FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

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CLERK, DISTRICT OF IDAHO

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, *ex rel.* Robbie Garrett and James Daniel Garrett, and **ROBBIE GARRETT** and **JAMES DANIEL GARRETT**, individually, Plaintiffs, v. **KOOTENAI HOSPITAL DISTRICT d/b/a KOOTENAI HEALTH,** Defendant.	**DOCKET NO.** 2:17-cv-00314-CWD **FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)** **JURY TRIAL DEMANDED**

COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiffs and *qui tam* Relators Robbie Garrett and James Daniel Garrett, by and through

their undersigned counsel Craig Swapp & Associates and the JTB Law Group, LLC, allege of personal knowledge as to their observations and actions, and on information and belief as to all else, as follows:

I.
PRELIMINARY STATEMENT

1. Relators Robbie Garrett ("Robbie") and James Daniel Garrett ("JD") bring this *qui tam* action on behalf of the United States of America (the "Government") under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"), and the common law to recover treble the damages actually sustained by, and civil penalties and restitution owed to, the United States as a result of a scheme by Kootenai Hospital District d/b/a Kootenai Health ("Defendant") to commit fraud.

2. Defendant brazenly and systemically violated Medicare laws to fraudulently extract millions of dollars in undeserved reimbursements from the United States.

3. Specifically, Defendant has:

a. knowingly submitted false information, and/or omitted true and material information, to fraudulently classify its facilities as "provider-based" facilities and thereby obtain higher levels of reimbursement from Medicare;

b. knowingly billed for services and treatments using the physicians' fee schedule even though such services and treatments were not provided by physicians and do not otherwise qualify for use of the physicians' fee schedule;

c. knowingly admitted inpatients without obtaining a physician's order;

d. knowingly misclassified outpatients as inpatients in violation of Medicare's "two-midnight rule";

e. knowingly violated the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (the "EMTALA"), by requiring emergency room patients to make payments prior to receiving medical screening and treatment;

f. knowingly submitted incorrect diagnosis codes for patients for the purpose of circumventing the Hospital-Acquired Condition ("HAC") Reduction Program under 42 U.S.C. § 1395ww(p); and

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g. knowingly violated numerous rights of its patients, in violation of the conditions of participation in Medicare.

4. Because of the foregoing violations, the certification Defendant provided with each of the claims it submitted to Medicare – that Defendant complied with all Medicare laws, regulations, and program instructions – was fraudulent and false, rendering each such claim fraudulent and false.

5. In effectuating this scheme, Defendant knowingly (a) presented or caused to be presented false claims to Medicare; (b) made or caused to be made or used false records or statements material to these false claims; and (c) conspired to cause these claims to be presented and/or these records or statements to be made or used, causing Medicare to pay millions of dollars in reimbursements that should not have been paid.

6. Relator Robbie Garrett also brings an action on her own behalf under the FCA, 31 U.S.C. § 3730(h), to seek relief from Defendant's actions against her in retaliation for her lawful efforts to stop the violations alleged herein. Defendant's directors and officers have engaged in a sustained campaign of harassment against Robbie as a direct response to her efforts to ensure Defendant's practices comply with all applicable laws and regulations. As of the filing of this complaint, Robbie's employment with Defendant has been terminated.

7. This Complaint has been filed *in camera* and under seal pursuant to 31 U.S.C. § 3730(b)(2). It will not be served on Defendant unless and until the Court so orders. A copy of the Complaint, along with written disclosure of substantially all material evidence and information that Relators possess, has been served upon the Attorney General of the United States and on the United States Attorney for the District of Idaho, pursuant to 31 U.S.C. § 3730(b)(2) and Fed. R. Civ. P. 4(d).

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II.
JURISDICTION AND VENUE

8. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331, because this action is brought for violations of the False Claims Act, 31 U.S.C. § 3729 *et seq.* (as amended), a federal statute.

9. The Court has subject matter jurisdiction over the common law claim pursuant to 28 U.S.C. § 1345.

10. The Court has personal jurisdiction over Defendant because Defendant (a) is a resident of, and is licensed to transact and does transact business in, this District; and (b) has carried out its fraudulent scheme in this District.

11. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391 (b)(2), because Defendant can be found in, is licensed to do business in, and transact or have transacted business in this District, and events and omissions that give rise to these claims have occurred in this District. This District is the locus of the fraud.

12. The Complaint has been filed within the period prescribed by 31 U.S.C. §§ 3731(b) and 3730(h)(3).

III.
NO PUBLIC DISCLOSURE; DIRECT AND INDEPENDENT KNOWLEDGE OF VIOLATIONS OF THE FALSE CLAIMS ACT

13. There has been no public disclosure, relevant under 31 U.S.C. § 3730(e), of the "allegations or transactions" in this Complaint.

14. Relators make the allegations in this Complaint based on their own knowledge, experience and observations.

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15. Relators are the original source of the information on which any allegations herein might be based, have direct and independent knowledge of such information, and have voluntarily disclosed such information to the United States before filing this action.

IV.
THE PARTIES

A. Plaintiff the United States

16. Plaintiff the United States of America brings this action by and through Relator Robbie Garrett. At all times relevant to this Complaint, the United States, acting through the Centers for Medicare & Medicaid Services ("CMS"), which is a part of the federal Department of Health and Human Services ("HHS"), has reimbursed Defendant for the provision of various services and treatments to eligible individuals through the Medicare program. Thus, the United States brings this action on behalf of its agencies, CMS and HHS, and on behalf of the Medicare program.

B. Plaintiff and Relator Robbie Garrett

17. Relator Robbie Garrett ("Robbie") also brings this action on behalf of herself and the United States.

18. Robbie is a citizen of the United States and, at all relevant times, has been a resident of Kootenai County, Idaho.

19. Robbie worked for Defendant from approximately August 2015 until July 24, 2017 as the Executive Director of Quality Services.

20. As the Executive Director of Quality Services, Robbie was responsible for auditing Defendant's practices to ensure they are compliant with federal regulations.

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21. In the exercise of her duties, Robbie audited Defendant's practices. These audits revealed widespread violations of the False Claims Act and other federal laws, regulations, and guidelines. Robbie personally observed numerous instances of the violations alleged herein.

22. Robbie attempted numerous times to correct Defendant's illegal practices. However, at every step she was met with resistance from Defendant's other directors and officers, and was persistently harassed for her efforts. Eventually, Defendant terminated Robbie.

C. Plaintiff and Relator James Daniel Garrett

23. Relator James Daniel Garrett ("JD") also brings this action on behalf of himself and the United States.

24. JD is a citizen of the United States and, at all relevant times, has been a resident of Kootenai County, Idaho.

25. JD is the spouse of Robbie Garrett.

D. Defendant

26. Defendant is an entity of Kootenai County, pursuant to I.C. §§ 39-1318, *et seq*. Defendant does business as Kootenai Health.

27. Defendant owns and operates a hospital, Kootenai Medical Center, as well as approximately 50 affiliated clinics and other facilities.

28. Defendant is headquartered at 2003 Kootenai Health Way, Coeur d'Alene, Idaho 83814.

29. On information and belief, during all times relevant herein, the majority of Defendant's patients have been Medicare beneficiaries.

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V.
DEFENDANT'S FRAUDULENT ACTS

A. Defendant Obtained Reimbursement for Services Rendered at Facilities It Fraudulently Represented as "Provider-Based" Facilities

30. Under the regulations implementing Title XVIII of the Social Security Act, medical facilities owned by and integrated with a hospital – called "provider-based facilities" – are allowed to bill Medicare at a rate higher than the rate allowed for freestanding facilities. *See* 42 C.F.R. 413.65(a)(ii)(L)(2) *et seq*. Provider-based facilities may be on or off the main hospital campus, but must meet certain requirements. *Id.*

31. According to a 2016 report by the HHS Office of Inspector General, "Under Medicare, payments for services performed in provider-based facilities are often more than 50 percent higher than payments for the same services performed in a freestanding facility. This increased cost is borne by both Medicare and its beneficiaries."[1]

32. In order to take advantage of this payment differential, many hospitals falsify or omit information so that their facilities are classified as provider-based instead of freestanding.[2] Defendant here did exactly that.

33. Specifically, Defendant abused a "grandfather" clause in the federal regulations, which provides:

> A facility that has requested provider-based status in relation to a hospital or CAH [Critical Access Hospital] on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed …, staffed and equipped to treat patients ***until the date on which CMS determines that the facility does not qualify for provider-based status.***

[1] Office of Inspector General, Department of Health and Human Services, "CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain," June 2016, *available at* https://oig.hhs.gov/oei/reports/oei-04-12-00380.pdf (last accessed July 18, 2017).

[2] *See id.* (noting that 50 hospitals that reported owning off-campus provider-based facilities had not voluntarily attested that the facilities met the requirements for that status).

42 C.F.R. 413.65(d)(5) (emphasis added).

34. In turn, 42 C.F.R. 413.65(b)(5) provides:

> ***A facility that is not located on the campus of a hospital*** and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished ***is presumed as a free-standing facility***, unless CMS determines the facility has provider-based status.

(emphasis added). So that CMS may make such a determination, a provider is required to attest that the off-campus facility meets certain more stringent requirements. See 42 C.F.R. 413.65(b)(3)(ii), 413.65(e).

35. Between October 1, 2000, and October 1, 2002, Defendant sought and obtained provider-based status for facilities that, at the time, met the requirements for that status.

36. Defendant subsequently moved several of these facilities from its hospital campus to a more remote location.

37. When Defendant moved these facilities off-campus, the facilities presumptively lost their provider-based status.

38. As of at least approximately November 2016, Defendant had not updated the Medicare enrollment information for the facilities it had moved off-campus to reflect the fact that these facilities were no longer on-campus, nor had Defendant submitted new attestations under 42 C.F.R. 413.65(b)(3)(ii) to re-obtain provider-based status for these off-campus facilities under the more stringent requirements of 42 C.F.R. 413.65(e).

39. Even now, Relators do not know whether Defendant has submitted new attestations for these off-campus facilities.

40. From the date of the relocation of these facilities until November 2016, Defendant continued to bill Medicare for services rendered there as if the facilities had provider-based status, even though Defendant had not submitted updated attestations to allow CMS to make accurate

eligibility assessments.

41. On information and belief, at least some of the facilities in question were at their new off-campus locations for as long as three years without Defendant updating their addresses or submitting new attestations.

42. Upon Robbie's insistence, Defendant submitted to CMS the accurate addresses of its off-campus facilities sometime after November 2016.

43. 42 C.F.R. 413.65(j)(1) provides:

> If CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request a determination of provider-based status from CMS under paragraph (b)(3) of this section and CMS determines that the facility or organization did not meet the requirements for provider-based status … ***CMS will … recover the difference between the amount of payments that actually was made and the amount of payments that CMS estimates should have been made, in the absence of compliance with the provider-based requirements….***

(emphasis added).

44. On information and belief, when Defendant finally submitted to CMS accurate addresses for its off-campus facilities, it submitted false effective dates for the relocation of those facilities, in an attempt to minimize the amounts that CMS could recover under 42 C.F.R. 413.65(j)(1).

45. As of the filing of this Complaint, Defendant has not reimbursed CMS as required under 42 C.F.R. 413.65(j)(1).

46. On information and belief, Defendant obtained provider-based status for other on-campus facilities that were not grandfathered-in and were subsequently moved off-campus. On information and belief, Defendant has not submitted new attestations to re-obtain provider-based status, and has continued to bill Medicare for services rendered there as if these facilities had provider-based status.

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47. On information and belief, Defendant has entirely failed to submit attestations to obtain provider-based status for other facilities that have *always* been off-campus, and has nevertheless billed Medicare as if these facilities had provider-based status. These facilities include formerly independent clinics that Defendant acquired.

48. When Robbie insisted, in approximately 2016, that Defendant provide to CMS accurate updated addresses for its off-campus facilities, one of Defendant's directors stated words to the effect that Robbie would cost Defendant $5 million in revenue.

B. Defendant Used the Physicians' Fee Schedule to Obtain Reimbursement for Services Not Provided by Physicians

49. In violation of federal laws, regulations, and guidelines, Defendant used the Medicare Physicians' Fee Schedule ("MPFS") to bill Medicare for services that were not rendered by physicians, and do not otherwise qualify for reimbursement under the MPFS.

50. Medicare billing guidelines provides that:

> The Physicians' Fee Schedule is used when paying for the following physicians' services.
>
> - Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors[3];
> - Services covered incident to physicians' services other than certain drugs covered as incident to services;
> - Physical and occupational therapy, and speech-language pathology services furnished by physical therapists, occupational therapists, and speech-language pathologists in private practices;
> - Diagnostic tests other than clinical laboratory tests. See chapter 16 for

[3] The regulations refer to doctors of medicine and osteopathy, optometry, podiatry, dental surgery and dental medicine, and chiropractors collectively as "physicians." *See* Medicare General Information, Eligibility, and Entitlement, Chapter 5 §70, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ ge101c05.pdf (last accessed July 18, 2017). *See also* Medical Practice Act, I.C. § 54-1801, *et seq.* (authorizing the practice of medicine).

payment for clinical diagnostic laboratory tests;

- Radiology services; and
- Monthly capitation payment (MCP) for physicians' services associated with the continuing medical management of end stage renal disease (ESRD) services.[4]

51. During Robbie's tenure, Defendant commonly billed for services rendered by registered nurses and other non-physician practitioners as if those services had been rendered by qualified physicians.

52. These services included: writing treatment orders, carrying out treatment orders, ordering supplies for treatment, and prescribing medication for treatment.

53. Such services were not rendered incidental to a qualified physician's services. On numerous occasions, a qualified physician was not present or even consulted when a patient received services from practitioners such as registered nurses.

54. The services rendered by practitioners who are not qualified physicians did not otherwise qualify for the MPFS under Medicare billing guidelines.[5]

55. Nevertheless, Defendant used the MPFS to fraudulently bill Medicare for such services as if they were rendered by qualified physicians.

56. Robbie directly observed the above billing practices, and reported such practices to Defendant's directors and officers.

57. As of the filing of this Complaint, Defendant has not promulgated any policy prohibiting these practices.

58. On information and belief, Defendant continues to engage in these practices.

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[4] Medicare Benefit Policy Manual, Chapter 23 § 30(A), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf (last accessed July 18, 2017).
[5] *See* Medicare Benefit Policy Manual, Chapter 23 § 30(A), *supra*, for a list of entities that may use the MPFS.

C. Defendant Obtained Reimbursement for Admitting Inpatients without Obtaining a Physician's Order

59. In violation of federal laws, regulations, and guidelines, Defendant admitted individuals as inpatients without obtaining an admission order by a physician or other qualified practitioner.

60. 42 C.F.R. 412.3 provides, in pertinent part:

> a. For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital ... if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or a qualified practitioner.
>
> b. The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. ...
>
> c. ***The physician order must be furnished at or before the time of the inpatient admission.***

(emphasis added).

61. During Robbie's tenure, Defendant routinely admitted inpatients to its hospital without a physician writing an admission order at or prior to the time of admission.

62. Instead, Defendant's nurses and other non-physician staff admitted inpatients based on instructions from Defendant's transfer center that processes patient intakes.[6]

63. Robbie is aware of numerous patients who were admitted for multiple weeks without a physician ever writing an admission order.

64. Robbie is aware of numerous patients who were admitted and discharged without a physician ever writing an admission order.

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[6] I.C. § 39-1396 permits "physicians, physician assistants and advanced practice nurses" to admit patients if they meet certain qualifications. However, Defendant's practitioners who admit patients in lieu of physicians do not meet these qualifications.

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65. On one occasion, a patient was admitted and passed away while in Defendant's care, without a physician ever writing an admission order. Regarding the incident, a care manager wrote:

> This patient was admitted through the transfer center and no orders were received. There were no orders noted in the system, and only a progress note with documentation of a response to a code. I do not see an H&P [history and physical examination] or DC [discharge] summary noted. Registration was not able to verify information due to pt expiring shortly after arrival. There may be some concern since this patient expired in our facility without ever being admitted.

See **Exhibit A** (email from Case Manager Broesch dated May 9, 2016).

66. Defendant submitted claims for reimbursement for the care and services provided to inpatients who had been admitted without a physician's order.

67. Robbie directly observed the above practices from approximately December 2015 until her termination.

68. In an effort to correct the above illegal practices, Robbie reported this issue to Defendant's directors, one of whom responded to Robbie with words to the effect that if Defendant were to wait for physicians' orders prior to admitting patients, Defendant would never get paid.

D. Defendant Obtained Reimbursement for Outpatients Misclassified as Inpatients

69. In violation of federal laws, regulations, and guidelines, Defendant misclassified outpatients who were under hospital observation as inpatients.

70. Services coded and billed as inpatient care are reimbursed by Medicare at higher levels compared to identical services coded and billed as outpatient care.[7]

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[7] *See* Medicare National/HCPCS Aggregate Table, CY2015, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier2015.html (last accessed July 18, 2017).

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71. 42 C.F.R. 412.3(d) provides:

> Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

72. This rule is referred to as the "two-midnight rule."[8]

73. Defendant routinely sought and received Part A reimbursement for patients whose admissions did not meet the two-midnight rule or any of its enumerated exceptions.[9]

74. Defendant thereby received higher reimbursements than it would have received had these services been accurately coded as outpatient care.

75. Robbie has direct knowledge of these practices, based on the audits she conducted as part of her duties.

76. An audit by Robbie in late 2015 found that approximately 80% of Defendant's admissions did not meet the two-midnight rule or its enumerated exceptions.

77. Upon information and belief, Defendant continues to misclassify outpatients as inpatients in violation of the two-midnight rule.

E. Defendant Obtained Reimbursement for Patients Billed for Co-Payments in Violation of the EMTALA

78. Defendant violated the EMTALA, 42 U.S.C. § 1395dd, by requiring patients entering Defendant's emergency room to make co-payments prior to receiving medical screening and treatment.

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[8] *See* Fact Sheet: Two-Midnight Rule, *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html (last accessed July 18, 2017).

[9] Care for patients whose stays do not cross two midnights can still be reimbursed under Medicare Part A when it meets these enumerated exceptions. *See* 42 C.F.R. 412.3(d)(1)(ii) (unforeseen circumstances); 412.3(d)(2) (procedures defined elsewhere as "inpatient only," regardless of duration of stay); 412.3(d)(3) (clinical judgment of admitting physician).

79. The EMTALA provides:

> A participating hospital may not delay provision of an appropriate medical screening examination … or further medical examination and treatment … in order to inquire about the individual's method of payment or insurance status.

42 U.S.C. § 1395dd(h).

80. Defendant's hospital is a participating hospital within the meaning of § 1395dd(h).

81. Defendant routinely requires patients entering its emergency room to not only confirm their method of payment but to actually *make* payment prior to receiving any medical screening, examination, or treatment. On information and belief, a substantial number of these patients are Medicare beneficiaries, for whose care Defendant submits claims for reimbursement.

82. Robbie directly observed numerous incidences of the above practices.

83. On information and belief, Defendant continues to engage in the above practices.

F. Defendant Obtained Reimbursement for Claims that Contained False Diagnosis Codes

84. In violation of federal laws, regulations, and guidelines, Defendant intentionally recorded incorrect diagnosis codes to circumvent the Hospital-Acquired Condition ("HAC") Reduction Program established by 42 U.S.C. § 1395ww(p).

85. The HAC Reduction Program is a "Medicare law" within the meaning of CMS Forms 855A, 855B, and 1500.

86. CMS has published a list of hospital-acquired conditions.[10] This list includes Pressure Ulcer Stage III and Pressure Ulcer Stage IV – i.e., bedsores.

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[10] *See* FY 2012 Final HAC List, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2012_Final_HACsCodeList.pdf (last accessed July 19, 2017).

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87. Under the HAC Reduction Program, hospitals that rank in the bottom quartile of HAC quality measures are penalized by having their Medicare payments for applicable hospital discharges reduced by one percent.[11]

88. On multiple occasions, Defendant's hospital inpatients have developed HACs, including Stage III and Stage IV pressure ulcers.

89. However, in order to fraudulently improve its HAC quality measures, Defendant intentionally used incorrect diagnosis codes for patients who developed HACs.

90. Defendant submitted claims for reimbursement to Medicare that included these incorrect diagnosis codes.

91. Robbie has direct knowledge of the above practices based on the audits she performed in the course of her duties.

92. On information and belief, Defendant continues to engage in the above practices.

G. Defendant Obtained Reimbursement for Patients Despite Violating Said Patients' Rights

93. As a condition for participating in Medicare, a provider is required to respect the patient's rights enumerated by 42 C.F.R. 482.13.

94. Defendant intentionally ignored this obligation in numerous ways.

95. For instance, Defendant knowingly failed to provide patients notice of their rights.

96. 42 C.F.R. 482.13(a)(1) provides:

> A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

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[11] *See* Hospital-Acquired Condition Reduction Program Fiscal Year 2017 Fact Sheet, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html (last accessed July 19, 2017); 42 U.S.C. § 1395ww(p)(1).

97. Specifically regarding the discontinuance of inpatient care, 42 C.F.R. 405.1205(b) provides, in pertinent part:

> For all Medicare beneficiaries, hospitals must deliver valid, written notice of a beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital must use a standardized notice, as specified by CMS.

98. CMS has prescribed the use of Form CMS-R-193, also known as the Important Message from Medicare ("IM") form, as the standardized notice of beneficiary rights that a hospital must issue to inpatients upon discharge.[12]

99. Defendant routinely and knowingly failed to provide IM forms to Medicare beneficiaries upon discharge from inpatient care.

100. In an email, one of Defendant's directors admitted to being aware that Defendant failed to provide IM forms, stating "The reason we are not getting to the delivery of these notices while the patient is in house is due to registration currently at a critical need. Both [redacted] and I are aware we are not compliant with this regulation." *See* **Exhibit B** (email from Director Dahlgren dated April 25, 2017).

101. Defendant also knowingly violated patients' rights by using handcuffs to restrain patients.

102. 42 C.F.R. 482.13(e) provides:

> All patients have the right to be free from physical or mental abuse, and corporal punishment. ***All patients have the right to be free from restraint or seclusion, of any form***, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

(emphasis added).[13] CMS interpretative guidelines for this regulation further specify that:

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[12] *See* Hospital Discharge Appeal Notices, *available at* https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html (last accessed July 20, 2017).

[13] A restraint is "Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. ..." 42 U.S.C. § 482.13(e)(1)(i)(A).

> The use of handcuffs, manacles, shackles, other chain-type restraint devices ... **are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint intervention for use by hospital staff to restrain patients.**[14]

(emphasis in original).

103. In violation of these regulations and guidelines, Defendant's hospital staff intentionally used restraint devices, including handcuffs, to restrain patients.

104. In an email, one of Defendant's directors stated "we have had a couple instances where handcuffs were applied to patients recently." *See* **Exhibit C** (email from Director Ewing dated Oct. 26, 2015).

105. On information and belief, Defendant did not train its hospital staff to follow the patient restraint protocols under 42 U.S.C. § 482.13.

106. Although protecting patients' rights is a condition of participation in Medicare, Defendant submitted claims for reimbursement for the care of Medicare beneficiaries whose rights Defendant knowingly violated.

107. Robbie directly observed numerous incidents of the above violations of patients' rights. Robbie reported these violations to Defendant's directors and officers.

108. On information and belief, Defendant continues to violate patients' rights, as described above.

VI.
DEFENDANT'S RETALIATION AGAINST RELATOR ROBBIE GARRETT

109. In violation of the FCA and other statutes, Defendant retaliated against Robbie for her attempts to stop the illegal activities alleged herein.

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[14] *See* CMS State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretative Guidelines for Hospitals, § 482.13(e), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads /som107ap_a_hospitals.pdf (last accessed July 20, 2017).

110. 31 U.S.C. § 3730(h)(1) provides:

> Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under [§ 3730] or other efforts to stop 1 or more violations of [Chapter 31].

111. In an effort to correct the illegal practices alleged herein, Robbie filed numerous reports and complaints to Defendant's officers and directors.

112. Instead of working with Robbie to ensure the hospital's compliance, Defendant's officers and directors openly resisted Robbie's efforts.

113. On multiple occasions, Robbie was told to stop looking for violations.

114. On multiple occasions, Robbie was told that her efforts had caused or would cause Defendant to lose revenue.

115. Furthermore, Defendant engaged in a campaign of harassment, including repeatedly subjecting Robbie to formal reprimands that have no basis in fact. For instance, Defendant once formally reprimanded Robbie for violating a policy that did not exist, and then created said policy after the fact.

116. After this harassment failed to deter Robbie, Defendant directly demanded that Robbie resign from her position. This was a termination in all but name; Robbie was explicitly told that staying on was not an option. Robbie resigned on July 24, 2017.

117. Defendant's actions against Robbie are in retaliation for her efforts to stop Defendant's violations of the FCA and other applicable laws and regulations.

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VII.
THE STATUTORY FRAMEWORK

A. The False Claims Act

118. The False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, (the "FCA"), reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345, at 1 (1986). As relevant here, the FCA establishes treble damages liability for an individual or entity that:

a. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(l)(A);

b. "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim, *id.* § 3729(a)(l)(B); or

c. "conspires to defraud the Government by getting a false or fraudulent claim allowed or paid," *id.* § 3729(a)(l)(C).

119. "Knowing," within the meaning of the FCA, is defined to include reckless disregard and deliberate indifference. *Id.*

120. In addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or each false claim.[15]

121. The FCA also provides for payment of a percentage of the Government's recovery to a private individual who brings suit on behalf of the Government (the "Relator") under the FCA. *See* 31 U.S.C. § 3730(d).

122. Furthermore, the FCA protects individuals who attempt to bring a Relator action under, or stop violations of, the FCA. *See* 31 U.S.C. § 3790(h).

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[15] Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461, FCA civil penalties are: (a) $5,500 to $11,000 for violations occurring from September 29, 1999, to November 2, 2015; (b) $10,781 to $21,563 for violations occurring from November 2, 2015, to February 3, 2017; and (c) $10,957 to $21,916 for violations occurring on or after February 4, 2017. *See* 28 C.F.R. 85.5.

123. Individuals who suffered retaliatory actions as a result of the foregoing are entitled to relief including reinstatement, back pay, interest, special damages, and litigation costs and reasonable attorneys' fees. *Id.*

B. The Medicare Program

124. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for certain healthcare services provided to certain segments of the population. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 1395 *et seq*.

125. HHS, through CMS, administers the Medicare program.

126. Part A of the Medicare program authorizes payment of federal funds for inpatient hospital services and other health services. *See generally* Medicare Benefit Policy Manual *at* Chapter 1.[16]

127. Part B of the Medicare program authorizes payment of federal funds for outpatient medical and other health services. *See generally* Medicare Benefit Policy Manual *at* Chapter 15.[17]

128. CMS enters into agreements with healthcare providers such as Defendant to establish their eligibility to participate in the Medicare program. Individuals or entities who are participating providers in Medicare, such as Defendant, may seek reimbursement from CMS for services rendered to patients who are program beneficiaries.

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[16] *Available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf (last accessed July 18, 2017).

[17] *Available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf (last accessed July 18, 2017).

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129. During the times relevant herein, to become an authorized participant in Medicare Part A, a provider must certify as follows:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. ... I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions ..., and on the provider's compliance with all applicable conditions of participation in Medicare.

Medicare Enrollment Application: Institutional Providers, CMS Form-855A, at 48.[18]

130. During all times relevant herein, to become an authorized participant in Medicare Part B, a provider has been required to certify as follows:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. ... I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions ..., and on the supplier's compliance with all applicable conditions of participation in Medicare.

Medicare Enrollment Application: Clinics/Group Practices, CMS Form-855B, at 31.[19]

131. In order to receive reimbursement from Medicare, providers such as Defendant must submit a claim form. *See* Form CMS-1500, attached hereto as **Exhibit D**.[20] That claim form requires the provider to make the following certification:

> In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete ... 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment.
> ...

Id., at 2.

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[18] *Available* at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf (last accessed July 18, 2017).

[19] *Available* at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf (last accessed July 7, 2017).

[20] Exhibit D is a true and correct copy of Form CMS-1500 (approved OMB-0938-1197 form 1500 (02-12)), *available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf (last accessed June 7, 2017).

132. The submission of such a certification, if false, is a violation of the FCA. 31 U.S.C. § 3729(a).

133. Each such false certification is a separate violation of the FCA.

C. The Emergency Medical Treatment and Labor Act

134. The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (the "EMTALA"), provides:

> A participating hospital may not delay provision of an appropriate medical screening examination ... or further medical examination and treatment ... in order to inquire about the individual's method of payment or insurance status.

42 U.S.C. § 1395dd(h).

135. Defendant's hospital is a "participating hospital" within the meaning of § 1395dd(h).

136. The EMTALA is a "Medicare law" within the meaning of CMS Forms 855A, 855B, and 1500.

137. The certification accompanying each CMS-1500 form submitted for reimbursement for services provided to a patient whose care violated the EMTALA is a false certification. The submission of such a false certification is a violation of the FCA. 31 U.S.C. § 3729(a).

138. Each such false certification is a separate violation of the FCA.

139. 42 U.S.C. § 1395dd(d)(1)(A) imposes upon participating hospitals a "civil monetary penalty of not more than $50,000" for each violation of the EMTALA.

VIII.
FIRST CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: PRESENTATION OF FALSE CLAIMS

140. Relators repeat and re-allege all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

141. Throughout the statutory period, Defendant presented claims for:

a. services that were rendered at facilities which Defendant fraudulently represented as provider-based facilities;

b. services that were rendered by non-physician practitioners, but billed as having been rendered by physicians;

c. services resulting from inpatient admissions unaccompanied by a physician's orders;

d. services misclassified as inpatient services;

e. services provided to patients whose treatments were delayed in violation of the EMTALA;

f. services for which Defendant deliberately used incorrect diagnosis codes to circumvent the HAC Reduction Program; and

g. services provided to patients whose enumerated rights were violated.

142. For each of its claims for reimbursement, Defendant certified that the information it was providing was true, accurate and complete; that it had provided or would provide sufficient information for CMS to determine eligibility; and that the claim complied with all applicable Medicare laws, regulations, and instructions for payment.

143. Each such certification was false, for the reasons described above.

144. Accordingly, Defendant knowingly presented false or fraudulent claims to CMS for payment in violation of 31 U.S.C. § 3729(a)(l) (2000), and, as amended, 31 U.S.C. § 3729(a)(l)(A).

145. The submission by Defendant of these false claims caused the Government, through its agency CMS and that agency's Medicare program, to pay out sums that it would not have paid if CMS had been made aware of the falsity of Defendant' claims and certifications.

146. Each false or fraudulent claim submitted to the United States is a separate violation of the FCA.

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147. By reason of the false or fraudulent claims that Defendant knowingly presented, the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

IX.
SECOND CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: MAKING OR USING FALSE RECORD OR STATEMENT TO CAUSE FALSE CLAIM TO BE PAID

148. Relators repeat and re-allege all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

149. As described above, throughout the statutory period, Defendant knowingly and falsely certified, stated, and/or represented that the information it was providing was true, accurate and complete; that it had provided or would provide sufficient information for CMS to determine eligibility; and that the claim complied with all applicable Medicare laws, regulations, and instructions for payment.

150. Defendant used false records and statements when they submitted these claims for reimbursement including, but not limited to, maintaining false addresses for its off-campus facilities.

151. Accordingly, Defendant knowingly used false records or statements material to false or fraudulent claims to CMS for payment in violation of 31 U.S.C. § 3729(a)(l)(B).

152. The submission by Defendant of these false records or statements caused the Government, through its agency CMS and through that agency's Medicare program, to pay out sums that it would not have paid if CMS had been made aware of the falsity of Defendant's records or statements.

153. Each submission of a false record or statement is a separate violation of the FCA.

154. By reason of the false or fraudulent records or statements that Defendant knowingly submitted, the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

X.
THIRD CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: CONSPIRING TO SUBMIT FALSE CLAIMS

155. Relators repeat and re-allege all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

156. As set forth above, Defendant conspired with unnamed co-conspirators to seek and obtain from CMS reimbursement by submitting claims that violated Medicare laws, regulations, and instructions for payment.

157. Accordingly, Defendant knowingly conspired to defraud the Government by getting false or fraudulent claims allowed or paid, in violation of 31 U.S.C. § 3729(a)(3) (1986), and conspired to commit violations of 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), in violation of 31 U.S.C. § 3729(a)(1)(C) (2009).

158. By reason of the false or fraudulent claims that Defendant conspired to get allowed or paid, or by reason of its conspiracy to violate 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

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XI.
FOURTH CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: RETALIATION

159. Relators repeat and re-allege all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

160. As set forth above, Robbie sought to stop Defendant's violations of the FCA and other laws. In response, Defendant engaged in retaliatory actions against Robbie, including harassment and termination.

161. By reason of Defendant's illegal retaliatory actions prohibited by 31 U.S.C. § 3730(h), Robbie has been damaged, and continues to be damaged, in an amount to be determined at trial. Relators respectfully request an order awarding Robbie re-instatement, damages, interest, costs and reasonable attorneys' fees under § 3730(h)(2).

XII.
FIFTH CLAIM FOR RELIEF
UNJUST ENRICHMENT

162. Relators repeat and re-allege all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

163. As set forth above, the Government issued Medicare reimbursements to Defendant based on Defendant's claims submitted in violation of Medicare laws, regulations, and instructions for payment.

164. The circumstances of Defendant's receipt of these monies from the Government, in an amount to be determined at trial, are such that, in equity and in good conscience, Defendant should not be permitted to retain such monies.

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165. By reason of Defendant's unjust enrichment, Relators respectfully request an order requiring Defendant to disgorge all monies it received as a result of the illicit scheme described herein.

PRAYER FOR RELIEF

WHEREFORE, Relators respectfully request that this Court enter judgment in their favor and that of the United States, and against Defendant, granting the following:

(A) On the First, Second, and Third Claims for Relief (violations of the FCA, 31 U.S.C. §§ 3729(a)(1)(A), 3729(a)(l)(B), and 3729(a)(l)(C)), an award to the United States for treble its damages, in an amount to be determined at trial, plus a statutory penalty for each false claim submitted in violation of the FCA;

(B) On the First, Second and Third Claims for Relief, an award to the United States in the amount of $50,000 for each violation of the EMTALA, 42 U.S.C. § 1395dd, as proven at trial;

(C) On the First, Second, Third and Fifth Claims for Relief, an award to the United States for its costs pursuant to 31 U.S.C. § 3729(a)(3);

(D) On the Fourth Claim for Relief, an award to Relators for their costs and reasonable attorneys' fees pursuant to 31 U.S.C. § 3730(h)(2);

(E) On the First, Second, and Third Claims for Relief, an award to Relators in the maximum amount permitted under 31 U.S.C. § 3730(d);

(F) On the Fourth Claim for Relief, an award to Robbie for her damages and interest, as well as reinstatement, pursuant to 31 U.S.C. § 3730(h)(2);

(G) On the Fifth Claim for Relief (Unjust Enrichment); an award for the damages sustained by the United States, and amounts of monies illegally obtained from the United States and retained by Defendant, plus interest, costs, and expenses;

(H) And on all Claims for Relief,

1. An award to Relators of the reasonable attorneys' fees, costs, and expenses they incurred in prosecuting this action;
2. Awards to the United States and to Relators for their costs of court;
3. Awards to the United States and to Relators for pre- and post-judgment interest at the rates permitted by law; and

(I) An award of such other and further relief as this Court may deem to be just and proper.

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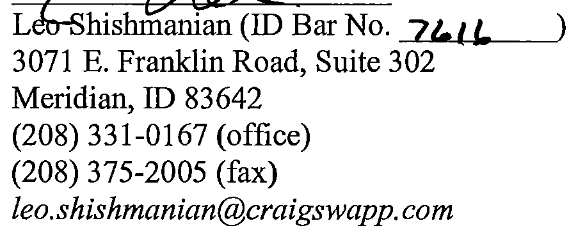
DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Relators demand trial by jury on all questions of fact raised by the Complaint.

Dated:

Respectfully submitted,

CRAIG SWAPP & ASSOCIATES



Leo Shishmanian (ID Bar No. 7616)
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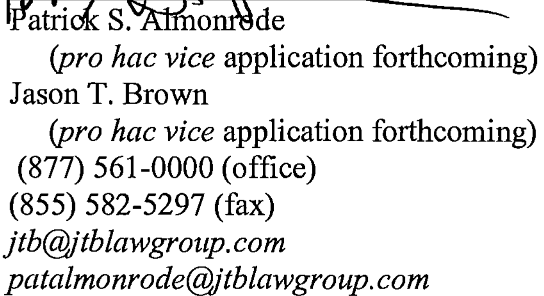
(208) 331-0167 (office)
(208) 375-2005 (fax)
leo.shishmanian@craigswapp.com

JTB LAW GROUP, LLC



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(*pro hac vice* application forthcoming)
Jason T. Brown
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Attorneys for Relators Robbie Garrett and James Daniel Garrett

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CERTIFICATE OF SERVICE

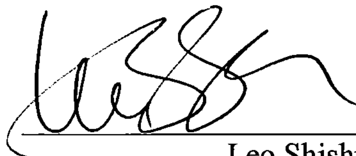
I hereby certify that on July 31, 2017, I caused a true copy of the Complaint in the matter captioned *United States of America ex rel. Robbie Garrett and James Daniel Garrett v. Kootenai Hospital District.* to be served upon the following, along with written disclosure of substantially all material evidence and information possessed by Relators:

by hand delivery to

Bill Humphries
Assistant United States Attorney
District of Idaho
United States Attorney's Office
Washington Group Plaza IV
800 E. Park Blvd., Suite 600
Boise, Idaho 83712

by USPS Registered Mail, Return Receipt Requested, to

Office of the Attorney General of the United States
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001



Leo Shishmanian

From: Broesch, Charlotte
Sent: Monday, May 09, 2016 2:16 PM
To: Porter, Amanda; Dahlgren, Kathleen; Magera, Christiane; Mooney, Jeanna
Subject: RE: KM15977418

This patient was admitted through the transfer center and no orders were received. There were no orders noted in the system, and only a progress note with documentation of a response to a code. I do not see an H&P or DC summary noted. Registration was not able to verify information due to pt expiring shortly after arrival. There may be some concern since this patient expired in our facility without ever being admitted....
Char

From: Porter, Amanda
Sent: Friday, May 06, 2016 1:44 PM
To: Broesch, Charlotte
Subject: FW: KM15977418

Char????

Amanda Porter, CPC
Coding Manager

Kootenai Health
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

208.625.4345 phone
208.625.4434 fax
aporter@kh.org
kh.org

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From: Mooney, Jeanna
Sent: Wednesday, May 04, 2016 12:22 PM

To: Porter, Amanda; Broesch, Charlotte
Subject: RE: KM15977418

I have to get with Char on this one. This patient doesn't even have a conditions of admission in the chart.

Jeanna Mooney, RN-BSN
Nurse Care Manager
UR Specialist
jeanna.mooney@kh.org
208-625-4297

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From: Porter, Amanda
Sent: Wednesday, May 04, 2016 11:04 AM
To: Mooney, Jeanna; Broesch, Charlotte
Subject: KM15977418

Hi Ladies,

Can you review, no status order and little documentation?

Thank you,

Amanda Porter, CPC
Coding Manager

Kootenai Health
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

208.625.4345 phone
208.625.4434 fax
aporter@kh.org
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From: Dahlgren, Kathleen
Sent: Tuesday, April 25, 2017 2:23 PM
To: Harling, Robyn <RHarling@kh.org>; Sauve, Lori <LSauve@kh.org>
Cc: Schneider, Corin <CSchneider@kh.org>
Subject: RE: Document1

Robyn, We have reviewed our current policy and I believe these issues are currently being addressed. I guess, I need to understand your perspective and your concern about not meeting the intent.

The reason we are not getting to the delivery of these notices while the patient is in house is due to registration staffing currently at a critical need. Both Lori and I are aware we are not compliant with this regulation.

Hence, we have reached out to Corin to help us manage the delivery of those IM notices after the patient status has been changed by care management and well after registration has done their registration process.

I would truly appreciate your perspective on where you believe we are non compliant with the current policy and the regulation????

Kathleen Dahlgren, RHIT, CCS
Executive Director, Revenue Cycle

Kootenai Health
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

208.625-4390 phone **PLEASE NOTE NEW PHONE NUMBER**
208-818-9552 cell
208.666.3963 fax
kdahlgren@kh.org **PLEASE NOTE NEW EMAIL ADDRESS**
kootenaihealth.org

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manager or the sender immediately and do not disclose or provide copies of the contents to anyone.

From: Harling, Robyn
Sent: Tuesday, April 25, 2017 9:13 AM
To: Sauve, Lori
Cc: Schneider, Corin; Dahlgren, Kathleen
Subject: Document1

Lori,
I copied and pasted the CMS requirements for the IMM. The link is at the bottom of this page for you to access it in its entirety. I think we need to really look at this and make sure we are meeting all the requirements of documentation for sending letters via certified mail as well as documentation of the required phone call. I have sent this to Kathleen and Corin as well and I believe it is being looked at for the policy revision.

From: Simon, Joan
Sent: Tuesday, October 27, 2015 11:02 AM
To: Garrett, Robbie
Subject: RE: Handcuff use

Robbie,
I am concerned with this messaging...it sends a double message. Security are not deputies. They are hospital employees. We are in some dicey water here....
I think we need to discuss all in the same room.
Joan

Wash your hands & ask your friends to do the same.... ***The power is in your hands!***

Joan Simon
Chief Nursing Officer

208.755.3651 mobile
208.625.4002 phone
208.625.4012 fax
jsimon@kh.org
www.kh.org

KootenaiHealth

From: Garrett, Robbie
Sent: Monday, October 26, 2015 9:20 PM
To: Simon, Joan
Subject: Fwd: Handcuff use

Hi Joan,

Do you think this will be strong enough wording to prevent them from using handcuffs on patients?

Sent from my iPhone

Begin forwarded message:

> **From:** "Ewing, Jeff" <JEwing@kh.org>
> **Date:** October 26, 2015 at 5:53:03 PM PDT
> **To:** "Garrett, Robbie" <RGarrett@kh.org>
> **Cc:** "Evans, Jeremy" <JEvans@kh.org>
> **Subject: FW: Handcuff use**

Robbie- below is the communication I've drafted for our Security Officers. I have reviewed with Jeremy and wanted to pass it by you before disseminating. Please let me know your thoughts and if we need to meet and discuss.

JE

Team- We have State surveyors on site reviewing a couple complaints (not believed to be specific to security), additionally our accreditation survey with DNV is expected to take place this week. That said, we have had a couple instances where handcuffs were applied to patients recently. After meeting with our Risk and Compliance department it was determined that the risk to Kootenai Health and our conditions of participation with CMS was significant (see attached CMS guideline). As a precautionary measure, we need to limit carrying and use of handcuffs while we obtain acknowledgement that our practices, policies & procedures are supported by CMS before we re-issue/carry. I expect this to be temporary, as does Jeremy Evans who understands and supports our need to have the proper tools for the safety of all parties. Knowing we deal with non-patient situations, criminal acts and to help support Officer safety, I'd like the Leads to continue carrying handcuffs as well as night shift external patrols.

Thank you,

Jeff

From: Garrett, Robbie
Sent: Monday, October 26, 2015 12:04 PM
To: Ewing, Jeff
Cc: Clark, Jason; Stielstra, Nathan; Fairfax, Walter; Hendrickson, Shari; Groat, Amanda; Holmes, Helen
Subject: RE: Handcuff use
Importance: High

Here is a copy of the CoP regarding use of handcuffs (attached) – it clearly states they cannot be used to restrain patients. Here is the wording from HCPro for clarity as well: