1) **ANTI-KICKBACK**

**Indiana Code § 12-15-24-2**
It is unlawful for a person who furnishes items or services to an individual for which payment is or may be made from the Medicaid program to solicit, offer, or receive a: (1) kickback or bribe in connection with the furnishing of the items or services or the making or receipt of payment; or (2) rebate of a fee or charge for referring the individual to another person for the furnishing of items or services. Violation of this section is a Class A misdemeanor.

**Indiana Code § 12-15-24-1**
Evidence that a person or provider received money or other benefits as a result of soliciting, offering, or receiving kickbacks constitutes prima facie evidence, for purposes of proving the criminal act of theft, a Class D felony, that the person or provider intended to deprive the state of part of the value of the money or benefits.

2) **PROHIBITIONS ON SELF-REFERRAL**

**Indiana Code § 25-22.5-11-3**
Establishes that a physician may refer a person to any organization or business that provides diagnostic, medical, or surgical services, dental treatment, or rehabilitative care in which the physician has a financial interest, so long as the physician’s financial interest in the entity is disclosed in writing to the individual and the individual is informed in writing that they may choose to be referred to another health care entity. The individual must sign the required notice to acknowledge receipt and the physician must keep a copy of the signed notice. Compliance with this section is not required, however, if a delay in treatment caused by compliance would
reasonably be expected by the referring physician to result in serious jeopardy to the individual's health, impairment to the individual's body functions, or dysfunction of a body organ or part.

**Indiana Code § 25-22.5-11-4**
As a condition of their state licensure, physicians must comply with the aforementioned notice requirements before referring an individual to a health care entity in which they have a financial interest.

**844 IAC 5-2-11**
Prohibits a person who holds an unlimited license to practice medicine or osteopathic medicine in Indiana (or a limited license or permit as issued by the medical licensing board) from paying, demanding, or receiving compensation for referral of a patient, except for a patient referral program operated by a medical society or association approved by the medical licensing board.

**846 IAC 1-3-3(9)**
Prohibits a chiropractor from paying or receiving compensation for referral of a patient.

**845 IAC 1-6-2(d)**
Prohibits a podiatrist from paying, demanding, or receiving compensation for referral of a patient, except for a patient referral program operated by a podiatry association approved by the board of podiatric medicine.

### 3) FALSE CLAIMS/FRAUD & ABUSE

**Indiana False Claims Act**

**Indiana Code § 5-11.5-5.1 and Indiana Code § 5-11.5.5-2**
Prohibits a person from knowingly (either has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information) or intentionally: (1) presenting a false claim to the state for payment or approval; (2) making or using a false record or statement to obtain payment or approval of a false claim from the state; (3) with intent to defraud the state, delivering less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state; (4) with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) receiving public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property; (6) making or using a false record or statement to avoid an obligation to pay or transmit property to the state; or (7) conspiring with, causing, or inducing another to perform one of the aforementioned acts.
A person who violates this section is liable for a civil penalty of at least $5,000 and for up to three times the amount of damages sustained by the state, in addition to the costs of a civil action brought to recover the penalty or damages. If, however, it is determined that the person who violated this section furnished state officials with all information known to the person about the violation not later than 30 days after the date on which the person obtained the information, fully cooperated with the investigation of the violation, and did not have knowledge of the existence of an investigation, criminal prosecution, civil action, or an administrative action concerning the violation at the time the person provided the information, the person is liable for a penalty of not less than two times the amount of damages that the state sustained and for the costs of a civil action brought to recover the penalty or damages.

**Indiana Code § 5-11-5.5-3**

Provides that the attorney general and inspector general have concurrent jurisdiction to investigate violations of Indiana's False Claims Act. The attorney general may bring a civil action if the attorney general discovers a violation. If the inspector general discovers a violation, he or she must certify a finding of a violation to the attorney general, who may bring a civil action.

**Indiana Code § 5-11-5.5-4 and Indiana Code § 5-11-5.5-6**

A civil action for a violation of Indiana Code Section 5-11-5.5-2 may be brought by a person on his or her own behalf and on behalf of the state. This section sets forth the requisite procedures to be followed in initiating an action and permits the state to intervene. If the state ultimately prevails in the action, the person who filed the complaint is entitled to receive at least 25% and not more than 30% of the proceeds or settlement if the state did not intervene and between 15% and 25% if the state intervened in the action. In both cases, the person may also recover reasonable attorney’s fees and an amount to cover the expenses and costs of the action. However, if the state intervened and the court finds that the evidence used to prosecute the action consisted primarily of specific information contained in a transcript of a criminal, civil, or administrative hearing; a legislative, administrative, or other public report, hearing, audit, or investigation; or a news media report, the person may not recover more than 10% of the proceeds or settlement, plus fees and costs. A person who planned, initiated, or was convicted of violating the Act himself is not entitled to any recovery.


**Case:** York Howze, as Relator on behalf of the United States, filed a whistleblower action against the Defendant, Sleep Centers of Fort Wayne, LLC, alleging violations of the federal False Claims Act, 31 U.S.C. § 3729, et seq. (the “FCA”) and the Indiana False Claims Act, Ind. Code § 5-11-5.5 (the “Indiana FCA”). Howze claimed that Defendant knowingly credentialed its sleep center incorrectly as being part of a “group practice” when the center should have been classified as a “Independent Diagnostic Testing Facility” because the center itself was not a group practice of
physicians, but rather was owned in large part by Fort Wayne Neurology, which was itself a group practice. Additionally, Howze claimed that the center failed to meet numerous requirements applicable to IDTFs, including, but not limited to, failing to have a site visit, failing to staff adequate physician supervision, and failing to staff properly credentialed or qualified non-physician technicians. According to Howze’s claims, the center did not comply with any category permitted to bill under the physician fee schedule and thus its billing to CMS was improper and part of a scheme to defraud the Medicare and Medicaid programs in violation of the FCA and the Indiana FCA.

Among other arguments, the Defendant contended that Howze’s complaint did not allege that the Defendant submitted claims that were “actually false,” but rather alleged that the claims were “impliedly false” because they were submitted when the center was enrolled as a group practice rather than an IDTF. The Defendant asserted that the Seventh Circuit refuses to consider the implied certification theory in cases where the alleged implied certifications are not conditions of payment and argued that Howze did not allege that the center’s failure to register as an IDTF and comply with all the requirements applicable to IDTFs was a violation of a condition of payment, and thus contended that Howze failed to allege a violation of the FCA even under the implied certification theory.

**Holding:** Howze’s complaint contains the minimal pleading requirements to assert a claim under the FCA based upon his allegation that the Defendant falsely certified that the center was in compliance with CMS regulations required for payment when it classified the center as a group practice in its CMS application form though it should have been designated as an IDTF. Further, since Howze claims that the Defendant actually certified that the center was in compliance with CMS regulations required for payment when it completed its CMS application form, Howze’s complaint is not based on implied certification theory. Additionally, Howze’s complaint argued that even if the Defendant had intended to classify the center as an IDTF, it knowingly failed to comply with all the requirements applicable to IDTFs and therefore was not eligible to bill CMS.

**Fraud and Other Deceptive Acts**

**Indiana Code § 35-43-5-7.1**

Prohibits a person from knowingly or intentionally filing a claim, including an electronic claim, for services in violation of the Indiana statutory Medicaid provisions set forth in Indiana Code Section 12-15, or from obtaining payment from the Medicaid program by means of false or misleading oral or written statements or other fraudulent means. This section also prohibits a provider from acquiring a provider number under the Medicaid program, except as authorized by law, concealing information for the purpose of applying for or receiving unauthorized Medicaid payments, or altering with the intent to defraud or falsifying a provider’s documents or records that are required to be kept under the Medicaid program. A violation of this section constitutes Medicaid fraud, a Class A misdemeanor. If the fair market value of the offense is at least $750 and less than $50,000, the offense is
considered a Level 6 felony. If the fair market value of the offense is at least $50,000, the offense is considered a Level 5 felony.

**Healthscript, Inc. v. State, 770 N.E.2d 810 (Ind. 2002)**

Case: The Defendant, a pharmacy, was charged with the crime of Medicaid fraud on the theory that the Defendant overcharged Medicaid for products provided to its customers at a long term care facility in violation of Indiana Code Section 35-43-5-7.1(a)(1). The state argued that the Defendant failed to comply with a Medicaid regulation then in effect (405 IAC 1-6-21.1(g)(3) repealed and codified at 405 IAC 5-24-4; see also 405 IAC 1-1-6(b)), which prohibited providers from being paid by Medicaid more than their "usual and customary charge" to private non-Medicaid customers. The state contended that the Defendant failed to comply with this regulation when it overcharged the Medicaid program and thus, violated Indiana Code Section 12-15-21-1, which required a provider who accepts payment of a claim submitted under the Medicaid program to comply with the statutes and rules governing the program.

Holding: The general cross-reference in Indiana Code Section 35-43-5-7.1(a)(1) to Indiana Code Section 12-15 (which establishes the general operations of the Indiana Medicaid Program) was determined too vague in defining the conduct sought to be proscribed to meet due process requirements for penal statutes and did not provide fair warning required by the rule of lenity.

**Indiana Code § 35-43-5-7.2**

Prohibits a person from knowingly or intentionally filing a false Children's Health Insurance Program (CHIP) claim, obtaining payment from the CHIP program by means of false or misleading oral or written statements, acquiring a provider number under the CHIP program (except as authorized by law), altering with the intent to defraud or falsifying documents or records of a provider required to be kept under CHIP, or concealing information for the purpose of applying for or receiving unauthorized payments from CHIP.Violation of this section is a Class A misdemeanor. The offense is a Level 6 felony if the fair market value of the offense is at least $750 and less than $50,000. The offense is a Class 5 felony if the fair market value of the offense is at least $50,000.

**Indiana Code § 35-43-5-4.5 and Indiana Code § 34-24-3-1**

It is insurance fraud, a Level 6 felony, for a person knowingly and with intent to defraud to make, utter, present, or cause to be presented to an insurer or an insurance claimant a claim statement that contains false, incomplete, or misleading information concerning the claim, or to present, cause to be presented, or prepare with knowledge or belief that it will be presented to or by an insurer, an oral, written, or electronic statement that the person knows to contain materially false information concerning a fact material to a claim for payment or benefit under an insurance policy, or payments made in accordance with the terms of an insurance policy. Persons committing insurance fraud with prior, unrelated insurance fraud convictions
or where the value of the property or benefits at issue are at least $2,500 are liable for a Level 5 felony.

A person who suffers a pecuniary loss as a result of a violation of Indiana Code Section 35-43-5-4.5 may also bring a civil action against the person who caused the loss to recover an amount of up to three times the damages suffered plus costs, expenses, and reasonable attorney's fees.

**Exploitation of Dependent or Endangered Adult**

**Indiana Code § 35-46-1-12**

Provides that a person who recklessly, knowingly, or intentionally deprives an endangered adult (person 18 years of age, incapable by reason of physical or mental incapacity of directing the management of the individual's property or providing self-care and harmed as a result of exploitation of the individual's personal services or property) or dependent of the proceeds of the individual's benefits under the Social Security Act or other retirement program that the division of family resources has budgeted for the individual's health care commits financial exploitation, a Class A misdemeanor. The offense is a Level 6 felony if the amount of the proceeds is more than $10,000 or the endangered adult or dependent is at least 60 years of age.

**State Medicaid Fraud Control Unit**

**Indiana Code § 4-6-10-1 and Indiana Code § 4-6-10-1.5**

Establishes the State Medicaid Fraud Control Unit authorized to investigate Medicaid fraud, misappropriation of a Medicaid patient's private funds, abuse of Medicaid patients, neglect of Medicaid patients, and abuse or neglect of patients in board and care facilities.

**Indiana Code § 4-6-10-3**

Provides the attorney general and investigators of the Medicaid Fraud Control Unit authority to issue, serve, and apply to a court to enforce a subpoena for a witness to appear before the attorney general to produce documents and electronic records for inspection and examination during an investigation or prosecution of an alleged offense.


**Case:** Clinic providing abortion and reproductive health services sought an injunction against the Indiana Medicaid Fraud Control Unit's (IMFCU’s) demand for access to minor patients' medical records in order to investigate complaints that clinic failed to report child sexual abuse as required by law.

**Holding:** Neglect of a patient, for purposes of IMFCU's investigative authority, includes health care provider's failure to report the suspected sexual abuse of minor patients. Enjoining IMFCU's investigation would not violate the separation of powers doctrine. In balancing the minor patients' limited constitutional right to privacy in their medical records against IMFCU's interest in investigating complaints of patient
neglect, the court concluded that the clinic had demonstrated a reasonable likelihood of proving at trial that granting IMFCU's demand for unlimited access to the medical records of the clinic's minor patients would violate the patients' constitutional privacy rights. Accordingly, the court reversed the trial court's denial of the clinic's request for a preliminary injunction and remanded with instructions for the trial court to immediately enter a preliminary injunction in favor of the clinic against IMFCU. Notwithstanding the preliminary injunction, IMFCU could still refer any neglect complaint "to an appropriate criminal investigative or prosecutive authority" pursuant to 42 C.F.R. § 1007.11(b)(2). Likewise, the attorney general and IMFCU could issue a subpoena for medical records pursuant to Indiana Code Section 4-6-10-3.

Medicaid: Improper Payments


Provides that the Office of the Secretary of Family and Social Services or administrator of the office may deduct overpayments from subsequent payments to the provider, including interest due from the provider for the amount of the overpayment. Allows a provider and administrator of the Office of Medicaid Policy and Planning 60 days after discovery of an overpayment to enter an agreement for return of the overpayment and interest. If the parties fail to enter into such an agreement, the administrator is required to certify the facts of the case to the Medicaid Fraud Control Unit.


Investigations by the Medicaid Fraud Control Unit ending in a determination that a crime may have been committed by a provider shall be certified and submitted to the prosecuting attorney in the judicial circuit in which the crime may have been committed. The prosecuting attorney may refer the matter to the attorney general who may bring a civil action or refer a provider for sanctions to the administrator of the Office of Medicaid Policy and Planning under Indiana Code Section 12-15-22. Judgment in favor of the attorney general in a civil action may result in a penalty against the provider of not more than three times the amount paid to the provider in excess of the amount that was legally due, a civil penalty of not more than $500 for each instance of overpayment found by the court, and/or an order that the provider reimburse the attorney general for the reasonable costs of investigation and enforcement action. The court may only assess a civil penalty and order reimbursement of court and investigation costs if the provider knew or had reason to know that an item or a service was not provided as claimed.

Medicaid: Provider Sanctions

**Indiana Code § 12-15-22-1**

Enables the Office of Medicaid Policy and Planning to impose one or more sanctions on a provider for violation of a Medicaid statute or rule adopted under a Medicaid statute, including denial of payment to the provider for Medicaid services provided during a specified time, rejection of a prospective provider's application for participation in the Medicaid program, termination of a provider agreement permitting
a provider's participation in the Medicaid program, assessment of a civil penalty against the provider in an amount not to exceed three times the amount paid to the provider in excess of the amount legally due, and/or an assessment of an interest charge on the amount paid to the provider in excess of the amount legally due.

**Indiana Code § 12-15-22-1.5**
Prohibits a provider from participating in the Medicaid program for ten years following conviction for a crime involving Medicaid fraud.

**Indiana Code § 12-15-22-8**
Establishes that a provider convicted of a crime relating to the provision of services under the Medicaid program or who has been subjected to a sanction for violation of the provisions of the Medicaid program on three separate occasions by directive of the administrator of the Office of Medicaid Policy and Planning is ineligible to submit claims to Medicaid.

**Medicaid: Drug Utilization Review**

**Indiana Code § 12-15-35-28**
Establishes the Drug Utilization Review Board authorized to conduct a statewide program, including the approval of software programs used by pharmacists for prospective recommendations concerning the provisions of contractual agreements between the state and any other entity processing and reviewing Medicaid drug claims and profiles. Authorizes the Board to develop predetermined criteria and standards for appropriate prescribing of medication developed with professional input and in accordance with resources widely accepted by the medical profession for the efficacious use of prescription drugs. Requires the Board to publish and disseminate educational information to physicians and pharmacists regarding the Board and the Drug Utilization Review program, including information on identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients. Mandates that the Board research, develop, and approve a preferred drug list for the Medicaid program. Enables the Board to require prior authorization for a drug included on the preferred drug list to prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

**Professions and Occupations: Health Professions Standards of Practice**

**Indiana Code § 25-1-9-4**
Requires a practitioner (broadly defined to include an individual who holds an unlimited, limited, probationary, or temporary license, certificate or registration, intern permit, or provisional license) to conduct the practitioner's practice in accordance with standards established by the board regulating the profession in question and subjects the practitioner to disciplinary sanctions if the board finds: (1) the practitioner has engaged or cooperated in fraud or material deception in the course of his or her professional services, finds the practitioner has advertised services in a false or misleading manner, or the practitioner has been convicted of a crime or assessed a civil penalty involving fraudulent billing of Medicaid, Medicare, the
Indiana Children’s Health Insurance Program, or insurance claims; (2) the practitioner has been convicted of a crime that has a direct bearing on the practitioner’s ability to continue to practice competently or is harmful to the public; (3) the practitioner has knowingly violated any state statute or rule, or federal statute or regulation, regulating the practitioner’s profession; (4) the practitioner has continued to practice although the practitioner has become unfit to practice; (5) the practitioner has engages in a course of lewd or immoral conduct in connection with the delivery of services to the public; (6) the practitioner has allowed the practitioner’s name or license to be used in connection with an individual who renders services beyond the scope of that individual’s training, experience, or competence; (7) the practitioner has had disciplinary action taken against him/her or their license; (8) the practitioner has diverted drugs; (9) the practitioner has knowingly prescribed, sold or administered any drug classified as a narcotic, addicting, or dangerous to a habitue or addict; (10) the practitioner has failed to comply with an order imposing sanctions; (11) the practitioner has engaged in sexual contact with a patient under the practitioner’s care or has used the practitioner-patient relationship to solicit sexual contact with a patient under the practitioner’s care; (12) the practitioner has knowingly collected or attempted to collect from a subscriber or enrollee in an HMO any sums owed by the HMO; (13) the practitioner has assisted another person in committing an act that would be ground for disciplinary sanction; or (14) a practitioner has failed to report to the department of child services or a local law enforcement agency suspected child abuse.

**Indiana Code § 25-1-9-9**

Lists the disciplinary sanctions the board may impose, singly or in combination, for violation of the standards of professional practice, including permanent revocation of a practitioner’s license, suspension of a practitioner’s license, censure of a practitioner, issuance of a letter of reprimand, placement of a practitioner on probation status, or assessment of a fine against a practitioner in an amount not to exceed $1,000 for each violation, except for a finding of incompetency due to physical or mental disability.

**Indiana Code § 25-22.5-2-8**

Lists violations that a physician may commit—such as licensure renewal fraud, practicing with an expired license, and failure to disclose documentation required for licensure renewal—which may result in a civil penalty of not more than $1,000 per violation. Gives the medical board the authority to implement a program to investigate such violations.

**Insurance**

**Indiana Code § 27-1-3-22**

Prohibits the preparation or presentation of a written statement as part of a fraudulent claim of insurance, as well as the presentment or preparation of an oral or written statement that the person knows contains materially false information in support of or concerning any fact material to a claim for payment under an insurance policy.
Indiana Administrative Code
Title 405—Office of the Secretary of Family and Social Services

405 IAC 1-1-4
Authorizes the Office of Medicaid Policy and Planning to deny payment to any provider for medical assistance services rendered, including materials furnished to any individual or claimed to be rendered or furnished, if, after investigation by the Office it is discovered, among other violations, that the claims cannot be documented by the provider, the claims were made for services or materials determined not medically reasonable or necessary, the amount claimed for such services can be paid from other sources, the services claimed were provided to a person other than the person in whose name the claim was made, the services were provided to a person who was not eligible for medical assistance at the time of the provision of the service, or the claims at issue were false or fraudulent claims for services or merchandise.

405 IAC 1-1-5
Establishes the appropriate procedures for the Office of Medicaid Policy and Planning to recover payment from any Medicaid provider for services rendered to an individual, or claimed to be rendered to an individual, if the Office, after investigation or audit, classifies funds received as overpayments. Details the procedural requirements for a provider contesting a determination that specific funds were overpayments. Provides that any overpayments recovered by the Office subsequently found not to have been owing to the Office are to be repaid to the provider with interest on the amount erroneously recovered.

405 IAC 1-1-6
Lists the sanctions the Medicaid Policy and Planning Office, Medicaid Fraud Control Unit, or other governmental authority may impose on a provider if, after an investigation, the Office determines that a provider has violated any provision of Indiana Code Section 12-15 governing the Medicaid program or rule established thereto. Establishes that a provider may be subject to one or more sanctions for the violation, including denial of payment to the provider for medical services rendered, rejection of a prospective provider’s application for participation in the medical assistance program, removal of a provider’s certification for participation in the medical assistance program, assessment of a fine against the provider not to exceed three times the amounts paid to the provider in excess of the amounts legally due, and/or assessment of an interest charge on the amounts paid in excess of the amounts legally due.

Identifies the offenses for which sanctions will be imposed on a provider for violating the rules governing the Medicaid program, including: submission of false claims for medical assistance services that cannot be documented by the provider; submission of claims for medical assistance services provided to a person other than the person in whose name the claim is made; submission of false or fraudulent claims for assistance; submission of information with the intent of obtaining greater compensation than that which the provider is legally entitled; submission of false
information for the purposes of meeting prior authorization requirements; engagement in an act or course of conduct deemed by the Office to be abusive of the Medicaid program; breach of the terms of the Medicaid provider certification agreement; failure to comply with the terms of the provider agreement; overutilization of the Medicaid program; submission of a false or fraudulent provider certification agreement; submission of claims for medical services or merchandise arising out of any act or course of conduct prohibited by the criminal provisions of the Indiana Code or the rules of the Office; failure to meet standards required by the state of Indiana or federal law for participation in the program; charge of a Medicaid recipient for covered services over and above that paid for by the office; failure to repay or make arrangements to repay identified overpayments; or billing the Medicaid program more than the usual and customary charge to the provider’s private pay customers. Authorizes the assistant secretary of the Medicaid Policy and Planning Office to enter a directive imposing a sanction upon a provider that may include a corrective action plan. Sets forth the procedural requirements for provider appeal of sanctions imposed by the Office.

**Title 407: Office of the Children's Health Insurance Program**

405 IAC 13-1-1
Establishes the Office of the Children’s Health Insurance Program (CHIP), the general intent and purpose of which is to ensure the efficient and medically reasonable operation of CHIP, and to safeguard against overutilization, fraud, abuse, and utilization and provision of services and supplies that are not medically reasonable or necessary and are not covered by CHIP.

4) **UNFAIR BUSINESS PRACTICES**

**Indiana Code § 24-1-2-1**
Prohibits any person from entering a scheme, contract, or combination in restraint of trade or commerce, or to create or carry out restrictions in trade or commerce. Persons who make such a contract, engage in such a combination, enter into such a scheme, or do any act in furtherance of such within the state commit a Class A misdemeanor.

**Indiana Code § 24-1-1-1**
Voids all contracts, agreements, arrangements, trusts, or combinations between persons or corporations made with a view to lessen, or that tend to lessen, full and free competition, and all arrangements, contracts, agreements, trusts, or combinations between persons or corporations that advance, reduce, or control the price or the cost to the producer or to the consumer of any product or article, as against public policy.

**Indiana Code § 27-4-1-4**
Enumerates unfair methods of competition and unfair and deceptive acts and practices in the business of insurance. Among other things, prohibits unfair
discrimination between individuals of the same class involving the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance. Prohibits excessive or inadequate charges for premiums, policy fees, or rates between persons of the same class involving the same hazards for policies of insurance. Bars monopolizing or attempting to monopolize any part of commerce in the business of insurance or entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance. It is unlawful for an insurer to refuse, because of the for-profit status of a hospital or medical facility, to make payments otherwise required under a policy of insurance for charges incurred by the insured in such for-profit facility.

*Rumple v. Bloomington Hospital, 422 N.E. 2d 1309 (Ind. App. 1981)*

**Case:** Patient's father accused a hospital of maintaining an illegal monopoly with a radiology company because the hospital required that all patient X-rays be interpreted by a radiologist, and the hospital maintained an exclusive contract with one group of radiologists.

**Holding:** Plaintiff was unable to provide evidence of an agreement between the entities to fix prices, restrain competition, or demonstrate the existence of any illegal tying arrangement wherein the hospital wielded its economic power by exploiting its dominant position in one market to expand into another market. Plaintiff therefore failed to establish a violation of Indiana's antitrust law and judgment for the hospital was appropriate.

5) GENERAL WHISTLEBLOWER PROVISIONS

**Indiana Code § 5-11-5.5-8**
Indiana’s False Claims Act provides relief for an employee who has been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by the individual's employer due to the employee’s initiation, testimony, assistance, or participation in an investigation, action, or hearing regarding the violation of a state or federal regulation, including presenting a false claim to the state for payment or approval, making or using false records to obtain payment or approval of a false claim from the state, or the employee's objection to such act or omission. Relief may include: (1) reinstatement with the same seniority status the employee would have had but for the action taken by the employer against the employee; (2) two times the back pay owed the employee; (3) interest on the back pay owed the employee; and (4) compensation for any special damages sustained as a result of the action, including costs and expenses of litigation and reasonable attorney's fees.

**Indiana Code § 4-2-7-8**
Prohibits the Inspector General from disclosing the identity of an individual who discloses, in good faith, information alleging a violation of a state or federal statute,
rule, regulation, or ordinance, to anyone other than the governor, the staff of the U.S. Department of Health & Human Services, Office of Inspector General, or an authority to whom the investigation is subsequently referred. Confidentiality is maintained for any such individual unless the individual consents in writing to disclosure of the individual's identity or the Inspector General makes a written determination that it is in the public interest to disclose the individual's identity. The governor may also authorize disclosure of this confidential information, records, or the identity of such person if in the public interest.

**Indiana Code § 27-2-19-7**
Provides that any law enforcement agency, insurer, or governmental agency, or agent, employee, or representative thereof, that receives or provides information regarding fraudulent insurance claims to the appropriate state agency, in good faith, is immune from liability arising from the act of receiving or providing the information.

6) **HELPFUL LINKS**
- Indiana Statutes and Administrative Rules
- Office of the Indiana Attorney General
- Indiana Family and Social Services Administration
- Indiana State Department of Health