Compliance Plan

IMMEDIADENT/ SAMSON

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I. Introduction

Founded in January of 2003 and headquartered in Kansas City, Missouri, Samson Dental Partners, LLC ("Samson") provides management, administrative and other support services to ImmediaDent-branded urgent dental care practices in Indiana, Ohio and Kentucky. These dental care practices (the "Practices") are owned and operated by ImmediaDent of Indiana, LLC, Dental Services of Ohio, LLC and Dental Services of Kentucky, LLC. The urgent and comprehensive dental care practice model as performed by the Practices is referred to herein as "ImmediaDent".

Where this policy refers to both ImmediaDent and Samson, the terms "the Companies" will be used.

ImmediaDent's mission is to be the Nation's Premier Urgent dental care provider. We deliver quality comprehensive same day dentistry. 9am – 9pm seven days a week. We are passionate about overcoming obstacles to dental care and improving our patients' oral health in an accessible, respectful and professional atmosphere.

Samson and ImmediaDent are dedicated and committed to meeting high ethical standards and compliance with all applicable laws in all activities regarding the delivery of dental care through its Practices. It is our goal that this Compliance Program will assist Samson and ImmediaDent in fulfilling ImmediaDent's fundamental vision, mission, and values.

Our organization has adopted this Medicaid Compliance Plan to comply with the provisions of the Deficit Reduction Act of 2005 and the Office of Inspector General of the Department of Health and Human Services. Specifically, Appendix A to this Policy includes detailed information concerning the Federal and State False Claims Acts along with Federal and State laws protecting whistleblowers and providing for criminal and administrative penalties and sanctions in the health care arena. This Policy describes our procedures for detecting and preventing fraud, waste and abuse.

As is detailed within this Compliance Plan, it is the duty of all of our employees, contractors, vendors and agents to comply with the policies as applicable to their individual areas of employment or contracts.

This Compliance Plan also advises all of our employees, contractors, vendors and agents of the procedures to be used in reporting non-compliance with Federal and State laws.

It is also the intent of this plan to organize our resources to resolve payment discrepancies and detect inaccurate billings as quickly and efficiently as possible, and to impose systemic checks and balances to prevent such occurrences.

A. Benefits to our Compliance Program

Benefits to our Compliance Program include, but are not limited to the following:

- Demonstrates to the employees and community at large our strong commitment to honesty, responsibility and appropriate conduct.
- Develops a system to encourage employees to report potential problems that may be detrimental to patients and to ImmediaDent.
- Develops procedures that allow for a thorough investigation of alleged misconduct.
- Develops procedures for promptly and effectively conducting internal monitoring and auditing which may prevent non-compliance.
- Through early detection and reporting, minimizes the risk to ImmediaDent and, thereby, reduces our exposure to any civil damages or penalties, criminal sanctions or administrative remedies.

II. Compliance Code of Conduct

In addition to ImmediaDent's general policies and procedures as found on InfoSource and in the Employee Handbook, the following Compliance Code of Conduct gives specific guidance for Samson and ImmediaDent employees. It is not intended to prescribe a specific response to every conceivable situation, but is intended to assist employees in determining an appropriate response as salient situations arise. Whenever an employee has a question about an appropriate response in a given situation, (s)he should consult his/her supervisor.

- ImmediaDent will bill only for services actually rendered and shall seek the amount to which it is entitled.
- ImmediaDent does not tolerate billing practices that misrepresent the services actually rendered.
- Supporting documentation must be prepared for all services rendered.
- ImmediaDent employees shall bill private insurance and Medicaid by the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
- All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable contracts, regulations, and laws and ImmediaDent policies and procedures.
- An accurate and timely billing and documentation structure is critical to ensure that ImmediaDent employees can effectively implement and comply with required policies and procedures.
- Demonstrated lapses in the documentation and billing systems infrastructure should be remedied in a timely manner at the program level with input from the Medicaid Compliance Committee (“MCC”) whenever possible. The Compliance Officer must approve all proposed remedies.
- ImmediaDent employees are not to falsify documentation for the purposes of billing.
- Never assume a service has been provided. Always verify services by referring to clinical and medical records for documentation.
- If you personally did not provide a service, never sign/initial that the service has been provided.
- Never pre or postdate documentation.
- Samson/ImmediaDent employees are not to delete/erase documentation in clinical or medical records, – always add/addend.

III. Compliance Officer

Samson has designated a Compliance Officer who oversees the development and implementation of ImmediaDent's Compliance Program and ensures appropriate handling of instances of suspected or known illegal or unethical conduct. The Compliance Officer may be reached at any time using the contact information shown below. The Compliance Officer will receive and coordinate complaints or concerns involving its health care operations:

Dept:	Email Address:	Primary Phone No.:	Alternate Phone No.:
Compliance	compliance@samsondentalpartners.com	913-428-1674	913-428-1687

Duties of the Compliance Officer include:

- Oversee and monitor the implementation of the Compliance Program;
- Maintain the effectiveness of the Compliance Program;
- Establish methods such as conducting periodic audits, developing effective lines of communication on compliance issues and preparing written standards and procedures that reduce ImmediaDent's vulnerability to fraud and abuse;
- Periodically revise the Program in light of changes in the needs of the organization, in the law, policies, and procedures of the government;
- Develop, coordinate and participate in a training program that focuses on the components of the Compliance Program and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards; and that independent contractors, consultants and volunteers who furnish dental services to ImmediaDent' patients are aware of the requirements of the Compliance Program;
- Ensure that the List of Excluded Individuals and Entities have been checked with respect to all employee and independent contractors.
- Report on a regular basis to the Executive Management Team, The Clinical Quality Committee, the Board, and the Medicaid Compliance Committee on the progress of implementation, any investigations and corrective actions.

IV. Communication and Changes in Compliance Manual

The Compliance Officer will distribute by email and on InfoSource any modifications of, or amendments to, this Compliance Plan. The Compliance Officer will also provide employees, contractors, vendors, agents of the ImmediaDent with written explanations of any substantial changes in these policies. If the Compliance Officer determines that email communication and updates on InfoSource are insufficient, in-service will be conducted (please refer to section on Education and Training below).

V. Education and Training

The proper education and training of employees is a significant element of an effective compliance program. As such, employees will be expected to participate in appropriate training.

A. Compliance Plan

All current employees will be provided a copy of the Compliance Plan and will be required to view a eLearning Module on the Plan. The first time they receive Plan they will be expected to electronically sign a certification stating that they have read and understand the Plan and understand their responsibility for ensuring compliance with the Compliance Plan. All employees will annually certify receipt and review of the Plan through their participation in annual compliance training.

For new employees, an eLearning Module covering the Compliance Plan will be included as part of the onboarding process. New employees will complete a short assessment of understanding and will be expected to electronically acknowledge that they understand and will comply with the Plan.

These trainings are a requirement of the Compliance Plan. Employees will view the trainings on DentalU and completion will be electronically certified, tracked and documented.

For vendors, consultants, contractors and other agents who provide any service where Medicaid dollars are used; the Compliance Plan and any updates will be on our ImmediaDent website.

In conjunction with initial and annual training on the Compliance Plan, all ImmediaDent employees will be trained annually on the Federal and State False Claims Act and Whistleblower Protection (Please see Appendix A for a summary of the laws). This training is a requirement of the Compliance Plan.

The Human Resources Department will maintain a database that shows all employees who have completed training for the year. If any employee is non-compliant, the supervisor will be informed and further non-compliance may result in disciplinary action.

VI. Reporting Concerns

Samson and ImmediaDent believe that it is our employees who best know where organizational policy or regulation is not being followed. Therefore, the effectiveness of our Compliance Program depends on the willingness of employees in all parts and at all levels of the organization to step forward, in good faith, with questions and concerns.

We believe strongly that in all of these cases, resolution of the problem behaviors or actions will result in better care for our patients. Therefore, each person reporting problems or concerns will be contributing positively to the overall quality of the services at ImmediaDent.

If there is suspicion of possible fraud, waste and abuse or other matter related to the Compliance Program, it is the responsibility of the employee who suspects such action to inform a person in

senior level authority who they feel may assist in directing the issue/concern to resolution. Samson/ImmediaDent request that the first person informed be the direct supervisor; however, if employees want to keep anonymity they can call Lighthouse (our anonymous Employee Hotline) and/or call or email the Compliance Officer. (See procedures for reporting possible non-compliance below.)

All reports of possible fraud, waste and abuse, or other matters related to Medicaid compliance will be reported to the Compliance Officer who will implement the necessary steps as set forth in this Compliance Program for investigating the matter.

Examples of provider fraud or abuse

- Billing for services that were not provided.
- Billing under the name of a DDS other than the doctor who performed the treatment
- Upcoding – billing for a higher reimbursed code than the appropriate code per CDT and InfoSource guidelines.
- Performing and billing for medically unnecessary services

A. Reporting Policy

Every employee is responsible for doing his/her job in a manner that is ethical and complies with the laws and regulations that govern our work.

Every employee is responsible for seeking supervisory assistance if he or she has doubts or is unclear about what the right action is to stay compliant. If the employee does not believe their supervisor is correct in their advice, they can report the problem directly to the Compliance Officer or via the Employee Hotline.

Every employee has a duty to ImmediaDent and to our patients to report actions or behaviors they feel violate the code of conduct, required procedures, laws or regulations. Any employee that fails to report misconduct or illegal behavior may be subject to disciplinary procedures up to and including termination.

Samson/ImmediaDent will encourage employee questions and/or reports by:

- Taking each report seriously;
- Investigating each report; and where there is enough information, determining the extent of the problem and corrective action(s) needed;

Making sure that employees who do report:

- Do not suffer any retaliation by their peers or supervisors for their good faith reports or questions.
- Have more than one way to report questionable behavior or for asking questions about compliance. This includes giving employees the option of reporting directly to their supervisor, directly to the Compliance Officer or via the Employee Hotline.
- Have the choice of keeping their name confidential in regard to a specific report for as long as the organization can reasonably do so.
- Have an agreed upon method for determining the status of their report and any subsequent investigation where possible.

B. Reporting Procedures

Employees may report at any time using one or more of the reporting methods shown below:

- VOICE MAIL OR FACE-TO-FACE REPORTS:
  - Voice mail or face-to-face reports to the Compliance Officer or any manager or supervisor.
- MAIL AND EMAIL:
  - Employees may use mail or email to report problems or concerns. Mail and email can be directed to the Compliance Officer or to any manager or supervisor.
- COMPLIANCE OFFICER:
  - Directly to the Compliance Officer via Incident Report or at 913-428-1674.
  - Lighthouse anonymous phone line, referred to as the Employee Hotline (844-230-0006 or www.lighthouse-services.com/immediadent)

In all cases, supervisors who get employee reports will be required to prepare an Incident Report and discuss the report with the Compliance Officer and any calls to the Hotline will be referred to the Compliance Officer for appropriate action.

VII. Enforcement and Discipline

In the event of an investigation or through monitoring and auditing it is determined that fraud, waste or abuse has occurred, there may need to be disciplinary action.

A. Discipline Policy and Actions

All employees are expected to report any breaches of laws, regulations, policies and standards that govern our work as well as our Standards of Conduct as spelled out in the Employee Handbook. Upon receipt of such reports, the matter will be investigated by Samson Dental's Compliance Department with the assistance of others. Additionally, Samson, through its ongoing monitoring, may determine breaches may have occurred. In either instance, where a breach is confirmed, appropriate actions will be taken by Samson and ImmediaDent.

If it is determined the violation is or may be a result of lack of proper education or training, Samson and ImmediaDent will use education, training and performance management as a first step to correct the situation. However, there may be times (such as when an outcome from an investigation determines fraud has taken place) where more severe action is appropriate. In these cases, formal disciplinary actions will range from verbal warnings to termination. When disciplinary action other than a verbal warning is proposed, the Human Resources Department will be contacted and they will coordinate such action.

B. Non-retaliation Policy

To the extent possible, all employee reports will be handled in a manner that protects the confidentiality of the reporter if they request it. However, there may be circumstances in which confidentiality cannot be maintained. Some examples of this include situations where the problem is known to only a very few people or situations in which the government or one of our other payers or funders must be involved. In most cases, they will require the name of the individual who first brought the problem to the attention of the organization. In all cases, however, Samson and ImmediaDent are determined that the reporting employee will not suffer from any retaliation for their good faith actions. Reports to the Hotline will protect anonymity, but the Compliance Officer may not be able to follow through without the cooperation and name of the reporting employee.

It is the responsibility of the Compliance Officer to ensure that those reporting in good faith do not suffer any retaliation for doing so. As such, the following will occur:

- The Compliance Officer will explain the ImmediaDent's Non-retaliation Policy to each caller or reporter.
- The Compliance Officer will give the reporter a means for contacting them confidentially to report any actions the reporter believes is retaliatory.
- The Compliance Officer will investigate any reports of retaliation and will make recommendations through management regarding disciplinary and other corrective actions that should take place, if there is a positive finding.

C. List of Excluded Individuals or Entities

To be in compliance with HIPAA and other Federal and State requirements, Samson/ ImmediaDent checks the OIG List of Excluded Individuals and Entities on the OIG website *http://www.oig.hhs.gov/fraud/exclusions.html* prior to hiring or contracting with individuals or entities. Persons and entities who are listed on the Federal OIG Exclusion Database must receive reinstatement through the OIG to be eligible for reimbursement through Medicaid/ be employed by Samson or ImmediaDent.

VIII. Monitoring and Sampling

Samson/ImmediaDent's Monitoring and Sampling Procedures and reporting process will uncover activities that could potentially constitute violations of the Compliance Plan or a failure to comply with federal and state law, or other types of misconduct. We understand our obligation to investigate any incidents uncovered to determine:

- That a violation has, in fact, occurred;
- That disciplinary action must be taken; and

- Corrective actions are put into place as required.

All issues reported to the Compliance Officer will be handled in a consistent fashion so that the integrity of the Plan is maintained, and so employees will have confidence in the workings of compliance investigations.

Samson/ImmediaDent has a management hierarchy that is designed to deal with employee misconduct through normal avenues of supervision. Most day-to-day issues should be handled through this hierarchy. Action from the Compliance Officer is required when systemic problems give rise to misconduct and require system-wide changes to prevent misconduct from occurring in the same fashion in the future.

A. Daily Review of Coding and Billing Practices

- Samson/ImmediaDent's commitment to accurate coding and the prevention of fraud and abuse includes the proactive review of services billed to Medicaid, and other third party plans, to identify and correct billing submission errors and inaccuracies.
- Samson/ImmediaDent's Medicaid billing review may include, but not be limited to, screening specific code usage as well as screening for the documentation of clinical necessity. At ImmediaDent, the clinical necessity of the treatment provided must be established and documented in the clinical patient record. This will be achieved through a combination of clinical examination charting, periodontal charting, radiographs, clinical photographs, and clinical progress note documentation. Clinical diagnoses and treatment plans will support the other forms of documentation in establishing the clinical necessity for care.
- Reviews will cover, but not be limited to, items covered in Appendix B – Medicaid Review Process
- Weekly and monthly reports of billing inaccuracies will be prepared for PC President and Management review and action. Summary reports will be presented to the Clinical Quality Committee and the Medicaid Compliance Committee.
- Ongoing or intentional coding inaccuracies will be handled as described under Reporting, and Corrective Action.

B. Sampling for Targeted Reviews

- Recognizing that daily billing reviews will generally focus on documentation and may not catch all potential coding issues, Samson/ImmediaDent will also do periodic analysis of the use of particular codes to identify outliers that may indicate improper coding, due to intent or lack of training or education. A code will be selected by the Compliance Officer in consultation with the Chief Dental Officer ("CDO") each time and will not be identified in advance.

- Outliers, those using a particular code materially more frequently than other dentists in the company, will be selected for detailed chart and radiography review of a random sample of patient records where the code is used. The CO will oversee the billing reviewer's review of the sample. Should the review indicate more than an expected margin of error, the issue will be addressed through corrective action, as described below.

C. Record retention

Through compliance activities, the Compliance Officer will receive and generate records in hard copy and electronically. Certain records will be kept for given periods of time because of law, regulation or contract obligations. Other records maintained or created will be retained or destroyed pursuant to a standard policy.

This policy will help the Compliance Officer manage the records of the Compliance Program in a manner that will promote the organization and integrity of the program. In addition, the policy will help protect the anonymity or confidentiality of patients, employees or others who report problems or concerns to the Compliance Officer or to other employees of the program.

Compliance records management is the responsibility of the Compliance Officer. Records will be kept secure and the confidentiality of patients, employees and business operations and activities will be protected. Records that are no longer needed, are no longer required to be kept or are duplicative of other records maintained will be destroyed on a routine basis using the standard procedures outlined below. Before destroying records of an investigation, the Compliance Officer will prepare a summary of all material activities, lists of interviewees, findings and actions taken in light of findings.

Records relating to a specific incident or report should be retained at least during the period the review or the investigation is ongoing. The Compliance Officer will make the decision to destroy any records or set of records during this review only after all issues relating to a specific incident or problem have been resolved. Resolution includes the completion of any investigation or inquiry, implementation of any disciplinary actions, implementation of any corrective action and evaluation of the efficacy of the corrective action plan Otherwise, all records (with the exception of a summary of activities, findings and corrective actions) related to a specific incident that has been resolved should be destroyed on a periodic basis unless otherwise required by applicable state or federal law or the organization is advised to retain the records by corporate counsel.

Records relating to the Compliance Program including memoranda, meeting minutes and reports will be retained indefinitely in order to maintain a record of Compliance Program activities. These documents can be used by the organization to prove the existence of an active and effective Compliance Program.

In addition to records relating to reports, incidents or potential problems, during each review period the Compliance Officer will also assess the need to retain other records (in both paper and electronic form) including correspondence, calendars, diaries, notepads, personal files, telephone message pads, chronological correspondence files and other similar materials.

If the Compliance Officer should receive notice of any kind that an investigation is underway, she/he will take immediate steps to secure all relevant documents and/or to cease their destruction until

notice that the investigation or any related litigation has concluded.

D. Medicaid Compliance Committee (MCC)

Samson/ImmediaDent have established the Medicaid Compliance Committee (MCC) to assist the Compliance Officer in the development, implementation, oversight and evaluation of the Compliance Program. The MCC will be chaired by the Compliance Officer and other members will include Regional Directors, the Chief Dental Officer, the Billing Reviewer and one active ImmediaDent Dentist. The Committee will meet quarterly.

The role of the MCC includes, but is not limited to:

- Assessing the impact of current and future Medicaid Regulations on ImmediaDent's day to day operations;
- Working with the Compliance Officer and Billing Reviewer to develop any necessary changes for compliance;
- Initiate and review the Annual Self Audit
- Ensuring that Medicaid compliance is occurring throughout ImmediaDent;
- Recommending solutions to barriers that may exist in the successful implementation of compliance activities;
- Addressing issues regarding billing (private and Medicaid) that impact our ability to maximize our revenue, and make recommendations on how to improve them;
- Assessing the success of the Compliance Plan by reviewing compliance-related activities and recommending any needed updates to the Plan;
- Addressing any compliance and billing issues that may present a risk to ImmediaDent and make recommendations on how to correct and prevent them from occurring;
- Establishing and maintaining an open line of communication with the Clinical Quality Committee in order to ensure that recommendations and feedback are implemented in a timely manner.

The MCC is expected to work with the highest level of confidentiality and members may be sought to provide information that can assist in making a determination on any pending investigations. The Compliance Officer will also provide the MCC with reports of any monitoring and auditing findings as necessary. As an advisory committee, the MCC may provide feedback on the findings and make recommendations for corrective actions.

IX. Response and Prevention

The goal of our Compliance Program is to prevent and reduce the likelihood of improper conduct. Samson and ImmediaDent's response to information concerning possible violations of law or the requirements of the Compliance Program is an essential component of its commitment to compliance.

A. Investigations

Upon identifying persistent miscoding or receiving a report or other reasonable indication of suspected non-compliance, the Compliance Officer will initiate prompt steps to investigate the conduct in question and determine whether a material violation of applicable law or the requirements of the Program has occurred.

Upon receipt of information concerning alleged misconduct, the Compliance Officer will, at a minimum, take the following actions:

1. Notify the CEO, Chief Financial Officer, VP Operations, Co-PC President and Regional Director.

2. Ensure that the investigation is initiated as soon as reasonably possible and in a timely manner following receipt of the information.

    - Interviews of all persons who may have knowledge of the alleged conduct and a review of the applicable coding, laws, regulations and standards to determine whether or not a violation has occurred.
    - Identification and review of relevant documentation including, where applicable, representative bills or claims submitted to the Medicaid Program, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.
    - Interviews of persons who appear to play a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct, and may include, but shall not be limited to:

        - The person's understanding of the applicable coding, laws rules and standards;
        - Identification of relevant supervisors or managers;
        - Training that the person received;
        - The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference

3. Written transcript of interviews, to be signed by the interviewer and interviewee attesting the transcript as written is correct.

4. Preparation of a summary report that

    - Defines the nature of the alleged misconduct
    - Summarizes the investigation process
    - Identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws
    - Assesses the nature and extent of potential civil or criminal liability
    - Where applicable, estimates the extent of any resulting overpayment by the government.

5. Establish a due date for summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and the appropriate disciplinary or corrective action is taken if warranted.

6. In the event the investigation identifies employee misconduct, ongoing or chronic coding errors or suspected criminal activity, Samson/ImmediaDent will undertake the following steps:

- Immediately cease the offending practice.
- Consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authority is warranted.
- If applicable, calculate and repay any duplicate or improper payments made by a federal or state government program as a result of the misconduct.
- When appropriate, handle any over payments through the administrative billing process by informing the billing employees and making appropriate adjustments via software used for billing.
- Ensuring that any investigation and overpayment is finalized no later than 60 days after it was first identified. This ensures compliance with Federal and state laws.
- We will initiate disciplinary action as noted in "Section VII – Enforcement and Discipline" of this Compliance Plan.
- Promptly undertake appropriate training and education to prevent a recurrence of the misconduct.
- Conduct a review of applicable ImmediaDent Policies and procedures to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.

B. Addressing Daily Billing Inaccuracies

Inaccurate billing will be corrected by the Compliance department and then sent to third party for payment. Any adjustments identified after the billing has been submitted will be reversed for the practice and refunded to the third party payer. The Area Manager and Dentist will be notified of all adjustments. If based on the compilation of weekly and monthly adjustments, it is determined there is an ongoing and chronic problem, the situation will be handled as described under Investigations, as described above.

C. Reporting

A weekly and monthly report of all billing reviews and adjustments (Appendix C) will be prepared by the Compliance Department and distributed to the Regional Directors, VP Operations, CDO, CFO, CEO, and PC Presidents.

The Compliance Officer will report investigations to the PC Owners and CEO within two business days of having received a possible fraud, waste or abuse allegation.

Once a quarter, in concert with the Clinical Quality Committee meeting, the Compliance Officer will provide a report to Clinical Quality Committee that includes all internal investigations and their status.

She/he will also provide to them the audit findings from any reviews that have taken place throughout the year, as well as corrective actions that have been implemented.

At least twice a year, the Compliance Officer will provide a report to the Board of Directors which includes all investigations and their status. She/he will also provide to them the audit findings from any reviews that have taken place throughout the year, as well as corrective actions that have been implemented

In the event the Compliance Officer believes the CEO and/or the Chief Financial Officer are involved in non-compliant activities, the Compliance Officer can directly report to the Chair of the Board of Directors his/her concerns.

X. Outside Legal Counsel

Outside legal counsel is available to assist the CEO, Board of Directors, Chief Financial Officer and Compliance Officer as needed to identify and interpret federal and state laws and regulations in the Corporate Compliance Plan.

Outside legal counsel may be notified at the discretion of the CEO of incidents that have a reasonable cause to support the assertion of non-compliance at which time the Compliance Officer will be responsible for facilitating an investigation. The results of the investigation will be used by legal counsel to provide legal advice to the Compliance Officer and ImmediaDent.

XI. Assessing Effectiveness of ImmediaDent's Compliance Program

As part of our effort to implement an effective Compliance Program, Samson on behalf of ImmediaDent will periodically conduct routine self-audits of its operations including its billing practices, its hiring and retention practices, its written standards, policies and procedures to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.

Every December, Samson will use Self-Assessment Tool (see Appendix C), which addresses all of the required elements of a strong compliance plan and whether we are or have implemented these elements throughout ImmediaDent and Samson. The assessment tool will be completed by the Compliance Officer and the findings will shared with the Clinical Quality Committee and the Medicaid Compliance Committee. The outcome of this assessment is used to update our Plan and implement new systems that address any deficiencies in our compliance program.

XII. Conclusion

This Medicaid Compliance Plan has been prepared to outline the broad principles of legal and ethical business conduct embraced by ImmediaDent and Samson Dental. It is not a complete list of legal or ethical questions we might face in the course of business. Therefore, this plan must be used together with common sense and good judgment.

If you are in doubt or have a specific question, you should contact your supervisor or the Samson Compliance Officer.

Appendix A – Federal & Applicable State Fraud and Abuse Laws & Whistleblower Provisions

I.PURPOSE

The purpose of this section of the employee handbook/manual is to fully comply with certain requirements set forth in the federal Deficit Reduction Act of 2005 (the "DRA"), and sections 6031 and 6032 of the DRA in particular, with regard to educating employees about federal false claims laws, whistleblower protections and the Companies' policies and procedures for detecting and preventing fraud, waste, and abuse ("fraud prevention"). Under the DRA, the Companies must provide a discussion of applicable State and Federal law relating to civil and criminal false claims/penalties along with a whistleblower protections and the Companies' own policies relating to fraud prevention. Sections II through VI of this Part of the handbook provides the discussion mandated by DRA in this regard.

II. POLICY

The Companies have adopted a Medicaid Compliance Plan which is distributed to all employees providing a summary of the corporate compliance program, including specific provisions which provide notice of how employees may report and cooperate in the identification and prevention of fraud, waste and abuse. Employees are expected to adhere to the requirements included in the Compliance Manual with regard to the Companies' obligations under Medicaid, Medicare and other publicly funded health care programs.

III. SCOPE

This section applies to all The Companies programs, operations and employees. This section which will also be in our employee handbook/manual will provide the detail required under the DRA and related compliance mandates of State and Federal law. The Companies' policies for detecting and preventing fraud, waste and abuse also apply to contractors, subcontractors and agents and their employees, particularly those which or who, on behalf of the Companies, furnish, or otherwise authorize the furnishing of Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring the health care provided by the Companies.

IV. FALSE CLAIMS

False claims laws seek to prevent fraud, waste, and abuse in government programs. They permit the government to bring civil lawsuits to recover damages and penalties against providers that submit false claims. These laws often permit private persons, including current or former employees of such providers, to bring so-called "whistleblower" actions against the providers on the government's behalf.

False Claims and Penalties

The Federal False Claims Act ("Act"; 31 USC §§3729-3733) imposes civil liability upon any person (individual or entity) for knowingly making a false claim to the United States government ("Government"). Specifically, the Act sets forth seven circumstances for which civil liability will be imposed for false claims. These seven circumstances are when a person:

(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

The civil monetary penalty that can be imposed for a false claim under the Act is not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461), PLUS three times the amount of damages which the Government sustained because of the false claim, PLUS the costs of a civil action.

A Court may impose a lesser penalty of not less than two times the amount of damages sustained by the Government where the Court finds the following:

- The person committing the violation furnished governmental officials responsible for investigating false claims with all information known to the person about the violation within thirty (30) days after the date on which the person first obtained the information;
- The person fully cooperated with any governmental investigation of the violation; and

- At the time the person furnished the Government with the information about the violation, no criminal prosecution, civil action, or administrative action had been commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.

The Act defines the terms “Claim”, “Knowing” and “Knowingly”, “obligation”, and “material” as follows:

“Claim”: any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--

- is presented to an officer, employee, or agent of the United States; or
- is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government; or
- provides or has provided any portion of the money or property requested or demanded; or
- Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property.

“Knowing” and “Knowingly”:

That a person, with respect to information:

- 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, and no proof of specific intent to defraud is required.

“**Obligation”** means:

an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment. (see discussion below regarding potential liability under 42 USC §1320a-7k(d)(2))

"Material" means:

> Having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.
>
> > In essence, civil monetary penalties may be imposed upon a person for making a false claim to the Government where the individual knows the information in the claim is false, or acts in deliberate ignorance of the truth or falsity of the information in the claim or acts in reckless disregard of the truth or falsity of the information in the claim. Civil monetary penalties are imposed even where there is no specific intent to defraud the Government.
>
> The Act applies to claims submitted under Medicare, Medicaid, other federal health care programs and other state health care programs funded, in whole or in part, by the federal government. Examples of false claims include, but are not limited to:
>
> - Filing a claim for payment knowing that the services were not provided or were medically unnecessary;
> - Submitting a claim for payment knowing that excessive charges are being billed;
> - Submitting a claim for payment knowing that a higher billing code which does not reflect the services provided is used;
> - Filing a claim knowing that the claim is for duplicate services.

The Act has been used as a basis to impose civil monetary penalties upon persons in situations involving egregious substandard quality of care, that is, the resident's condition is so bad that the services billed for could not have been provided.

Lastly, pursuant to 42 U.S.C. §1320a-7k(d)(2) enacted as §6402 of the Patient Protection and Affordable Care Act (PPACA), Congress added new provisions to the false claims act requirements and imposed upon providers the obligation to **report, explain and repay** overpayments within calendar 60 days of identification. Those that fail to properly disclose, explain and repay the overpayment in a timely manner may be subject to liability under the False Claims Act.

Under the revised PPACA standard, an "obligation" under 42 U.S.C 3729(a)(1)(G) is referenced as creating a liability when a person "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government". Liability under section 3729(a)(1) is "subject to" section 3729(a)(2), which provides that damages are reduced if the person violating the section "furnished… all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information".

Civil Actions Under the Act – Qui Tam

Enforcement of the Act is the responsibility of the United States Attorney General. However, private

individuals have the ability to bring a civil action for a violation of the Act. These private actions are known as “Qui Tam” actions.

Qui Tam actions are brought by private individuals in the name of the Government. When the complaint in an action brought by a private individual is filed with the Court, it remains under seal for a period of sixty days and cannot to be served upon the defendants named therein until ordered by the Court. Under seal means that the action remains confidential and is not subject to disclosure. The private individual must serve a copy of the complaint and written disclosures of substantially all material evidence and information the individual possesses on the Government. Within sixty days of the Government’s receipt of the complaint and written disclosures, the Government shall either intervene and proceed with the action, in which case, the action shall be conducted by the Government, or notify the Court that it declines to take over the action, in which case, the private individual bringing the action shall have the right to proceed with the action.

If the Government elects to proceed with the action brought by a private individual, the private individual shall receive at least 15% but not more than 25% of the proceeds of the action or settlement of the claim, depending upon the extent to which the private individual contributed to the prosecution of the action. If the Government does not proceed with the action, and the private individual is successful in the action or settles the action, the private individual is entitled to an amount not less than 25% and not more than 30% of the proceeds of the action or settlement which shall be paid out of the proceeds of the action or settlement. In addition, the private individual is entitled to receive an amount for reasonable expenses necessarily incurred in the action plus reasonable attorneys’ fees and costs. On the other hand, if the private individual is unsuccessful in prosecuting the action, the Court, upon a finding that the action was clearly frivolous, clearly vexatious or brought primarily for purposes of harassment, may award the defendant in the action its reasonable attorneys’ fees and expenses. If the private individual in the action is a person who planned or initiated the violation of the Act, the Court, where appropriate, may reduce the amount of the award to the private individual. Moreover, if such private individual is convicted of a crime arising from his or her role in the violation, the person will not receive any share of the proceeds of the action. A civil action under the Act may not be brought

i. More than six years after the date on which the violation of the Act is committed; or

ii. More than three years after the date when facts material to the right of action are known or reasonably should have been known by an official of the Government charged with responsibility to act in the circumstances but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

31 U.S.C. §3801 Et. Seq.

31 U.S.C. §3801 imposes additional civil penalties for the filing of false claims or statements with the federal government. The term “Claim” is defined as:

Any request, demand or submission - -

(A) made to [the Government] for property, services or money (including money representing grants, loans, insurance or benefits);

(B) made to a recipient of property, services or money from [the Government] or to a party to a contract with [the Government] - -

(i) for property or services if the United States - -

provided such property or services;

(II) provided any portion of the funds for the purchase of such property or services; or

(III) will reimburse such recipient or party for the purchase of such property or services; or

(ii) for the payment of money (including money representing grants, loans, insurance or benefits), if the United States –

(I) provided any portion of the money requested or demanded; or

(II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(C) made to [the Government] which has the effect of decreasing an obligation to pay or account for property, services or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1986.

The term **"Statement**" is defined as:

Any representation, certification, affirmation, document, record or accounting or bookkeeping entry made:

A. with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

B. with respect to (including relating to eligibility for - -

i. A contract with, or a bid or proposal for a contract with; or

ii. grant, loan or benefit from, an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan or benefit, or if the Government will reimburse such State, political subdivision or party for any portion of the money or property under such contract or for such grant, loan or benefit, except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1986.

Specifically, civil monetary penalties under 31 U.S.C. §3801 et. seq. will be imposed against:

1. Any person (individual or entity) who makes, presents, or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know:

A. is false, fictitious or fraudulent;

B. includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;

C. includes or is supported by any written statement that:

a. omits a material fact;

b. is false, fictitious or fraudulent as a result of such omission; and

c. is a statement in which the person making, presenting or submitting such statement has a duty to include such material facts; or

D. Is for payment for the provision of property or services which the person has not provided as claimed; or

2. Any person who makes, presents or submits, or causes to be made, presented or submitted, a written statement that:

(A) The person knows or has reason to know:

a. asserts a material fact which is false, fictitious or fraudulent; or

b. is false, fictitious or fraudulent as a result of such omission;

(B) in the case of a statement described in clause (ii) of subparagraph (A) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and

(C) contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement.

3.The term “knows or has reason to know” means that:

A person, with respect to a claim or statement - -

(A) has actual knowledge that the claim or statement is false, fictitious or fraudulent; or

(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(C) acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required.

Civil monetary penalties under 31 U.S.C. §3801 et. seq. are not more than $5,000 for each false claim or statement. Also, in lieu of damages sustained by the federal government, an assessment of not more than twice the amount of such claim(s) may be imposed. An individual or entity against whom civil monetary penalties are sought under 31

U.S.C. §3801 et. seq. is entitled to notice, an opportunity for a hearing and judicial review.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative ImmediaDent, not by prosecution in the federal court system.

Additional Civil and Criminal Penalties and Exclusions for False Claims

Civil

In addition to the Act and 31 U.S.C. §3801 et. seq., the federal government may, pursuant to 42 U.S.C. §1320a-7a, impose civil monetary penalties for false claims. Such additional civil monetary penalties may be up to but not exceed $10,000 for each item or service which is the subject of a false claim.

In addition to civil monetary penalties, the federal government may, pursuant to 42 U.S.C. §1320a-7, exclude an individual or entity from participation in federal and state health care programs (including Medicare and Medicaid) for certain false claims or actions. Generally, exclusion is mandatory in cases where the individual is convicted of a felony relating to health care fraud, otherwise, exclusion is permissive, that is, subject to the discretion of the Government.

Furthermore, pursuant to 42 U.S.C. §1320a-7k (d)(2) (enacted as §6402 of the Patient Protection and Affordable Care Act), providers are obligated to **report, explain and repay** overpayments within calendar 60 days of identification. Those that fail to properly disclose, explain and repay the overpayment in a timely manner may be subject to liability under the New York and Federal False Claims Act.

Criminal

Pursuant to 42 U.S.C. §1320a-7b, criminal sanctions may be imposed against an individual or entity for making or causing to be made false statements or representations. Specifically, criminal sanctions will be imposed against an individual or entity who:

1. Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program;
2. At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefits or payments;
3. Having knowledge of the occurrence of any event affecting (1) his/her initial or continued right to any such benefit, or (2) the initial or continued right to any such benefit or payment of any other individual in whose behalf he/she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;
4. Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person;
5. Presents or causes to be presented a claim for a physician's service for which payment may be made under a federal health care program and knows that the individual who furnishes the services was not licensed as a physician; or
6. For a fee knowingly and willfully counsels or assistants an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under [Medicaid] if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

In addition, criminal sanctions will be imposed against any individual or entity who knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution, facility or entity in order that such institution, facility or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled facility, facility, intermediate care facility for the mentally retarded, home health ImmediaDent, or other entity for which certification is required under Medicare or a state health care program or with respect to information required to be provided under 42 U.S.C. §1320a-3a (disclosure requirements for other providers under Medicare Part B).

V. WHISTLEBLOWER PROTECTION

A. Federal False Claims Act

Any employee, contractor, or agent shall be entitled to all necessary "relief" if discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the person furtherance of efforts to stop a violation(s) of the False Claim Act including a civil action under the Act whether brought by the Government or a private individual, including investigation for, initiation of, testimony for, or assistance in any such action maybe because of such actions. Any employee who has been discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment because of such lawful acts shall be entitled to "relief" necessary to make the employee whole, including, reinstatement with the same seniority status such employee would have had but for the discrimination, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

VI. INDIANA LAW SUMMARY

A. FALSE CLAIMS/FRAUD LAWS

1) **Indiana False Claims Act (*Indiana Code § 5-11-5.7-1 and Indiana Code § 5-11-5.7-2),*** in key ways, is similarto the federal False Claims Laws. The Indiana Code prohibits a person from knowingly *(either has actual knowledgeof 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; and requires no proof of specific intent to defraud)* or intentionally: (1)presenting a false claim to the state for payment or approval; (2) making, using, or causing to be made or used, a false record or statement to obtain payment or approval of a false claim from the state; (3) has possession, custody, or control of property or money used, or to be used, by the state, and knowingly delivers, or causes to be delivered, less than all of the money or property; (4) with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) receiving public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property; (6) making or using a false record or statement to avoid an obligation to pay or transmit property to the state; or (7 & 8) conspiring with, causing, or inducing another to perform one of the aforementioned acts.

Penalties: A person who violates this section is liable for a civil penalty of at least $5,500 and not more than $11,000, and for up to three times the amount of damages sustained by the state, in addition to the costs of a civil action brought to recover the penalty or damages.

If it is determined that the person who violated this section furnished state officials with all information known to the person about the violation not later than 30 days after the date on which the person obtained the information, fully cooperated with the investigation of the violation, and did not have knowledge of the existence of an investigation, criminal prosecution, civil action, or an administrative action concerning the violation at the time the person provided the information, the person is liable for a penalty of not less than two times the amount of damages that the state sustained and for the costs of a civil action brought to recover the penalty or damages.

Enforcement by the Government As stated in **Indiana Code § 5-11-5.7-3,** the attorney general and inspector general have concurrent jurisdiction to investigate violations of Indiana's False Claims Act. The attorney general may bring a civil action if the attorney general discovers a violation. If the inspector general discovers a violation, he or she must certify a finding of a violation to the attorney general, who may bring a civil action.

Private ("Qui tam" like) Lawsuits: Available. Under **Indiana Code § 5-11-5.7-4 and Indiana Code § 5-11-5.7-6,** a civil action may be brought by a person on his or her own behalf and on behalf of the state. If the state ultimately prevails in the action, the person who filed the complaint is entitled to receive at least 25% and not more than 30% of the proceeds or settlement if the state did not intervene and between 15% and 25% if the state intervened in the action. In both cases, the person may also recover reasonable attorney's fees and an amount to cover the expenses and costs of the action. However, if the state intervened and the court finds that the evidence used to prosecute the action consisted primarily of specific information contained in a transcript of a criminal, civil, or administrative hearing; a legislative, administrative, or other public report, hearing, audit, or investigation; or a news media report, the person may not recover more than 10% of the proceeds or settlement, plus fees and costs. A person who planned, initiated, or was convicted of violating the Act himself is not entitled to any recovery.

2) **Fraud and Other Deceptive Acts (Medicaid only),** found in **Indiana Code § 35-43-5-7.**1, is a criminal statute that prohibits a person from knowingly or intentionally filing a claim, including an electronic claim, for services in violation of the Indiana statutory Medicaid provisions set forth in Indiana Code Section 12-15, or from obtaining payment from the Medicaid program by means of false or misleading oral or written statements or other fraudulent means. This section also prohibits a provider from acquiring a provider number under the Medicaid program, except as authorized by law, concealing information for the purpose of applying for or receiving unauthorized Medicaid payments, or altering with the intent to defraud or falsifying a provider's number.

Penalties: A violation of this section constitutes Medicaid fraud, a Class C or D felony, depending upon the fair market value of the offense.

Private Lawsuits: Not Available. (Only the Attorney General can prosecute a criminal action of Medicaid Fraud.)

3) **Indiana Code § 35-43-5-4.5 and Indiana Code § 34-24-3-1 (Insurance fraud)** imposes similar criminal penalties for a person who knowingly and with intent to defraud to make, utter, present, or cause to be presented to an insurer or an insurance claimant a claim statement that contains false, incomplete, or misleading information concerning the claim, or to present, cause to be presented, or prepare with knowledge or belief that it will be presented to or by an insurer, an oral, written, or electronic statement that the person knows to contain materially false information concerning a fact material to a claim for payment or benefit under an insurance policy, or payments made in accordance with the terms of an insurance policy.

Penalties: A violation constitutes Insurance Fraud, a Class C Felony. (See also below as to Private Lawsuits.)

Private Lawsuits: Available. In addition to criminal prosecutions by the Attorney General, a person who suffers a pecuniary loss as a result of a violation of Indiana Code Section 35-43-5-4.5 may also bring a civil action against the person who caused the loss to recover an amount of up to three times the damages suffered plus costs, expenses, and reasonable attorney's fees.

B. GENERAL WHISTLEBLOWER PROVISIONS

Like the Federal False Claims Act, Indiana's False Claims Act (**Indiana Code § 5-11-5.7-8)** has anti-retaliation safeguards. Specifically, any employee who has been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by the individual's employer due to the employee's initiation, testimony, assistance, or participation in an investigation, action, or hearing regarding the violation of a state or federal regulation, including presenting a false claim to the state for payment or approval, making or using false records to obtain payment or approval of a false claim from the state, or the employee's objection to such act or omission. Relief may include: (1) reinstatement with the same seniority status the employee would have had but for the action taken by the employer against the employee; (2) two times the back pay owed the employee; (3) interest on the back pay owed the employee; and (4) compensation for any special damages sustained as a result of the action, including costs and expenses of litigation and reasonable attorney's fees.

Informants can remain anonymous in most cases. In fact, **Indiana Code § 4-2-7-8,** with few exceptions, prohibits the Inspector General from disclosing the identity of an individual who discloses, in good faith, information alleging a violation of a state or federal statute, rule, regulation, or ordinance, to anyone other than the governor, the staff of the U.S. Department of Health & Human Services, Office of Inspector General, or an authority to whom the investigation is subsequently referred. Confidentiality is maintained for any such individual unless the individual consents in writing to disclosure of the individual's identity or the Inspector General makes a written determination that it is in the public interest to disclose the individual's identity. The governor may also authorize disclosure of this confidential information, records, or the identity of such person if in the public interest.

1) **Indiana False Claims Act (*Indiana Code § 5-11-5.5-1 and Indiana Code § 5-11-5.5-2),*** in key ways, is similar to the federal False Claims Laws. The Indiana Code prohibits a person from knowingly (either 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) or intentionally: (1) presenting a false claim to the state for payment or approval; (2) making or using a false record or statement to obtain payment or approval of a false claim from the state; (3) with intent to defraud the state, delivering less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state; (4) with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) receiving public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property; (6) making or using a false record or statement to avoid an obligation to pay or transmit property to the state; or (7) conspiring with, causing, or inducing another to perform one of the aforementioned acts.

   Penalties: A person who violates this section is liable for a civil penalty of at least $5,000 and for up to three times the amount of damages sustained by the state, in addition to the costs of a civil action brought to recover the penalty or damages.

   If it is determined that the person who violated this section furnished state officials with all information known to the person about the violation not later than 30 days after the date on

which the person obtained the information, fully cooperated with the investigation of the violation, and did not have knowledge of the existence of an investigation, criminal prosecution, civil action, or an administrative action concerning the violation at the time the person provided the information, the person is liable for a penalty of not less than two times the amount of damages that the state sustained and for the costs of a civil action brought to recover the penalty or damages.

Enforcement by the Government As stated in **Indiana Code § 5-11-5.5-3,** the attorney general and inspector general have concurrent jurisdiction to investigate violations of Indiana's False Claims Act. The attorney general may bring a civil action if the attorney general discovers a violation. If the inspector general discovers a violation, he or she must certify a finding of a violation to the attorney general, who may bring a civil action.

Private ("Qui tam" like) Lawsuits: Available. Under **Indiana Code § 5-11-5.5-4 and Indiana Code § 5-11-5.5-6,** a civil action may be brought by a person on his or her own behalf and on behalf of the state. If the state ultimately prevails in the action, the person who filed the complaint is entitled to receive at least 25% and not more than 30% of the proceeds or settlement if the state did not intervene and between 15% and 25% if the state intervened in the action. In both cases, the person may also recover reasonable attorney's fees and an amount to cover the expenses and costs of the action. However, if the state intervened and the court finds that the evidence used to prosecute the action consisted primarily of specific information contained in a transcript of a criminal, civil, or administrative hearing; a legislative, administrative, or other public report, hearing, audit, or investigation; or a news media report, the person may not recover more than 10% of the proceeds or settlement, plus fees and costs. A person who planned, initiated, or was convicted of violating the Act himself is not entitled to any recovery.

2) **Fraud and Other Deceptive Acts (Medicaid only),** found in **Indiana Code § 35-43-5-7.**1, is a criminal statute that prohibits a person from knowingly or intentionally filing a claim, including an electronic claim, for services in violation of the Indiana statutory Medicaid provisions set forth in Indiana Code Section 12-15, or from obtaining payment from the Medicaid program by means of false or misleading oral or written statements or other fraudulent means. This section also prohibits a provider from acquiring a provider number under the Medicaid program, except as authorized by law, concealing information for the purpose of applying for or receiving unauthorized Medicaid payments, or altering with the intent to defraud or falsifying a provider's

   Penalties: A violation of this section constitutes Medicaid fraud, a Class C or D felony, depending upon the fair market value of the offense.

   Private Lawsuits: Not Available. (Only the Attorney General can prosecute a criminal action of Medicaid Fraud.)

3) **Indiana Code § 35-43-5-4.5 and Indiana Code § 34-24-3-1 (Insurance fraud)** imposes similar criminal penalties for a person who knowingly and with intent to defraud to make, utter, present,

or cause to be presented to an insurer or an insurance claimant a claim statement that contains false, incomplete, or misleading information concerning the claim, or to present, cause to be presented, or prepare with knowledge or belief that it will be presented to or by an insurer, an oral, written, or electronic statement that the person knows to contain materially false information concerning a fact material to a claim for payment or benefit under an insurance policy, or payments made in accordance with the terms of an insurance policy.

Penalties: A violation constitutes Insurance Fraud, a Class C Felony. (See also below as to Private Lawsuits.)

Private Lawsuits: Available. In addition to criminal prosecutions by the Attorney General, a person who suffers a pecuniary loss as a result of a violation of Indiana Code Section 35-43-5-4.5 may also bring a civil action against the person who caused the loss to recover an amount of up to three times the damages suffered plus costs, expenses, and reasonable attorney's fees.

VII. KENTUCKY LAW SUMMARY

A. FALSE CLAIMS/FRAUD LAWS

1) **The Kentucky Control of Fraud and Abuse statutes (*KRS 205.8451 to 205.8483* and regulations *907 KAR 1:671*)**, impose civil liability on persons or organizations that make or cause to be made false or fraudulent claims to the government for payment or who knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid by the government.

Any person who knows or has reasonable cause to believe that a violation of the Kentucky Medicaid Fraud and Abuse laws is being committed ***is required*** to report the violation to the Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline. The identity of the person making such a report will be kept confidential by the party receiving the report, and the good-faith reporter will not be subject to civil or criminal liability in any action based upon that report.

Penalties: Any provider found to have knowingly violated the Kentucky Fraud and Abuse laws shall be liable for:

(1) restitution in the amount of the excess payments, plus interest;

(2) a civil payment in an amount up to three times the amount of excess payments;

(3) a civil payment of $500 for each false or fraudulent claim submitted for providing treatment, services, or goods; and

(4) payment of legal fees and costs of investigation and enforcement of civil payments. The state will have a lien against the property of any provider who is found to have defrauded the Medicaid program, in the amount of the defrauded sum plus interest.

In addition, those found to have violated the Kentucky Fraud and Abuse laws will be removed as a participating provider in the Medical Assistance Program for two months to six months for a first offense, for six months to one year for a second offense, and for one year to five years for a third offense.

Private ("Qui tam" like) Lawsuits: Not Available. (Only the Attorney General can bring a civil lawsuit (or criminal prosecution) to enforce this statute.)

2) **KRS 205.8463 imposes criminal penalties** upon a person who: (1) knowingly or wantonly devise a scheme or plan a scheme or artifice, or enter into an agreement, combination, or conspiracy to obtain or aid another in obtaining payments from any medical assistance program under this chapter by means of any fictitious, false, or fraudulent application, claim, report, or document submitted to the Cabinet for Health and Family Services, or intentionally engage in conduct that advances the scheme or artifice; or (2) intentionally, knowingly, or wantonly makes any false, fictitious, or fraudulent statement, representation, or entry in any application, claim, report, or document used in determining rights to any benefit or payment; or (3) conceals or covers up by any trick, scheme, or device a material fact, or make any false, fictitious, or fraudulent statement or representation, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry to defraud the Cabinet for Health and Family Services.

Penalties: A violator is guilty of a misdemeanor or a felony, depending upon the value of funds obtained in violation of the Statute.

Other Sanctions: Further, any licensed professional found guilty of any criminal provision contained within Kentucky's fraud and abuse laws, is required, in addition to any other penalties, to forfeit their license for a minimum period of five years.

Private ("Qui tam" like) Lawsuits: Not Available. (Only the Attorney General can prosecute a criminal action of Medicaid Fraud)

B. GENERAL WHISTLEBLOWER PROTECTIONS (ANTI-RETALIATION)

As stated in **KRS 205.8465**, any person who reports suspected fraud to the state Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline shall not be liable in any civil or criminal action based on the report if it was made in good faith, nor may an employer, without just cause, discharge or in any manner discriminate or retaliate against any person who in good faith makes such a report or who participates in any proceeding related to such report.

Penalties: A violator is subject to civil action for compensation (lost wages and benefits) or specific relief (such as job restitution, restoration of seniority, etc.), attorney's fees and all costs in bringing the action

Private Lawsuit: Only remedy available. (The Attorney General cannot add a "retaliation" claim to a civil action of Medicaid Fraud.)

VIII. OHIO LAW SUMMARY

A. FALSE CLAIMS/FRAUD LAWS

(1) Ohio's **Medicaid Fraud Statute (Ohio Revised Code § 2913.40)**, makes it a criminal offense for any person to knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the Ohio Medicaid program, such as altering, falsifying, destroying, or removing any records necessary to determine the goods or services, or income and expenditures for the claim or reimbursement, for a period of six years after reimbursement is received from the Ohio Medicaid program. The statute also prohibits doing, with a purpose to commit fraud or knowing that the person is facilitating a fraud, any of the following, contrary to the terms of a person's provider agreement: charge, solicit, accept, or receive for goods or services that the person provides under the Medicaid program any consideration in addition to the amount of reimbursement under the Ohio Medicaid program and the person's provider agreement for the goods or services and any cost-sharing expenses authorized by law; or solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by law, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the Ohio Medicaid program.

Penalties: In addition to any overpayments that the Ohio Medicaid Department may collect, a violator is guilty of a misdemeanor or a felony, depending upon the value of funds obtained in violation of the Medicaid Fraud Statute.

Private ("Qui tam" like) Lawsuits: Not Available. (Only the Attorney General can prosecute a criminal action of Medicaid Fraud.)

Ohio courts have held that a corporation (medical/dental practice or hospital) may be found guilty of Medicaid fraud if high-level managerial personnel approve, recommend, or implement the actions involving the criminal offense. ***See, e.g., State v. Wintersong Village of Delaware, Inc.*** **(1990) 69 Ohio App. 3d 552.**

2) **Forfeiture (Ohio Revised Code § 2981.01 *et seq.).*** Applies to and governs forfeitures relating to offenses including Medicaid fraud. The act provides that, upon application by the prosecutor who prosecutes or brings an action that allows forfeiture, the court in which the action is prosecuted or filed may issue an order taking any reasonable action necessary to preserve the reachability of the property. The burden of proof is on the defendant to show that any forfeiture of property is disproportionate or should not be forfeited.

(3). Ohio's **General Insurance Fraud Statute (Ohio Revised Code § 2913.47)** is similar, in that it is a criminal statute with no civil remedies/lawsuits available. Section 2913.47 provides that no person, with a purpose to defraud or knowing that the person is facilitating a fraud, shall present or cause to be presented, or assist, aid, or conspire with another to present or cause to be presented, to an insurer any written or oral statement that is part of or in support of: an application for insurance; a claim for payment pursuant to a policy; or a claim for any other benefit pursuant to a policy.

Penalties: A violator is guilty of a misdemeanor or a felony for "insurance fraud," depending upon the value of funds obtained in violation of the Statute.

Private ("Qui tam" like) Lawsuits: Not Available. (Only the Attorney General can prosecute a criminal action of Medicaid Fraud.)

B. GENERAL WHISTLEBLOWER PROTECTIONS ("ANTI-RETALIATION")

Ohio Revised Code § 4113.51, *et seq*.

The Whistleblower Protection statute gives a general right to employees to report a violation of law by an employer or fellow employees. Before an employee may report the violation to law enforcement or a government official, however, the employee must first report the violation to his/employer and give the employer 24 hours to respond. If the employee follows this procedure, he/she may not be disciplined or retaliated against by the employer for making the report, or taking any part in an investigation related to the report. For purposes of this provision a disciplinary or retaliatory action by the employer includes, but is not limited to: (1) terminating or suspending the employee; (2) withholding salary increases or benefits otherwise earned; (3) transferring or reassigning the employee; (4) denying a promotion otherwise earned; or (5) reducing the employee's pay or position.

Penalties: A violator is subject to civil action for compensation (lost wages and benefits) or specific relief (such as job restitution, restoration of seniority, etc.), attorney's fees and all costs in bringing the action

Private Lawsuit: Only remedy available. (The Attorney General cannot add a "retaliation" claim to a criminal action of Medicaid Fraud.) A retaliation lawsuit must be filed within 180 days of the retaliatory act.

IX. PROCEDURE

The Companies take compliance with the FCA seriously. Any employee who becomes aware of a violation or potential violation of such laws, or any fraudulent or potentially fraudulent conduct for that matter, is expected to report the same immediately. Employees, including management, contractors, and agents, should review, understand, and follow the procedures detailed in the Corporate Compliance Manual.

The Companies encourage employees to initially report compliance concerns to

their immediate supervisors, when appropriate, but they may, in the alternative, report directly

to the Compliance Officer in person or by telephone at: 845-871-1097.

Any information that employees provide in good faith to their supervisors or the Compliance Officer will be kept in confidence to the extent feasible and legal. In the event of a government investigation or if the need otherwise arises for the Companies to disclose the information, such information may be disclosed at the direction of legal counsel.

The Companies will not take adverse action against an employee for reasonably requesting assistance from, or reporting potential violations of law or the Companies policy in good faith to, a supervisor, and the Compliance Officer or government authorities. By reporting his or her own misconduct, however, an employee will not insulate himself or herself from potential disciplinary action for such a violation. Employees should report concerns about possible retaliation or harassment to the Compliance Officer.

The Companies do not condone and will not tolerate abuse of the reporting process. Any employee who makes an intentionally false statement, or makes a report of alleged misconduct in bad faith, shall be subject to appropriate disciplinary action.

Appendix B – Medicaid Review Process

At the direction of the Shareholders/Presidents of the ImmediaDent PCs, Samson Dental has developed a billing review process to ensure claims submitted to Medicaid programs, third party plans, and self-pay patients on behalf of ImmediaDent are supported with appropriate documentation for payment and sufficient evidence of medical necessity. The guidelines and process were developed in conjunction with Samson Chief Dental Officer John Vaselaney and Compliance Manager Allee Mertes, and have been approved by the Clinical Quality Committee (PC Owners/Presidents and selected members of Samson Management). The purpose of this communication is to build understanding of the reasons for and the methods of conducting these reviews. The Compliance Department at Samson Dental conducting the reviews will not change treatment plans, treatment notes or in any way interfere with ImmediaDent dentists' clinical judgment. The purpose of the reviews is to insure that the correct code was used and that the chart – including items such as exam records, PSR scores, periodontal chartings, treatment plans, and progress notes – **supports the use of the selected code for billing purposes**, as required under our payer contracts and organizational standards.

ImmediaDent and Samson DPM are committed to full compliance with all federal and state Medicaid laws, rules, standards, and guidelines. We will conduct our respective businesses in an ethical, legal, professional, and disciplined manner. On a daily basis, we are committed to accurate, reliable dental coding and dental care data submission and to the prevention of fraud and abuse of any kind in association with our Medicaid participation and with all third party payers with whom we contract. In addition, we will do statistical analysis of use of particular codes to identify unusual coding patterns that warrant sampling for more in-depth review of radiography and notes to ensure the treatment billed was medically necessary and appropriately billed.

Medicaid billing can be alleged to be inaccurate, fraudulent or abusive if the treatment is miscoded, upcoded, or if submitted for treatment that was not clinically necessary, has already been submitted or was not actually provided.

A. Daily Review Items – Potential Errors, Fraud, and Abuse

ImmediaDent's commitment to accurate coding and the prevention of fraud and abuse includes the proactive review of services billed to identify and correct billing submission errors and inaccuracies.

ImmediaDent's billing review may include, but not be limited to, screening specific code usage as well as screening for the documentation of clinical necessity. At ImmediaDent, the clinical necessity of the treatment provided must be established and documented in the clinical patient record. This will be achieved through a combination of clinical examination charting, periodontal charting, radiographs, clinical photographs, and clinical progress note documentation. Clinical diagnoses and treatment plans will support the other forms of documentation in establishing the clinical necessity for care.

Individual records will be selected and reviewed for coding accuracy, proper documentation, and clinical necessity. ImmediaDent's areas of focus to identify and correct billing submission errors and inaccuracies and prevent fraud and abuse include but is not limited to:

- Diagnostic
    - Billing for a comprehensive evaluation (0150) at a higher fee, when only a limited evaluation (0140) at a lower fee was actually provided
    - Billing for a limited evaluation (0140) instead of a post-op visit when no additional evaluation is necessary, or when another ImmediaDent dentist has already billed a 0150 or 0140 to address the existing complaint.
- Restorative
    - Billing for a restoration with more surfaces than required treatment or were actually restored
        - Documentation of clinical need of all tooth surfaces restored with composite or amalgam (CDT 2140-2161, 2330-2394) must be in the patient record in the form of radiographic evidence of need, photographic evidence of need, clinical examination charting, and/or a clinical description of necessity in the progress notes
    - Establishing clinical necessity for resin-based and stainless steel crowns on pediatric patients (2929-2934)
        - Documentation of clinical necessity in the patient record must be in the form of radiographic evidence of need, photographic evidence of need, clinical examination charting, and/or a clinical description of necessity in the progress notes
    - Prefabricated post and core (2954) billed as indirect post and core (2952)
    - Billing a composite restoration of any number of surfaces (2330-2394) as a crown buildup when a crown is treatment planned and the patient is intending to proceed with the restoration. Direct placement composite restorations are considered final restorations and must have anatomy, occlusion, and/or interproximal contacts.

- Endodontics
  - Documentation of the completion of endodontic therapy must include 1) a preoperative radiograph, 2) a wire measure OR gutta percha master cone try-in radiograph assessing canal length, and 3) a post-obturation radiograph showing all root apices and the periapical area of the treated tooth

- Periodontics
  - Billing for 4 or more teeth of scaling and root planing (4341), when only 1-3 teeth (4342) required treatment or were actually treated
  - Establishing clinical necessity for scaling and root planing (4341, 4342), antimicrobial therapy (4381), and surgical periodontal services (4210-4266)
    - Documentation must include a periodontal charting and radiographs of the treated area(s)
- Extractions
  - Billing a "simple" extraction (7140) as a surgical extraction (7210)
  - Billing a "simple" extraction (7140) as a surgical removal of residual roots (7250)
  - Billing a "simple" extraction (7140) as an impaction (7220, 7230, 7240)
  - Billing the surgical removal of residual roots (7250) as a surgical extraction (7210)
  - Billing a surgical extraction (7210) as an impaction (7220, 7230, 7240)
  - Billing an impaction as a more difficult impaction (7220 to 7230 or 7240, 7230 to 7240)
  - Documentation of the clinical basis for coding extractions other than 7140 must be in the patient record in the form of radiographic evidence of need, photographic evidence of need, and/or a clinical description of necessity in the progress notes

(See InfoSource for detailed "Guidelines for the use of CDT Extraction Codes" and "Guidelines for the use of Selected CDT Codes")

- Alveoloplasty
  - Billing for 4 or more teeth or tooth spaces of alveoloplasty (7310, 7320), when only 1-3 teeth or tooth spaces (7311, 7321) required treatment or were actually treated

- Establishing the clinical necessity for alveoloplasty (7310, 7311, 7320, 7321)
    - Documentation must include a description of why the procedure is clinically necessary in the specific area being treated. The smoothing of rough bony edges after an extraction (of any kind or code, even for extractions involving bone removal) is included in the extraction code and is not billable or payable as alveoloplasty as a separate procedure. The clinical necessity requirement of this code is not met solely by the need for multiple tooth extractions.

- Radiography
    - Billing FMX (0210) for fewer than 14 films.
    - Billing FMX (0210) for a combination of Pano and 4 bitewings.

Appendix C - Self Assessment Tool

	Description	Provide r Yes	Provide r No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*
Element 1: Written policies and procedures				
1. 1	Do you have written policies and procedures that describe compliance expectations in a code of conduct or code of ethics?			
1. 2	Have you implemented the operation of the compliance program?			
1. 3	Do you have written policies and procedures that provide guidance to *employees* on dealing with potential compliance issues?			
1. 4	Do you have written policies and procedures that provide guidance to *others* on dealing with potential compliance issues?			
1. 5	Do you have written policies and procedures that provide guidance on how to communicate compliance issues to appropriate compliance personnel?			
1. 6	Do you have written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved?			
Element 2: Designate an employee vested with responsibility				
2. 1	Has a designated employee been vested with responsibility for the day-to-day operation of the compliance program?			
2. 2	Are the designated employee's (referred to in 2.1) duties related solely to compliance?			
2. 3	If the designated employee's (referred to in 2.1) compliance duties are combined with other duties, are the compliance responsibilities satisfactorily carried out?			
2. 4	Does the designated employee (referred to in 2.1) report directly to the entity's chief executive or other senior administrator?			

2. 5	Does the designated employee (referred to in 2.1) periodically report directly to the governing body on the activities of the compliance program?	
Element 3: Training and education		
3. 1	Is training and education provided to *all affected employees* on compliance issues, expectations and the compliance program operation?	
3. 2	Is training and education provided to *all affected persons associated with the provider* on compliance issues, expectations and the compliance program operation?	
3. 3	Is training and education provided to *all executives* on compliance issues, expectations and the compliance program operation?	
3. 4	Is training and education provided to *all governing body members* on compliance issues, expectations and the compliance program operation?	
3. 5	Does the compliance training occur periodically?	
3. 6	Is compliance training part of the orientation for *new employees*?	
3. 7	Is compliance training part of the orientation for *appointees or associates*?	
3. 8	Is compliance training part of the orientation for *executives?*	
3. 9	Is compliance training part of the orientation for *governing body members*?	
Element 4: Communication lines to the responsible compliance position		
4. 1	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all employees* to allow compliance issues to be reported?	
4. 2	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all persons associated with the provider* to allow compliance issues to be reported?	
4. 3	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all executives* to allow compliance issues to be reported?	

4. 4	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all governing body members* to allow compliance issues to be reported?	
4. 5	Is there a method in place for *anonymous* good faith reporting of potential compliance issues as they are identified for each group noted in items 4.1 through 4.4?	
4. 6	Is there a method in place for *confidential* good faith reporting of potential compliance issues as they are identified for each group noted in items 4.1 through 4.4?	
Element 5: Disciplinary policies to encourage good faith participation		
5. 1	Do disciplinary policies exist to encourage good faith participation in the compliance program by all affected individuals? For purposes of Element 5, "affected individuals" shall mean those persons who are required to receive training and education under Element 3 above.	
5. 2	Are there policies in effect that articulate expectations for reporting compliance issues for all affected individuals?	
5. 3	Are there policies in effect that articulate expectations for assisting in the resolution of compliance issues for all affected individuals?	
5. 4	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all affected individuals?	
5. 5	Is there a policy in effect that outlines sanctions for participating in non-compliant behavior for all affected individuals?	
5. 6	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals?	
5. 7	Are all compliance-related disciplinary policies fairly and firmly enforced?	
Element 6: A system for routine identification of compliance risk areas		

6. 1	Do you have a system in place for routine identification of compliance risk areas specific to your provider type?	
6. 2	Do you have a system in place for self-evaluation of the risk areas identified in 6.1, including internal audits and as appropriate external audits?	
6. 3	Do you have a system in place for evaluation of potential or actual noncompliance as a result of self-evaluations and audits identified in 6.2	
Element 7: A system for responding to compliance issues		
7. 1	Is there a system in place for responding to compliance issues as they are raised?	
7. 2	Is there a system in place for investigating potential compliance problems?	
7. 3	Is there a system in place for responding to compliance problems as identified in the course of self-evaluations and audits	
7. 4	Is there a system in place for correcting compliance problems (as referred to in 7.3) promptly and thoroughly?	
7. 5	Is there a system in place for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?	
7. 6	Is there a system in place for refunding Medicaid overpayments?	