SIGNATURE HEALTHCARE
BROCKTON HOSPITAL
SIGNATURE MEDICAL GROUP

Subject: Fraud and Abuse Policy		Page 1 of 9
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PURPOSE: It is the policy of Signature Healthcare Corp., Brockton Hospital, Inc. d/b/a Signature Healthcare Brockton Hospital, and Signature Medical Group (collectively "SHC") to comply fully with all rules, regulations, and laws pertaining to the delivery of and billing for health care services including payer program and participation requirements of Medicare, Medicaid, other federal payers, and third parties.

Below is a general discussion of several key fraud and abuse laws that may impact SHC's operations. All affected parties, as defined below, shall be aware of and comply with the following fraud and abuse policies and procedures required by § 6032 of the Deficit Reduction Act of 2005 (amending § 1902(a) of the Social Security Act, 42 U.S.C. § 1396a (a)). Failure to comply with this policy and applicable fraud and abuse laws can lead to disciplinary action, up to and including termination or possible legal action.

This policy provides guidance regarding Signature Healthcare's responsibilities, detailed information about the Federal and Massachusetts False Claims Acts, the whistleblower protections under these laws, and the roles of these laws to prevent and detect fraud, waste and abuse in federal health care programs.

POLICY: In order to protect against fraud, waste and abuse, SHC maintains a Compliance Program that encourages the reporting of ethical and legal concerns, including potential fraud and abuse violations, and detects, deters, and corrects fraud, waste and abuse.

It is the policy of Signature Healthcare (SHC) to promote an honest and ethical culture. All employees, medical staff, volunteers and contractors share responsibility for adhering to SHC's standards of business ethics and reporting violations of law or of our policies. Contractors are defined for purposes of this policy to include any subcontractor, agent, or other person which or who, on behalf of SHC, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care provided by SHC.

PROCEDURE:

A. All SHC employees as well as the contractors and agents defined below shall be known as "affected parties." Affected parties shall review and comply with this policy and procedure.

B. A "contractor" or "agent" shall include any contractor, subcontractor, agent, or other person which or who, on behalf of USA Health, furnishes or otherwise authorizes the furnishing of medical health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by SHC.

C. SHC shall post this policy on its web site.

D. SHC shall notify affected parties of this policy.

E. SHC is committed to compliance with applicable laws and regulations, including those laws and regulations designed to detect and deter fraud, waste and abuse.

F. SHC is committed to correcting conduct that results in fraud, waste or abuse.

G. SHC has a process to review reports of violations or suspected violations of applicable law and/or SHC policies.

H. SHC shall not retaliate (i.e., discharge, demote, suspend, threaten, harass, or discriminate) against any affected party for reporting in good faith a violation or suspected violation of applicable law and/or SHC policies. In addition, SHC 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.

I. SHC is committed to the submission of accurate claims for payment, and provides training regarding the claim submission process.

J. SHC shall periodically review its policies and procedures, including those policies regarding billing, in an effort to prevent and detect fraud, waste and abuse and to comply with applicable laws and regulations.

K. Affected parties shall not engage in fraud, waste or abuse.

L. Affected parties shall not present or cause to be presented claims which are false, fictitious or fraudulent.

M. Affected parties shall not make, use, or cause to be made or used a false record or statement to get a false or fraudulent claim paid.

N. Affected parties shall comply with the SHC policies and procedures which apply to them, including those policies regarding documentation, medical records, medical necessity, billing, coding, waiver of coinsurance and deductibles, overpayments, licensure, compliance with state and federal laws and regulations, and government audits, reviews and investigations.

O. Affected parties who perform billing or coding services on behalf of SHC shall have the skills, quality assurance processes, systems, and procedures that are necessary for submitting accurate claims.

P. If an affected party engages in conduct which is considered fraud, waste or abuse, violates SHC policy or otherwise violates applicable state or federal laws and regulations, such affected party may be subject to adverse consequences, including disciplinary action, termination, investigation, audit and/or prosecution.

Q. 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 SHC's policies and procedures regarding detecting and preventing fraud, waste and abuse. Specifically, affected parties shall become familiar with the following:

1. The federal definitions of fraud and abuse.

'Fraud' means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to their self or some other person. It includes any act that constitutes fraud under applicable federal or state law.

'**Abuse**' means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to federal payer programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to federal payer programs (42 C.F.R. § 455.2).

2. The purpose of the fraud and abuse laws.

The purpose of the fraud and abuse laws is to ensure the safety of beneficiaries and the integrity of health care programs. The laws target conducts that result in over-utilization, increased program costs, corruption of medical decision making and unfair competition. They work to prevent and detect fraud, waste and abuse by encouraging whistleblowers, punishing violators and deterring potential violators through criminal and civil penalties, which may include imprisonment, exclusion, debarment, suspension, civil monetary penalties and corporate integrity agreements.

3. The applicable fraud and abuse laws.

The applicable fraud and abuse laws, include, but are not limited to, the laws mentioned below. The summaries of the laws below are not intended to alter the rights or obligations of the parties affected by the laws.

a. **Federal False Claims Act**. The federal False Claims Act ("FCA"), found at 31 U.S.C. §§3729 to 3733 makes it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. "Knowing," according to the FCA, means the person has actual knowledge, 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. The FCA also applies to any false record or statement made or used to get a false or fraudulent claim paid, as well as the failure to pay an obligation or overpayment to the government. Violations of this statute include, but are not limited to:

- Submitting claims for services that were never provided;
- Submitting claims for services that are not medically necessary;
- Submitting claims for services that may be medically necessary but are not covered;
- Using a code for a higher level of reimbursement than the code for the services actually provided;
- Billing separately for services that should be billed as a single global service;
- Billing for services provided by an excluded or unlicensed provider;

- Providing false information on cost reports;
- Billing for services where there is an illegal relationship, such as a kickback relationship between a provider submitting a claim and the provider's referral source; or
- Retaining known overpayments for more than sixty (60) days after the overpayments are detected.

Violators of the FCA are subject to damages, civil penalties, and exclusion. Civil penalties are assessed per false claim and up to three (3) times the amount of damages. Damages may be lowered to not less than (2) times the amount of damages if certain requirements are met.

The FCA allows for a private whistleblower, otherwise known as a relator, to file a qui tam suit on behalf of the government. If the case is successful, the court may award the whistleblower a percentage of any recovery. The employer of a whistleblower may not retaliate against the whistleblower for filing a legitimate qui tam or for being involved with a lawful FCA case. This means an employer may not discharge, demote, suspend, threaten, harass or discriminate against the whistleblower because of his/her whistleblower actions. If a court finds that an employer retaliated, the court will grant the employee the relief it believes is necessary to make the employee whole. However, if the government does not proceed with the case and the court finds that the relator's claim was frivolous, vexatious, or brought primarily for purposes of harassment, the court may order the relator to pay the defendant's reasonable attorneys' fees and expenses.

b. **Federal Anti-Kickback Statute**. The federal Anti-Kickback Statute prohibits anyone from providing or offering to provide any remuneration (*i.e.*, generally anything of value) in cash or in kind, directly or indirectly, in return for the referral of a patient whose treatment (item or service) is paid for in whole or in part by a federal health care program, including Medicare or Medicaid. The Anti-Kickback Statute also bans the payment or receipt of remuneration in return for purchasing, leasing, ordering, or recommending the purchase, lease, or order of any goods, facilities, services or items covered by a federal health care program.

Examples of conduct and activities that may violate the Anti-Kickback Statute include, but are not limited to:

- Offering or receiving gifts, loans, rebates, services or anything of value between SHC and physicians or other providers of designated Health Services (DHS), in exchange for patient referrals.
- Offering gifts, loans, rebates, services, or anything of value to a patient who utilizes or may utilize SHC services;
- Discounts or payments offered by suppliers and vendors intended to induce business referrals from USA Health; or
- Rental of space and equipment to sources of patient referrals below fair market value, or at a rate based on the volume or value of referrals.
- Violations of the Anti-Kickback Statute may result in criminal sanctions including imprisonment for up to five (5) years and a fine or both. In addition to criminal sanctions, violators may be excluded from participation in federal health care programs, civilly fined per violation, and

assessed a monetary penalty of up to three (3) times the total amount of remuneration offered, paid, solicited or received. An Anti-Kickback Statute violation may also subject the violator to penalties under the False Claims Act.

c. **Federal Stark Self-Referral Law**. Under the federal Stark Self-Referral Law ("Stark Law"), if a physician or any member of the physician's immediate family has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of certain defined health care services (called "designated health services"), which are paid for in whole or in part by Medicare or Medicaid, and the entity may not present or cause to be presented a claim or bill to Medicare or Medicaid for the designated health service, unless an exception is met. Designated health services covered by the Stark Law include the following: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology or certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral or enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. Any relationship in which remuneration flows between the parties is considered a financial relationship.

Violations of the Stark Law may result in civil penalties, including denial of payment for the designated health services, and refund of amounts collected from improperly submitted claims. A civil monetary penalty is assessed for each service a person knows or should know was provided in violation of the Stark Law, or each arrangement or scheme which the physician knows or should know has a principle purpose of assuring referrals. Damages may be assessed up to three (3) times the amount of the monetary penalty, and exclusion from federal health care programs. Violation of the Stark Law may also result in penalties under the False Claims Act.

d. **Civil Monetary Penalties Law.** The federal Civil Monetary Penalties ("CMP") law covers an array of fraudulent and abusive activities and is very similar to the False Claims Act (discussed above). For example, the CMP law prohibits a person from offering or transferring remuneration to a beneficiary that such person knows or should know is likely to influence the beneficiary to order items or services from a particular provider or supplier for which payment may be made under the Medicare and Medicaid programs. The CMP law also prohibits a health care provider from presenting, or causing to be presented, claims for services that the provider knows or should know were:

- Not provided as claimed;
- False or fraudulent; or
- Furnished by a person who is not properly licensed or who is excluded.

A violation of the CMP law can result in civil fines per item or service and exclusion from federal health care programs.

e. **Federal Program Fraud Civil Remedies Act**. For false claims or statements, the Program Fraud Civil Remedies Act ("PFCRA") provides for an administrative process to find liability, to impose civil penalties, and to make the federal health care programs whole. The penalties for violating the PFCRA are assessed per false claim plus two (2) times the amount of the claim, if the claim was actually paid. If a

person is found to have violated the law, the government may commence an action to suspend or exclude the provider from participation in the federal health care programs.

f. **Obstruction of Proceedings, Audits or Investigations**. It is a crime to willfully prevent, obstruct, mislead, delay, influence or impede or attempt to prevent, obstruct, mislead, delay, influence or impede an investigation, audit or proceeding. Persons who alter, destroy, mutilate, conceal or falsify a record or document with the intent to impede, obstruct or influence an investigation, audit or proceeding may be subject to prosecution. Penalties for these crimes may include a fine, imprisonment of up to five (5) years, or both, or up to twenty (20) years, depending upon the conviction.

g. **Massachusetts False Claims Act** (M.G.L. c.12, §§5A to 5O). The Massachusetts FCA makes it a felony to make or cause to be made or to assist in the preparation of any false statement, representation, or omission of a material fact in any claim for Medicaid payment or for any claim for medical benefits from the Medicaid Agency, if the person has the intent to defraud or deceive and knows that the statement, representation or omission is false. Violators may be fined, or imprisoned for not less than one (1) nor more than five (5) years, or both.

Pursuant to the Massachusetts Medicaid regulations, when there has been fraud or abuse against the Medicaid program, in addition to the criminal penalties discussed above, administrative sanctions may also be imposed. These sanctions include, among other things, suspension of Medicaid payments, suspension of Medicaid participation, termination of Medicaid participation, and restitution. The Medicaid program defines fraud for these purposes as "an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person." 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 or in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care." Examples of Medicaid fraud and abuse include the following:

- Billing for services or equipment that the patient did not receive;
- Charging recipients for services over and above that paid for by Medicaid;
- Double billing or other illegal billing practices;
- Submitting false medical diplomas or licenses in order to qualify as a Medicaid provider;
- Ordering tests, prescriptions or procedures the patient does not need;
- Rebating or accepting a fee or a portion of a fee for a Medicaid patient referral;
- Failing to repay or make arrangements for the repayment of identified overpayments; or
- Physical, mental, emotional or sexual abuse of a patient.

h. **Massachusetts Anti-Kickback Law**. The Massachusetts Anti-Kickback law (M.G.L. c.175H,§3prohibits any person from soliciting or receiving any remuneration (which includes any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind) (a) in return for

referring an individual to a person for the furnishing or arranging for furnishing of any item or service for which payment may be made in whole or in part by the Medicaid Agency or its agents, or (b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, service, or item for which payment may be made in whole or in part by Medicaid. It also prohibits any person from offering or paying any remuneration to induce a person to refer an individual for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicaid, or to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, service, or item for which payment may be made in whole or in part by Medicaid. Violators may be fined or imprisoned for not less than one (1) nor more than five (5) years, or both.

i. **Massachusetts Licensure Penalties**. The Massachusetts Board of Registration in Medicine and other relevant licensure agencies may suspend, revoke or restrict any license to practice medicine or fine any licensee if the licensee is found guilty of the following: (i) a felony, (ii) dividing fees received for professional services with any person for bringing or referring a patient (i.e., fee- splitting), (iii) performing unnecessary medical services, (iv) charging grossly excessive fees, or (v) intentionally filing or causing to be filed false or fraudulent claims.

Affected parties shall report violations or suspected violations of this or any SHC policy or of any applicable laws or regulations.

Affected parties may direct questions regarding this policy or applicable fraud and abuse laws to:

SHC Compliance Hotline
508-941-1085 or at Compliancematters@signature-healthcare.org

And / Or
Alternatively, affected parties can report suspected fraud and abuse activities directly to the Federal Department of Justice at:

Federal Department of Justice
(202) 514-2000

If the suspected fraud or abuse involves Medicaid claims, reports can be made directly to the Massachusetts Medicaid Agency Fraud Hotline at:

Massachusetts Medicaid Agency Fraud Hotline
1-671-913-2360

1. If a SHC employee, affiliate, professional staff member, contractor, vendor or agent has a question concerning the interpretation or applicability to a particular circumstance of any of the laws, regulations or standards referred to in this policy, such SHC associate or agent should contact the Corporate Compliance Officer for guidance.

2. Any SHC employee affiliate, professional staff member, contractor, vendor or agent who is in doubt as to the propriety or legality of any decision or course of action must consult with the Corporate Compliance Officer or General Counsel prior to taking action.

3. As reflected in SHC's Code of Ethical Behavior (Policy No. 100.006), if at any time any SHC employee or professional staff member becomes aware of any actual or threatened violation of any SHC policy, including any part of the SHC Corporate Compliance Plan, or of any applicable law (including but not limited to the Federal and state false claims and statements laws), regulation or standard of conduct, such individual **must** report the situation to the Corporate Compliance Officer. Suspected violations may be made directly to the Corporate Compliance Officer or to SHC's Compliance Hotline (855) 941-7085 in accordance with the SHC Compliance Hotline Policy. **The Compliance Hotline Policy** (Policy No. 100.017) details the protection of the privacy of the caller, the methodology for investigating any items brought to SHC's attention through the Compliance Hotline, and how allegations will be addressed.

4. SHC will not take any adverse action/retaliate against any SHC employee, affiliate, professional staff member, contractor, vendor or agent who reports, in good faith, any violation, actual or threatened, regardless of whether the situation giving rise to the report is ultimately determined not to have any factual basis. Any SHC employee who violates this non-retaliation policy may be subject to discipline up to and including termination. If any SHC employee, affiliate, professional staff member, contractor, vendor or agent knows of any actual or potential violation of any applicable law, regulation or standard and fails to report the situation, such employee, affiliate, professional staff member, contractor, vendor or agent may be subject to disciplinary action.

RESPONSIBILITY:

Corporate Compliance Officer; Office of the General Counsel

REFERENCES:

MGL c. 175H,§3 Massachusetts Anti-Kickback Law
M.G.L. c.12, §§5A, 5O Massachusetts False Claims Act
42 CFR § 411.350 et seq. Stark Law Regulations
42 USC §1395nn Stark Law Statute
42 USC §1320a-7b Anti-Kickback Statute
42 CFR § 1001.952 Anti-Kickback Statute
Safe Harbor Regulations
Eliminating Kickbacks in Recovery Act of 2018

REVIEWED BY:	**DATE:**
Chief Compliance Officer	7/22
Vice President/General Counsel	7/22
Administrative Policy Committee	7/22
SMG Quality Committee	8/22
Medical Executive Committee	12/22

SIGNATURE HEALTHCARE
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POLICY APPROVAL SIGNATURE PAGE

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APPROVED BY	SIGNATURE	PRINT NAME	DATE APPROVED
Administrative Policy Committee Chair		Kim Walsh, RN	12/6/22
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