advocare	**Policy & Procedure-** Compliance	Policy #:	CO-36
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	Subject: Preventing Fraud, Waste and Abuse	Effective Date:	6/9/22
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I. Purpose: Advocare, LLC is required by the Federal Deficit Reduction Act ("DRA") to maintain policies regarding how it prevents and detects fraud, waste and abuse in the federal and state health care programs and to provide detailed information about applicable federal and state laws, such as the federal and New Jersey False Claims Acts (FCA). All employees, members, vendors, affiliates and business partners should be aware of Advocare's policies and reporting responsibilities regarding detection and prevention of health care fraud and abuse.

II. Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation program. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisors, the Advocare Compliance Officer or through Advocare's confidential Compliance Hotline (1-866-410-0001) or make a report online at www.lighthouse-services.com/advocaredoctors.

III. Background: The Federal False Claims Act (the "FCA"), the principal federal enforcement statute, prohibits an individual or organization from knowingly or recklessly submitting a false claim for payment or approval to a federal or state health care program. It also prohibits knowingly or recklessly making, using, or causing to be used a false record or statement to get a false or fraudulent claim paid by the government. Violations may result in civil, criminal, and administrative actions and be punishable by substantial monetary penalties, fines, imprisonment, and exclusion from Federal and State health care programs. Advocare prohibits any Employee or Member from knowingly or recklessly presenting or causing claims to be presented for payment or approval that are false, fictitious, intentionally misleading, fraudulent, or in violation of any law.

Advocare practices medicine in New Jersey and Pennsylvania, and as such those states' laws applicable to compliance issues also govern all Advocare business. Violations of these state laws may result in criminal actions punishable by imprisonment, substantial monetary penalties, and fines. For a further description of Pennsylvania's and New Jersey's laws, please refer to the attached **Appendix.**

IV. Fraud Prevention: All Advocare employees, members, vendors, affiliates and business partners are responsible to prevent Fraud, waste and abuse. Specific obligations include:

A. Coding and Documentation

All Advocare physicians and other licensed professionals (together referred to as "Other Licensed Professionals") are expected to know, understand, and comply with the essential requirements of government and private payor programs in all substantive ways, but particularly with respect to CPT coding for and documentation of services rendered to Advocare patients. This includes, but is not limited to, the requirements for proper chart documentation and the supervisory requirements of and for the collaboration of Other Licensed Professionals and other clinical personnel, and the Centers for Medicare & Medicaid Services ("CMS") standards for "incident to" services rendered by Other Licensed Professionals. Each Other Licensed Professional shall be responsible for ensuring that the appropriate CPT codes are used for the services rendered by him/her prior to submission of any claim for payment.

B. Claims Submission

Advocare diligently works to ensure that the systems it utilizes result in fair, reasonable and accurate claims submissions. Advocare's billing protocols include the following objectives:

a. No Employee or Member may submit a claim for payment for services or supplies, which were not provided by Advocare, or for which the Employee or Member knows Advocare is not entitled, or for services which were not medically necessary.

b. No Employee or Member shall make a false representation in the submission of a claim for payment with respect to the nature of the services rendered, the charges for services rendered, the identity of the patient for whom the services were rendered, the dates of services, or other information pertaining to a patient visit.

c. No Employee or Member shall alter claim forms or medical records for the purpose of obtaining greater reimbursement than that to which Advocare is legally entitled. This would include up-coding an encounter to a higher level than was actually rendered or using incorrect modifiers.

d. Clinicians shall create and maintain supporting written medical record documentation for services provided and billed to patients or payors.

e. No Employee or Member shall submit a claim for a service arising from an impermissible, anti-kickback or referral arrangement.

Advocare maintains oversight systems to verify that claims are submitted only for services actually provided and that the services are billed only as actually provided. Advocare ensures that Employees, Members or subcontractors engaged to perform billing or coding services for it have the necessary skills and training, quality assurance processes, systems and appropriate procedures to ensure that all billings submitted on

behalf of Advocare are accurate and complete. It is all Employees and Members' obligation to bring to the attention of the Compliance Officer any observed billing practices which are not truthful, accurate or in conformity with the requirements of federal, state, and local laws and regulations or the rules and requirements of private payors.

C. Collection of Co-Pays

a. It is Advocare's policy to collect all patient co-payment amounts at the time services are rendered. It is Advocare's policy to bill for all co-pays not paid at the time of service and for all other amounts due to Advocare from patients.

b. Employees or Members charged with collecting patient co-pays shall make a good faith effort to collect them. Except in the event of documented financial hardship, or other exemption allowed by law, patient co-pays shall not be waived. Each patient claiming financial hardship shall be evaluated on an individual basis.

c. Advocare shall treat patient credit balances and bad debt relating to co-pays in compliance with applicable law and regulations.

V. Reporting Protections

In addition, the FCA allows private persons to bring “whistleblower” (or "qui tam") actions in the name of the government if they believe the FCA has been violated, and to recover a monetary reward if their actions result in a settlement or judgment in favor of the government. The FCA protects the rights of “whistleblowers” and it is a violation of the FCA for an employer to take any action against someone for initiating and/or participating in an action under the FCA. Other laws, including state laws, also provide protection of “whistleblowers” in certain circumstances. Advocare prohibits any Employee, Member or agent from violating the non-retaliation provision of the FCA or any other applicable law.

Summary of Federal and State Laws

I. Federal laws

a. The False Claims Act (31 U.S.C. § 3729-3733)

The False Claims Act ("FCA") provides in pertinent part at 31 U.S.C. § 3729(a):

(1) [A]ny person who –

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
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> * * *
>
> (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person.

The Act defines the terms "know" and "knowingly" at 31 U.S.C. § 3729(b) as: "a person, with respect to information -- (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and . . . require no proof of specific intent to defraud."

b. The Anti-Kickback Statute ("AKS") (42 U.S.C. § 1320a-7b(b))

The AKS is a criminal law which prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any

item or service payable by a federal health care program (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and includes, in addition to cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. The AKS covers the payors of kickbacks (those who offer or pay remuneration) as well as the recipients of kickbacks (those who solicit or receive remuneration). Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the federal health care programs. Under the Civil Monetary Penalties Law, individuals who pay or accept kickbacks also face penalties of up to $50,000.00 per kickback plus three times the amount of the remuneration. Safe harbors protect certain payment and business practices which could otherwise implicate the AKS from criminal and civil prosecution.

c. Physician Self-Referral Law (42 U.S.C. § 1395nn)

The Physician Self-Referral Law, commonly referred to as the "Stark Law," prohibits physicians from referring patients, for the purpose of receiving "designated health services" payable by Medicare or Medicaid, to other providers/entities with which the physician or his/her immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark Law requires the resulting financial relationship to fit within an exception or he/she may not refer patients to that facility, and the facility may not bill for the referred imaging services. "Designated health services" are:

i. clinical laboratory services;
ii. physical therapy;
iii. occupational therapy and outpatient speech/language pathology services;
iv. radiology and certain other imaging services;
v. radiation therapy services and supplies;
vi. DME and supplies;
vii. parenteral and enteral nutrients, equipment, and supplies;
viii. prosthetics, orthotics, and prosthetic devices and supplies;
ix. home health services;
x. outpatient prescription drugs; and
xi. inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is *not* required.

d. Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))

The Beneficiary Inducement Statute imposes civil monetary penalties on physicians who offer remuneration which exceeds nominal value to Medicare and Medicaid beneficiaries to influence them to use their services. The current limit of for items considered to be of nominal value is $15 per item and $75 aggregate per year and excludes cash and cash equivalents.

II. Pennsylvania Laws

a. Pennsylvania's Medicaid "False Claims Act" (62 P.S. § 1407)

There can also be liability under the state of Pennsylvania for false or fraudulent claims with respect to Medicaid program expenditures. The statute in question prohibits false claims and statements as follows:

> "It shall be unlawful for any person to knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance. See 62 P.S.1407(a)(1)

Pennsylvania law also prohibits the following conduct:

- Soliciting or receiving or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the medical assistance program ("Pennsylvania's Anti-Kickback Act").
- Submitting duplicate claims for services, supplies or equipment for which the provider has already received reimbursement.
- Submitting claims for services, supplies or equipment which were never provided;
- Submitting a claim for services, supplies or equipment which includes costs or charges not related to the services provided to the recipient.
- Submitting a claim or referring a recipient to another provider for services, supplies or equipment which are not documented in the record, are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.
- Submitting a claim which misrepresents the description of services, the dates of services, the identity of the recipient or the attending physician or the identity of the referring or actual provider;
- Submitting a claim for reimbursement for a service or item at a charge higher than the provider's usual and customary charge to the general public for the same;
- Providing a service or item without a practitioner's written order or the consent of the recipient, except in emergency situations.
- Except in emergency situations, providing a service or item to a patient claiming to be a recipient without making a reasonable effort to verify a current medical assistance identification card, that the person is, in fact, a recipient who is eligible.

- Entering into an agreement or conspiracy to obtain reimbursement or payments for which there is not entitlement.
- Making a false statement in the application for enrollment as a provider.
- Violating 62 P.S. Section 1403(d)(1),(2),(4) and (5) with respect to prohibitions regarding shared health facilities by: leasing on percentage of earnings, paying for referrals in lease, providing improper or unwarranted services, referral to another provider in the facility absent medical justification.

b. Other Prohibited Acts, Criminal Penalties and Civil Remedies (62 P.S. § 1408)

Under Pennsylvania law it is unlawful for providers to knowingly or intentionally submit false information or false claims or costs, reports for furnishing services or merchandise under the medical assistance program, or claims or cost reports for medically unnecessary services or merchandise; solicit, receive, or offer to pay remuneration, including kickbacks, bribes, or rebates in connection with furnishing services or merchandise under the medical assistance program; submit duplicate claims for which the provider has already received or claimed reimbursement; submit a claim for services, supplies or equipment not rendered to a recipient; submit claims for or refer recipients to another provider for unnecessary services, supplies or equipment, submit claims which misrepresent information about such things as the services provided, the recipient, date of service, or the identity of the practitioner or provider, submit claims for reimbursement higher than the provider's usual and customary charge for the service or item; submit claims for a service or item not rendered; provide a service or item without a practitioner's written order and consent of the recipient (except in emergencies); or render a service or item without making a reasonable effort to verify through the current medical assistance card that the patient is in fact, currently eligible (except in emergencies).

Violations can result in criminal and civil penalties, including monetary penalties and termination of participation as a provider in the medical assistance program. It is also unlawful for other persons to knowingly or intentionally make false statements or fail to disclose material facts regarding eligibility for themselves or another for medical assistance benefits, fraudulently conceal knowledge of events affecting the person's initial or continual right to receive such benefits, convert benefits to a use other than for himself of the person for whom the benefits were intended, visit multiple providers for the purpose of obtaining excessive services or benefits beyond what is reasonably needed, or borrow or use a medical assistance card without entitlement to do so. Violations can result in criminal and civil penalties, including monetary penalties and restrictions on continued eligibility for medical assistance benefits.

b. Whistleblower Law (43 P.S. § 1422-1428)

This law provides that no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste. Further, under the law, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the

employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or in a court action.

III. New Jersey Law

a. Health Care Claims Fraud Act (N.J.S.A. 2C:21-4.2 and 2C:21-4.3)

This law makes it a crime for licensed health care practitioners and persons who are not practitioners to knowingly or recklessly commit health care claims fraud in the course of providing professional services. Conviction under the Health Care Claims Fraud Act subjects the person to criminal penalties as permitted under New Jersey law, and fines of up to $150,000 or up to five times the pecuniary benefit received or sought.

b. Conscientious Employee Protection Act ("CEPA" or "Whistleblower Act") (N.J.S.A. 34.19-3)

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee:

(1) Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer, or another employer, with whom there is a business relationship, that the employee reasonably believes:

(a) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care; or

(b) is fraudulent or criminal, including any activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity;

(2) Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation promulgated pursuant to law by the employer, or another employer, with whom there is a business relationship, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, in the case of an employee who is a licensed or certified health

care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into the quality of patient care; or

(3) Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:

(a) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;

(b) is fraudulent or criminal, including any activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity; or

(c) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

c. <u>New Jersey False Claims Act P.L. 2007, Chapter 265, as amended by P.L. 2009, Chapter 265</u>

New Jersey law, which was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts:

(1) the main part authorizes the NJ Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections;

(2) another part amends the NJ Medicaid statute to make violations of the NJ False Claims Act give rise to liability under NJS 30:4D-17(e); and

(3) a third part amends the NJ Medicaid statute to a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act (31 U.S.C.s.3729 et seq.)

d. <u>New Jersey Insurance Fraud Prevention Act, N.J.S.A 17:33A-1 et seq.</u>

The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.