Purpose: To ensure that all those associated with Self Regional Healthcare (SRH), including its board members, physicians, employees, vendors, independent contractors and volunteers remain committed to and informed of their responsibility to help maintain high ethical standards and strict legal compliance in all aspects of our patient care and business relationships. SRH is committed to maintaining these standards as well as:

- Helping to avoid and eliminate waste, fraud and abuse in all federal, state and privately funded healthcare insurance programs.
- Remaining in full compliance with all federal, state, and local laws, statutes, regulations and guidelines relating to the documentation, billing, reimbursement and payment for healthcare services.

Scope: This policy applies to all those involved in the provision, documentation and/or billing for healthcare services as well as the administration of SRH and its services. This policy also applies to all persons, groups or entities that may provide services, components or supplies related to services billed by or on behalf of SRH.

Responsibility: SRH has developed policies and standards that address all laws, statutes, regulations and rules that control the provision of healthcare services, and more specifically the participation in federal or state funded healthcare programs (i.e. Medicare and Medicaid). As a condition of employment or affiliation, SRH expects all employees and affiliates (board members, physicians, vendors, independent contractors and volunteers etc.) to report concerns about actual or suspected wrongdoing. In addition, all employees and affiliates of SRH have various rights related to the reporting and resolution of incidents of suspected wrongdoing.

The SRH policy, *Non-Retaliation, Non-Retribution for Reporting* (QSP-CCI-0006) guarantees certain rights to individual(s) who may report an issue, including confidentiality when possible and the freedom from fear of retaliation or retribution. The Federal False Claims Act and The Deficit Reduction Act of 2005 [*see references and definitions below*] also offer whistleblower, or "*qui-tam*", rights to those who may wish to report suspected fraud, waste or abuse in government healthcare programs. These rights include certain levels of confidentiality and a potential share of settlements related to false claims for reimbursement of healthcare services.

Reference:

Federal Regualtions:

- **The Federal False Claims Act (FCA) - [31 U.S.C. §3729-3733]**
- **The Federal False Claims Act *qui tam* and whistleblower provisions – [31 U.S.C. §3730]**
- **The Federal Program Fraud Civil Remedies Act (1986) (PFCRA) – [31 U.S.C. §3801-3812]**

- **The Deficit Reduction Act (2005) (DRA) – Section 6032. [42 U.S.C. §1396a(a)(68)]**

State Regulations:

- **The South Carolina Presenting False Claims for Payment statute [S.C. Code Ann. §38-55-170]**
- **The South Carolina Medicaid False Claims Statute [S.C. Code Ann. §43-7-60]**
- **The South Carolina Medicaid False Application Statute [S.C. Code Ann. §43-7-70]**
- **The South Carolina Insurance Fraud and Reporting Immunity Act [S.C. Code Ann. §38-55-510 *et seq.*]**
- **The South Carolina Computer Crime Act [S.C. Code Ann. §16-16-10, *et seq*.]**
- **South Carolina Department of Health and Human Services (DHHS) Administrative Sanctions Against Medicaid Providers [S.C. Code of Regulations R. 126-400 *et seq.*]**
- **Employment Protection for Reports of Violations of State or Federal Law or Regulation [S.C. Code Ann. §8-27-10 *et seq.*]**

SRH Policies:

- **SRH *Non-retaliation and Non-retribution for Reporting* policy [QSP-CCI-0006]**
- **SRH *Compliance Incident Response* policy [QSP-CCI-0007]**

Definitions:

- **False Claims**: A false claim is defined in The Federal False Claims Act, The Federal Program Fraud Civil Remedies Act and the Deficit Reduction Acts as the following:

  1). Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of the Social Security Act),

  2). at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

  3). having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

  4). having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

5). presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

6). for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX of the Social Security Act, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c) of the Social Security Act.

Federal Regulations:

- **The Federal False Claims Act (FCA):**
  - **Provisions:** the FCA was originally enacted during the Civil War to fight fraud in supplying the government's war operations. The law has since undergone multiple changes and was revised to include federal healthcare programs (Medicare and Medicaid etc.) in 1986. The FCA uses the provisions detailed above to impose civil penalties for violations of the statute.
  - **Penalties:** The FCA it is not a criminal statute, therefore, no proof of specific intent is required for consideration as a violation. Persons (including organizations) may be fined a civil penalty of not less than $5,000 and not more than $10,000, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages is determined by the amounts paid for each false claim filed.

- **The Federal False Claims Act Qui Tam and Whistleblower provisions:**
  - **Provisions:** The FCA allows for any person (called a *qui tam* relator or whistleblower) to initiate a civil case against a person or organization for violations related to false claims. Any case initiated by a whistleblower will be served in Federal Court and will remain sealed for at least 60 days and not served on the defendant so the government can investigate the complaint.

    After the 60 day period, the government may pursue the matter in its own name or decline to proceed. If the government declines to proceed, the individual may conduct the action on their own in federal court. In addition, the government may also initiate cases under the FCA on its own accord.

    If the government proceeds with a *qui tam* case, the relator bringing the action will receive 15-25% of the proceeds, depending on their contributions to the success of the case. If the relator pursues the case on their own, then they will be entitled to 25-30% of the proceeds, plus reasonable expenses and attorney's fees awarded against the defendant.

    The FCA also provides that relators initiating frivolous *qui tam* claims can be held liable to a defendant for reasonable attorney's fees and costs.
  - **Antidiscrimination Provisions:** Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by their employer. The employee is

authorized under the FCA to initiate court proceedings to recover any job related losses resulting from any such discrimination or retaliation.

- **The Federal Program Fraud Civil Remedies Act (1986) (PFCRA):**
  - **Provisions:** The PFCRA was enacted to address lower dollar frauds, and is used separate from and in addition to claims provided by the FCA. The PFCRA generally applies to dollar amounts of $150,000 or less. These cases are investigated directly by the Health and Human Services Office of Inspector General, but due to the availability of the FCA and other criminal, civil and administrative remedies, cases are not routinely prosecuted under the PFCRA.
  - **Penalties:** Using the same definitions and statutory language as the FCA, the PFCRA provides that any false claims can result in fines of up to $5,000 per false claim and up to twice the amount claimed.
- **The Deficit Reduction Act (2005) (DRA):**
  - **Provisions:** Under the DRA, any entity that receives at least $5,000,000 on an annual basis from Medicaid must, as a condition of payment from Medicaid is required to:

    1). Establish written policies for all employees of the entity, (including management), and of any contractor or agent of the entity, that provide detailed information about (A) the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, (B) administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, (C) any State laws pertaining to civil or criminal penalties for false claims and statements, and (D) whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal healthcare programs (as defined in subsection (f) of the Social Security Act),

    2). Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse, and

    3). Include in any employee handbook for the entity, a specific discussion of the laws described in section (1) above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

    In addition, the DRA requires all states to develop and implement a law that meets the FCA requirements and directly addresses fraud, waste and abuse in the State's Medicaid Program.

State Regulations:

- **State Criminal False Claims Statue:**
  - **Provisions:** The South Carolina Presenting False Claims for Payment statute provides that a person who knowingly causes, assists with, solicits, or conspires in the presentation of a false claim to an insurer, health maintenance organization, or to any person (including the State of South Carolina) providing benefits for health care in South

Carolina is, depending upon the amount of the claim, guilty of anywhere from a misdemeanor for which the person can be fined and imprisoned to a felony whereby the person is subject to imprisonment for ten years and/or a fine of five thousand dollars.

- **State Medicaid False Claims Statute:**
  - **Provisions:** The South Carolina Medicaid False Claims Statute provides criminal, civil, and administrative penalties and sanctions related to health care providers who knowingly and willfully make a false statement in an application or request for a benefit, reimbursement or in a report or certificate submitted to the Medicaid program. The Statute also provides that it is unlawful for a provider to knowingly and willfully conceal or fail to disclose any material fact which affects the provider's initial or continued entitlement to reimbursement or the amount of payment under the Medicaid program. Each false claim or concealed fact constitutes a separate offense.

    A person who violates the Medicaid False Claims Statute is guilty of a misdemeanor and subject to imprisonment for up to three years and a fine of not more that one thousand dollars per offense. In addition, the Attorney General may bring a civil action to recover treble damages and seek penalties of two thousand dollars per false claim. The state agency administering the Medicaid program may impose additional administrative sanctions on providers convicted under the Statute.
- **State Medicaid False Application Statute:**
  - **Provisions:** The South Carolina Medicaid False Application Statute provides criminal penalties for any applicant, recipient or other person acting on their behalf to knowingly and willfully (1) make or cause to be made a false statement or representation of material fact on a Medicaid application for entitlements, or (2) conceal or fail to disclose any material fact affecting initial or continuing entitlement to receive assistance, goods or services under the state’s Medicaid program.

    A person who violates the provisions of this statute is guilty of medical assistance recipient fraud, a misdemeanor, and upon conviction must be imprisoned not more than three years or fined not more than one thousand dollars, or both.
- **State Insurance Fraud and Reporting Immunity Act:**
  - **Provisions:** The South Carolina Insurance Fraud and Reporting Immunity Act provides for criminal and civil penalties related to insurance fraud and established an Insurance Fraud Division in the office of the Attorney General to prosecute violations.

    The term "false statement and misrepresentation" is defined as one made with knowledge and the intent of obtaining an undeserved economic benefit or deny another a benefit in connection with an insurance transaction. Any person or insurer who makes a "false statement or misrepresentation" is, depending upon the amount received and number of offenses, guilty of anywhere from a misdemeanor, thirty days imprisonment or fine to a felony, ten years imprisonment, and a fifty thousand dollar fine. In all cases the person must make full restitution to the victim of the fraud.

In addition to criminal liability, a person who violates the statute faces potential civil fines up to fifteen thousand dollars and may be ordered to pay court costs and attorneys' fees to the director of the Insurance Fraud Division which retains the fines for use in enforcing and administering the Act.

Any person, insurer, or agency (1) having reason to believe that another has made a false statement or misrepresentation, or (2) has knowledge of a suspected false statement or misrepresentation shall notify the Insurance Fraud Division. If the reporter acts without malice or in good faith, the reporter is immune from any liability arising out of the report.

- **State Computer Crime Act:**
  - **Provisions:** The South Carolina Computer Crime Act provides criminal penalties related to causing direct or indirect access to a computer for, among other things, the purpose of devising or executing a fraud scheme or obtaining money, property or services by means of false or fraudulent pretenses, representations or promises.

    Any person convicted of computer crime is, depending upon the amount of the victim's loss and number of offenses, guilty of anywhere from a misdemeanor, thirty days imprisonment or fine of not more than two hundred dollars to a felony, five years imprisonment, and/or a fifty thousand dollar fine.
- **State Administrative Sanctions Against Medicaid Providers Act:**
  - **Provisions:** Pursuant to the South Carolina Department of Health and Human Services (DHHS) Regulations, Administrative Sanctions Against Medicaid Providers, the Administrator of Medicaid may invoke administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program. "Abuse" is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid Program, reimbursement for medically unnecessary services, or services that fail to meet professionally recognized standards for health care.

    Grounds for sanctioning providers under the DHHS regulations include presenting a false claim for services, submitting false information to obtain greater compensation than that to which the provider is entitled, overutilization, conviction for a criminal offense related to Medicaid or Medicare, failure to meet standards required by State or Federal law for participation in Medicaid, and other acts. Sanctions may include educational intervention, peer review, recoupment of overpayments, suspension, termination, postpayment or prepayment review of claims, and referral to licensing and certifying boards or agencies.

  The factors considered in determining sanctions include, but are not be limited to: the seriousness of the offense; the extent of violation; history of prior violation(s); prior imposition of sanction; and, the providers failure to obey program rules and policies as specified in the appropriate Provider Manual or other official notices.

- **State Employment Protection Act**

  - **Provisions:** State employees who report violations of state or federal law or regulation are provided protection against retaliation or disciplinary action related to the report pursuant to the Employment Protection for Reports of Violations of State or Federal Law or Regulation. The Act prohibits a public body from dismissing, suspending, demoting, or taking other adverse actions against an employee based on the employee's filing of a report of wrongdoing with an appropriate authority.

    An "appropriate authority" is defined as the public body that employs the reporting individual or a federal, state, or local government body having jurisdiction over criminal law enforcement, regulatory violations, professional conduct or ethics, or wrongdoing.

    If an employee suffers adverse actions related to employment within one year after having timely (within sixty days of first learning) reported alleged wrongdoing, the employee may institute a nonjury civil action against the public body after exhausting all available grievance or other administrative remedies. In the event the appropriate authority which received the report determines the employee's report is unfounded or a mere technical violation and is not made in good faith, the public body may take disciplinary action including termination and, notwithstanding the filing of a report, a public body may dismiss, suspend, demote, or decrease the compensation of an employee for causes independent of the filing of a protected report.

    A public body may also impose disciplinary sanctions against any direct line supervisory employees who retaliate against another employee for having filed a good faith report.

Actions / Tasks / Procedures:

Education: This policy, as well as all other SRH organization-wide and department-specific policies, manuals, handbooks and Code(s) of Conduct is intended to encourage compliance with all laws, regulations and statutes and facilitate reporting of wrongdoing without the fear of retaliation. SRH has committed to the continual compliance with all internal and regulatory standards and, is also dedicated to ensuring the continual education and awareness of all our employees and affiliates.

To address these statutes and laws listed above more specifically, SRH will take the following steps on an ongoing, regularly scheduled basis:

- All new employees will receive comprehensive training regarding the Corporate Compliance and Integrity Program as well as specific laws and SRH policies pertaining to the prevention and detection of fraud, waste and abuse in federal healthcare programs, prior to beginning work.
- All existing employees will receive comprehensive training on an annual basis regarding the Corporate Compliance and Integrity Program as well as specific laws SRH pertaining to the prevention and detection of fraud, waste and abuse in federal healthcare programs.

- All SRH non-employed affiliates will receive information regarding the Corporate Compliance and Integrity Program, SRH policies regarding vendor relationships, and any specific laws pertaining to the prevention and detection of fraud, waste and abuse.

  This training will be completed through, face-to-face presentations, focused online training modules or through direct, focused communications.

- Resolution of any compliance, legal or ethics-related issues discovered or reported will include documented, focused education for the areas affected.

Communications, Investigations and Resolutions: SRH expects all employees and affiliates to report any suspected unethical or illegal behavior, whether or not it relates to waste, fraud or abuse in the Federal healthcare programs. To encourage this communication, SRH has established a comprehensive program that can be used to report unethical or potentially illegal behavior on the part of anyone affiliated with the organization. This program, as detailed below, has been designed to encourage communication, as well as enable confidentiality when possible and provide assurances that all issues or questions can be reported without the fear of retaliation or retribution. All SRH employees and affiliates are encouraged to first use the traditional supervisory chain of command to report any suspect behavior. If they are uncomfortable or apprehensive about using this channel, they are also able to use the other available methods listed below:

- SRH maintains two (2) confidential HelpLines that are both available 24 hours. The HIPAA HelpLine utilizes an internal voice mailbox and can be reached by calling (864) 725-4700. The Compliance HelpLine is maintained by an external vendor that provides secure documentation and reporting capabilities and can be reached at (888) 398-2633.

- The Corporate Compliance and Integrity Department staff is also available for reporting suspect behavior in a confidential manner. The Vice President of Corporate Compliance and Integrity and other staff members are available at all times and their contact information is published as an option for all reporting needs related to Corporate Compliance or HIPAA.

Communication Process: SRH is committed to maintaining its program for confidential and non-retaliatory reporting of any suspected unethical or potentially illegal behavior regardless of its connection to waste, fraud or abuse in government healthcare funding programs. In order to maintain the integrity of this system, SRH has several processes and policies that dictate the standards and processes used to guarantee this. The key policies are listed below:

- The SRH Corporate Compliance and Integrity policy on *Non-retaliation and Non-retribution for Reporting* [QSP-CCI-0006] details the standards and process established to foster the elimination of potential retaliation or retribution. The policy also reaffirms the responsibility of all employees and affiliates to help maintain an effective reporting and communication program.

- The SRH Corporate Compliance and Integrity policy on *Compliance Incident Response* [QSP-CCI-0007] details the standards and process established to ensure fair and accurate investigation and resolution or all compliance related incidents, no matter how they are communicated.

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