employee Handbook.

Hutchinson Regional Medical Center requires that its employees, contractors, and agents familiarize themselves with the Corporate Compliance Program, the DRA Section 6032 Policy, and the Employee Handbook as applicable, and follow those policies to facilitate compliance with the above laws, principles, and standards. The Corporate Compliance Program and the DRA Section 6032 Policy are available to employees, contractors, and agents on Hutchinson Regional Medical Center's website at [www.hutchregional.com](http://www.hutchregional.com). If for any reason you cannot access the Compliance Program or the DRA Section 6032 Policy through the website, you may contact Hutchinson Regional Medical Center's Compliance Officer, Melissa Moodie at [moodiem@hutchregional.com](mailto:moodiem@hutchregional.com) to obtain a copy. The DRA Section 6032 Policy is additionally included as an appendix to the Employee Handbook and is available from Human Resources.

Employees, contractors, and agents who suspect noncompliance with any of the above laws regarding the submission of false claims shall contact the Compliance Officer by calling (620) 665-2447, or e-mailing [moodiem@hutchregional.com](mailto:moodiem@hutchregional.com), or calling Hutchinson Regional Healthcare System's Compliance Hotline at (620) 665-3939.

**2005 DEFICIT REDUCTION ACT (DRA)  
SECTION 6032 COMPLIANCE POLICY**

I. PURPOSE:

- a. Hutchinson Regional Medical Center (“HRMC”) is committed to conducting its operations in compliance with applicable Federal and State laws, and regulatory guidance. The Hutchinson Regional Healthcare System’s (“Healthcare System”) Corporate Compliance Program and this Policy describe the mechanisms for compliance with the requirements of Federal and State laws and with Section 6032 of the 2005 Federal Deficit Reduction Act. The purpose of this Policy is to inform and educate the HRMC’s employees, contractors and agents about the Healthcare System’s Compliance Program, and the Federal and State False Claims Acts, including applicable administrative, civil and criminal penalties and protections provided under the laws for those who report suspected fraud, waste and abuse. All employees, contractors and agents must understand how the Compliance Program and the requirements and obligations of the Federal and State False Claims Acts prevent and detect fraud, waste and abuse in federal healthcare programs.

II. POLICY:

- a. Healthcare System, directors, employees, contractors, and agents will comply with the State and Federal False Claims Acts and the Corporate Compliance Program. All employees, contractors and agents of the Healthcare System have a responsibility to report to the Healthcare System’s Compliance Officer any incident of actual or suspected fraud, waste and abuse, or any misconduct which potentially violates Federal or State laws.
- b. Any employee, contractor, or agent who knowingly and intentionally submits a false claim to the State or Federal government will be reported to the necessary authority.
- c. Employees, contractors, or agents should contact the Compliance Officer in person, at 620.665.2447, via email to [moodiem@hutchregional.com](mailto:moodiem@hutchregional.com), or anonymously to the Compliance Hotline at 620.665.3939, to report any concerns related to compliance with the Federal and State False Claims Acts. Concerns may also be reported to Administration, a Supervisor, Senior Manager, or Officer of the Healthcare System.
- d. The Healthcare System will make this Policy and its Compliance Program available to all employees, contractors and agents. Information regarding individual protections and rights are included within this Policy and included in the Employee Handbook. Information about the Healthcare System’s Compliance Program and this Policy may also be obtained by contacting the Compliance Officer, or by accessing them on the Healthcare System’s website.

III. SCOPE:

- a. The Compliance Officer and/or the designee are responsible for implementing this Policy.

#### IV. GUIDELINES:

By adhering to the following guidelines, the chances of violating the False Claims Acts can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, guidance should be sought from appropriate accounting representatives within the Healthcare System, the Healthcare System's Compliance Officer, the Compliance Committee or legal counsel. Generally, covered persons should comply with the following guidelines:

1. **Billing for Items or Services Not Actually Rendered:** No patient or his or her payor should be billed for services that are not actually rendered or performed.
2. **Providing Medically Unnecessary Services:** Claims should not be submitted to a patient or his or her payor that seek reimbursement for a service that is not warranted by the patient's current or documented medical condition.
3. **Upcoding and DRG Creep:** Billing codes and the assignment of DRG's should not be used that provide for a higher payment rate than the billing code that actually reflects the service furnished to the patient.
4. **Outpatient Services Rendered in Connection with inpatient stays:** Claims should not be submitted for non-physician outpatient services that are included in inpatient payment under the Prospective Payment System.
5. **Duplicate Billing:** Duplicate billings should be avoided. This occurs when more than one claim is submitted to more than one primary payor at the same time.
6. **False Cost Reports:** False cost reports should not be submitted. Statistics, financial data, and payor information should be accurate and supported by auditable documentation.
7. **Unbundling:** Bills should not be submitted piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost.
8. **Billing for Discharge in Lieu of Transfer:** When HRMC transfers a patient to another Prospective Payment System hospital; HRMC should charge Medicare only the per diem amount. The receiving hospital may charge the full DRG.
9. **Refund of Credit Balances:** Credit balances should be fully refunded on a timely basis.
10. **Falsely Billing Physician Services:** Claims for physician services should not be presented if the person providing the service is not a physician.
11. **Conversion of payments:** The knowing and willful conversion (stealing) of a payment intended for the use of another person is a crime.
12. **Transactions with Physicians and Others:** Any transaction potentially involving fraud and abuse laws shall only be entered into after consultation with legal counsel and/or the Compliance Officer.

#### V. ADDITIONAL INFORMATION:

- a. All Healthcare System employees, contractors, and agents will comply with all State and Federal laws related to the Compliance Program and the State and Federal False Claims Acts to prevent and detect fraud, waste, and abuse in federal healthcare programs, or any program in which the government pays any portion of the healthcare provided. Information regarding employee protections and rights is contained in the Employee Handbook. Information about the System's Compliance

Program and this Policy may also be obtained by contacting the Compliance Officer, or by accessing them on the System's website.

- b. **FEDERAL FALSE CLAIMS ACT (FCA):** The FCA imposes civil liability on persons or corporations who, among other things “(1) knowingly present or cause to be presented a false or fraudulent claim for payment to the government; (2) knowingly use a false record or statement to obtain payment on a false or fraudulent claim paid by the government; or (3) engage in a conspiracy to defraud the government to obtain allowance for, or payment of, a false or fraudulent claim. The FCA defines “knowing” or “knowingly” as having actual knowledge of the information; acting in deliberate ignorance of the truth or falsity of the information; or acting in reckless disregard of the truth or falsity of the information; and requires no proof or specific intent to defraud. Violations of the FCA are subject to civil, monetary penalties of not less than \$5,000 and no more than \$10,000, plus three times the amount of damages which the government sustains because of the act of that person. In healthcare, the amount of damages sustained is the amount paid for each false claim that is filed. Examples of the type of activities prohibited by the FCA include billing a federally funded program, such as Medicare or Medicaid, for services that were not provided and/or upcoding, i.e., billing for a highly reimbursed service in lieu of service actually provided. Another example is retaining improper overpayments received from a federally funded program. The FCA applies to billing and claims sent from a medical provider to any government payor program, including Medicare and Medicaid, other Federal healthcare programs, and other State healthcare programs funded, in whole or in part, by the Federal government.
- c. **FEDERAL ANTI-KICKBACK LAW:** A violation of the Anti-Kickback statute is also a false claim. The Anti-Kickback statute forbids the knowing or willful offer, payment, solicitation, or receipt of any type of remuneration to induce or in return for referrals of items or services paid for by Medicare or Medicaid. An example of a “kick-back” in violation of this law would be allowing a physician who refers patients to Hutchinson Regional Medical Center, or its affiliates, to lease space within HRMC's facility or an affiliate building for free. The free rent could be construed as a payment for that physician's referral of patients to the system. The law is also violated in the event inappropriate inducements are made to patients, such as waiving co-insurance or deductibles without regard to financial need.

Violations of Anti-Kickback law can result in significant civil and criminal liability for physicians, non-physicians and organizations, and the penalties can include significant fines, imprisonment, or both.

- d. **STARK LAW:** A violation of the Stark Laws may, under some circumstances, also create a violation of the False Claims Act. Stark Law prohibits physicians from referring Medicare and Medicaid patients for certain “designated health services” reimbursable by the Medicare and Medicaid programs to entities with which the physicians (or their immediate family members) have a financial relationship. A financial relationship may be an ownership interest or a compensation arrangement, and may be direct or indirect. In addition to prohibiting the referral for services, the Stark Law bans billing and collecting for services rendered pursuant to a prohibited referral.

Billing in violation of the Stark Law subjects the parties, both the referring physician and the billing entity, to monetary penalties equal to \$15,000 per claim, two times the amount claimed, and potential exclusion from the Medicare and Medicaid programs. Other civil monetary penalties apply for failing to report information and for circumvention schemes, which can be substantial. There are exceptions to Stark Law, but they require a proper legal analysis before entering into any such relationship.

- e. **CIVIL ACTIONS UNDER THE FCA:** Enforcement of the FCA is the responsibility of the U.S. Attorney General, but the FCA also includes a qui tam or whistleblower provision. Qui tam actions are brought by private individuals on behalf of the government. More specifically, a “qui tam action” is defined as a claim brought by a relator or informer under a statute that establishes a penalty for the commission or omission of a certain act. If a wrongdoing is found, part of the penalty paid by the wrongdoer is paid to the relator or informer, with the remainder going to the government.

A qui tam action is initiated by a relator filing his or her lawsuit in the Federal District Court on behalf of the government for false or fraudulent claims submitted by an individual or entity doing business with or being reimbursed by the United States government. The lawsuit is filed and shall remain under seal for a period of sixty (60) days in order for the government to investigate and decide whether it will pursue the action. At the end of the 60-day period, the complaint is unsealed and the Department of Justice or the U.S. Attorney General’s office begins prosecuting the claim. If the government decides not to pursue the case, the relator has the right to continue with the case on his or her own. The government may join the action at a later date, if it can demonstrate good cause for doing so. If the government proceeds with the lawsuit and is successful, the person who filed the action will receive between 15% and 25% of any proceeds of the action, plus attorney’s fees and costs. The amount of the award depends on contributions of the individual to the success of the case. If the government declines to pursue the case, the qui tam plaintiff will be entitled to between 25% and 30% of the proceeds of the successful case, plus reasonable expenses and attorney’s fees and costs awarded against the defendant. On the other hand, if the qui tam plaintiff is unsuccessful and the court finds that the lawsuit was clearly frivolous, clearly vexatious, or primarily for the purpose of harassment, it may reward the defendant in the action reasonable expenses and attorney’s fees. Whether or not the government proceeds with the lawsuit, if the court finds that the qui tam plaintiff planned and initiated the violation upon which the lawsuit was brought, the court may reduce the share of the proceeds which the person would have otherwise received. If the qui tam plaintiff is convicted of criminal conduct arising from his or her role in the violation, the person will be dismissed from the civil lawsuit and shall not be paid any part of the proceeds.

- f. **ANTI-RETALIATION PROTECTIONS FOR WHISTLEBLOWERS UNDER THE FCA:** Any individual associated with an organization who observes activities or behavior that may violate the law in some manner and who reports their observations either to management or to the governmental agencies is provided protections under the law. Whistleblowers initiating a qui tam action may not be discriminated or retaliated against in any manner by their employer. Any employee, who is discharged, demoted, suspended, threatened, harassed, or confronts discrimination in

furtherance of a qui tam action, or as a consequence of whistleblowing, are entitled to all relief necessary to make the employee whole.

- g. SOCIAL SECURITY ACT: The Social Security Act authorizes the Secretary of Health and Human Services to seek civil monetary penalties and assessments for many types of conduct. The Secretary of Health and Human Services has delegated many of these civil monetary penalties to the Office of Inspector General (OIG). In most of the cases for which the OIG may seek civil monetary penalties, the OIG may also seek exclusion from participation in all federal healthcare programs.