1301 Fifth Ave., Ste. 2900
Seattle, WA 98101
mcn.com | IRO@mcn.com

t:888.447.9036
t:206.621.9097
f:206.973.8459

MCN Compliance Provider Training for Medicare Parts C & D and Fraud, Waste, and Abuse

Dear Reviewer,

Thank you for contracting with Mitchell International, Inc. dba MCN to perform clinical reviews for our Independent review program. As part of your contract you agree to adhere to state and federal laws, which includes Medicare parts C & D, Fraud, Waste, and Abuse (FWA), as well as numerous other laws and rules you should already be familiar within your normal practice/business operations. We have outlined many of them for your convenience but it is not an exhaustive list.

The following pages contain three policies constituting as your compliance and FWA training from MCN. Please review them within 90 days of contracting and annually thereafter. The policies included in this training are as follows:

1. MCN Compliance Manual: Overview of MCN's approach to CMS compliance and the compliance program.
2. MCN Code of Conduct: Sets expectations for compliance and ethics and discipline for violations. Includes examples of reportable prohibited acts and how to report them to MCN.
3. MCN Fraud, Waste, and Abuse policy: Describes what FWA is, how it applies to MCN and its contracted entities, and provides examples of FWA.

Please complete this required compliance training as part of the contracting process. If you have additional compliance specific questions please email Compliance@MCN.com for clarification. Additionally, as part of contracting with MCN, you are agreeing to review this training annually, MCN will send a reminder regarding this requirement.

Thank you,

Logan Randall

Senior Regulatory Affairs Specialist, herin referenced as Compliance Officer

1301 Fifth Ave., Ste. 2900
Seattle, WA 98101
mcn.com | IRO@mcn.com

t:888.447.9036
t:206.621.9097
f:206.973.8459

MCN Compliance Manual

Table of Contents

1301 Fifth Ave., Ste. 2900
Seattle, WA 98101
mcn.com | IRO@mcn.com
t:888.447.9036
t:206.621.9097
f:206.973.8459

A. CORPORATE PHILOSOPHY STATEMENT

To assist with the provision of quality services in compliance with the law, Mitchell International, Inc., dba MCN (MCN), a division of Mitchell International Inc. and its subsidiary Genex Services, LLC, has developed a Compliance Program, and this Compliance Manual is an integral part of the Compliance Program. This Compliance Manual establishes standards, policies, and procedures regarding compliance with laws governing MCN's financial relationships with physician contractors or other potential sources of referrals. This Compliance Manual applies exclusively to employees of Genex Services, LLC (Genex) who perform, or are affiliated with performing, Independent Medical Reviews (IMRs) for Medicare providers and other administrative functions related to those IMRs on behalf of the dba MCN. All other references to "MCN" and the services performed under its dba refer to work performed by Genex Services, LLC employees.

MCN is dedicated to providing quality services by:

- Providing fair, accurate, and on time IMRs;
- Conducting comprehensive, convenient, and objective medical peer reviews and medical bill reviews;
- Conducting utilization reviews that are accurate and timely; and
- Providing its services in a fiscally responsible manner.

To achieve these goals, MCN is committed to conducting its business activities in compliance with ethical standards and all applicable laws, rules, and regulations.

Genex employees as part of their job performance should be familiar with the laws governing compliance. This Compliance Manual does not address every aspect of compliance. Direct any questions about this Compliance Manual or compliance generally to your manager. If an employee's immediate manager cannot or does not answer the questions or resolve the concerns, the employee should address the issue with the Compliance Officer.

Any action taken that violates this Compliance Manual is beyond the scope of employment and will subject the employee to discipline, which in some cases may result in termination. This Compliance Manual is intended to be read, in addition to, and not in place of other existing policies and in no way limits MCN's obligations under other policies adopted by Mitchell International, Inc. and Genex Services, LLC (hereinafter referred to as "Company").

Any documents, reports, or other products of the Compliance Program shall be protected to the extent allowed by law under the copyright, self-evaluative, ombudsman, attorney-client, work-product, and any other applicable privileges.

MCN has a strict no-tolerance policy for retaliation, retribution, or intimidation against those who make a report in good faith. This no-tolerance policy applies to MCN and its Medicare downstream entities and Genex employees.

1301 Fifth Ave., Ste. 2900
Seattle, WA 98101
mcn.com | IRO@mcn.com

t:888.447.9036
t:206.621.9097
f:206.973.8459

B. POLICIES AND PROCEDURES

Consistent with MCN's vision is to reduce the human and economic loss of injury and disability, MCN intends to provide quality services by performing its services in accordance with this Compliance Manual.

This Compliance Manual provides policies and procedures for potential compliance issues including:

1. Services and Source of Payment
2. Patient Privacy and Confidentiality
3. Screening
4. Gifts
5. Inducements and Self-Referrals
6. Billing
7. Identifying False Claims
8. Record Keeping and Documentation

These policies and procedures are intended to establish a framework for adherence to laws, regulations, and recognized quality standards. The Compliance Manual is not intended to set forth all of MCN's substantive programs and practices. Rather, it is intended to further the commitment that the operations and services provided by MCN comply with ethical and legal standards.

Services and Source of Payment

Physician Contractors must provide services consistent with applicable legal requirements and standards of practice regardless of the source of payment for treatment.

Additionally, Physician Contractors must:

- Conduct his/her practice in a manner consistent with that of a reasonable and prudent health care provider under the same or similar circumstances;
- Maintain accurate records that meet all state and federal requirements;
- Make all reports related to abuse and neglect and such other requirements as may be imposed by federal or state law; and
- Otherwise adhere to any and all standards of care promulgated by law.

Patient Privacy and Confidentiality

It is the policy of MCN to ensure that each patient has the right to privacy and confidentiality of records. MCN will comply with applicable federal and state regulations.

Screening

MCN will check the List of Excluded Individuals/Entities maintained by the OIG, GSA, and (as applicable) state Medicaid agency, for potential employees and Physician Contractors who perform or are affiliated with the conducting of IMRs.

1301 Fifth Ave., Ste. 2900 t:888.447.9036
Seattle, WA 98101 t:206.621.9097
mcn.com | IRO@mcn.com f:206.973.8459

All employees and Physician Contractors must alert MCN of any conviction or finding that would disqualify them from their continued position with MCN.

Before executing applicable contracts, MCN will review the List of Excluded Individuals/Entities and verify that the person or entity is currently certified to participate in the Medicare or Medicaid programs and is not subject to any sanction that would render MCN unable to legally contract with that person/entity.

Employees or Physician Contractors who become aware of potential violations of licensing or certification requirements must report them promptly as set out in this Compliance Manual. If the perceived violation could place any patient in jeopardy, the person shall immediately report this directly to his/her manager or the Compliance Officer.

Gifts

Genex employees and Physician Contractors who perform, or are affiliated with performing, IMRs shall not obtain any improper personal benefit by virtue of his/her affiliation with MCN.

Employees and Physician Contractors shall not:

- Accept any gift, hospitality, or entertainment in any amount from or on behalf of a patient; and shall not accept from any other person any cash or cash equivalents, any gift of more than the nominal value that because of its source or value might influence that person's independent professional judgment; or
- Provide any gifts or gratuities to any government or public agency representatives (except as permitted by law, such as to family members); or
- Pay or receive anything of financial benefit in exchange for any government-reimbursed referrals.

Inducements and Self-Referrals

Genex employees and Physician Contractors shall not knowingly and willfully solicit or receive any remuneration directly or indirectly, overtly or covertly, in cash or in kind:

- In return for referring an individual to a person for furnishing (or arranging for the furnishing) of any item or service, or
- In return for purchasing or recommending purchasing any good, service, or item for which payment may be made in whole or in part under a federal or state program.

Billing

MCN is committed to prompt, complete, and accurate billing of all services provided. Billing may only be for services actually provided, directly or under contract, pursuant to all terms and conditions specified by the government or third-party payor and consistent with practice.

Identifying False Claims

False claims and billing fraud may take a variety of different forms, including, but not limited to, false statements supporting claims for payment, misrepresentation or concealment of material facts, or theft of benefits or payments from the party entitled to receive them. MCN shall specifically refrain from engaging in the following billing practices:

- Making claims for items or services or supplies not rendered, reasonable and necessary, or ordered or provided as claimed (this includes double billing and upcoding the service provided);
- Submitting claims for non-covered services as if covered, services provided by an unqualified or unlicensed individual, or items or services that are not provided as claimed;
- Submitting claim forms to any payor for individual items or services when such items or services are of the type that may be billed only as a unit and not unbundled;
- Knowing misuse of identification numbers, which results in improper billing; and
- Inadequate resolution of overpayments.

If any employee or physician contractor has any reason to believe that anyone (including that person) is engaging in false billing practices, that person shall immediately report the practice to his/her immediate manager or the Compliance Officer or his/her designee. Failure to so report shall be considered a breach of that person's responsibilities and shall subject such person to disciplinary action up to and including termination/removal.

Record Keeping and Documentation

MCN's policy is that all documentation shall be timely, accurate, and consistent with applicable professional and legal guidelines and standards. Falsification of records is strictly prohibited, including backdating of records, with the exception of appropriate late entries duly noted and made consistent with applicable professional and legal standards. All Genex employees involved in record keeping and documentation on behalf of the MCN product shall ensure that:

- All records are complete and legible; and
- All records are secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, and damage.

C. IMPLEMENTATION AND SUPERVISION FRAMEWORK

Compliance Oversight

An effective compliance program provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing Fraud Waste and Abuse (FWA) and improving operational quality, and the quality of care and reducing the costs of care.

The Compliance Officer

The Compliance Officer serves as the focal point for all compliance activities and is responsible for implementing the Compliance Program.

The Compliance Officer shall:

- Be a full-time employee who does not have operational responsibilities;
- Receive periodic training in compliance procedures;
- Have access to members of the Board of Directors, General Counsel, and (as necessary) outside legal counsel;
- Have access to necessary records and documentation, including patient records, billing records, and marketing agreements and records; and
- Have detailed involvement in and familiarity with MCN's Medicare operational and compliance activities including MCN's FWA Compliance Plan development and implementation.

The Compliance Officer is responsible for:

Training and education

- Distributing MCN's Compliance Manual and Code of Conduct to all Genex employees, and downstream entities within 90 days of the date they are hired/appointed/contracted with and annually thereafter;
- Publicizing the Compliance Program, including disciplinary standards, throughout MCN's facilities and its downstream entities' facilities;
- Primarily responsibility for overseeing the FWA prevention plan as part of the overall Compliance Program. This responsibility includes training employees and managers on issues of Medicare compliance, FWA risks based on the employee's job function, and reporting suspected violations and questionable conduct. This training will also include associated reporting requirements and available methods for reporting noncompliance and FWA. This training will take place within 90 days of the date the employee is hired/appointed and annually thereafter. The CMS standardized training modules may be used (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf);
- Publicizing and enforcing MCN's no-tolerance policy for retaliation or retribution against any employee, downstream entity (or their employees) for good faith reporting of FWA;
- Making employees aware of the Medicare requirements related to their job functions; and

- Revising MCN's Compliance Manual and Code of Conduct as needed to reflect changes in state or federal law or regulations.
- Timely and effectively communicate all changes in laws, regulations and sub-regulatory guidance as well as changes to MCN's Code of Conduct and other policies to the CEO, senior management, and MCN employees.

Background checks

- A background check is conducted of all prospective employees and contractors of Genex including a licensing/certification check where applicable and a determination made of whether the prospective employee is subject to sanctions under or exclusion from Medicare;
- A check is made of OIG and GSA exclusion lists and a determination is made of whether each employee and contracted entity is subject to sanctions under or exclusion from Medicare or any other federal/state program on an at least monthly basis; and
- Enrollees are educated on the identification and reporting of FWA.

Monitoring and auditing

- He/she is aware of daily business activity by interacting with the operational units;
- Periodic random sampling auditing is conducted. Data analysis trends of the randomized sample is used for monitoring FWA and applicable coding, billing, and documentation requirements;
- In accordance with this Compliance Manual, developing an auditing and monitoring work plan that includes (1) a process for responding to all monitoring and auditing results, (2) a process for conducting follow-up reviews of noncompliant areas to determine if corrective actions have fully addressed the underlying problems, and (3) a schedule (with estimated target dates) that lists all auditing and monitoring activities for the calendar year; and
- Conducting periodic reviews (other than a CMS audit) at least once each year to confirm that the Compliance Program is being followed and to determine its effectiveness.
- The Compliance Officer receives regular reports from any individual who conducts monitoring or auditing, and of any corrective action plans that are implemented.

Investigation and corrective actions

- Compliance questions and concerns and reports are received, recorded, responded to appropriately, and tracked;
- An appropriate inquiry or investigation, done by the Compliance Officer and/or SIU, including, but not limited to, root cause analysis, is initiated as quickly as possible, and not later than two weeks, after the date the noncompliance or FWA is identified;
- Appropriate corrective and/or disciplinary action is taken, which action should be tailored to address the particular FWA, problem, or deficiency identified and include specific timeframes for achievement as appropriate;
- Refer potential FWA issues to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) and report serious issues of program noncompliance to CMS; and
- Maintaining a compliance filing system, which records are maintained for ten years.

1301 Fifth Ave., Ste. 2900
Seattle, WA 98101
mcn.com | IRO@mcn.com
t:888.447.9036
t:206.621.9097
f:206.973.8459

Reports to governance

- Periodically provides reports on compliance and FWA to the Compliance Committee at least quarterly and on an as needed basis; and
- Report the findings of internal and external monitoring and audits to senior leadership including the CEO as necessary.

Medicare downstream entities

- Identify downstream entities (and their employees) subject to Medicare compliance requirements and communicate to such entity which of its employees are subject to Medicare compliance requirements;
- Require that downstream entities (and their employees) are not on OIG and GSA exclusion lists prior to hiring or contracting and monthly thereafter. This review of exclusion lists may be performed by MCN or downstream entities themselves; and
- Maintain thorough documentation of identified deficiencies and monitoring of corrective actions.
- If a downstream entity fail to satisfactorily implement a corrective action then the noncompliance and ramifications will be clearly documented and reported to the required parties.

Compliance Committee

The Compliance Committee will assist the Compliance Officer in performing his/her duties, as described in this Compliance Manual, and oversee the Compliance Program. The Compliance Committee may monitor internal and external audits and investigations for the purpose of identifying troublesome issues and deficient areas experienced by MCN and implement corrective and preventive action. The Compliance Committee is accountable to, and must provide regular compliance reports to, Genex's CEO.

Managers

Managers within the MCN business should serve as the first line of communication regarding compliance issues for employees. As such, managers must report concerns, questions, and reports of suspected activity immediately to their manager or the Compliance Officer.

Managers must be available to discuss with each employee under their direct supervision:

- Adhering to the content and procedures of the Compliance Manual and Code of Conduct of the Compliance Program is a condition of employment;
- That appropriate disciplinary action, up to and including termination, may occur for violating the Compliance Program and applicable laws and regulations; and
- The importance of participating in ongoing training of the Compliance Program.

Board of Directors

1301 Fifth Ave., Ste. 2900 t:888.447.9036
Seattle, WA 98101 t:206.621.9097
mcn.com | IRO@mcn.com f:206.973.8459

Genex's Board of Directors has oversight over this Compliance Program and must be knowledgeable about the content and operation of the Compliance Program. If compliance issues occur, the Board of Directors should make further inquiry and take appropriate action to resolve the issues.

The Board of Directors shall:

- Approve the Compliance Manual and Code of Conduct;
- Understand the Compliance Program structure;
- Receive regularly scheduled, periodic updates from the Compliance Officer and Compliance Committee;
- Review the results of performance and effectiveness assessments of the Compliance Program; and
- Genex Board of Directors shall report to appropriate parties as necessary.

CEO and Senior Management

The CEO of Genex shall be engaged in the Compliance Program. The CEO and senior management shall provide the Compliance Officer with the credibility, authority, and resources necessary to operate the Compliance Program in an effective manner. The Compliance Officer has express authority to make in-person oral and reports to the CEO and senior management.

Legal Counsel

The Compliance Officer and CEO shall consult with the Legal business partner for MCN and/or General Counsel, on issues raised by reports of suspected violations or questionable conduct. Legal counsel shall review the Compliance Program to ensure that:

- It addresses all applicable federal and state laws and regulations;
- It is effective in curtailing unethical or illegal conduct; and
- Any necessary amendments or corrections to the Compliance Program, including the Compliance Manual and the Code of Conduct have been made.

Education and Communication

MCN's Compliance Manual and Code of Conduct will be provided and explained to all new employees and contracted First Tier, Downstream and Related entities (FDRs). All employees and contracted FDRs will reaffirm their acknowledgement of the Code of Conduct on an annual basis.

All employees will be apprised of applicable federal and state laws, regulations, and standards of ethical conduct applicable to their jobs and the consequences that will follow for violations of them or of the compliance program. And, changes in laws and regulations will also be provided.

Training will be provided to all employees and contracted FDRs, and at least annually. New employees and contracted FDRs will undergo compliance training within 90 days of beginning

employment. Participation is a condition of employment/contracting and ongoing performance evaluations. Records of training completion will be maintained for a period of 10 years.

Periodic Monitoring

The Compliance Officer, or his/her designee, is responsible for conducting periodic monitoring of various areas to ensure that applicable laws, regulations, sub-regulatory guidance, and contractual agreements are being followed, and that accurate information is being conveyed or submitted. In fulfilling this responsibility, the Compliance Officer shall:

- Conduct a baseline risk assessment of the major compliance and risk areas in all Medicare operational areas;
- Develop a plan for conducting reviews on a regular basis;
- Conduct reviews of MCN's operational areas, and determine the appropriate sample size for such reviews and extrapolate review findings to the full universe, using statistically valid methods that comply with generally accepted auditing standards; and
- Prepare written reports detailing the areas examined and findings for the Compliance Committee, and/or legal counsel as appropriate, and house such reports in relevant files.

Glossary of Terms

Compliance Manual means this manual and all of its respective attachments, exhibits, modifications, supplements, and amendments.

Compliance Program means all aspects of the corporate compliance program undertaken by MCN, including, but not limited to, the MCN Compliance Manual, MCN Code of Conduct, compliance training seminars, and maintenance of the toll-free compliance and ethics hotline.

CMS means Centers for Medicare & Medicaid Services.

Physician Contractor means a physician contractor, that is credentialed and providing services to MCN as an independent contractor, and their respective employees, professionals, and staff.

Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee means persons employed by Genex Services, LLCwho perform or are affiliated with conducting IMRs for the dba MCN business.

FWA means fraud, waste, and abuse. "Fraud" is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. It is a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. "Waste" includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources. "Abuse" includes actions that may, directly or indirectly result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

GSA means the General Services Administration.

IMR means independent medical review.

Office of Inspector General ("OIG") means the U.S. Department of Health and Human Services' Office of Inspector General or State Medicaid Agency Office of Inspector General, the agencies charged with interpreting and enforcing many of the federal fraud and abuse laws applicable to health care physician contractors.

Operational Responsibilities means review and processing of Independent Reviews for the purpose of providing reports to contracted Customers.

MCN Code of Conduct

Table of Contents

Notice to Genex Employees and contracted downstream entities Performing Services for dba MCN and Medicare Downstream Entities

To assist with the provision of quality services in compliance with the law, Mitchell International, Inc., dba MCN (MCN), a division of Mitchell International, Inc. and its subsidiary Genex Services, LLC (Genex), has developed a Compliance Program. As part of its operations, MCN is a downstream entity to certain Medicare entities, and therefore certain physician contractors of MCN are also downstream entities. This Code of Conduct applies exclusively to Genex employees performing services on behalf of dba MCN and physician contractors who perform, or are affiliated with performing, IMRs for Medicare providers and other administrative functions related to those IMRs. All other references to "MCN" and the services performed under its dba refer to work by Genex employees.

All Genex employees and downstream entities (and their employees) **shall**:

- Be aware of all requirements related to their job functions.
- Perform their duties ethically and in good faith and to the best of their ability;
- Comply with policy regarding the receipt, acceptance, offering, or giving of gifts in connection with his/her role or status as an affiliate or employee;
- Participate in scheduled training regarding the compliance program and applicable state and federal laws and standards;
- Comply with all policies governing the workplace;
- Promptly report all violations or suspected violations of the Compliance Manual, Code of Conduct, violations or suspected violations of federal or state law, and potential fraud waste and abuse (FWA) to his/her immediate manager, the MCN Employer Ethics Hotline, or the Compliance Officer through a written report;
- Assist in the resolution of compliance issues as needed; and
- **Notify the MCN Compliance Officer, immediately upon the receipt of an inquiry, subpoena (other than for medical records or other routine licensing or tax matters), or other agency or government request for information regarding patient treatment, claims for payment or other business practices. The Compliance Officer will notify the appropriate Legal team member of the inquiry.**

All Genex employees and downstream entities (and their employees) **shall not**:

- Engage in any illegal conduct. When uncertain of the meaning or application of a statute, regulation, or policy, or the legality of a certain practice or activity, he or she shall seek guidance from his/her immediate manager or the Compliance Officer;
- Obtain any improper personal benefit by virtue of their affiliation or employment;
- Destroy or alter clinical or business information or documents in anticipation of, or in response to, a request for documents by an applicable government agency or from a court of competent jurisdiction;
- Engage in any business practice to unlawfully obtain favorable treatment or business from any government entity, provider, patient, vendor, or any other party in a position to provide such treatment or business;

- Participate in any false billing of patients, government entities, or other party;
- Use confidential or proprietary information for their own personal benefit or for the benefit of any other person or entity, except MCN, its subsidiaries or its affiliated service providers during or after affiliation or employment; or
- Disclose confidential or personal information pertaining to patients without the express written consent of the patient or appropriate legal representative and in accordance with applicable law and policies and procedures.

Corporate Compliance Process

MCN has developed a Compliance Program that includes explanations of the legal and ethical standards governing the conduct of employees and contracted entities performing services on behalf of MCN. Other Genex employees who wish to read the full text of the Compliance Manual are encouraged to do so and may ask their immediate supervisor for a copy. In addition, the Compliance Manual is located on the MCN shared drive at http://intranet/is/gov/Policies_and_Prodecures/Forms/AllItems.aspx. Below is a brief summary of the processes used by MCN for corporate compliance.

A. Background Screening

State and federal laws prohibit a Medicare provider from hiring employees if it knows or should know that the individual has engaged in certain illegal activity. Therefore, professional licensure/certification checks may be conducted on all potential Genex employees. In addition, Genex employees will be checked for proper Medicare certification status to ensure that he/she has not been excluded from participation with a reimbursement program.

B. Responsibility for Corporate Compliance

Employees must report all violations, suspected violations, questionable conduct, questionable practices, and potential FWA to an immediate manager or the Compliance Officer, via compliance@mcn.com. Managers receiving such report will, in turn, report such information to the Compliance Officer and all reported incidents will be recorded and responded to accordingly. An employee who fails to promptly report this kind of activity will be subject to appropriate disciplinary action, which may include termination.

An Employer Ethics Hotline is available 24 hours a day with the ability to leave a voicemail at:

- Making a confidential report through the Employer Ethics Hotline at #206-455-8363

The person making the report may provide all information anonymously, and every effort will be made to preserve the confidentiality of the matter and anonymity of the person to the fullest extent possible. However, confidentiality and anonymity cannot be guaranteed in all situations.

The Compliance Officer and/or the SIU will investigate all reports, work with all necessary parties to remedy any issues that arise, and respond promptly to the reporting party.

C. Procedures Following a Compliance Report

MCN prohibits any intimidation or retaliatory action against an employee or downstream entity for, in good faith, participating in its Compliance Program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. If any person attempts an intimidating or retaliatory action, he or she is subject to discipline, up to and including termination.

Although employees are encouraged to report their own wrongdoing, they may not use a verbal or written report to try and insulate themselves from the consequences of their own violations or misconduct. However, prompt and complete disclosure may be considered as a mitigating factor in determining an employee's discipline. Also, discipline shall not be increased because an employee reported his/her own violation or misconduct.

Employees and/or supervisors shall not prevent, or attempt to prevent, a person from communicating via the Employer Ethics Hotline or to a designated official.

Anonymous reports will be treated seriously and investigated as thoroughly as those filed by employees who identify themselves.

D. Confidentiality of Reports

The name of the reporting employee and the contents of the report shall be kept confidential to the fullest extent possible. However, confidentiality cannot be guaranteed in all situations.

Employees filing reports, either orally or in writing, should not disclose the contents of the report to anyone other than their manager, or the Compliance Officer (or its designee).

E. Discipline for Violations

Violations of the Compliance Program will not be tolerated. Disciplinary action may be taken for any of the following:

- Authorizing an action that violates the Compliance Program;
- Failing to report a violation of the Compliance Program;
- Refusing to cooperate in the investigation of a suspected violation of the Compliance Program;
- Failing to detect and report a violation of the Compliance Program, if such failure indicates inadequate supervision or lack of oversight by a violator's manager; and/or
- Intimidating or retaliating against a person for making a good faith report, conducting a self-evaluation of compliance, investigation of a suspected violation of the Compliance Program, or conducting audits or other remedial actions in accordance with MCN policies and procedures.

F. Reportable Prohibited Acts

Below is a non-exclusive list of potential grounds for enforcement under the Medicare program and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were violations.

Claims and Billing

- Submitting or causing to be submitted:
  - a false statement or misrepresentation, or omitting pertinent facts when claiming payment under Medicare or when supplying information used to determine the right to payment under;
  - a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;
  - a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;
  - claims with a pattern of inappropriate coding or billing that results in excessive costs to the Medicare program;
  - a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;
- Billing or causing claims to be submitted to the Medicare program:
  - for services or merchandise that were not provided to the recipient;
  - for services or items furnished personally by, at the direction of, or on the prescription or order of a person who is excluded from the Medicare program, other state reimbursement program, or has been excluded from and not reinstated within Medicare, or other reimbursement program;
  - for services or items that are not reimbursable by the Medicare program;
  - for a service or item which requires a prior order or prescription by a licensed practitioner when such order or prescription has not been obtained;
  - for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Medicare program; or
  - by a provider or person for charges in which the provider discounted the same services for any other types of patient.

Records and Documentation

- Failing to maintain for the period of time relevant to the provider records and other documentation that is required by law or regulation/contract. Such records and documentation include, without limitation, those necessary:
  - to verify specific delivery, necessity, appropriateness, and adequate written documentation of items or services furnished; or
  - to confirm the eligibility of the provider to participate in the Medicare program, as applicable; e.g., records (including, without limitation, x-rays, laboratory and test results, and other documents related to diagnosis), billing and claims records;
- Failing to provide:

- immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation; or
- records, documents, and other items or equipment upon written request that are determined necessary by the agency to complete their statutory functions related to a fraud and abuse investigation.

- Developing a false source.

Program-Related Convictions

- Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of the Medicare program.
- Pleading guilty, or being convicted, of:
  - a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;
  - or engaging in, conduct involving moral turpitude; or
  - a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of an item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency.

Provider Eligibility

- Failing to:
  - meet standards required for licensure, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Medicare, or other reimbursement program; or
  - fully and/or correctly complete a provider enrollment agreement or other enrollment form prescribed by the relevant operating agency or its agent for enrollment.
- Being excluded, suspended, or otherwise sanctioned:
  - within any federal program involving the provision of health care; or
  - under any state health care program for reasons bearing on the person's professional competence, professional performance, or financial integrity.

Program Compliance

- Failing to:
  - comply with the terms of the Medicare contract or provider agreement, assignment agreement, the provider certification, or rules or regulations published by the federal or state agency;
  - correct deficiencies in provider operations after receiving written notice of them from an operating agency, the commission or their authorized agents;
  - abide by applicable federal and state law regarding handicapped individuals or civil rights;

    - comply with policies, published program bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to the provider by an operating agency regarding the Medicare program, including statutes or standards governing occupations;
    - repay or make arrangements that are satisfactory to the commission to repay identified overpayments or other erroneous payments or assessments identified by the applicable agency;
- Submitting a false statement or misrepresentation or omitting pertinent facts on any application or any documents requested as a prerequisite for Medicare participation;
- Refusing to execute or comply with a provider agreement or amendments when requested;
- Committing an act described in the Social Security Act, §1128A (mandatory exclusion) or §1128B (permissive exclusion); or
- Marketing, supplying or selling confidential information (e.g., recipient names and other recipient information) for a use that is not expressly authorized by the Medicare, Medicaid, or other reimbursement program.

Delivery of Services

- Failing to provide services or items to Medicare, or other reimbursement program recipients in accordance with accepted industry standards or standards required by statute; regulation, or contract, including statutes and standards that govern medical practice;
- Furnishing services for a recipient-patient that substantially exceed the recipient's needs, are not medically necessary, are not provided economically, or are of a quality that fails to meet professionally recognized standards of care; or
- Engaging in any negligent practice that results in death, injury, or substantial probability of death or injury to the provider's patients.

Improper Collection and Misuse of Funds

- Charging recipients for services when payment for the services was recouped by Medicare for any reason;
- Failing to notify and reimburse the relevant agency or their agents for services paid by Medicare, or other reimbursement programs if the provider also receives reimbursement from a liable third party;
- Rebating or accepting a fee or a part of a fee or charge for a patient referral; or
- Requesting from a recipient in payment for services or items delivered within the Medicare program any amount that exceeds the amount the program paid for such services or items, with the exception of any cost-sharing authorized by the program.

Licensure Actions

- Having a voluntary or involuntary action taken by a state licensing or certification agency/board that requires the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing or certification requirements; or

- Having a license to provide health care revoked, suspended, or probated by the state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person's professional competence, professional performance, or financial integrity, non-compliance with statutes governing healthcare occupations, or surrendering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.

Kickbacks and Referrals

- Violating any of the provisions of state law or regulations relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation.

G. Federal and State Laws

The Role of Federal and State Laws in Preventing Fraud, Waste, and Abuse

CMS defines "**fraud**" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "**abuse**" as incidents or practices of providers that are inconsistent with sound practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are unnecessary.

The Federal Government and states have enacted criminal and civil laws pertaining to the submission of false or fraudulent claims for payment or approval to the federal and state governments and to private payors. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and also provide anti-retaliation provisions for individuals who make good faith reports of FWA.

The Federal Civil False Claims and Program Fraud Civil Remedies Acts, applicable state laws, and anti-retaliation provisions are summarized in the following sections.

Federal Civil False Claims Act

The *Civil False Claims Act* (31 U.S.C. § 3729 *et seq.*) (FCA) is a statute that imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- conspires to defraud the government by getting a false or fraudulent claim allowed or paid,
- uses a false record or statement to avoid or decrease an obligation to pay the Government, and
- other fraudulent acts enumerated in the statute.

The term *"knowingly"* as defined in the FCA includes a person who 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. No proof of specific intent to defraud is required.

The term *"claim"* includes any request or demand for money or property if the Federal Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA currently includes penalties of $10,957 to $21,916 per claim, treble damages, and the costs of any civil action brought to recovery such penalties or damages.

The Attorney General of the United States is required to diligently investigate violations of the FCA and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents, written answers, and oral testimony.

The FCA also provides for Actions by Private Persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit has the right to conduct the action.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five percent of the proceeds of the action or settlement. If the *qui tam* plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty percent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

<u>Section 1557 of the Affordable Care Act</u>

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive Federal financial assistance or are administered by an Executive Agency or any entity established under Title I of the ACA. Health care providers and insurers are barred, among other things, from excluding or adversely treating an individual on any of these prohibited bases.

The Section 1557 final rule applies to recipients of financial assistance from the Department of Health and Human Services (HHS), the Health Insurance Marketplaces and health programs administered by HHS. The final rule is consistent with existing, well-established Federal civil rights laws and clarifies the standards HHS will apply in implementing Section 1557 of the ACA. These standards provide that individuals cannot be denied access to health care or health coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability.

<u>41 CFR Equal Opportunity Employment</u>

As a requirement of being a Federal Government Contractor MCN and its subcontractors must comply as an organization with the Equal Opportunity Clause below.

EEO Clause 41 CFR §

[If applicable,] This contractor and subcontractor shall abide by the requirements of 41 CFR 60-1.4(a) (as amended by E.O. 13665 regarding pay transparency), 60-300.5(a) 60-741.5(a) and 29 CFR 471. These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability or veteran status.

Civil Rights Act of 1964

Federal law prohibits discrimination on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance including Federal Government Contracts.

Section 504 of the Rehabilitation Act of 1973

Section 504 of the 1973 Rehabilitation Act was the first disability civil rights law to be enacted in the United States. It prohibits discrimination against people with disabilities in programs that receive federal financial assistance, and set the stage for enactment of the Americans with Disabilities Act. Section 504 works together with the ADA and IDEA to protect children and adults with disabilities from exclusion, and unequal treatment in schools, jobs and the community.

Whistleblower Protection

Federal law also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest and other enumerated costs, damages, and fees.

Federal Program Fraud Civil Remedies Act of 1986

The *Program Fraud Civil Remedies Act of 1986* ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. § 3801 *et seq.*) is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

The term “knows or has reason to know” is defined in the Act as a person who 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. No proof of specific intent to defraud is required.

The term *“claim”* includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The authority, i.e., federal department, may investigate and with the Attorney General’s approval commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the submission of the claim. The Act allows for *civil monetary sanctions* to be imposed in administrative hearings, including monetary penalties and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

MCN FRAUD WASTE & ABUSE POLICY

As a part of its commitment to abide by applicable rules, regulations, and laws, and in conjunction with its Compliance Manual and Code of Conduct, Mitchell International, Inc., dba MCN (MCN) a division of Mitchell International, Inc. and its subsidiary Genex Services, LLC (Genex), is committed to correcting conduct that results in fraud, waste or abuse. All directors, officers, employees, and contractors of Genex (as that term is defined in the Compliance Manual)[1] shall be aware of and comply with the following fraud and abuse policies and procedures and all applicable federal and state rules, regulations, and laws and shall not engage in fraud, waste or abuse; present or cause to be presented claims which are false, fictitious or fraudulent; or make, use, or cause to be made or used a false record or statement to get a false or fraudulent claim paid. All other references to "MCN" and the services performed under its dba refer to work performed by Genex employees.

Failure to comply with this policy and applicable fraud and abuse rules, regulations, and laws can lead to disciplinary action, up to and including termination or possible legal action.

MCN shall post this policy on its intranet portal, and affected parties shall be notified of this policy. Fraud, Waste, and Abuse training will be provided to all employees, and at least annually. New employees will undergo compliance training within 90 days of beginning employment.

Affected parties shall know about applicable fraud and abuse laws, the role of such laws in preventing and detecting fraud, waste and abuse, protections applicable to whistleblowers and MCN's policies and procedures regarding detecting and preventing fraud, waste and abuse, including the following:

Fraud, Waste, and Abuse

Fraud, Waste, and Abuse ("FWA") is in reference to a series of federal and state laws and regulations designed to prevent excessive and inappropriate claims reimbursement by a government entity or third party payor.

"**Fraud**" is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. It is a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program.

"**Waste**" includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

"**Abuse**" includes actions that may, directly or indirectly result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

[1] The foregoing persons are collectively referred to in this policy as "affected parties."

Examples of potential FWA done intentionally by providers may include the following:

- Billing or claiming reimbursement for services/items:
    - that are not medically necessary
    - that have not been provided (up-coding, false encounter or utilization data)
    - provided by an unlicensed individual
    - for compensable, covered health services under a primary payment source
- Misrepresenting the diagnosis to justify payment
- Misrepresenting dates or identities of members
- Bundling/unbundling
- Characterizing the service differently than the service actually rendered
- Falsely indicating that a particular health care professional attended a procedure
- Quality concern of six months or more in duration of failing to provide medically necessary services/items or providing inappropriate treatment
- Routine waiver of co-payments
- Balance billing members for services
- Soliciting, offering, or receiving a kickback
- Making reckless false statements about the credentials of another provider
- Marketing violations
- Health care research grant fraud
- Improper financial interest
- "Redlining" (a discriminatory practice by hospitals or payors of discouraging enrollment by higher risk patients)

Examples of potential fraud specific to pharmaceuticals may include the following:

- Medicare Part D Fraud:
    - Duplicate billing
    - Overcharging
    - Enrollment fraud
    - Red-lining
    - Improper rebates from pharmaceutical manufacturers and wholesalers
- Pharmaceutical companies:
    - Off label marketing of drugs
    - Illegal kickbacks to hospitals and/or physicians
    - Financial inducements to insurance companies to list a drug on the preferred formulary
    - Inflating the price
    - Best price fraud
- Pharmaceutical Benefits Manager (PBM) firms:
    - Illegal rebate and discount agreements with pharmaceutical companies
    - Offering kickbacks to insurance companies

- Violating contractual responsibilities by shorting prescriptions, switching medications and canceling prescriptions to conceal failures to meet contractually mandated deadlines for filling prescriptions

Examples of potential FWA done intentionally by enrollees are called “soft fraud,” are harder to detect and may include the following:

- Forging, altering or selling a prescription
- Improperly obtaining prescriptions for controlled substances
- Emergency room abuse or overuse (at least 3 visits within 6 months) without an emergent diagnosis
- Sharing a benefit identification card
- Falsifying benefit applications
- Using transportation benefit for non-medical related business

Oversight

The Compliance Officer is the manager of regulatory compliance and accreditations and has the primary oversight of this FWA Policy.

The Compliance Committee assists the Compliance Officer in the performance of his/her tasks as described in this Policy and the Compliance Manual.

The Board of Directors is also knowledgeable about this FWA Policy and the compliance program and exercises reasonable oversight regarding the same.

The CEO and Senior Management are also committed to the FWA Policy and the compliance program.

Investigation and Reporting

Affected parties shall promptly report all violations or suspected violations of the Compliance Manual, violations or suspected violations of federal or state law, and potential FWA by his/herself or other employees to his/her immediate supervisor, the Compliance and Ethics Hotline or the Compliance Officer as set out in the Standards and Code of Conduct.

Upon report, the Compliance Officer, along with the Special Investigative Unit (SIU), will conduct an investigation in a reasonable and timely manner from the notification of a suspected FWA case. A reasonable inquiry should be initiated. During the investigation process, the confidentiality of the patient and/or persons referring the potential FWA case is maintained as much as possible.

The Compliance Officer in conjunction with the Medical Director, Executive Vice President and/or the Chief Operations Officer will implement any corrective action plan required.

Self-reporting of FWA is a critical element to an effective program to control FWA. The Compliance Officer will report all suspected or confirmed cases to the appropriate body.

No Retaliation

MCN has a strict no-tolerance policy for retaliation, retribution, or intimidation against those who make a report in good faith. This no-tolerance policy applies to MCN and its downstream entities and their respective employees.

MCN shall not retaliate in any manner against any affected party for reporting in good faith a violation or suspected violation of applicable law and/or MCN policies. In addition, MCN shall not retaliate against an affected party because of lawful acts done by the affected party in furtherance of a False Claims Act action, including investigation for, initiation of, testimony for, or assistance in filing a False Claims Act action. However, any person who deliberately makes a false accusation with the purpose of harming or retaliating against another affected party, person or entity will be subject to discipline.

Current Version	Date Reviewed/Reason	Approval Date	Short Description (Previous Rev Archived)
V1.0	Policy Creation to provide CMS Compliance training to contracted physicians	6/1/2021	Policy Creation
Previous Version History			