COMBINED POLICY, PROCESS & PROCEDURE DOCUMENT

POLICY: Healthcare Fraud Waste and Abuse Policy

POLICY NUMBER: COM-09

POLICY OWNER: Compliance Officer

POLICY LAST UPDATED: June 18, 2020

POLICY VERSION: 1.0

POLICY STATUS: Final

This document is the property of Insight Global, LLC and is marked "Confidential" in accordance with Insight Global LLC's Information Security Policy. Unless prior written authorization is provided, this document is for use only by authorized personnel that require this information to perform their job function. All ideas, concepts, processes, drawings and information contained herein are considered the proprietary intellectual property or trade secrets of Insight Global, LLC Unauthorized use or distribution in any form or means including electronic, mechanical, photocopying or otherwise is illegal and prohibited.

Printed copies of this document are uncontrolled.

The latest revision of this document is kept: http://sharepoint/governance

REVISION AND APPROVAL HISTORY

Revision History

Version	Date	Author	Revision Notes
1.0	6/18/2020	Outside Counsel	Initial draft of policy

Approval History

Approver	Title	Date	Signature
Lexie Conway	CO	5/26/2021	Lexie Conway
Lexie Conway	CO	11/14/2023	Lexie Conway

Review History

Review Date	Reviewer	Review Comments

I. PURPOSE

The purpose of this policy is to provide guidance to all Insight Global, LLC ("Insight Global" or the "Company") Company employees, directors, management, and individuals contracted by the Company to provide staffing support or related services directly to Insight Global customers (collectively, "Personnel") on compliance with certain federal and state laws aimed at preventing and detecting fraud, waste and abuse. Insight Global is committed to complying with all applicable requirements of section 6032 of the Federal Deficit Reduction Act of 2005, and to preventing and detecting any fraud, waste and abuse applicable to federal or state laws and standards of business conduct.

II. DEFINITIONS

- Abuse - Describes practices that either directly or indirectly result in unnecessary costs to a federal or state healthcare program or to the Company. Abuse includes any practice that is not consistent with the goal of providing patients (when applicable) with services that are medically necessary, meet professionally recognized standards, and are fairly priced.
- CO – Compliance Officer.
- Fraud - Knowingly making a false (claim) statement for payment or benefit; twisting or bending the facts to obtain payment or other benefit(s) under a federal or state healthcare program.
- FWA - Fraud, waste and abuse.
- Knowingly - a person with respect to information:
  - Has actual knowledge of falsity of information in the claim for payment from a federal or state healthcare program;
  - Acts in deliberate ignorance of the truth or falsity of the information of such claim; *or*
  - Acts in reckless disregard of the truth or falsity of the information in such claim.
- PFCRA - Program Fraud Civil Remedies Act.
- Respondent - The person or party alleged to have committed potential wrongdoing related to FWA.
- Waste - Occurs whenever federal or state taxpayers do not receive a reasonable return on their money, for government-funded activities, due to incorrect acts or errors. Most waste does not involve a violation of law; rather, waste relates mainly to negligence, incorrect actions, and insufficient or poor controls.

III. PROCEDURE

Insight Global maintains a corporate compliance program that includes compliance training, monitoring and auditing activities for the detection, prevention and investigation of fraud, waste, and abuse. This policy establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim or report, or any other potential fraud, waste and abuse related to a federal or state law or standards of business conduct.

The proof to be held liable does not require any specific intent to defraud the government or Company. All that is required is that the person has knowledge, or has acted with deliberate

ignorance or reckless disregard of the truth or falsified claim(s) which are reimbursable for federal or state healthcare programs. The defense of "didn't know it was illegal" is not valid.

Any employee who reports such information will have the right and opportunity to do so anonymously, and will be protected against retaliation and intimidation for reporting such information as outlined in the Company's policies and procedures as well as federal law.

A. False Claims Act:

False claims laws are intended to recognize and combat fraud and abuse against the government, including fraud and abuse in Medicare or any other federally funded healthcare programs. The law allows the government, and in some cases, private individuals, to bring civil actions against healthcare providers or their agents to recover damages and penalties when a person knowingly (or conspires to) make(s), uses or causes to be made or used, a false record or statement material to a false or fraudulent claim. Violations of the False Claims Act may constitute felonies, subject to substantial fines or imprisonment by Personnel participating in alleged misconduct. Examples include:

- Receiving unlawful inducements from healthcare providers for referrals of services.
- Altering a medical record.
- Timesheet falsification.
- Offers of gifts, money or other gratuities from contractors, grantees, or other individuals.
- Providing false or misleading information in order to receive reimbursement under federal or state healthcare programs.

Violations of the False Claims Act can result in fines against the Company in the amount of three times the amount the government paid for each false claim, plus an additional penalty of up to $11,000 per false claim.

B. Program Fraud Civil Remedies Act:

The Program Fraud and Civil Rights Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act. The PFCRA imposes liability on individuals or entities that file a claim that they know or have reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that contains false or fictitious or fraudulent information; Includes or is supported by a written statement omitting material fact that renders a statement as false, fictitious or fraudulent, and the individual has a duty to submit a statement that included the omitted fact; or
- Is for payment for property or services not provided as claimed.

Violation of PFCRA carries a $5,000 civil penalty for each wrongfully filed claim. In addition, an assessment of two times the amount of the claim can be made, unless the claims have not actually been paid.

A person also violates the PFCRA if they submit a written statement which they know or should have known, asserts a material fact which is false, fictitious or fraudulent, or omits a material fact and is false, fictitious or fraudulent as a result of an omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the prohibition for submitting an improper statement carries a civil penalty of up to $5,000.

C. Anti-Kickback Statute:

The federal Anti-Kickback Statute prohibits knowingly and willfully offering, paying, soliciting or receiving remuneration as an inducement to refer business or patients for which reimbursement is available under the federal or state healthcare programs. Violations of the Anti-Kickback Statute are classified as felonies and are punishable by fines of up to $25,000 and up to 5 years in prison. Violations of the Anti-Kickback Statute may also cause Personnel and the Company to be excluded from participating in federal healthcare programs or from working for entities that participate in federal healthcare programs. The federal government also has authority to impose civil and administrative penalties for violations of the Anti-Kickback Statute. Monetary penalties include up to $50,000 per violation, up to 3 times the amount of actual damages as calculated by the government, and exclusion from participation in federal healthcare programs.

D. The Limitation on Certain Physician Referrals (The Stark Law):

The Stark Law prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship - unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral. Notably, DHS includes all inpatient and outpatient hospital services. Sanctions for violating the Stark Law include disallowing all Medicare payments for any DHS provided pursuant to a referral from the physician and possible penalties of up to $25,820 per DHS item or service plus three times the amount claimed for payment from Medicare; circumvention schemes can result in a penalty of up to $172,137 and exclusion from participation in federal healthcare programs.

IV. RESPONSIBILITY:

Insight Global will review and investigate all allegations of fraud, waste and abuse, whether internal or external. Investigations will only be conducted by, or under the direction of the CO, internal legal counsel, and or their designee.

It is the responsibility of all Insight Global Personnel to comply with the requirements of this policy; reporting in good faith, any observed, suspected, or apparent fraud, waste and or abuse. If an individual is unsure whether a suspected incident falls within the definition of fraud, waste and abuse, he or she may discuss the suspected misconduct with the Compliance Department and the Legal Department; they may also report the incident anonymously via the Compliance Hotline at: (800) 367-2884.

V. PROCESS:

A. Inquiry:

Inquiries on reports of potential violations of fraud, waste and abuse are initiated within two weeks of the date the potential incident was identified. If the inquiry results appear to involve potential violations, this issue will be investigated.

Upon receiving an allegation of FWA, the CO will immediately assess the allegation to determine whether it is sufficiently credible of wrong doing. An inquiry must be conducted if the CO determines that an employee knowingly participated in wrong doing.

Prior to the initiation of the Inquiry process, the CO will make a good faith effort to notify the identified respondent(s) in writing, if the respondent(s) is known. On or before the date which the respondent(s) is notified, or the inquiry begins, whichever is sooner. The CO must take all reasonable and practical steps to obtain custody of and sequester in a secure manner, any documentation and or records.

B. Inquiry Report:

The CO shall be responsible for drafting an inquiry report that includes:

- The name and position of the respondent(s);
- The description of the allegations of FWA;
- The rationale for recommending or not recommending an allegation that warrants investigation; and
- Any comments made in response to the allegations during the inquiry by the respondent.

C. Investigation:

The investigation must begin within 30 calendar days after the determination by the CO that an investigation is warranted. The purpose of the investigation is to develop a factual record by exploring the allegations in detail and examining the evidence in depth, leading to recommended findings on whether and to what extent wrong-doing may have been committed, and by whom. The investigation will also determine whether there are additional instances of possible wrong-doing that would justify broadening the scope beyond the initial allegations.

The CO will, make a good faith effort to notify the identified respondent(s) that the identified allegations are being investigated. The CO will again take all reasonable and practical steps to obtain custody of and sequester in a secure manner, any documentation and or records needed for the FWA investigation that were not previously sequestered during the inquiry. The need for additional sequestration of records for the investigation may occur for any number of reasons, including: the company's decision to investigate additional allegations not considered during the inquiry stage or the identification of records during the inquiry process that had not been previously secured. The procedures to be followed for sequestration during the investigation are the same procedures that apply during the inquiry.

D. Investigative Report:

The CO must give a copy of the draft investigative report to the respondent within 14 business days after the investigation has concluded. The respondent will have 7 days from the receipt of the draft investigation report to add comment to the draft investigative report. If the CO has not received any communication from the respondent after 7 days from the receipt of the respondent's investigation report, the CO shall assume that the respondent has no further comments to add to the draft investigative report and commence to draft the final investigative report.

The CO shall be responsible for drafting a written investigation report that includes:

- The identification of the respondent.
- A description summary of the nature of allegation.
- Description and documents that support the allegation.
- Documents and or records sequestered and reviewed as evidence or evidence that was sequestered but not reviewed.
- A description of the specific allegations of FWA considered in the investigation.
- The company policy name (and or procedure(s)) under which the investigation was conducted.
- A statement of finding for each allegation identified during the investigation. Each statement finding must include:
  - Identification of the type of claim.
  - A summary of factual analysis that supports the conclusion and considerations of merit of any reasonable explanation by the respondent.
  - Identification of appropriate corrective and/or disciplinary actions.
- The final investigative report must be completed within 14 business days from the final date that draft investigative commentary was due from the respondent.
- Any commentary submitted by the respondent in the draft investigative report, must be included in the final investigative report.

E. Discipline, Corrective Action Plan, and Reporting

Following completion of the investigation and issuance of the Investigation report, the CO shall comply with the discipline, corrective action plan and reporting procedures set forth in the Company's Investigating and Responding to Compliance Issues Policy.

VI. REFERENCE / REGULATORY COMPLIANCE:

- Deficit Reduction Act of 2005
- False Claims Act 31 U.S.C 3729-3733
- Health Care Fraud (18 U.S.C. § 1347)
- Medicare Managed Care Manual - Chapter 21: Compliance Manual Guidelines, Section 50.7
- Patient Protection and Affordable Care Act ("PPACA"); 42 U.S.C 1301
- Program Fraud Civil Remedies Act; 31 U.S.C § 3801-3812
- 42 U.S.C. 1395nn

VII. SCOPE

This Policy governs Company Personnel rendering services *on behalf of, and at the direction of,* customers, with particular focus on services rendered in the healthcare setting or otherwise implicating federal healthcare programs.

VIII. APPROVAL/MAINTENANCE

This policy is approved by the CO and/or the Compliance Committee. Maintenance of this policy will be the responsibility of the Compliance Committee in coordination with the CO. The terms of this policy are subject to the terms of the Company's policy inventory and alignment policy (the "Wrapper Policy"), as may be amended from time to time.