

Fraud, Waste, and Abuse Job Aid



**IMPORTANT FRAUD, WASTE AND ABUSE LAWS
PEACEHEALTH CAREGIVERS AND CONTRACTORS
SHOULD KNOW**



Table of Contents

Federal Laws	1
<i>Federal False Claims Act</i>	2
<i>Federal Anti-Kickback Statute</i>	3
<i>Federal Physician Self-Referral, or “Stark” Law</i>	3
<i>Federal Civil Monetary Penalties Law</i>	4
<i>Federal Law Prohibiting Concealment of Known Overpayments,</i>	4
<i>Criminal Health Care Theft and Embezzlement and Fraud Provisions,</i>	4
<i>Criminal Health Care Fraud</i>	4
<i>Medicare/Medicaid Exclusion Statute</i>	5
Oregon State Laws	6
<i>False Claims for Health Care Payments</i>	6
<i>Falsifying Business Records</i>	6
<i>The Oregon False Claims Act</i>	7
<i>Oregon Medicaid False Claims Act</i>	8
<i>Oregon Administrative Sanctions</i>	8
<i>Fraud and Abuse Reporting</i>	10
<i>Oregon Physician Referral Disclosure Requirement</i>	10
<i>Whistleblower Protections</i>	10
<i>Unlawful Trade Practices</i>	11
<i>Perjury and Related Offenses</i>	11
<i>Theft and Related Offenses</i>	11
<i>Racketeering</i>	12
Washington State Laws	12
<i>Medicaid Fraud False Claims Act</i>	12
<i>Health Care False Claims Act</i>	13
<i>Fraudulent Practices</i>	14
<i>False Statements</i>	14
<i>Washington Anti-Kickback Law</i>	14
<i>Washington Physician Self-Referral Law</i>	14
<i>Concerning Excessive Charges for Medicaid Services and Inappropriate Gifts</i>	15
<i>Washington Anti-Rebate Law</i>	15
Alaska State Laws	16
<i>Medical Assistance Fraud</i>	16
<i>Alaska Medical Assistance False Claim and Reporting Act</i>	17



IMPORTANT FRAUD, WASTE AND ABUSE LAWS PEACEHEALTH CAREGIVERS AND CONTRACTORS SHOULD KNOW

INTRODUCTION

PeaceHealth is committed to ensuring ethical and compliant behavior among PeaceHealth employees, caregivers and contractors. The federal Deficit Reduction Act of 2005 ("DRA") requires PeaceHealth to provide detailed information about the federal False Claims Act, administrative remedies for false claims and statements, state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, to PeaceHealth employees, contractors and agents. This document contains a summary of such laws, as well as a summary of other fraud and abuse laws that PeaceHealth employees, contractors and agents should know. Together, these laws play an important role in PeaceHealth's commitment to prevent, detect and remediate health care fraud, waste and abuse.

This document should be used in conjunction with PeaceHealth's [Fraud, Waste, and Abuse Policy](#), which outlines PeaceHealth's policies and procedures for detecting and preventing fraud, waste and abuse. PeaceHealth's Fraud, Waste, and Abuse Policy also outlines the mechanisms by which PeaceHealth employees, agents, and contractors can report, anonymously and without fear of retaliation, suspected instances of fraud, waste, and abuse. Please note that failure of an employee, agent, or contractor to comply with any applicable state and federal laws, will subject them to PeaceHealth's SYS.52.166 Corrective Action policy.

If you have any questions regarding any of the information contained within this document, or if you have any related concerns, please contact PeaceHealth's Legal Department by emailing Sally Wright at swright1@peacehealth.org. Any suspected fraud, waste and abuse or violation of PeaceHealth policies and procedures must be reported in accordance with the PeaceHealth Code of Conduct and Vendor Code of Conduct and Fraud and Abuse Policy by contacting the PeaceHealth Integrity Hotline at 877-261-8031 or online at peacehealth.alertline.com. These channels are available 24 hours a day, 365 days a year, to ensure confidentiality and allow for anonymity.

SUMMARY OF LAWS

1. Federal Laws

The following are detailed summaries of federal fraud, waste, and abuse laws, including the False Claims Act, administrative remedies for false claims and statements, and whistleblower protections under such laws. This information is to be used as a tool to inform PeaceHealth employees, contractors, and agents of the requirements under these fraud, waste, and abuse laws, as well as the whistleblower protections in place for reporting any suspected fraud, waste, or abuse.

These summaries should not be seen as a replacement for the text of the actual laws. In conjunction with the following summaries, PeaceHealth employees, contractors, and agents who wish to obtain further information regarding the federal fraud, waste, and abuse laws and their impact on healthcare providers can review the U.S. Department of Health and Human Services' educational materials titled "[A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse,](https://oig.hhs.gov/compliance/physician-education/)" available at: <https://oig.hhs.gov/compliance/physician-education/>.

Federal False Claims Act, 31 U.S.C. §§ 3729-3733 & 3801-3812

The federal False Claims Act ("False Claims Act") creates civil liability against any person who:

- a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval by the federal government, including payments by Medicare or Medicaid;
- b. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- c. Has possession, custody, or control of property or money used, or to be used, by the federal government and knowingly deliver, or causes to be delivered, less than all of that money or property;
- d. Is authorized to make or delivery a document certifying receipt of property used, or to be used, by the federal government and, intending to defraud the federal government, makes or delivers the receipt without completely knowing that the information on that receipt is true;
- e. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the federal government, or a member of the Armed Forces, who lawfully may not sell or pledge property;
- f. Knowingly makes use, or causes to be made or used, a false record statement material to an obligation to pay or transmit money or property to the federal government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the federal government; or
- g. Conspires to commit a violation of any of the foregoing.

Under the False Claims Act, "*knowingly*" is defined to include actual knowledge, "reckless disregard" of the truth or falsity of the claim, or "deliberate ignorance" of the truth or falsity of the claim. No proof of specific intent to defraud is required.

The False Claims Act's whistleblower provision allows private citizens to sue in the name of the government and collect 15-30% of any recovery. The False Claims Act also provides for protection for employees against retaliation for being a whistleblower.

Penalties under the False Claims Act include treble (three (3) times) damages, plus \$11,803 to \$23,607 in civil penalties per false claim.

The False Claims Act also includes various administrative remedies which may be utilized by federal agencies to whom false claims are submitted, including a civil penalty of not more than \$5,000 for each false claim, and an assessment, in lieu of damages sustained by the U.S. because of the claim, of not more than two (2) times the amount of the claim.

Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)

The federal Anti-Kickback Statute (“Anti-Kickback Statute”) is a criminal statute that makes it a crime to knowingly or willfully pay or receive any remuneration, directly or indirectly, in cash or in kind, to induce or reward the purchase of any item or service payable by a federal health care program.

Various “safe harbors” exist that protect certain arrangements from liability under the Anti-Kickback Statute, if all requirements of the applicable safe harbor are fully satisfied. While failure to comply with a safe harbor does not mean an arrangement is illegal, in instances where an arrangement does not satisfy all elements of an applicable safe harbor, the Government will review the arrangement to determine the intent of the parties on a case-by-case basis based on the totality of the facts and circumstances.

The Anti-Kickback Statute is violated where just one (1) purpose of an arrangement is to reward or induce a referral, even if there are other, lawful purposes. In 2010 Congress modified the intent requirement so that the Government need not prove actual knowledge of the statute or a specific intent to violate it.

Violations are punishable as felonies and include fines up to \$25,000 per violation and/or imprisonment up to five (5) years, and automatic exclusion from participation in federal health care programs.

Violations of the Anti-Kickback Statute may also constitute false claims under the federal False Claims Act discussed above, and can result in civil penalties under the Civil Monetary Penalties Law discussed below.

Federal Physician Self-Referral, or “Stark” Law, 42 U.S.C § 1395nn

The federal Stark Law prohibits physicians who have financial relationship with entities that provide “designated health services” from making referrals to that entity for such designated health services payable by a federal health care program, unless an exception applies. “Designated health services” include clinical laboratory services, physical therapy services, occupational therapy services, radiology including MRI, CT, and ultrasound services, radiation therapy services and supplies, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.

The Stark Law contains a number of complex exceptions that exempt certain arrangements from the referral prohibitions of the law.

Unlike the federal False Claims Act and the federal Anti-Kickback Statute, the Stark Law is a “strict liability” statute, meaning that no intent to violate the law is required.

Violations of the Stark Law result in the denial of payment or recoupment of all claims submitted pursuant to a Stark Law prohibited referral, plus civil penalties of \$23,863 per claim, and \$100,000 for each “arrangement or scheme” that a physician or entity knows violates the Stark Law, and possible exclusion from federal health care programs.

Federal Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a

The federal government can impose civil money penalties for the following acts:

- a. Knowingly presenting a claim for payment by the federal government that the person knows or should know is false or fraudulent;
- b. Knowingly presenting a claim for payment by the federal government that is for a pattern of medical or other items or services that a person knows or should know are not medically necessary; or
- c. Knowingly offering or transferring remuneration to a federal health program beneficiary that the person knows or should know is likely to influence the beneficiary to order or receive from a particular provider, practitioner, or supplier (unless an exception is met).

Civil money penalties the federal government can impose under the Civil Monetary Penalties Law include a fine of up to \$50,000 for each violation plus treble damages.

Federal Law Prohibiting Concealment of Known Overpayments, 42 U.S.C. § 1320a-7b(a)(3)

Under this law, the federal government can impose criminal sanctions on anyone who has knowledge of "any occurrence" affecting the person's "initial or continued right" to a benefit or payment but who fails to disclose such occurrence "with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than it due or when no such benefit or payment is authorized." If an individual is convicted of concealing known overpayments under this law, the individual will be guilty of a felony, fined up to \$100,000, and/or imprisoned for up to ten (10) years.

Criminal Health Care Theft and Embezzlement and Fraud Provisions, 18 U.S.C § 669

This statute provides criminal penalties for anyone who "knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program." The term "health care benefit program," is defined broadly to include Medicare and Medicaid, as well as private insurance companies. The criminal penalties associated with this statute include fines and/or imprisonment of not more than ten (10) years.

Criminal Health Care Fraud 18 U.S.C. § 1347

This statute creates criminal liability for anyone who "knowingly or willfully executes, or attempts to execute, a scheme or artifice (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, an of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery or of payment for health care benefits, items or services." The criminal penalties associated with this statute include fines and imprisonment of not more than: ten (10) years if no one is injured; twenty (20) years if an individual sustains serious bodily injury; or life in the event the violation results in death.

Medicare/Medicaid Exclusion Statute, 42 U.S.C. § 1320a-7

The federal agency that enforces the Medicare and Medicaid laws, the U.S. Department of Health and Human Services Office of Inspector General (“HHS-OIG”), can exclude individuals and entities from participating in federal health care programs under various circumstances.

Specifically, HHS-OIG is required to exclude individuals and entities from participation in any federal health care program for:

- a. Criminal convictions related to the delivery of a Medicare or Medicaid item or service;
- b. Criminal convictions relating to neglect or abuse of patients;
- c. Felony convictions related to health care fraud; or
- d. Felony convictions related to controlled substances.

Additionally, HHS-OIG has the option to exclude individual and entities from participation in any federal health care programs for:

- a. Misdemeanor convictions related to health care fraud or conviction of a criminal offense relating to fraud in non-health care programs operated or financed by a federal, state or local government agency;
- b. Conviction relating to obstruction of an investigation or audit;
- c. Misdemeanor conviction relating to any controlled substance;
- d. License revocation, suspension, or surrender;
- e. Exclusion or suspension under a federal or state health care program;
- f. Submitting claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
- g. Fraud, kickbacks, and other prohibited activities as outlined in 42 U.S.C. §§ 1320a-7a, 1320a-7b, or 1320a-8.
- h. Being an entity controlled by an individual who has been convicted of any of the offenses providing for mandatory exclusion, against whom a civil monetary penalty has been assessed, or who has otherwise been excluded from participating in a federal or state health care program;
- i. Failure to disclose required information;
- j. Failure to supply requested information on subcontractors and suppliers;
- k. Failure to supply requested payment information to the Secretary of Health and Human Services
- l. Failure to provide immediate access to the Secretary of Health and Human Services, a State Medicaid agency, or the Inspector General of the Department of Health and Human Services as required by law;
- m. Failure by a hospital to comply with a corrective action required by the Secretary of Health and Human Services;

Medicare/Medicaid Exclusion Statute, 42 U.S.C. § 1320a-7 (continued)

- n. Default on health education loan or scholarship obligations;
- o. Being an individual that controls a sanctioned entity;
- p. Making any false representation of material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a federal health care program; or
- q. Knowingly misclassifying covered outpatient drugs.

2.State Laws

A. Oregon State Laws

False Claims for Health Care Payments ORS §§ 165.690-165.698 & 165.990

Oregon law prohibits the false claims for healthcare payment. Specifically, it is a class C felony to:

- a. Knowingly make or cause to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or
- b. Knowingly conceal from or fail to disclose to a health care payor the occurrence of any event or the existence of any information with the intention to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person was entitled.

This statute applies to any claims submitted to private third-party payors as well as Medicaid claims, and prosecution under the statute may only be commenced by the Oregon district attorney or the Attorney General.

Upon a conviction under this statute, the prosecuting attorney is required to notify the Oregon Health Authority and any appropriate licensing boards of the conviction.

Falsifying Business Records, ORS § 165.080

A person commits the crime of falsifying business records if, with the intent to defraud, the person:

- a. Makes or causes a false entry in the business records of an enterprise; or
- b. Alters, erases, obliterates, deletes, removes or destroys a true entry in the business records of an enterprise; or
- c. Fails to make a true entry in the business records of an enterprise in violation of a known duty imposed upon the person by law or by nature of the position of the person; or
- d. Prevents the making of a true entry or causes the omission thereof in the business records on an enterprise.

Falsifying business records is a Class A misdemeanor.

The Oregon False Claims Act, ORS § 180.750 - .785

The Oregon False Claims Act prohibits any person from knowingly (whether with actual knowledge, deliberate ignorance, or reckless disregard) submitting a false claim to any public agency, including Oregon Medicaid.

Specifically, the Act prohibits an individual from:

- a. Presenting for payment or approval, or cause to be presented for payment or approval, a claim that the person knows is a false claim;
- b. In the course of presenting a claim for payment or approval, making or using, or causing to be made or used, a record or statement that the person knows to contain, or to be based on, false or fraudulent information;
- c. Agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim;
- d. Delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt;
- e. Making or delivering a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information;
- f. Buying property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property;
- g. Receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property;
- h. Making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or
- i. Failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

The Oregon False Claims Act authorizes civil actions by the Oregon Attorney General against persons who make false claims from a state agency or knowingly defraud a state agency. It imposes damages plus a penalty equal to the greater of \$10,000 per violation or two (2) times the amount of damages.

Importantly, the State may not impose a penalty against an individual if the individual provided the Attorney General with all information known to them about the violation within thirty (30) days after they first acquired the information, they fully cooperated with the Attorney General in the investigation of the violation, and, at the time they provided the information to the Attorney General, an investigation, court proceeding or administrative action related to the violation had not been commenced.

An action under the Oregon False Claims Act may only be brought within three (3) years after the date an officer or employee of the public agency charged with responsibility of the claim discovers the violation, but in no event may be brought more than ten (10) years after the date on which the violation was committed.

Oregon Medicaid False Claims Act, ORS §§ 411.670– 690

The Oregon Medicaid False Claims Act prohibits a person from knowingly: (i) submitting or causing to be submitted a false or fraudulent claim for payment under the Medicaid program; (ii) submitting or causing to be submitted a duplicate claim unless clearly marked as such; (iii) submitting or causing to be submitted a claim paid by any source unless clearly marked as such; or (iv) accepting payment for services not rendered. A person who violates the Oregon Medicaid False Claims Act is liable to the State for a refund of the amount received in excess of the amount payable under the Medicaid program and treble damages.

Oregon Administrative Sanctions, OAR §§ 410-120-1397 – 1460

Under the Oregon Administrative Rules, providers are required to submit true and accurate claims to the Oregon Department of Human Services. In the event that a provider submits an untrue claim to the Department of Human Services, the Department may deny the payment of the claim, or request return of any overpayment.

Additionally, the Oregon Health Authority is permitted to impose administrative sanctions and suspend providers from participating in all Oregon medical assistance programs upon the submission of an untrue statement or the commission of any of the following acts:

- a. Being convicted of fraud related to any federal, state, or locally financed health care program or committing fraud, receiving kickbacks, or committing other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;
- b. Being convicted of interfering with the investigation of health care fraud;
- c. Being convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;
- d. Having their health care license suspended or revoked by a professional licensing agency;
- e. Being suspended or excluded from participating in any federal or state health care program for reasons related to professional competence, performance, or any other reason;
- f. Billing excessive charges;
- g. Furnishing items or services substantially in excess of a Medicaid beneficiary's needs or in excess of those services ordered by a medical provider, or in excess of generally accepted standards, or of a quality that fails to meet professionally recognized standards;
- h. Failing to furnish medically necessary services as required;
- i. Failing to disclose required ownership information;
- j. Failing to supply requested information on subcontractors and suppliers of goods or services;
- k. Failing to supply requested payment information;
- l. Failing to grant access or to furnish records to Oregon's Medicaid Fraud unit;
- m. Failing to take corrective action to prevent or correct inappropriate admissions or practice patterns, based on information supplied by the Quality Improvement Organization;
- n. Repeatedly submitting a claim with required data missing or incorrect;

Oregon Administrative Sanctions, OAR §§ 410-120-1397 – 1460 (continued)

- o. Failing to develop, maintain, and retain adequate clinical or other records that document the medical appropriateness, nature and extent of the health care provided;
- p. Submitting claims or written orders contrary to generally accepted standards of medical practice;
- q. Submitting claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical provider;
- r. Breaching the terms of the provider contract or agreement;
- s. Rebating or accepting a fee or a portion of a fee or charge for a client referral, or collects a portion of a service fee from the client and bills the Health System Division for the same service;
- t. Submitting false or fraudulent information when applying for the Health System Division assigned provider number, or fails to disclose information requested on the provider enrollment application;
- u. Failing to correct deficiencies in operations after receiving written notice of the deficiency from the Health System Division;
- v. Submitting any claim for payment for which payment has already been made by the Division or any other source unless the amount of the payment from the other source is clearly identified;
- w. Threatening, intimidating, or harassing clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Health System Division;
- x. Failing to properly account for a Health System Division's client's personal incidental funds, including but not limited to using a client's personal incidental funds for payment of services that are included in a medical facility's all-inclusive rate;
- y. Providing or billing for services provided by ineligible or unsupervised staff;
- z. Participating in collusion that results in inappropriate money flow between the parties involved;
- aa. Refusing or failing to repay an overpayment; or
- bb. Failing to report to the division payments received from any other source after the Health System Division made payment for the services.

Administrative sanctions that the Health Authority may issue against a provider include:

- a. Terminating the provider's participation in Oregon's Medicaid program;
- b. Suspending the provider's participation in Oregon's Medicaid program;
- c. Withholding payments due to the provider;
- d. Requiring the provider to attend education sessions;
- e. Requiring that payment for certain services only be made after the supporting documentation for such services have been reviewed;
- f. Requiring the provider to pay any investigative and legal costs sustained by the Division of Medical Assistance Programs;

Oregon Administrative Sanctions, OAR §§ 410-120-1397 – 1460 (continued)

- g. Reducing any amount otherwise due to the provider, such reduction may be up to three (3) times the amount a provider sought to collect due to such violation; and
- h. Any other sanctions reasonably designed to remedy or compel future compliance with the laws.

Fraud and Abuse Reporting, OAR § 410-120-1510

The Oregon Administrative Rules require providers to promptly refer all instances of suspected healthcare fraud and abuse to the Oregon Medicaid Fraud Unit or to the Provider Audit Unit. If the provider is aware of suspected fraud or abuse by a client of the Health Authority or the Department of Human Services, the provider must report the incident to the Department's Fraud Investigations Unit (FIU). Contact information may be found online at: <http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>

Oregon Physician Referral Disclosure Requirement, ORS § 441.098

The Oregon laws related to licensing health care facilities require health practitioners who refer patients for treatment at a facility in which he/she or immediate family member has a financial interest, to inform the patient orally and in writing of that interest and to disclose how care will be provided if complications occur requiring services beyond what the facility can provide. Importantly, the health practitioner may not deny, limit or withdraw a referral to a facility solely for the reason that the patient chooses to obtain the test, treatment or service from a different facility. There is no stated penalty for a violation of this requirement.

Whistleblower Protections, ORS §§ 659A.199 & 659A.200 - 659A.233

Oregon law prohibits an employer from discharging, demoting, suspending, or discriminating against or retaliating against any employee in the event that an employee has, among other actions, reported information that the employee believes is evidence of a violation of any state or federal law (including those state and federal laws related to healthcare fraud and abuse), cooperated with any law enforcement agency in conducting a criminal investigation, or disclosed mismanagement, gross waste of funds or abuse of authority or substantial and specific danger to public health and safety resulting from action of the nonprofit employer, brought a civil proceeding against the employer, or testified in good faith at a civil proceeding or criminal trial against the employer.

Nonprofit employers are also prohibited from discouraging or interfering with their employees' reporting of any federal, state, or local law violation, mismanagement of funds or abuse of authority or substantial and specific danger to public health due to the employer's actions, and the fact that a person receiving services, benefits or assistance from the state, is subject to a felony or misdemeanor warrant for arrest. Violation of this prohibition will result in a Class A misdemeanor.

Unlawful Trade Practices, ORS §§ 646.605 - 646.656

Oregon law prohibits certain trade practices, and provides certain remedies for affected individuals in the event they are harmed by a violation of one of these trade practice prohibitions. These trade practice prohibitions include: price discrimination; misappropriation of trade secrets; certain telephone solicitations; failure to deliver a good or service; making a false or misleading representation or statement in connection with a good or service; or any other unconscionable tactic in connection with provision of a good or service, or collecting or enforcing an obligation of another party.

Perjury and Related Offenses, ORS § 162.055 – 162.130

Several Oregon laws make it a crime to provide false information to an Oregon government official or agency. Each of these laws may be implicated in the event that a health care provider is found to have violated any of the fraud and abuse laws listed herein.

Oregon law makes it a class C felony to commit perjury. Perjury is defined as “making a false sworn statement or a false unsworn declaration in regard to a material issue, knowing it to be false.”

Oregon law makes it a class B misdemeanor to commit unsworn falsification. Unsworn falsification is defined as knowingly making any false written statement to a public service in connection with an application for any benefit.

Oregon law makes it a class A misdemeanor to commit false swearing. False swearing is defined as knowingly making a false sworn statement or a false unsworn declaration.

Theft and Related Offenses, ORS §§ 164.015 – 164.140

Oregon law contains multiple statutes criminalizing theft and related offenses. Generally, a person commits theft when, with intent to deprive another of property or to appropriate property to the person or to a third person, the person takes, appropriates, obtains or withhold such property from an owner thereof. Importantly, Oregon law makes it a crime to commit theft by deception, which can occur when an individual creates or confirms another’s false impression if the actor does not believe it to be true, or if an individual fails to correct a false impression they know to be false. The crime of theft by deception may be implicated in the event that a health care provider is found to have violated any of the fraud and abuse laws listed herein and either knowingly created the false impression which the Oregon government relied on in providing payment to the provider, or failed to correct the false impression in order to keep the payment from the Oregon government. Committing a crime of theft can result in a class C misdemeanor to a class B felony depending on various circumstances surrounding the theft.

Racketeering, ORS §§ 166.715 - 166.735

Oregon law makes it a crime to commit a racketeering activity, to acquire or maintain any money gained through a racketeering activity, to spend or invest any proceeds gained from a racketeering activity, or, in the case of an employed individual, to conduct or participate, directly or indirectly, with the employer through a pattern of racketeering activity. A racketeering activity is defined as committing, attempting to commit, conspiring to commit, or soliciting, coercing, or intimidating another person to commit any of the following Oregon criminal acts: perjury; theft; falsifying business records; making a false claim for health care payment; and violating the Oregon Medicaid False Claims Act. The crime of racketeering is a Class A felony, and the individual found to be in violation of this law will be required to forfeit any proceeds gained through the racketeering activity to the state of Oregon, and may be required to pay a fine of up to three (3) times the value of money gained through the racketeering activity.

Additionally, a court may order an entity found to have committed a racketeering activity in violation of this law to:

- a. Divest of any interest in any enterprise;
- b. Impose reasonable restrictions upon the future activities or investment of the entity;
- c. In the case of a corporation, dissolve or reorganize;
- d. Suspend or revoke any Oregon license or permit; and
- e. Forfeit the charter of a corporation organize under the laws of the state, or revoke a certificate of authority authorizing a foreign corporation to conduct business within the state of Oregon.

B. Washington State Laws

Medicaid Fraud False Claims Act, RCW §§ 74.66.005 – 130

The Washington Medicaid Fraud False Claims Act prohibits a person from knowingly (whether with actual knowledge, deliberate ignorance, or reckless disregard), directly or indirectly:

- 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 one or more of the violations listed in the law;
 - d. Has possession, custody, or control of property or money used, or to be used, by the government entity and knowingly delivers, or causes to be delivered, less than all of that money or property;
 - e. Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and, intending to defraud the government entity, makes or delivers the receipt without completely knowing that the information on the receipt is true;
 - f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government entity who lawfully may not sell or pledge property;
- or

Medicaid Fraud False Claims Act, RCW §§ 74.66.005 – 130 (continued)

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 entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

Similar to the federal False Claims Act, the Washington Medicaid Fraud False Claims Act imposes a civil penalty of \$11,803 to \$23,607 per false claim, plus treble (three (3) times) damages. However, the Act also provides that in place of treble damages, the court may assess double damages if certain situations apply (such as full cooperation with an investigation).

The Washington Medicaid Fraud False Claims Act permits private citizens to bring Qui Tam actions against providers alleging Medicaid fraud on behalf of the State government and to collect 15% to 25% of any recovery.

The Washington Medicaid Fraud False Claims Act also contains whistleblower protections. Specifically, if an employee asserts a claim, assists with an investigation, or testifies in a trial against their employer for violation of the Washington Medicaid Fraud False Claims Act, the employee will be entitled to relief in the event the employer discharges, demotes, suspends, threatens, harasses, or in any other manner discriminates against the employee based on any of the aforementioned acts. The relief must include reinstatement of the employee with the same seniority status that the employee had prior to the prohibited act by the employer, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees.

Health Care False Claims Act, RCW §§ 48.80.010 - 060

The Washington Health Care False Claims Act mirrors the federal False Claims Act, and prohibits an individual from knowingly:

- a. Making, presenting or causing to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false;
- b. Presenting to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards;
- c. Making a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment;
- d. Concealing the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service;
- e. Willfully collecting or attempting to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payor to which the provider is a party

This is a criminal statute, punishable as a Class C felony, and is applicable to claims presented to any "health care payer" as defined in the law (not just to federal and state health care programs).

Fraudulent Practices, RCW § 74.09.210 – 220

This law imposes civil liability on those who obtain or attempt to obtain benefits or payments from the state of Washington in an amount greater than the person or entity is entitled, by means of willful false statements, willful misrepresentation of any material facts, or any fraudulent scheme (including billing for items or services not provided, misrepresenting the items billed, or billing for purportedly covered items, which were in fact not covered). Penalties include repayment of amounts wrongfully obtained plus interest, and possible civil penalties of up to three (3) times the amount of excess payments received.

False Statements, RCW § 74.09.230

This law makes it a crime to:

- a. Knowingly make or cause to be made any false statement or representation of material fact in any application for payment under the state Medicaid program, or any other medical program authorized under the law;
- b. Knowingly make or cause to be made any false statement or representation of material fact for use in determining rights to such payment; or
- c. Knowingly falsify or conceal a material fact in connection with such application of payment, with the intent to fraudulently secure such payment either in a greater amount or quantity than is due or when no such payment is authorized.

Violations of this law are punishable as Class C felonies with up to five (5) years in prison and fines up to \$25,000.

Washington Anti-Kickback Law, RCW § 74.09.240(1) & (2)

Washington's Anti-Kickback Law applies to services or items payable by the Washington Medicaid program. Specifically, the law makes it a crime for any person to solicit or receive any remuneration directly or indirectly, overtly or covertly, in cash or in kind for (1) the referral of an individual to a person for furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by the Washington Medicaid program or other applicable law, or (2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made by the Washington Medicaid program or other applicable law. Violation of this law is punishable as a Class C felony with up to 5 years in prison and fines not to exceed \$25,000.

Washington Physician Self-Referral Law, § RCW 74.09.240(3)

Washington's physician self-referral law applies to "designated health services" payable by the Washington Medicaid program. Specifically, the law provides that, unless an exception to the federal Stark Law applies, a physician is prohibited from referring any Washington Medicaid beneficiary to receive any of the designated health services enumerated in law to an entity in which the physician or an immediately family member of the physician has a financial relationship.

Washington Physician Self-Referral Law, § RCW 74.09.240(3) (continued)

Those designated health services include:

- a. Clinical laboratory services;
- b. Physical therapy services;
- c. Occupational therapy services;
- d. Radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;
- e. Durable medical equipment and supplies;
- i. Parenteral and enteral nutrients equipment and supplies;
- j. Prosthetics, orthotics, and prosthetic devises;
- k. Home health services;
- l. Outpatient prescription drugs;
- m. Inpatient and outpatient hospital services;
- n. Radiation therapy services and supplies

Concerning Excessive Charges for Medicaid Services and Inappropriate Gifts, RCW § 74.09.260

This law imposes criminal penalties for:

- a. Knowingly charging for services provided to a patient under any medical care plan authorized by the Washington Medicaid program or other applicable laws at a rate exceeding the rates established by the Department of Social and Health Services; and
- b. Charging, soliciting, accepting or receiving any remuneration (other than a charitable contribution) as a precondition of admitting a patient to a hospital or nursing facility, or as a requirement for the patient's continued stay in such facility.

Violation of this law is punishable as a Class C felony with up to five (5) years in prison and fines not to exceed \$25,000.

Washington Anti-Rebate Law, RCW § 19.68.010

This criminal statute prohibits the payment of an unearned discount or profit by means of a credit to a person licensed by the state to practice medicine and surgery, drugless treatment in any form, dentistry, or pharmacy for:

- a. The furnishing of medical diagnosis, treatment or service;
- b. The sale, rental furnishing of clinical laboratory supplies, or services of any kind;
- c. Drugs, medication, or medical supplies; or
- d. Any other goods, services, or supplies prescribed for medical diagnosis, care or treatment.

Washington Anti-Rebate Law, RCW § 19.68.010 (continued)

There are two (2) exceptions to this law. First, it is not illegal to own an entity that furnishes any clinical laboratory or other services for medical, surgical or dental diagnosis so long as the practitioner discloses his or her financial interest and provides a list of alternative providers. Second, the law is not intended to prohibit two (2) or more licensed practitioners who practice as copartners to charge or collect compensation for any professional services rendered by any member, or to prohibit a licensed practitioner who employs another licensee to charge or collect compensation for professional services rendered by the employee.

Violations can result in a misdemeanor conviction, and violations of the anti-rebate law are deemed "unprofessional conduct" for practitioner licensing purposes.

C. Alaska State Laws

Medical Assistance Fraud, Alaska Stat. §§ 47.05.210 – 290

The Alaska Medical Assistance Fraud Law prohibits a person from:

- a. Knowingly submitting a claim to a program run by the Alaska Department of Health and Social Services (including Alaska Medicaid) for a benefit that the claimant is not entitled to;
- b. Knowingly preparing or assisting another person in preparing a claim for submission to a program run by the Alaska Department of Health and Social Services (including Alaska Medicaid) for a benefit the claimant is not entitled to;
- c. Offering, soliciting, conferring, or agreeing to accept a benefit to refer a beneficiary of a program run by the Alaska Department of Health and Social Services (including Alaska Medicaid) to a health care provider or for providing a health care to a Medicaid recipient if the benefit is in addition to payment by a medical assistance agency;
- d. Not producing records required to be kept by state or federal law or regulations regarding claims submitted to the Alaska Department of Health and Social Services to a person authorized to request the records; or
- e. Knowingly destroying, concealing, removing, impairing, or falsely altering a record required to be kept by state or federal law or regulations regarding claims submitted to the Alaska Department of Health and Social Services.

Depending on the severity, violations of the Medical Assistance Fraud Law are punishable as a Class A misdemeanor or Class B or C felony. In addition, a licensed provider can be subject to civil penalties of between \$100 and \$25,000 per violation of the Law and exclusion from the Alaska Medicaid Program for up to ten (10) years.

Alaska also requires that Medicaid providers conduct biennial audits of Medicaid claims and report any overpayment within ten (10) business days after identification. Failure to audit or to report can result in civil monetary penalties of between \$100 and \$25,000 per violation.

Alaska Medical Assistance False Claim and Reporting Act, Alaska Stat.
§§ 09.58.010 – 110

The Alaska Medical Assistance False Claim and Reporting Act makes it illegal for a Medicaid provider or recipient to:

- a. Knowingly submit, authorize, or cause to be submitted to an officer or employee of the State a false or fraudulent claim for payment or approval under the Medicaid program;
- b. Knowingly make, use or cause to be made or used, directly or indirectly, a false record or statement to get a false or fraudulent claim for paid or approved by the State under the Medicaid program;
- c. Conspire to defraud the State by getting a false or fraudulent claim paid or approved under the Medicaid program;
- d. Knowingly make, use, or cause to be made or used, a false record or statement to conceal, avoid, increase, or decrease an obligation to pay or transmit money or property to the Medicaid program; or
- e. Knowingly enter into an agreement, contract, or understanding with an officer or employee of the state for approval or payment of a claim under the Medicaid program knowing that the information in the agreement, contract, or understating is false or fraudulent.

Violating the Alaska Medical Assistance False Claim and Reporting Act is a criminal offense and allows for civil monetary penalties of \$5,500 to \$11,000 for each false claim submitted to Alaska Medicaid, treble (three (3) times) damages, and reasonable attorney's fees and costs. No punitive damages may be awarded for a violation.

The Alaska Medical Assistance False Claim and Reporting Act also provides certain whistleblower protections for employees of providers who are alleged to have violated the Act. Specifically, it provides that an employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of their employment because of lawful acts done by the employee in furtherance of an action under the Alaska Medical Assistance False Claim and Reporting Act, including assisting in an investigation, initiation of a claim, and testimony for assistance in an action filed or to be filed under the Act, is entitled to not more than \$10,000, potential punitive damages, and other appropriate relief granted by the court.



In support of our commitment to integrity and honesty, PeaceHealth requires every caregiver to follow our policies and procedures, professional standards, and legal requirements. They represent expectations about our conduct and encourage us to do the right thing. They protect PeaceHealth and our patients, and you — our caregivers— and demonstrate our commitment to the highest ethical standards and to each other.

TO REPORT A CONCERN OR COMPLIANCE ISSUE:

We encourage all caregivers to contact us with compliance concerns using any of the following methods:

By phone via the Integrity Line: 877-261-8031

Online using the “REPORT INCIDENT” link on the right side of the Crossroads banner

Additional contact information available in the “Resources” section (**Page 41**) of our Code of Conduct

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