



13.3 PHI Air Medical Compliance Plan

A. Overview and Goal of the Air Medical Group Compliance Plan

The Goal of this Plan:

The goal of this Compliance Plan (“the Plan”) is to ensure that all employees of **PHI Air Medical** (a Subsidiary of PHI, Inc.) adhere to all applicable Medicare, Medicaid, and any other federally funded health care (for ease of reference, collectively referred to as “Medicare”) laws, rules and policies relating to the submission of claims for ambulance services, and the general operation of an air ambulance service.

The key to avoiding claims of fraud or abusive billing practices is to *prevent* the potential for fraud and/or non-compliance in the first place, and to have a system in place that promotes early detection of potentially non-compliant practices. That is the purpose of this Compliance Plan...to prevent and detect problems before they evolve into a government investigation or lawsuit.

This includes, among other things, ensuring proper documentation of services, billing, coding, and claims submission, and the prevention, prompt detection, and appropriate action steps for health care fraud and abuse. Other purposes of the Plan are to:

- Outline and emphasize the organizational commitment to accurate and lawful documentation and submission of all claims for ambulance service to Medicare and other third party payors;
- Promote the prevention, detection and resolution of instances of conduct that is not in conformance with applicable federal or state laws, rules and regulations;
- Minimize, through early detection and reporting, any potential loss to the government from erroneous claims, as well as reduce PHI Air Medical’s potential exposure to damages, and/or civil or criminal penalties that might result from questionable activities.



Importance of Adherence to This Plan:

The Plan, having been approved by PHI Inc. officials, is our formal Medicare and third party payor policy as to our approach to billing and compliance. PHI Air Medical's staff members who fail to comply with the elements of this Plan may face disciplinary action including reprimand, suspension without pay, termination, or even civil and/or criminal charges.

PHI Air Medical has always strived to maintain a good faith effort to comply with all applicable regulations and laws. PHI Air Medical has determined that it would be best to organize, centralize, and formalize procedures and implement a voluntary compliance plan, referring to existing guidance from the U.S. Department of Health and Human Services, Office of Inspector General ("OIG"), and to existing compliance policies, and procedures. We expect all staff members to be fully supportive of this effort.

PHI Air Medical is committed to proactive management of its billing submission processes to ensure full compliance with Medicare and other government regulations. The policies and procedures described in this document apply to all staff members of PHI Air Medical (including officers, employees, and volunteers) as well as all vendors who do business or have a contractual relationship with PHI Air Medical and are involved in delivering and/or billing for healthcare goods and services ("Vendors"). It is the intention of PHI Air Medical to enforce all policies and procedures, most importantly those that are designed to prevent and detect issues of noncompliance, so that all reasonable steps necessary are enacted to facilitate full compliance with the law.

PHI Air Medical has an important relationship with Golden Hour Data Systems, Inc. who provides a number of critical services to PHI Air Medical as an independent contractor including data management, integrated electronic charting *and communications dispatch software management system*. Golden Hour Data Systems, like PHI Air Medical, is committed to complying with all applicable regulations and laws, and has its own Compliance Program and Employee Code of Conduct. PHI Air Medical strives to work cooperatively on compliance issues with Golden Hour Data Systems. At times employees of Golden Hour Data Systems may offer support and educational programs to PHI Air Medical employees on key issues that have significant compliance implications, including medical and demographical documentation. While employees of PHI Air Medical are encouraged to work with Golden Hour Data Systems employees to the greatest extent possible in assisting them in all areas of compliance, their primary responsibility is to PHI Air Medical. Should any inconsistencies or conflicts occur with respect to the compliance policies of the respective organizations, PHI Air Medical employees should follow the policies established by PHI Air Medical, and any inconsistencies or conflicts found should be reported to the PHI Air Medical Compliance Officer immediately. Once so notified, the PHI Air Medical Compliance Officer will collaborate with the Compliance Officer for Golden Hour Data Systems in an attempt to resolve any differences.



Contacting the Compliance Officer:

PHI Air Medical's Compliance Officer should be contacted when questions on compliance arise or to report potential violations or any concerns regarding compliance. To the fullest extent possible, all communication to the Compliance Officer will be treated confidentially. We also encourage the voluntary reporting of potential compliance issues. To this end and to encourage an open atmosphere of support for this Plan, there will be no adverse action or retaliation against any staff member who makes a good faith report of a compliance concern. Reports can be made to the Compliance Officer anonymously whenever possible through the use of the Compliance Hotline established for this purpose.

Plan Summary:

The federal government has set forth seven elements necessary for an "effective" compliance program for ambulance services in its "Compliance Program Guidance for Ambulance Suppliers" originally published by the OIG on March 24, 2003. These guidelines describe that an effective program to prevent and detect violations of law means a program that has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct. This Plan adheres to the seven elements set forth by the OIG.

Failure to prevent or detect an offense does not necessarily mean that the program was not effective. The hallmark of our program to prevent and detect violations of law is that PHI Air Medical will exercise "due diligence" in seeking to prevent and detect criminal conduct by its staff members and other agents. Due diligence requires, at a minimum, that we adhere to the steps established in our organizational compliance program as set forth in this Plan.



B. Compliance Plan Components

1. Development of Compliance Standards, Policies and Procedures

PHI Air Medical has established compliance standards and procedures to be followed by its staff members and others with whom we are associated in order to reduce the possibility of criminal conduct. This includes written standards of conduct, as well as written policies and procedures that reflect PHI Air Medical's commitment to compliance and to address specific areas of potential fraud and abuse. These written policies and procedures will be reviewed periodically (at least annually) and revised when necessary to ensure they are current and relevant to our operation.

a. Documentation

All efforts to comply with applicable statutes and regulations must be documented. This includes documentation of the following compliance related activities:

- Distribution and review of the Code of Conduct to existing and incoming staff members;
- Staff compliance training;
- Log sheets and other documents that show tracking of compliance incidents and inquiries and the disposition of each incident or inquiry;
- Method for staff members to provide confidential reporting of perceived compliance issues;
- Evidence that periodic internal auditing of billing activities takes place, including: baseline reviews, pre-billing reviews, and periodic post-claim submission reviews; and
- Any inquiries of third party payors or Medicare Administrative Contractors ("MACs") and the outcome of these inquiries.



b. Guiding Principles

The following guiding principles shall guide the conduct of all PHI Air Medical staff members. In conjunction with the more detailed Code of Conduct, all staff members are expected to adhere to these guiding principles. These principles affirm PHI Air Medical's policy of conducting its patient transportation operations in accordance with both the law and the highest ethical standards.

- PHI Air Medical requires its staff to function in compliance with all applicable laws and regulations. When the application of a law or regulation is uncertain, the guidance and advice of PHI Air Medical's Compliance Officer will be sought.
- PHI Air Medical is committed to the highest quality of patient care, patient care documentation, data and claim submission, and reimbursement practices measured by accuracy, reliability, timeliness, and validity.
- PHI Air Medical's policy is to maintain proper contacts with governmental officials and other government personnel, whether directly or indirectly, as proper business relationships. These contacts must never suggest undue influence upon these officials, or cast any doubt on PHI Air Medical's integrity. Furthermore, PHI Air Medical is committed to ensuring the accuracy of all filings with the government, including claims and supporting documentation to obtain reimbursement.
- PHI Air Medical maintains accurate and reliable patient and other related records that appropriately document the actual services provided and properly disclose all disbursements and other transactions to which PHI Air Medical is a party.
- PHI Air Medical requires the undivided loyalty of its staff members and other agents when they exercise their respective responsibilities. Except as may be approved otherwise by PHI Air Medical, personal investments, acceptance of gifts, or other activities that may create, or give the appearance of a conflict of interest are to be avoided. Any questions concerning conflicts of interest should be directed to the Compliance Officer.

c. Compliance Standards and Procedures

PHI Air Medical has complete confidence in the integrity and ethical conduct of its staff members. To fortify existing conduct, PHI Air Medical has adopted a "Code of Conduct" to assist all staff members in avoiding both the appearance and commission of improper activities. The Code of Conduct is a "guidepost" to be used to help assure that all applicable laws and regulations are understood and followed by all personnel.



The Code of Conduct will be distributed to all staff members. All staff members will be required to certify that they have read, and fully understand, the Code of Conduct. Staff members' certifications will be kept on file in a secure location as directed by the Compliance Officer. Furthermore, adherence to the principles of this Plan, and the ethical and legal requirements established by PHI Air Medical, will be an element in evaluating the performance of all staff members.

PHI Air Medical is committed to conducting its operations in a lawful and ethical manner. PHI Air Medical staff members and contractors are required to comply with all applicable laws, regulations, and policies affecting the operations of PHI Air Medical's operations. There are specific compliance areas that relate to operations and billing that we all must follow. Some of these areas include the following:

- Following proper call intake and following dispatch procedures.
- Providing services to the extent necessary for the treatment of the patient;
- Billing for items or services only when they are properly documented;
- Proper documentation of "No transport" calls and calls where there was actual pronouncement of death at the scene;
- Proper documentation and claim submission for transports where there is more than one patient in the ambulance;
- Proper documentation of any ambulances involved in the treatment of the patient;
- Where applicable, proper procedures for the restocking of supplies and drugs used in connection with patients transported to hospitals or other emergency receiving facilities;
- Monitoring and oversight of PHI Air Medical's Patient Financial Services (PFS) that performs coding and billing to ensure that coding is conducted properly, there is proper use of billing modifiers, and billing for services occurs only when there is proper documentation of the service provided, and ensuring that all necessary documentation (call intake records, dispatch records, patient care report, etc.) are available at the time of the preparation of the claim for submission;
- Monitoring and oversight of PFS to ensure that there is no inappropriate balance billing in violation of any applicable mandatory assignment rules;



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- Avoiding establishing a charge policy that results in billing Medicare an amount “substantially in excess” of the usual charges for services in accordance with regulations;
- Monitoring and oversight of PFS to ensure proper and prompt reporting of overpayments received for claims that have been submitted for reimbursement;
- Ensuring that overpayments are appropriately repaid in a timely basis;
- Applying proper safeguards for the security and protection of confidential patient information;
- Providing physical and technical integrity of all computer systems and data entry devices including those provided by a Vendor;
- Ensuring that computer software programs that have certain “defaults” are turned off or carefully monitored to avoid inaccurate claim submission (Example: a software default that permits personnel to enter data in fields indicating services were rendered though not actually performed or documented, or a default that automatically indicates the patient was more seriously injured than they were);
- Ensuring that all personnel maintain the confidentiality of patient information and patient records in accordance with the HIPAA Privacy Regulations and state law;
- Ensuring the security of provider identification numbers (such as a service’s Medicare provider number and patient identification numbers) and preventing misuse of identification numbers which can result in improper billing;
- Ensuring there is a process in place to avoid duplicate billing;
- Ensuring that there is a process in place to prevent the payment of incentives or anything else of value in return for influencing the referral of ambulance services to PHI Air Medical in violation of the federal anti-kickback statute (AKS) or other similar Federal or State statute or regulation;
- Ensuring that only appropriate and fair market value payments are made to assisting agencies who provide services but who also are in a position to influence the selection of the transporting entity;
- Making only appropriate arrangements with hospitals and nursing facilities, including contracts with facilities to provide medical transportation based on the fair market value of the services provided;



- Establishing properly constructed joint ventures with other ambulance services and providers;
- Making sure that arrangements with patients do not or cannot be inferred to improperly cause a patient to choose a particular ambulance service (Example: providing any other “free” service to patients or other healthcare providers who chose PHI Air Medical over XYZ Ambulance for their billable ambulance trips);
- Monitoring and oversight of PFS to ensure proper collection of any co-payments and deductibles that the patient is normally required to pay, unless permitted by properly structured ambulance membership/subscription programs or municipal contracts, or the patient is determined to meet financial hardship criteria;
- Properly amending and correcting Patient Care Reports (PCRs) and other documents so that there is no misrepresentation of any information contained in the documentation;
- Employing or contracting only with individuals or other entities that have not been excluded from participation in federal health care programs under the Office of Inspector General’s exclusionary authority.

The Compliance Officer should be consulted if questions arise or to report a potential violation or any compliance concern relating to any of these key areas.

d. New Standards and Procedures

In addition to its pre-existing policies and procedures, PHI Air Medical has created specific policies and procedures which, in part, are designed to ensure compliance with all Medicare regulations and policies established by the Medicare contractor, or other insurance company to which ambulance claims for reimbursement will be submitted. These policies are developed for each key area of responsibility, such as dispatch, operations, and billing. The requirements applicable to the Medicare program may also be applicable to services furnished to patients covered by other federal and state health care programs such as Medicaid as well as private insurance, unless these requirements are outlined in a separate regulation or payor policy.



e. Documentation Practices

The Patient Care Report (“PCR”) is the foundation for documenting the services provided to patients and performed by PHI Air Medical staff in the field. The PCR forms the basis for the submission of claims for reimbursement. It is essentially the “official record” of all care provided. As such, the PCR has significant patient care, billing, and liability ramifications.

The purpose of a PCR is to provide the reader with an accurate “picture” of the continuum of care provided to the patient, from the arrival of the first responders to the transfer of care to the hospital staff. In a lawsuit, the PCR becomes the provider’s “substituted memory.” Most liability lawsuits end up in trial years after the alleged harm to the patient occurred, at which point caregivers may have trouble remembering what actually occurred.

If our staff are to be seen as knowledgeable and credible witnesses before a jury, they need a complete and accurate record of what they found on scene and what they did; hence the need for an accurate and concise PCR. Sloppy, incomplete and poorly constructed patient documentation reflects unfavorably on the individual nurse or paramedic and on the ambulance service itself. Poor documentation also may be used against providers in a lawsuit or federal investigation.

Now more than ever, we must be vigilant in our documentation efforts at PHI Air Medical. There are a number of ways in which PHI Air Medical staff may now find themselves in court or at an administrative hearing trying to justify their services. Previously most providers had to worry about negligence cases---the law of negligence comes into play when a patient sues a service for the care that was provided (or not provided). Now, however, the recent focus on anti-fraud and abuse laws make documentation a concern outside of the traditional patient care areas. MACs, CMS, and the Office of the Inspector General (OIG) are more closely scrutinizing patient care documentation for false statements, inconsistent information, and other inaccuracies that may lead to a federal False Claims Act (FCA) action, other criminal prosecution, or civil sanctions.

i. Documentation to Prevent False Claims Act Violations

Overview of FCA. A very significant area of documentation that does not always relate directly to patient care deals with the federal False Claims Act (FCA), as well as similar state false claims laws. The Federal False Claims Act (“FCA”) prohibits anyone from knowingly presenting, or causing to be presented, a false or fraudulent claim in order to secure payment from the federal government. A person found to have violated this statute is liable of not less than \$5,500 and not more than \$11,000 for each claim, plus three times the amount of damages sustained by the federal government. The False Claims Act defines “knowing” and “knowingly” as: actual knowledge; deliberate ignorance of the truth; or, reckless disregard of the truth or falsity. Therefore, no proof of specific intent to defraud is required to demonstrate a violation of this Act.



The False Claims Act was recently amended to address situations where the claim was not known to be false at the time it was filed, but the claimant subsequently determines that it was not entitled to payment in the amount received after the fact. The revised False Claims Act makes knowing retention of an overpayment grounds for a violation. In other words, if a provider has no reason to believe that a claim is false at the time it is submitted, but later determines after receiving payment that the claim was legally deficient (e.g., the provider's state license had unknowingly lapsed temporarily), knowing retention of the payment would constitute grounds for the government, or a whistleblower, to allege a violation of the FCA.

The FCA helps the federal government combat fraud and recover losses resulting from fraud in federal programs, purchases, or contracts. A person or entity may violate the FCA by knowingly: (1) submitting a false claim for payment, (2) making or using a false record or statement to obtain payment for a false claim, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the U.S. Government (the "Government").

Qui Tam and Whistleblower Provisions. An individual also has the right to file a civil suit for him or herself and for the government to challenge a FCA violation. The suit must be filed in the name of the government. Such an individual is called a *qui tam* plaintiff or "relator". Successful relators may receive between 15 and 30 percent of the total amount recovered (plus reasonable costs and attorney fees) depending on the involvement of the relator and whether the government prosecuted the case. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

The FCA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination are entitled to all relief necessary to be made whole, including two times their back pay plus interest, reinstatement at the seniority level they would have had except for the discrimination, and compensation for any costs or damages they have incurred.

Administrative Remedies. Federal law also provides administrative remedies against any person who makes, or causes someone else to make, a false claim or a false statement, in the amount of \$5,000 for each false claim or statement. A "false claim" (for purposes of the civil remedies) is defined as a claim that the person knows or has reason to know: is false; includes or is supported by any written statement which asserts a material fact which is false; includes or is supported by any written statement that omits a material fact; is false as a result of such omission; and is a statement in which the person making 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). A "false statement" is defined as a statement that the person knows or has reason to know: asserts a material fact which is false; or omits a material fact that makes the statement false.



State False Claims Acts. Many states in which PHI Air Medical does business also have state false claims acts that prohibit anyone from knowingly presenting, or causing to be presented, a false or fraudulent claim in order to secure payment from local and/or state government. Many of these state false claims acts are similar to the federal FCA and provide for lawsuits either by the government or a qui tam plaintiff (or “relator”). Many of these laws also include whistleblower protections similar to the federal FCA. A summary of the relevant provisions of the state FCAs in some of the states in which PHI Air Medical conducts business is found at Attachment 1 to this Plan.

Implications for Documentation. The significant risks of criminal and civil action, as well as the automatic exclusion from the Medicare program that goes with a FCA conviction (as well as certain convictions under other federal laws), make it critically important to reconcile the documentation in the field with the information submitted to Medicare or any other insurance company. In other words, it is necessary to make sure that any inconsistencies are reviewed and that only completely accurate and truthful information is relied on when determining whether a claim should be submitted for reimbursement to Medicare, Medicaid or other insurers.

The process of documentation should be “seamless” throughout the organization. All field, administrative and billing contractors must understand the procedures and work together to ensure that all documentation from the call intake forms, to the PCR to the completed billing claims, are consistent and contain only accurate information.

Both management and field personnel need to be sensitive about their approaches to documentation in the current legal environment. For example, it would be improper for management to require or suggest that crews always document that a patient was “carried to the stretcher” -- even if they walked -- for the purpose of enabling a claim to meet medical necessity requirements.

Management will instead conduct training and continuing education sessions on documentation in which crews are instructed – and reinforced – to document all patient conditions as they are encountered, accurately and without regard to whether or not the claim might be paid. Of course, it is by all means appropriate for management to expect that those conditions supporting medical necessity will be completely and accurately documented both for patient care *and* for payment purposes.

Field personnel should likewise maintain a commitment to ethics, honesty and integrity in their approach to documentation. Just as it would be improper for management to ask crew members to falsify or exaggerate your documentation, so to would it be improper for crew members to engage in such activity, whether at management’s request or of the individual crew member’s own actions. Management has a right to expect staff members to document in a way that facilitates not only effective patient care but maximizes billing opportunities, as long as the



documentation truly and accurately reflects the patient's condition without improper embellishment.

PHI Air Medical shall strive to keep accurate records of all documentation training and continuing education sessions attended by their personnel. Copies of the curriculum and the instructional materials should be maintained to demonstrate the company's efforts in properly educating their personnel on proper documentation principles and practices.

ii. Correcting Deficiencies in a PCR

The False Claims Act raises concerns with respect to what documentation is included in a PCR, and what can be done to make changes or additions at a later date without the appearance of the documentation being constructed to enhance the likelihood of obtaining reimbursement from Medicare or other payors. Common misconceptions have emerged about documentation. You may make changes to a PCR as long as the late entries (addendums in the Golden Hour software) or changes are clearly identified with the individual's initials and the date and time that the change or addition was made. The key is to make certain that any late entries or changes after the initial completion of the PCR do not look like they were done contemporaneously at the time you completed it. Specific procedures for this consistent with electronic charting have been established with Golden Hour Data Systems that clearly indicate the date and time of any subsequent additions, changes or corrections.

iii. Confidentiality in Documentation

The importance of confidentiality and protecting the integrity of a medical record, such as a PCR, cannot be overemphasized. Recently, new federal privacy regulations greatly limit our ability to use and disclose protected health information unless that information is needed for treatment of the patient, billing, or health care operations.

PHI Air Medical field personnel and billing personnel need to understand the critical importance of not showing or releasing PCRs and other documentation or information they contain to others who are not authorized to receive the information. Legal claims involving "invasion of privacy" as well as violations of the federal privacy regulations can arise when we do not treat medical records and reports with the highest degree of respect.

iv. "Best Practices" in Documentation

When looking at a PCR, outsiders such as the Medicare carrier, a judge or a jury will expect the records to be similar in quality to that of other similarly situated ambulance service providers, and that the records will contain the information necessary to support the claim for



reimbursement. To this end, they will ask questions that reflect the following “best practices” in documentation:

- Is the PCR concise, yet thorough? An incomplete PCR can destroy a good defense case and make the provider look incompetent. If the PCR is too long and does not create a clear picture of the continuum of care, it may be confusing. Incomplete PCRs that do not provide enough information for billing personnel to determine the appropriate charge for services and to properly apply the appropriate charge codes are not acceptable.
- Is the PCR factual and objective? The report should not contain the provider’s opinions or beliefs, but should instead be an unbiased description of events and observations and be as objective as possible.
- Are the correct terminology, spelling and abbreviations used? Nothing looks worse than a poorly completed PCR with misspellings and bad grammar. The presence of such a report is a sure way for the service to lose credibility with an outside observer. The document should include recognized abbreviations that all professionals in the course of the patient’s experience will understand. Slang EMS abbreviations should be avoided and a standardized set of abbreviations used whenever possible.
- Is the PCR organized and legible? A good PCR follows a systematic approach that puts the most critical information “up front” and documents care chronologically. Make sure the document is legible. If the narratives are not being typed or inputted into a reporting program, they should at least be neat and readable.
- Is the PCR complete and accurate? False or purposely misleading information should never be included in a PCR. All sections of the document must be completed in their entirety.
- Are appropriate items included that are necessary for proper billing for services? A number of items should be included as part of the PCR documentation for purposes of billing. For example:
 - The PCR should indicate which agency ordered air ambulance, the circumstances surrounding the request and the patient’s reported condition at the time of dispatch and transport.

All assessments and treatment performed on the patient should be documented.

- The circumstances supporting the medical necessity and appropriateness of air ambulance transport should be documented. For inter-facility transports, this should include, if applicable, a properly completed Reason For Transport



(RFT) and EMTALA certification by the ordering physician (as applicable-ED transports, L&D, higher level of care)

- The zip code of the point of pickup of the patient is essential for billing to determine the proper mileage rate and the payor to which the claim should be submitted.
- The exact trip mileage should be indicated for the period when the patient is loaded and transported. There is a specific policy on how this information shall be obtained with the assistance of the pilot in command, including documentation of any additional mileage resulting from an unavoidable deviation from a straight-line route.
- All medications given to the patient should be documented clearly, including the route of administration, dosage, and timing of the dosage as this documentation is not only essential for patient care purposes, but also for determining medical necessity.

When PHI Air Medical operates a ground transport service, different documentation considerations apply. These include the following:

- If there was an emergency response, documentation should include the condition of the patient as reported at the time of dispatch, whether an advanced life support assessment was performed by a paramedic crew, the name(s) of the paramedics who performed the assessment and the agency they represent.
- If it is a non-emergency transport, areas to document include: whether the patient was bed-confined at the time of the transport, whether the patient had a medical condition that required ambulance transportation, the method by which the patient was moved to the stretcher, whether restraints or other immobilization devices were used, whether continuous oxygen was needed, and whether a properly completed Physician Certification Statement (PCS) has been obtained by dispatch or the ambulance crew. In sum, extensive documentation must be included on all non-emergency transports so that the following question can be answered: *Why were other means of transportation, such as a car, taxi, or wheelchair van contraindicated for this patient?*



2. Designation of the Compliance Officer and Other Oversight Responsibilities

Specific individual(s) with high-level authority within PHI Air Medical have been assigned overall responsibility to oversee compliance with such standards and procedures. PHI Air Medical has designated a Compliance Officer charged with the responsibility for operating and monitoring the organization's compliance program. PHI Air Medical will use due care not to delegate substantial authority to individuals who may have the propensity to engage in illegal activities.

a. Compliance Officer

PHI Air Medical has appointed a Compliance Officer, who is responsible for overseeing implementation of this Plan, making recommendations to senior management regarding changes to enhance compliance, updating the Compliance Plan, and serving as liaison to Vendors and those served by PHI Air Medical on issues related to compliance. The Compliance Officer has the following specific responsibilities:

- Develop compliance policies and standards;
- Oversee/monitor implementation of compliance activities;
- Report on a regular basis to PHI Air Medical, L.L.C. senior management and/or PHI Air Medical, L.L.C. Board of Directors;
- Report on an annual basis to PHI, Inc. Board of Directors;
- Assist in developing methods for reducing the company's vulnerability to fraud, abuse, and waste;
- Periodically revise the Plan to reflect changes in practice, or in the laws and policies of government and private payor health plans;
- Develop, coordinate, and/or conduct educational activities and other methods of communication that focus on elements of the Plan and the specific risk areas identified in the Plan, e.g., training for staff members regarding appropriate documentation and medical necessity of transports;



- Ensure that all staff members have read the Code of Conduct and sign a statement acknowledging their understanding of its requirements;
- Seek to assist provider clients in ensuring that all relevant staff members and management are knowledgeable about and comply with relevant federal and state standards;
- Work with individuals responsible for personnel decisions to ensure that appropriate credentials and references are checked for all staff members;
- Conduct or assist in the conducting of appropriate internal compliance reviews and audits;
- Develop policies that encourage reporting of suspected fraud and other improprieties without fear of retaliation;
- Independently investigate compliance problems and bring them to the attention of the PHI Air Medical senior management staff for appropriate response and disciplinary action if necessary; and
- Carry out and document corrective actions with approval of PHI Air Medical management.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities including, but not limited to, patient records, billing records, contracts, and records relating to marketing of the service, as well as the company's arrangements with other clients, including ambulance services, hospitals, independent contractors, Vendors, agents, etc.

It should be clearly understood that the Compliance Officer is not responsible for the organization's actual compliance with applicable laws, rules and regulations or for transacting business in conformity with the law. Rather, the Compliance Officer is responsible for ensuring that the organization has in place, at all times, an effective Compliance Program, and that the applicable policies, procedures and practices are sufficient for purposes of communicating, monitoring and effectively enforcing PHI Air Medical's ongoing commitment to compliance.



b. Compliance Oversight Committee

The PHI Air Medical Compliance Officer will appoint a Compliance Oversight Committee that will assist the Compliance Officer with education and oversight of compliance activities.

Other responsibilities of the Compliance Oversight Committee may include:

- Keep up to date on current issues and trends in the ambulance industry as well as regulatory activities of the federal government that may affect PHI Air Medical in its compliance initiatives;
- Review company policies to ensure that they are up to date and reflect the latest national industry standards and recommend to PHI Air Medical management revisions to existing policies and new policies that may be necessary in light of industry-wide changes in compliance standards;
- Review specific trends and issues identified by the Compliance Officer and other staff members and work with the Compliance Officer and others to spearhead necessary change in the overall compliance program; and
- Serve as the “watchdog” group on all corporate compliance issues and provide guidance to management on a regular basis to evaluate operational and administrative changes in procedures that could impact on the overall compliance program.

Due to the potential seriousness of compliance issues that may be violations of the law and the negative consequences a violation may have on PHI Air Medical, both the Compliance Officer and the Compliance Committee will have direct access to the corporate officers of PHI Inc. The Compliance Officer will also have the authority to deal directly with operational managers on any compliance issue and will have an “open door” to all staff members of PHI Air Medical with respect to any compliance concerns that any individual in the organization may wish to report or discuss.



3. Development of Education and Training Programs

PHI Air Medical will take all necessary steps to communicate effectively its standards and procedures to all staff members and other agents, e.g., by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required of them to avoid compliance issues. Our training content will be tailored appropriately and will be delivered in a way that will maximize the likelihood that the information will be understood by all staff members.

a. Overview of Compliance Training Programs

PHI Air Medical believes that continuing education for its staff members and agents promotes professional excellence and regulatory compliance. Coding proficiencies require that billing staff (or the staff of billing agency contracted by PHI Air Medical) enroll in continuing education where necessary.

In addition to professional training, the Compliance Officer will ensure that PHI Air Medical employees are afforded regular training and educational programs about regulatory compliance issues. Likewise, PHI Air Medical billing contractors are expected to participate in such programs and to educate themselves regarding compliance issues as a condition of working in the claims submission field and failure to do so may result in disciplinary action, including termination. Compliance training may include lectures, videos and interactive sessions. It may be conducted by PHI Air Medical personnel, outside trainers and lecturers, or a combination of both.

Staff members participating in training will complete a post-compliance training test to verify comprehension of the material presented.

b. Core Content of Our Compliance Training Program

Compliance-related education programs will, at a minimum, include:

- An overview of federal and state fraud and abuse laws and regulations, coding requirements, documentation requirements, and market practices that reflect current legal and program standards.
- How the Plan operates and the significance of this Plan; and
- The role of each PHI Air Medical staff member and agent in adhering to this Plan.



Training will be geared to level of responsibility and job function. Training for patient care providers will focus on patient care reports and other record documentation. Training for management will include oversight and interaction with the outsourced billing company. Specific appropriate training topics should include, among other things:

- Government and private payor reimbursement principles and policies;
- General prohibitions on false claims, self-referrals, and the payment or receipt of remuneration (i.e., anything of value) to induce referrals;
- Proper confirmation of patient condition or interpretation of documentation submitted by the patient care staff;
- Proper completion of all documentation and the importance of not altering patient care reports after they have been submitted unless for routine demographic and other minor corrections that would be appropriate for billing staff to complete (e.g., adding a social security number that was missing, correcting an incorrect address, etc.); and
- Duty to report any billing concerns, improper procedures or any possible misconduct.

c. Compliance Officer's Role in Training

The Compliance Officer along with the Compliance Oversight Committee shall provide oversight for coordinating these training activities. PHI Air Medical staff members will be required to have a minimum number of educational hours per year, as an appropriate part of their organizational responsibilities.

The Compliance Officer also is responsible for maintaining or has access to a library of regulatory compliance-related information and training manuals. This should include coding references, MAC newsletters, Medicare manuals, federal regulations, CMS interpretations, and other relevant resource materials. This material will be maintained by the Compliance Officer. The Compliance Officer is also responsible for regularly disseminating new compliance information to PHI Air Medical staff members and agents.

The Compliance Officer is required to thoroughly document all educational activities. Appropriate documentation includes a record of dates, time, attendance, and agenda for all professional and compliance training sessions in which staff members participate. It also includes development of measurement tools (test or quiz) to verify comprehension of the compliance material by the training participants. Copies of materials disseminated at training sessions should also be maintained to the extent feasible.



4. Development of Internal Monitoring and Reviews

PHI Air Medical will take reasonable steps to achieve compliance with its standards by using monitoring and review systems reasonably designed to prevent and detect potentially criminal conduct by its staff members and other agents. This includes developing and using appropriate monitoring methods to detect and identify problems, and to help reduce the future likelihood of problems. Claims and system reviews are common internal monitoring methods that will be employed. Another key element of PHI Air Medical's Plan is our reporting system that staff members and others can use to report compliance issues and suspected criminal conduct by others within the organization without fear of retribution.

a. Coding and Billing Decisions

It is PHI Air Medical's policy that all claims submitted for reimbursement shall be accurate and based upon information provided by PHI Air Medical's staff members and other applicable sources, such as dispatch information and the patient's physician.

In order to ensure that this policy is implemented appropriately, PHI Air Medical has established procedures for the review and application of all existing criteria for determining appropriate billing practices. The Compliance Officer shall be responsible for assuring that regular reviews and updates of these policies take place and any changes are communicated to the appropriate personnel.

It is essential that all services that are provided by PHI Air Medical are submitted for reimbursement using the proper procedure codes, and the proper ICD-9 codes as appropriate. The Compliance Officer shall take necessary steps to review the standards and criteria which the billing contractor uses to make coding decisions and to assure that those standards and criteria are accurate. The Compliance Officer shall assure that PHI Air Medical has a procedure for the prompt and accurate answering of all of its staff member questions regarding coding decisions. Thereafter, reviews of coding procedures shall be repeated periodically by the Compliance Officer.

b. Illegal Remuneration and Prohibited Referrals

PHI Air Medical's reputation for quality service is due to the professional and ethical conduct of its staff members and other agents. All staff members should conduct themselves with personal integrity, good judgment and common sense. This includes avoiding violations of



Federal and state anti- kickback laws. These laws prohibit the offer, payment, solicitation, or receipt of anything of value in exchange for the referral of patients or business. In order to comply with these laws, PHI Air Medical employees

- Shall not offer or give to any person or entity, anything of material value if that person or entity is in a position to refer business to PHI Air Medical, except as permitted by law. The law permits, among other things, meals of moderate value in connection with customary face to face marketing activities, or promotional items of nominal value such as pens, pads, plastic cups, key chains, penlights, etc.
- Shall not solicit or receive any discounted or free services, supplies, or medications from any health care provider or Vendor seeking the referral of patients or business from PHI Air Medical, except as permitted by law.

The Compliance Officer or legal counsel should be consulted regarding legally permissible arrangements with sources or recipients of referrals.

c. Billing and Claims Submission

PHI Air Medical requires PFS to comply with all billing and claims submission requirements promulgated by federal, state, and other payors. For instance, PHI Air Medical must adhere to the following principles:

- Proper and timely documentation of all services provided to patients must be maintained to ensure that only accurate and properly documented services are billed;
- Under no circumstances may claims be submitted for services not provided or for a level of service that exceeds the level of service actually provided;
- Patient care reports, dispatch records, physician certification statements, medical and nursing notes, and other documentation used as a basis for a claim submission should be appropriately organized and in a legible form so they can be audited and reviewed;
- Levels of service, patient condition and procedures reported on claims for reimbursement should be based on the patient care report and other legitimate supporting documentation;

Among other things, PHI Air Medical requires PFS to follow the billing and coding rules issued by the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agencies, and the local MAC. PHI Air Medical recognizes its greatest role in this effort is in the accurate completion of Medical Records and supporting documents. To ensure compliance in this area,



PHI Air Medical regularly monitors and audits the coding decisions of the billing contractor and takes corrective action as necessary.

- While proper documentation is the responsibility of the ambulance transport supplier, the billing staff should be aware of proper documentation requirements and should encourage other health care providers to document their services appropriately.

d. Assessment of the Claims Submission Process

i. Information and Documentation on the Patient Care Report

The documentation in the Patient Care Report (PCR) must provide evidence that the patient's medical condition required air ambulance transportation and that no other means of transportation were appropriate for the patient. The PCR should include enough information to allow the billing staff to verify the appropriate level of service to bill.

Documentation on the PCR should provide a clear answer to the question: Why did the patient require air ambulance transportation at this particular time? Was the service requested by a physician? Was the service requested by a first responder, and if so, who? Patient care reports should be reviewed prior to bill submission to ensure that the trip is only billed for services that are considered covered services.

ii. Medical Necessity

Medically unnecessary transports have formed the basis for a number of Medicare and Medicaid fraud cases. Consequently, PHI Air Medical will devote considerable effort to ensure that all air ambulance services are provided only when medically necessary.

iii. Coding of the Claim

PHI Air Medical staff and its contractors should be extremely careful to bill at the appropriate level for services actually provided. The federal government has prosecuted a number of ambulance cases involving "upcoding," where claims are billed at a higher level than what was justified by the services actually performed. Compliance activities will focus on ensuring that the likelihood of inadvertent or intentional upcoding is minimized.



iv. Copayment Collection Procedures

PHI Air Medical and its contractors will follow all regulations and payor policies with respect to collection of copayment amounts from Medicare and other patients. Regular follow up procedures will be used to ensure that a patient's coinsurance is properly billed and that "waiver" of any co-payments is approved only in limited circumstances, such as in bona fide financial hardship cases, or in the case of an actuarially sound subscription or membership program.

v. Subsequent Payor Reimbursement

PHI Air Medical and its contractors will ensure that all payments received subsequent to initial receipt of reimbursement are proper. These payments will be properly credited to the patient account and any overpayments will be promptly refunded to the payor.

e. Integrity of Electronic or Computer Billing Systems

PHI Air Medical will establish procedures for verifying the integrity of its electronic or computer billing/data collection and storage systems and ensure that the third party billing agency has these procedures in place. This will include procedures for regularly backing-up data (either by diskette, restricted system or tape) to ensure the accuracy of all data collected in connection with submission of claims and reporting of overpayments. At all times, PHI Air Medical will have a complete and accurate "audit trail" to track all incoming and outgoing claims information.

Additionally, PHI Air Medical will continually evaluate, develop and update systems to prevent the contamination of data by outside parties. This system will include regularly scheduled virus checks. Finally, PHI Air Medical will ensure that electronic data is protected against unauthorized access or disclosure. In order to ensure compliance in this area, PHI Air Medical staff and its contractor must adhere to security policies regarding patient information and use of electronic equipment. PHI Air Medical shall regularly monitor and audit the system for integrity and take corrective action as necessary.

f. Auditing and Monitoring

PHI Air Medical is committed to ensuring that this Plan is properly implemented through a system of periodic monitoring and auditing. PHI Air Medical shall take steps to assure that the coding, documentation, and medical necessity determination activities of its third party billing company are appropriate and that the billing company has in place effective auditing and monitoring systems. Such requirements shall be included in the service agreement with the billing company and shall include periodic reports obtained from the billing company.



While the Compliance Officer will be ultimately responsible for coordinating formal audits, the audits themselves may be performed by internal or external auditors with expertise in federal and state health care statutes, regulations and policies. The internal audits will be conducted by staff members of PHI Air Medical. PHI Air Medical will also have, at the discretion of the Compliance Officer or Compliance Committee, external audits by auditors independent of PHI Air Medical or any billing company that PHI Air Medical may use.

The purpose of the internal audits is to detect potential errors in coding, documentation and medical appropriateness. The external audits should be conducted to detect possible billing errors or fraud. The Compliance Officer shall be responsible for investigating incidents of systemic errors or reports of noncompliance. If indicated, the results of the audit process may be communicated to and discussed with legal counsel to determine whether corrective action or self reporting is required.

Who Should Conduct Audits and Reviews

The claim reviews will be conducted by individuals with experience in coding and billing and familiar with the different payors' coverage and reimbursement requirements for ambulance services. The reviewers will be independent and objective in their approach. Claim reviewers who analyze claims that they themselves prepared or supervised often lack sufficient independence to accurately evaluate the claims submissions process and the accuracy of individual claims.

The review/audit methodology may consist of various techniques, such as:

- On-site visits;
- Testing billing and coding staff or contractors on their knowledge of reimbursement and coverage criteria, e.g., presenting hypothetical scenarios of situations experienced in daily practice and assess responses;
- Unannounced mock surveys, audits and internal reviews;
- Examination of complaint logs;
- Checking personnel records to determine whether any individuals who have been reprimanded or sanctioned for compliance issues in the past are among those currently engaged in improper or potentially improper conduct;
- Interviews with personnel involved in management, operations, coding, claim development and submission and other related activities;



- Questionnaires developed to solicit impressions of a broad cross-section of the PHI Air Medical staff; and
- Reviews of written materials and documentation prepared by the different divisions of PHI Air Medical.

The reviewer(s) should:

- Possess the qualifications and experience necessary to adequately identify potential compliance issues;
- Be objective and independent of line management;
- Have access to existing audit and health care resources, relevant personnel and all relevant areas of operation;
- Present written evaluative reports on compliance activities to the PHI Air Medical Compliance Committee on a regular basis, but not less than annually; and
- Specifically identify areas where corrective actions are needed.

Periodic Review of Claims Denials

PHI Air Medical will conduct periodic “spot-check” audits at regular intervals to ensure ongoing coding accuracy, medical appropriateness and compliance with any new rule or regulation implemented since the previous audit. The periodic audits should focus on problems discovered in previous audits, including any baseline audit that may have been performed.

PHI Air Medical will review their claims denials periodically to determine if denial patterns exist. If a pattern of claims denials is detected, the pattern will be evaluated to determine the cause and appropriate course of action. Staff education regarding proper documentation, coding, or medical necessity may be appropriate. If the PHI Air Medical

billing contractor believes its payor is not adequately explaining the basis for its denials, PHI Air Medical will seek clarification in writing.

Periodic audits will be conducted in accordance with policies established and approved by the Compliance Officer and Compliance Committee. Significant variations should be investigated to determine the cause. If there is a legitimate explanation and no systemic error, the Compliance Officer may not need to take any corrective action. If the deviation is due to



improper procedures, misunderstanding of rules, potential fraud, or systemic problems, then prompt corrective action should be taken.

The Compliance Officer or auditors should also review whether the requirements of the compliance program are being followed. For instance, the review should determine whether the program standards have been adequately disseminated, whether appropriate training and education programs have been conducted, and whether the disciplinary process is working properly. The reviewers should also determine whether appropriate records are being kept and that other documentation requirements are being satisfied. Where it is determined that the Plan is not being followed, corrective action should be taken.

System Reviews and Safeguards

PHI Air Medical will conduct a risk analysis to evaluate internal and external factors that affect PHI Air Medical's operations from a compliance perspective. This risk analysis may include a review of internal systems and management issues, as well as the federal health care program requirements that govern PHI Air Medical's operations. This evaluation will form the basis for the creation and adoption of written policies and procedures to ensure compliance.

The evaluation process will provide a "snapshot" of PHI Air Medical's strengths and weaknesses and assist management in recognizing areas of potential risk. This system review will be conducted initially upon implementation of the compliance program and periodically as the governing body or the Compliance Officer may suggest. The review will provide a "risk analysis" to evaluate a variety of practices and factors and may be completed by legal counsel knowledgeable in ambulance industry compliance issues, or outside consultants. The risk analysis may include a review of PHI Air Medical's policies and procedures, employee training and education, employee knowledge and understanding, claims submission process, coding and billing, accounts receivable management, documentation practices, management structure, employee turnover, contractual arrangements, changes in reimbursement policies, and payor expectations.

g. Disclosure of Review Results

i. Internal Disclosure

The Compliance Officer will ensure that the findings of reviews/audits are reported to the management of PHI Air Medical, and in particular, the Compliance Committee. There are many occasions where there are no violations discovered, but there may be trends or areas for improvement that should be addressed internally. In these situations, there may be no need to report any findings externally to the MAC, other payors, or government agencies. This includes



isolated overpayments involving individual beneficiaries where the overpayment has been corrected by repayment to the carrier.

Review results should be kept confidential, accessible only by those with a need to know. The fact of the review should be documented in writing on an appropriate Self Audit Form, but particular details of the review may not necessarily be documented in writing.

ii. External Disclosure

If regular patterns of errors, significant overpayments are uncovered, or violations of the law are discovered, thus necessitating corrective action, the advice of legal counsel must be sought. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether PHI Air Medical has any affirmative duties to report the violations and/or make restitution to health care payors. In some cases, legal counsel may recommend procedures for notifying the MAC or in implementing the OIG's Self Disclosure Protocol.

h. Overpayments

“Overpayments” are Medicare funds that PHI Air Medical has received in excess of amounts due and payable to PHI Air Medical under the Medicare statute and regulations. In addition, it is a debt owed to the U.S. Government by PHI Air Medical. Overpayments occur for a variety of reasons that may include among other things: a claim paid in error by the carrier, inadvertent miscoding of a claim, mistake in submitting mileage, or a later determination that a claim for ambulance service was not medically necessary or was not to a destination covered by Medicare.

Under Section 6402 of the Patient Protection and Affordable Care Act, providers must now report and refund any overpayment within 60 days of the date the overpayment is "identified." Failure to do so could result in a False Claims Act violation, a civil monetary penalty, or other penalties.

As an agent for the federal government, MACs must attempt to recover overpayments through timely and aggressive efforts. These efforts include demands for repayment, offsets of benefits and establishment of repayment schedules.

PHI Air Medical will regularly review claims that have been paid by Medicare to verify that the amounts paid were proper and that no overpayment exists. When an overpayment does exist, PHI Air Medical will take all reasonable steps to promptly refund the full overpayment amount to the MAC, with an explanation as to why the overpayment may have occurred. Such repayment will in all cases be made within 60 days from the date the overpayment was identified. In no case will PHI Air Medical keep reimbursement that has improperly been paid to it by Medicare or any other federal health care program. The Compliance Officer will



periodically review the overpayment process to ensure that overpayments are adjudicated and request for refunds are sent to PHI for payment, and that trends or repetitive overpayments are corrected.

The Medicare program is also the “secondary payor” with respect to items and services furnished to Medicare patients for whom it is reasonably expected that payment will not be made promptly under: (a) the patient's automobile policy or plan, (b) another person's automobile policy or plan, (c) the patient's workers’ compensation policy or plan, or (d) a group health policy or plan in which the patient is enrolled, unless such group health policy or plan has less than 20 employees with employment status for 20 or more calendar weeks of the current or preceding year. Medicare may also make payment when one of the foregoing primary payors pays less than the amount to which the provider is entitled.

Conditional payment may be made by the Medicare program for items and services with respect to which it is the secondary payor. However, to the extent the primary payor subsequently makes payment, or the total of payments received from the primary payor and Medicare exceeds the amount to which the provider is entitled, all necessary steps must be taken to ensure that repayment is made to the Medicare program as soon as reasonably possible thereafter.



5. Responding Appropriately to Detected Misconduct

If an offense has been detected, PHI Air Medical will take all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. This includes appropriate legal consultation, when necessary, and proper reporting of the misconduct to appropriate authorities. Any suspected misconduct may make it necessary to modify our compliance program to determine any weaknesses and to correct those weaknesses. The goal at all times is to further prevent and detect potential violations of law, or the established reimbursement regulations and policies set forth by the federal government or payors of health care services.

a. Government Investigations

PHI Air Medical's policy is to cooperate with reasonable demands of governmental investigations. While it is PHI Air Medical's policy to cooperate with governmental agencies, PHI Air Medical's legal rights must be protected. In the case where a governmental agent visits a PHI Air Medical staff member, the agent should be asked to contact the Compliance Official to arrange an interview. The Compliance Official, in turn, will notify legal counsel to discuss the matter.

Request for data in government investigations will be handled as follows. A request for data will be in the form of a subpoena with a specific time to respond. Alternatively, government agents may arrive without warning with search warrants granting them the right to take documents, electronic media and specified documents immediately. In the event of such requests, the response depends on the type of request received;

- i.* If you are served with a subpoena;
 1. Advise your supervisor immediately
 2. Immediately call the Compliance Official or designee
 3. Accept the subpoena professionally, taking down the name and badge number of the agency and person. Limit discussion with the server.
- ii.* If you are served by agents with a search warrant;
 1. Advise your supervisor immediately
 2. Immediately contact the Compliance Official or designee- advise them of the situation- follow their instructions
 3. Remain professional and courteous



- iii.* When served with a search warrant, if you are required to control the situation until applicable PHI Air Medical personnel respond;
1. Obtain agency's or individual identification
 2. Read and copy the search warrant and determine scope.
 3. Record where agents go along with any comments or conversation.
 4. Designate an employee to accompany each agent and record what they say, and what they take.
 5. Answer only questions related to location of documents or information they are requesting. Minimize subjective discussions.
 6. Be truthful, do not mislead- stay objective
 7. Cooperate- do not interfere, or obstruct the agents. Politely object to any actions beyond the scope of the warrant.
 8. Obtain or compile list of all documents requested
 9. Request permission to copy all documents prior to removal.
 10. Document all responses and conversations by agents.
 11. Do not destroy/alter any documents, computer files or items identified.

b. Reporting Intentional Wrong-Doing To Authorities

It shall be PHI Air Medical's policy to carefully evaluate all allegations of wrongdoing to determine: (a) if the allegation appears to be well founded, and (b) whether the allegation warrants reporting to enforcement authorities. When billing errors have been reported and payments returned, unless there is evidence of a pattern of wrongdoing, or an attempt to conceal wrongdoing, no further reporting to enforcement authorities is ordinarily required.

The Compliance Officer shall consult with any outside experts deemed necessary in order to comply with this policy. Unless immediate reporting is required to prevent personal injury, property damage, bodily harm or damage to the environment, or is otherwise mandated by law, the Compliance Officer will consult in advance with PHI Air Medical Management before reporting suspected violations of the law to third parties.

If, after a thorough internal investigation, PHI Air Medical decides to make a report to the authorities, it will assure that the report is made under the direction of PHI Air Medical legal counsel and to the appropriate governmental authorities; and that the report is both timely and thorough.



6. **Developing Open Lines of Communication**

PHI Air Medical has created and will maintain a process, such as an easy-to-use “hotline” phone number or other reporting system, to receive and process concerns and complaints and to ensure effective lines of communication between the Compliance Officer and all staff members. Procedures have been adopted to protect the anonymity of complainants, where the complainant desires to remain anonymous, and to protect whistleblowers (who make good faith reports of potential violations) from retaliation or other adverse action.

a. Hotline and Other Mechanisms For Reporting Violations

All PHI Air Medical staff members are required to report incidents of violations of this Plan or Code of Conduct, unethical conduct, or incidents of potential fraud and abuse to the Compliance Officer. Such reports may be made in person, through the reporting mechanisms established by PHI Air Medical or other forms of written communication. Reports will be treated as confidential to the extent reasonably possible. There shall be no retaliation against anyone who submits a good faith report regarding a compliance concern.

b. Protection of Staff Members

It is the policy of PHI Air Medical that no staff member shall be punished on the basis that he or she reported what he or she reasonably believed to be an act of wrongdoing or a violation of this Plan or the PHI Air Medical Code of Conduct. Furthermore, PHI Air Medical is committed to following all protections set forth in applicable law regarding anti-retaliation for reporting of potential violations of law.

However, a staff member will be subject to disciplinary action if PHI Air Medical reasonably concludes that the report of alleged wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect him or herself.

In determining what, if any, disciplinary action may be taken against a staff member, PHI Air Medical will take into account the person’s own admissions of wrongdoing; provided, however, that the admission was not previously known to PHI Air Medical or its discovery was not imminent, and that the admission was complete and truthful. A staff member whose report of misconduct contains admissions of personal wrongdoing will not be guaranteed protection from disciplinary action. The weight to be given the self-confession will depend on all the facts known to PHI Air Medical at the time it makes its disciplinary decisions.



c. Departing Staff Members - Exit Interview

All departing staff members will be encouraged to participate in an Exit Interview.

One of the purposes of the Exit Interview is to determine if the staff member has knowledge of any wrongdoing, unethical behavior or criminal conduct. The interview also may be used to obtain information about unsafe or unsound business practices and the like. Attempt will be made to conduct the interview while the staff member is still on the roster and on PHI Air Medical property. Someone other than the departing staff member's immediate supervisor should conduct the interview, when possible.

The interviewer should prepare a report of the Exit Interview with the staff member's answers duly noted, or provide an Exit Interview Questionnaire to the departing staff member. The report or questionnaire should be made a part of the staff member's personnel file. If any compliance issues are raised, or if the interviewer is otherwise concerned about the staff member's honesty, the Compliance Officer should be notified immediately.

PHI Air Medical should be notified as soon as possible upon the termination or resignation of any employee with access to the Golden Hour data system.



7. Enforcing Disciplinary Standards

PHI Air Medical has developed policies and procedures to ensure that there are appropriate disciplinary mechanisms and standards applied in a fair and consistent manner. These policies and standards address situations in which staff members, Vendors, or contractors violate, whether intentionally or negligently, internal compliance policies, applicable statutes, regulations, or other Federal health care program requirements.

The standards will be consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, corrective counseling and if necessary, discipline of individuals responsible for the failure to detect an offense. Adequate discipline of individuals responsible for an offense is a necessary component of enforcement. However, the form of correction or discipline provided will be case specific and may be based on a variety of factors, including severity of the offense, previous incidents involving the individual, and the individual's commitment to a positive change in behavior.

a. Compliance as an Element of Performance Evaluation

Staff members who fail to comply with the rules and procedures set forth in this Plan, the Code of Conduct or the laws and regulations governing PHI Air Medical's ambulance operations will be subject to disciplinary action. Adherence to compliance requirements will be a factor in staff member evaluations and will affect a staff member's continued relationship with PHI Air Medical.

b. Disciplinary Procedures

PHI Air Medical will not tolerate illegal or unethical conduct of any sort, business or personal, by its staff members. PHI Air Medical is prepared to take disciplinary action against individuals who violate the requirements of this Plan or otherwise engage in unethical or unlawful activities. PHI Air Medical will publish and distribute to all staff members its disciplinary policies and procedures. The sanctions available under this Plan may include required remedial training, verbal and/or written reprimand, or, for serious infractions, suspension, expulsion or termination.



All aspects of corrective action or disciplinary action against staff members will be thoroughly and impartially investigated and documented.

c. Record Retention

PHI Air Medical directly and/or via its contractors maintains a uniform system for record creation, distribution, retention, storage, retrieval, and destruction of documents. The type of documents developed under this system include patient care records, billing, claims documentation, and other financial records, and all records necessary to protect the integrity of our compliance process and confirm the effectiveness of the program. This includes documentation regarding staff member training, modifications to the compliance program, results of any investigations conducted, self-disclosures to enforcement agencies, and results of the company's auditing and monitoring efforts. Under no circumstances may documents relating to a pending investigation, or an inquiry regarding a report of a possible billing error, or an incident of fraud or abuse, be destroyed without permission of the Compliance Officer and approval of legal counsel.

d. Relationship With Competitors / Vendors

Information about our operations, such as marketing, strategy, service pricing, finances, etc. is in many cases confidential. PHI Air Medical business should generally not be discussed with anyone outside the organization. Contracts and contract negotiations are conducted in accordance with the law. Business integrity is important in choosing PHI Air Medical business partners.

PHI Air Medical personnel should be open and honest in their business relationships with other ambulance transport professionals, PHI Air Medical lawyers, accountants, consultants, and the Compliance Officer. PHI Air Medical encourages a free flow of information among these individuals. Furthermore, free flowing communication will reduce the potential for fraud, abuse or waste. The failure to deliver information that is known or thought to be necessary, or delivering information that is known or thought to be inaccurate, misleading, or incomplete, is unacceptable and disciplinary action may be taken in such cases.

The Compliance Officer is responsible for promoting communication between PHI Air Medical and any Vendor or supplier with which PHI Air Medical conducts business. PHI Air Medical staff is encouraged to solicit the opinion of the Compliance Officer if they are uncertain about a compliance-related matter. They are expected to report billing errors or suspected incidents of health care related fraud and abuse. Communication and reporting may take place in person, by telephone, memoranda, or through electronic mail. The Compliance Officer shall use best efforts to keep all communications confidential whenever possible.



e. Screening Staff Members and Contractors

PHI Air Medical staff members and subcontractors are expected to be honest and lawful in their business dealings. PHI Air Medical will not employ or do business with individuals who have been convicted of health care fraud or listed by a federal agency as excluded, debarred or otherwise ineligible to participate in federally funded health care programs. Consequently, PHI Air Medical will perform background investigations for prospective staff members, subcontractors, clients, and Vendors. The Office of Inspector General's List of Excluded Individuals/Entities and other databases as identified in our background checking policies will be utilized. In addition to checking these databases upon initial employment, PHI Air Medical shall periodically re-check to make sure that existing employees are not excluded. Applicants who wish to join PHI Air Medical will be required to disclose any criminal conviction or civil monetary penalties assessed against or paid by the applicant, or exclusion action imposed against the individual.

f. Plan Modifications

The Compliance Officer shall, on a regular basis, monitor developments in all applicable laws that might affect PHI Air Medical's legal duties under the Plan. This may include changes in applicable regulations and developments in payor policy that might require change in the design or implementation of the Plan.

g. Emergency Changes to the Plan

The Compliance Officer shall be authorized without prior consent of the management to make emergency changes and to expend such funds as are necessary to assure proper implementation of the Plan.

However, any such proposed changes shall be reported to management of PHI Air Medical prior to implementation, if at all possible, to permit the calling of an emergency meeting of the management where practical. Any such emergency changes shall be reported to the Board or governing body at its next regularly scheduled meeting.



SUMMARIES OF SELECTED STATE FALSE CLAIMS ACTS



PHI AIR MEDICAL STATE FALSE CLAIMS ACTS
INFORMATION

As referenced in this Policy, the following are detailed summaries of the False Claims Acts in certain of the states in which PHI Air Medical operates. This information is intended to comply with Section 6032 of the Deficit Reduction Act of 2005. If you have any questions regarding these summaries or other state laws, please contact the Compliance Officer.



PHI State False Claims Acts Information

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ARIZONA

The state of Arizona has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted fraud and false statement statutes that make it unlawful for a person to submit false and fraudulent statements or claims to an Arizona state department or agency. Violations of these statutes are civil and criminal offenses and are punishable by imprisonment and significant monetary penalties and assessments. See Ariz. Rev. Stat. §§ 13-2310, 13-2311, 36-2918 and 36-2957.



CALIFORNIA

The California False Claims Act (“CFCA”) is a state law that prohibits fraud in connection with state or local government programs. Cal. Govt. Code §§ 12650 - 12656.

Liability and Damages/Statute of Limitations

Actions that violate the CFCA include: (1) presenting a false claim for payment or approval; (2) making or using a false record material to a false claim; (3) making a false statement material to an obligation to pay a state or local government, or concealing or decreasing such an obligation to pay; (4) failure of a beneficiary of a false claim to disclose the false claim to the state or local government within a reasonable time after discovery; and (5) conspiring to commit any such violation.

CFCA imposes penalties of \$5,000 to \$10,000 per claim, three times the amount of damages to the state or local government for CFCA violations, plus reasonable costs and attorney fees.

A civil suit must be filed within three years of the date of discovery, and in no case may be brought more than 10 years after the violation was committed. The CFCA does not apply to false claims totaling less than \$500 in value.

***Qui Tam* Actions/Whistleblower Protections**

An individual (or *qui tam* plaintiff) can sue for violations of the CFCA. Individuals who report fraud receive between 15 and 33 percent of the total amount recovered if the government prosecutes the case, and between 25 and 50 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. The CFCA contains important protections for whistleblowers.

Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.



CONNECTICUT

The Connecticut False Claims Act (“CFCA”) is intended to help the state combat fraud in state medical assistance (Medicaid) programs operated by the Department of Social Services, and to allow the state to recover losses from such fraud. Conn. Gen. State §§ 17b-301a, *et seq.*

Liability and Damages/Statute of Limitations

- The actions that violate the CFCA include: (1) presenting (or causing to be presented) a false claim for payment or approval under a state medical assistance program, (2) making or using a false record related to a false claim under a state medical assistance program, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record material to an obligation to pay or transmit money or property to the to the state under a medical assistance program.
- Penalties range from between \$5500 and \$11,000, (plus potential adjustments for inflation), plus three times the amount of damages to the state and plus all costs of investigation and prosecution of the violation. However, the amount of damages may be lowered to two times the amount sustained by the state if the violator cooperates with the investigation.
- Lawsuits must be filed before the later of the following dates: (1) six years after the violation was committed; and (2) three years after the date when the facts became known or reasonably should have been known to the state official responsible for investigating violations (but no more than ten years after the violation was committed).

Qui Tam Actions/Whistleblower Provisions

- Individuals (or *qui tam* plaintiffs) can sue for violations of the CFCA. Individuals who report fraud receive between 15 and 25 percent of the amount recovered in cases where the State prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) in cases where the *qui tam* plaintiff litigates the case on his or her own. If the court finds the case is based on information that was not originally reported by the individual, the court may not award the individual more than 10% of the proceeds.
- The CFCA protects employees from being discharged, demoted, suspended, threatened, harassed or otherwise discriminated against in their employment because they reported or assisted with a false claims action. Employees who report fraud and consequently suffer discrimination may be awarded: (1) reinstatement at the seniority level they would have had but for the discrimination, (2) two times back pay plus interest, and (3) compensation for any costs or damages they have incurred. Anti-discrimination actions must be brought within 3 years from the date the retaliation occurred.



INDIANA

The Indiana False Claims Act (“IFCA”) helps the state combat fraud and recover losses resulting from fraud in programs, purchases, or contracts.
Ind. Code Ann. Chapter 5-11-5.5.

Liability and Damages/Statute of Limitations

Actions that violate the IFCA include: (1) presenting a false claim to the state for payment or approval, (2) making or using a false record to get a false claim paid, (3) conspiring with another person to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the governmental entity.

IFCA imposes a minimum penalty of \$5,000 per claim and damages up to three times the amount the state sustains may be awarded. The courts will waive penalties for IFCA violations and reduce damages if the false claims are voluntarily disclosed.

A civil suit must be filed within either (1) six years after the date that the violation was committed, or (2) within 3 years of the date in which the violation was discovered or reasonably should have been discovered, but not less than 10 years after the violation was committed.

***Qui Tam* Actions/Whistleblower Protections**

A private person (or *qui tam* plaintiff) can sue for violations of the IFCA. Individuals who report fraud receive between 10 and 15 percent of the total amount recovered if the state prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the private person litigates the case on his or her own as a *qui tam* action. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

The IFCA contains protections for whistleblowers. Employees who suffer discrimination due to their disclosure of fraudulent activity may be awarded: (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, and (3) compensation for any costs or damages they have incurred.



KENTUCKY

Kentucky has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Kentucky Medicaid program. The statute also makes it unlawful for any person to present false information regarding an institution or facility so that it may be licensed or recertified as a Medicaid provider. Violations of the statute are both civil and criminal offenses and are punishable by substantial fines and imprisonment. Ky. Rev. Stat. Ann. §§ 205.8451, 205.8463, 205.8465, 205.8467. Any person who reports suspected fraud to the state Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline shall not be liable in any civil or criminal action based on the report if it was made in good faith, nor may an employer, without just cause, discharge or in any manner discriminate or retaliate against any person who in good faith makes such a report or who participates in any proceeding related to such report. Ky. Rev. Stat. Ann. § 205.8465.



MARYLAND

The state of Maryland has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid fraud statute that makes it unlawful for a person to submit false and fraudulent claims to a state health plan. Violation of this statute is a criminal and civil offense punishable by substantial fines and imprisonment. See Md. Code Ann. §§ 8-501, *et seq.* No state false claims act exists at this time.



MICHIGAN

The Michigan Medicaid False Claims Act (“MMFCA”) is a state law that is designed prevent fraud, kickbacks, and conspiracies in connection with the Medical Assistance Program. Mich. Comp. Laws Ann. §§ 400.601-400.615.

Liability and Damages/Statute of Limitations

- Actions that violate the MMFCA include: (1) knowingly making (or causing to be made) a false statement in an application for benefits or for use in determining Medicaid eligibility; and (2) concealing or failing to disclose an event in order to obtain a benefit greater than that to which the person is otherwise entitled. Violations are punishable by civil and criminal penalties.
- Violation of the MMFCA constitutes a felony punishable by four years or less in prison, or a fine of \$50,000 or less, or both. Civil penalties range from \$5000 to \$10,000 plus triple the amount of damages suffered by the state.
- Civil actions under the MMFCA must be brought before the later of (1) 6 years after the date on which the violation was committed, and (2) 3 years after the date when the facts became known or reasonably should have been known to the Michigan state official charged with responsibility to act (but in no event more than 10 years after the violation was committed).

***Qui Tam* Actions/Whistleblower Protections**

- An individual (or *qui tam* plaintiff) can sue for violations of the MMFCA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case and between 25 and 30 percent if the *qui tam* plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.
- The MMFCA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement in their position without loss of seniority, and (3) compensation for any costs or damages they have incurred.



NEW JERSEY

The New Jersey False Claims Act (“NJFCA”) is a state law that helps the state combat fraud and recover losses resulting from fraud. N.J. Rev. Stat. §§ 2A:32C-1 through 2A:32C-18.

Liability and Damages/Statute of Limitations

Actions that violate the NJFCA include: (1) presenting a false claim for payment or approval; (2) making or using a false record to get a false claim paid; (3) conspiring to defraud the State by getting a false claim paid; or (4) making or using a false record or statement to conceal, avoid, or decrease an obligation to pay the State.

The state imposes penalties of not less and not more than may be imposed under the federal False Claims Act, plus three times the amount of damages the state sustains. The current penalties under the federal False Claims Act are \$5500 to \$11,000 per claim. These penalties may be adjusted for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990.

A civil suit must be filed within either six years of the date on which the violation was committed, or three years after the date when the violation became known or reasonably should have become known (in no case may a suit be brought more than 10 years after the violation was committed).

***Qui Tam* Actions/Whistleblower Protections**

An individual (or *qui tam* plaintiff) can sue for violations of the NJFCA in the name of the state. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own.

Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.



NEW MEXICO

The New Mexico Fraud Against Taxpayers Act (“FATA”) is a state law that prohibits fraud in programs, purchases, or contracts in which a portion of the money, property or services requested is provided by a state agency. N.M. Stat. §§ 44-9-1 through 44-9-14.

Liability and Damages/Statute of Limitations

Actions that violate the FATA include: (1) presenting a false claim for payment or approval; (2) making or using a false record to get a false claim paid; (3) conspiring to make a false claim or get one paid; (4) making or using a false record or statement to conceal, avoid, or decrease an obligation to pay the State; or (5) failing to disclose a false, beneficial claim to the State within a reasonable time after discovery.

The state imposes penalties of \$5,000 to \$10,000 per claim, three times the amount of damages to the state for FATA violations, plus the costs of a civil suit for recovery of penalties or damages and reasonable attorney fees.

A civil suit must be filed within three years after the date when the violation became known or reasonably should have become known, and in no case may be brought more than 10 years after the violation was committed.

***Qui Tam* Actions/Whistleblower Protections**

An individual (or *qui tam* plaintiff) can sue for violations of the FATA in the name of the state. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own.

Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.



OHIO

At this time, there is no Ohio false claims act that closely parallels the federal False Claims Act. However, Ohio law requires that certain health care entities provide certain information about the federal False Claims Act and Ohio false statement laws and whistleblower protections. (Ohio Rev. Code Ann. § 5111.101).

Section 2913.40 of the Ohio Revised Code is a criminal law statute that is designed to prevent the commission of fraud on the state medical assistance program. (Ohio Rev. Code Ann § 2913.40). The chief actions that violate this law are (1) knowingly making or causing to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program, (2) purposefully and knowingly charging, soliciting, accepting or receiving any property, money or other consideration in addition to the amount of reimbursement under the medical assistance program to which the person would otherwise be entitled, (3) purposefully and knowingly soliciting, offering or receiving any remuneration, other than authorized deductibles or co-payments, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medical assistance program, and (4) knowingly altering, falsifying, destroying, concealing, or removing any records within six years after submitting a claim under the medical assistance program that are necessary to fully disclose the nature of all goods and services on which the claim was submitted or for which reimbursement was received or that are necessary to disclose fully all income and expenditures upon which rates or reimbursement were based.

Ohio law prohibits false statements made in connection with an application for Medicaid eligibility. (Ohio Rev. Code Ann. § 2913.401). In particular, no person shall knowingly (1) make false or misleading statements in a Medicaid benefits or disclosure application or document, (2) conceal an interest in property in a Medicaid benefits or disclosure application or document, or (3) fail to disclose a transfer of property that occurred during the period thirty-six months before submission of the application or document.

Ohio law also prohibits the making of false statements in many situations, including (1) in any official proceeding, (2) with the purpose of securing government benefits, (3) with the purpose to mislead a public official in performing the public official's official function, and (4) with the purpose of obtaining an Ohio's "best Rx program" enrollment card. (Ohio Rev. Code Ann. § 2921.13).

The Ohio laws described above *do not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

However, state employees in classified or unclassified civil service who become aware of violations of state or federal laws may file a written report with their supervisor (if such supervisor has the authority to correct the violation). If the state employee reasonably believes



that the violation is a criminal offense, the employee may report it to, among other persons, a prosecuting attorney, chief legal officer of a municipal organization, peace officer, or inspector general, as applicable. (Ohio Rev. Code Ann. § 124.341).

Ohio law also provides protections for state employees. No state officer or state employee shall take any disciplinary action against a state employee for reporting any violations of state or federal law under Section 124.341, provided that the information in the report was not knowingly or recklessly false. “Disciplinary action” includes (1) the removal or suspension of the employee from employment, (2) the withholding of salary increases or employee benefits to which the employee is otherwise entitled, (3) transferring or reassigning the employee, (4) denying the employee promotion that otherwise would have been received, and (5) the reduction in the employee’s pay or position. If disciplinary action is taken against the employee, the employee may file an appeal with the state personnel board within thirty days after receiving actual notice of the appointing authority’s action.

What are the penalties?

Violations of Section 2913.40 (related to Medicaid fraud), Section 2913.401 (related to Medicaid eligibility fraud), and Section 2921.13 (related to certain false statements) result in penalties ranging from a first degree misdemeanor to a third, fourth or fifth degree felony, depending on the value of the property, services or funds obtained. A person found guilty of violating Section 2913.40 may have to pay the costs of the investigation and prosecution of the violation. A person found guilty of Section 2913.401 can be compelled to make restitution of the amount of benefits received for which the applicant or recipient was not eligible (plus interest). A person who violates Section 2921.13 is liable in a civil action to any person harmed by the violation. The remedies set forth in Sections 2913.40, 2913.401, and 2921.13 do not preclude the use of any other criminal or civil remedy.



TENNESSEE

The Tennessee False Claims Act (“TFCA”) is a state law that is designed to help the state government and political subdivisions combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. Tenn. Code Ann. §§ 4-18-101. The Tennessee Medicaid False Claims Act (“TMFCA”) applies solely to false claims under the Medicaid program. Tenn. Code Ann. §§ 71-5-182.

Liability and Damages/Statute of Limitations

- Actions that violate the both the TFCA and the TMFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed. In addition, anyone who benefits from a false claim that was mistakenly submitted also violates the TFCA if he or she does not disclose the false claim soon after he or she discovers it. Finally, the TFCA also broadly prohibits using any false representation or practice to procure anything of value from the state government or any political subdivision. The courts can waive penalties and reduce damages for violations if the false claims are voluntarily disclosed. The TFCA does not apply to controversies of less than \$500, workers’ compensation claims, Medicaid claims, or tax claims.
- Penalties of \$2,500 to \$10,000 per claim plus three times the amount of damages to the state or political subdivision may be imposed for TFCA violations.
- Under the TFCA, a civil suit must be filed within three years after the violation was discovered, but no more than ten years after the violation was committed.
- The TMFCA applies only to Medicaid claims. Penalties of \$5,000 to \$10,000 per claim plus treble damages may be imposed for TMFCA violations.
- Under the TMFCA, a civil suit can be filed within the later of: (1) six years after the violation was committed, or (2) three years after the violation was discovered (but no more than ten years after the violation was committed).

***Qui Tam* Actions/Whistleblower Protections**

- An individual (or *qui tam* plaintiff) can sue for violations of the TFCA or the TMFCA. Individuals who report fraud receive between 25 and 33 percent of the total amount recovered if the government prosecutes the case under the TFCA and between 15 and 25 percent under the TMFCA. If the *qui tam* plaintiff litigates the case on his or her own, he or she receives between 33 and 50 percent of the proceeds under the TFCA and between 25 and 30 percent



under the TMFCA (plus reasonable costs and attorney fees). Under both acts, an individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- Both the TMFCA and the TFCA contain important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, and (3) compensation for any costs or damages they have incurred. Under the TFCA, the employer may also be liable for punitive damages.



TEXAS

The Texas Medicaid Fraud Prevention Law (“FPL”) combats fraud and abuse by health care providers participating in the Medicaid Program. Tex. Hum. Res. Code Ann. §§ 36.001.

Liability and Damages

Actions that violate the FPL include: (1) making a false statement or concealing information that affects the right to a Medicaid benefit or payment, (2) submitting a claim for Medicaid payment for a product or service rendered by a person who is not licensed to provide that product or service or fails to indicate the license of the practitioner who actually performed the service, (3) submitting a claim for a service or product that has not been approved by the treating health care practitioner, or (4) conspiring to defraud the state by obtaining an unauthorized payment from the Medicaid program or its fiscal agent.

The law requires restitution of the value of any Medicaid payment plus interest, damages of two times the value of the payment, and a civil penalty of \$5,000 to \$15,000 for each violation that results in an injury to a disabled person, an elderly person, or a person younger than 18 years of age. If the violation does not result in such an injury, the law requires a civil penalty of \$1,000 to \$10,000 for each violation and damages of two times the value of the payment. A court may waive the civil penalties and award two times the amount of the payment if the defendant voluntarily discloses the violations.

Whistleblower Provisions

Private individuals who report fraud receive between 10 and 25 percent of the total amount recovered if the state prosecutes the case. A private individual cannot prosecute a case on his or her own. The FPL contains important protections for whistleblowers.

Employees who suffer discrimination because of their involvement in false claims actions may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages they have incurred.



VIRGINIA

The Virginia Fraud Against Taxpayers Act (“FTA”) is a state law that helps the Commonwealth combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. Va. Code Ann. §§ 8.01-216.1.

Liability and Damages/Statute of Limitations

Actions that violate the FTA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the Commonwealth or a political subdivision.

The Commonwealth imposes penalties of \$5,500 to \$10,000 per claim, three times the amount of damages to the Commonwealth for FTA violations, plus the costs of a civil suit for recovery of penalties or damages.

A civil suit must be filed within the latter of: (1) six year after the violation was committed, or (2) three years after the date that the violation was discovered (but no more than ten years after the violation was committed).

***Qui Tam* Actions/Whistleblower Protections**

An individual (or *qui tam* plaintiff) can sue for violations of the FTA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information. The FTA contains important protections for whistleblowers.

Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, and (3) compensation for any costs or damages they have incurred.