HEALTHCARE
MANAGEMENT • SYSTEMS

Coding & Compliance Plan

Policy
Jones-Bartley Enterprises, dba Healthcare Management Systems (HCMS) is committed to ensuring that HCMS is in compliance with federal, state, and local rules, laws, statutes and regulations concerning HCMS and the procedure and regulations governing the billing and reimbursement for health care services provided.

Our business regards the quality of work provided to our clients, and the accuracy of business processes that go along with this service, to be held as top priority. Continuous improvement in the areas of federal regulations and compliance issues must be addressed and improved upon by all staff members in this office. As we strive to comply with state and federal regulations, HCMS has devised a compliance program which provides policies and procedures to:

- Detect inaccuracies with regards to billing procedures.
- Identify deficiencies with regard to medical records documentation.
- Educate and train all employees on office compliance efforts.
- Obligate all staff members to learn new legal requirements.
- Implement polices to report violations.
- Perform productive audits and make appropriate changes to office procedures.

The policies set forth in this program are intended to be mandatory and apply to all HCMS staff, employees, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors and consultants.

The compliance program will be reviewed semiannually to be sure that the actual elements of the program have been satisfied. For example, whether there has been appropriate:

- Dissemination of the program's standards.
- Training.
- Chart reviews.
- Ongoing educational programs.
- Disciplinary actions.

If this review shows that deviations were detected by the program in place, appropriate modifications will be implemented. As part of the review process the compliance officer or reviewers will utilize such tools as on-site visits, interviews with personnel involved in all aspects of compliance, questionnaires, procedure checklists, and review of any documentation to support claims for reimbursement. Review of written material, chart documentation, and trend analyses/studies will be part of the review process. As an indication of HCMS's efforts to comply with a particular statute, regulation, or program requirement, if an employee speaks with or obtains information from a government agency or insurance carrier (such as a response to a claims question), the employee should document and retain a record of the request and any written or oral responses with the time,

date, and name of the person offering the advise. Written confirmation of information is preferred.

Employee Acknowledgments
All HCMS providers and other employees will make a written acknowledgment of their commitment to HCMS's compliance program.

HCMS Standards
Documentation of HCMS's routine standards is an integral part of the compliance program. Each employee's orientation to HCMS will include review of these standards. In addition to HCMS's Compliance Program Manual, guidelines for HCMS standards will be established in the following formats:

Policies and Procedures Manual
This manual outlines routine policies and procedures regarding billing systems and HCMS standards. Sample topics include:

- Safety
- Education
- Performance Improvement
- Chain of Command and Departmental structure
- Management of Information

Employee Handbook
This manual outlines routine policies and procedures relating to personnel matters. General employment policies, benefits, and employee responsibilities, including safety policies and discipline procedures are provided. Each employee will be provided with an employee handbook and acknowledge receipt in writing.

Reports & Forms

This manual outlines standard reporting procedures and contains sample forms utilized by HCMS.

All policies and procedures will be reviewed for compliance, efficiency, and effectiveness, on an annual basis by the compliance. Updates will be made as necessary.

Business records
HCMS will take great care to ensure that medical documentation, and all billing and claims submitted to all private and federal health insurance plans, are accurate and in compliance with federal, state, and local laws and regulations governing these matters. HCMS will take reasonable steps to assure that the financial reports and records are kept in accordance with generally accepted accounting principles and utilize a health care knowledgeable corporate accountant to ensure compliance with regulatory HCMS accounting.

Record Security, Retention, and Confidentiality
It is acknowledged that the medical records and other documents generated by HCMS are considered the legal business records of HCMS. HCMS will maintain the confidentiality and integrity of those records, including electronic information, with the appropriate storage and security. No one in HCMS may tamper with, alter, remove, or destroy the business documents of HCMS except in accordance with established clinical and legal

guidelines.

Retention of Compliance Records
All records required either by federal or state law or by the compliance officer will be maintained in separate compliance records electronic files. Adequate documentation of any compliance efforts will be maintained as well. Where applicable, federal and state statutes will be consulted for specific time frames in relation to the retention of HCMS's business records. Guidance from HCMS accountant and the local & state business associations will also be obtained.

Education and Training
Adherence to the guidelines and commitment to the program will be a condition of employment. All new and current employees will participate in an educational process regarding federal and state health care insurance regulations and laws, HCMS's commitment to be in compliance, and their cooperation in HCMS's compliance program. All employees will periodically be asked to attend educational seminars regarding compliance issues pertinent to their area of responsibility. These issues are likely to be documentation, specialty specific coding, appropriate billing practices, and other topics that relate to the integrity of HCMS's revenue cycle management operations.

Business Relationships

HCMS will make every effort to have compliant legal business arrangements with our physician-clients, other providers, third party payers, vendors, and other parties. Violations of these policies carry grave criminal and civil consequences and penalties for HCMS, its employees, and other affiliated parties or entities.

Commitment to Patients. HCMS will make its best efforts to protect the privacy and confidentiality of our clients' patients' health care information. HCMS will follow state and federal medical records laws and regulations.

Screening of Employees and Contractors
HCMS will make every effort to determine prior to employment if an employee or contractor has been excluded or sanctioned by federal health care program or has been convicted of a criminal offense.

Governmental Cooperation
In the event of a governmental audit or site inspection, all employees will make every effort to cooperate with government officials. At no time shall any employee conceal, destroy, or alter any HCMS documents, make misleading statements to the inquiring agents, or fail to provide accurate information or records relating to a possible violation of law. HCMS and its employees have a right to advice of legal counsel during such circumstances.

COMPLIANCE PROGRAM GOALS

This compliance program is designed and will be implemented to accomplish the following seven goals:

1. Implementation of written guidelines and standards of conduct; Establishment of written guidelines that include HCMS's clear commitment to be in compliance with all Medicare, or other federal insurance regulations, and applicable federal and state laws.

2. Designation of a compliance officer or compliance contact(s) ; Appointment of a Compliance Officer to Compliance Contact(s) to oversee and monitor HCMS's compliance program. This person will be a corporate officer or employee with sufficient authority and responsibility to influence other employees' behavior, change HCMS procedures if violations are found, and discipline employees for violations when necessary.
3. Development of education and training programs for all HCMS staff; Perform effective and routine training and education of all employees and corporate officers. HCMS will communicate its standards, policies, and procedures to all personnel through training programs, testing programs, and the distribution of all appropriate publications and educational literature. The Compliance Program Manual will be accessible for all staff members for reference or questions on in our network Compliance folder. *E:\HCMS\HCMSDOCS\HCMS\Compliance*

4. Creation of accessible lines of communication for staff compliance updates and an "open door" policy for reporting of potential violations; There must be an effective reporting and communication process.

5. Performance of internal audits to monitor compliance of HCMS; There must be regular review of HCMS's clients' medical records, coding and claim development, and claim submission process.

6. Enforcement of compliance standards through well publicized staff expectations and disciplinary actions; HCMS must be able to investigate any suspected violations and take disciplinary action if necessary. This will be accomplished through:

- Evaluation of employee behavior.
- Auditing medical charts and office billing procedures.
- Setting up a reporting system for employees to inform the compliance officer of potential violations.

7. Prompt corrective or disciplinary actions; If HCMS becomes aware of a violation of standards or laws it will respond with a thorough investigation of the offense and in turn make subsequent changes to the office procedures and/or compliance program as needed. HCMS will respond to identified offenses and document actions taken to prevent further similar misconduct or offenses.

Ultimately, it is our goal that this program will enable HCMS to improve our quality of revenue cycle management services and claims submission, and to be in compliance with laws and regulations governing HCMS of medicine.

Designation of a Compliance Program Officer

Compliance Officer (CO)
HCMS will designate a compliance officer who will report directly to the physician director or corporate president. Designating a compliance officer (CO) with appropriate authority is critical. Selection of the Co will be based on the employee's position, HCMS experience, and commitment to the compliance program. Coordination, communication, and staff authority are key functions of the CO. The CO for this HCMS will be

Luz Black.

The compliance officer's duties and responsibilities will include:

- Oversee and monitor the implementation of the compliance program.
- Report on a regular basis to the corporate president on the progress of the compliance program's implementation.
- Establish methods to improve the efficiency and quality of services, and reduce HCMS's vulnerability to improper HCMSs or regulatory violations.
- Ensure that no employee, medical staff or independent contractor has been excluded from federal programs.
- Develop and distribute to all employees written compliance policies and procedures.
- Periodically revise the compliance program to reflect changes in the needs of HCMS, the law, and policies and procedures of government and private payor health plans.
- Develop, coordinate, and participate in educational/training programs that focus on the elements of the compliance program.
- Ensure that providers who order services are informed of compliance standards in regards to coding, billing, and marketing for these services.
- Analyze HCMS's regulatory environment, i.e. coding and billing procedures, in relation to federal and private insurance policies.
- Recommend and monitor the development of internal systems and controls to implement HCMS's standards, policies, and procedures.
- Determine the appropriate strategy to promote compliance with the program and detection of any potential violations.
- Conduct internal compliance review and monitor activities.
- Develop a system to solicit, evaluate, and respond to complaints and problems.
- Investigate and act on matters related to compliance.
- Respond to reports of problems or violations and administer corrective action or employee discipline when necessary.
- Develop policies and programs that encourage managers and employees to report suspected improprieties or regulatory violations.
- Hold quarterly meetings with corporate president to report and discuss any compliance issues, concerns, or actions taken, and record minutes from those meetings reflection decision making actions.
- Maintain a binder or record of compliance program efforts, including educational activities and internal audit results.
- Maintain a confidential binder for internal investigation reports.

The CO will have authority to review all documents and other information that are relevant to compliance activities, including but not limited to, requisition forms, billing information, claim information, patient medical records and documents concerning any contractual agreements such as leases and insurance contract agreements.

BILLING POLICIES AND PROCEDURES

Compliance polices will ensure that all claims for services submitted to Medicare or other federal health

programs correctly identify the services ordered by the provider or other authorized individual. HCMS will be responsible for the review and auditing of the billing. The compliance officer will also conduct at least 4 review and audits per year as part of HCMS's checks and balances.

Under no circumstances will claims be submitted and payment sought for any of the following claims:

- FALSE CLAIMS
  Any claim in which the employee knows or should know is false or fraudulent. Example: Billing for medical services that were not provided to the patient.
- UPCODED CLAIMS
  Any claim in which the employee knows or should know is being billed at a greater reimbursement rate or amount that is warranted for the type of care given. Example: Billing for a Level IV visit when the patient really received a Level II visit.
- CLAIMS NOT MEDICALLY NECESSARY
  Any claim for care or services that are determined as not medically necessary by the insurance carrier or that the physician or provider's medical assessment does not support. Do not confuse the actual medical decision that a physician or provider makes when he or she decides what is medically necessary for the best medical care for the patient with what insurance carriers decide what is medically necessary. The two determinations are often not the same.

BILLING STAFF
The billing staff must be familiar with all aspects of the coding and billing process. Their duties and responsibilities include:

- Print daily and monthly A/R reports to ensure charges and monies total correctly. (They must add up to what was charged in the computer)
- Post hospitalization and office charges appropriately with correct codes.
- Process claims daily.
- Process statements daily.
- Identify errors made on encounter forms. When an error on an encounter form is discovered and verified by the billing staff the error will be corrected by the team leader for that area and the encounter form resubmitted. If a patient refund is due, the billing staff will process the refund and submit it to administration for refund check processing.
- Provide reports that will identify all provider charges and payments, and refunds to patients and insurance companies. These reports will be reviewed by HCMS administrator to insure accuracy of all totals. The compliance officer will also review these reports.
- Receive insurance payments only and enter them into the computer system to the appropriate account. If an EOB indicates a denial of payment, it is investigated. If the EOB indicates a low payment, it is investigated. The billing staff will post all payments received in the office mail or payment batches from clients. Cash payments received at the front desk will have a receipt attached that is put in petty cash for posting. A copy of that same receipt is given to billing staff for posting. This system helps to insure the accuracy of the insurance payments received from insurance carriers under which there is a contractual obligation, and helps to insure the timely payment of all claims in accordance with the contracts negotiated.
- Perform appropriate write offs and adjustments in accordance with insurance contracts.
- Computer system issues are the responsibility of HCMS Director of Revenue Cycle Management, Ami

Tucker. This includes software updates and pricing updates. Team Leaders of each specialty will update CPT, ICD-9 codes along with maintenance changes to insurance companies' addresses and information changes. Maintenance change forms are to be completed by anyone making a change in the computer system. The forms are turned in to HCMS Director of Revenue Cycle Management for approval. HCMS Director of Revenue Cycle Management will oversee any changes made in the system.

- Provide information needed to reprocess claims.
- Negotiate/monitor contracts in conjunction with HCMS RCM with insurance companies.
- Send out monthly patient statements and work with patients to resolve billing discrepancies.
- Refer accounts to a collection agency upon approval of HCMS RCM or provider of service.
- Investigate and collect return checks. Apply return check fees appropriately.

SELECTION OF CPT, ICD-9 AND HCPCS CODES

The physician (provider) is ultimately responsible for ensuring that the codes used to bill for medical services are current, and accurately reflect the service(s) provided. The Compliance Officer is responsible for ensuring that providers and necessary staff members are provided with current coding and billing information. The provider rendering medical services is responsible for entering the correct code at the time of service. The code(s) must correlate with the documentation in the patient's medical record.

Office personnel will not alter the provider's order in any way (i.e. increasing or decreasing the number of services performed) without the consent of the ordering provider or other authorized individual. To ensure coding accuracy, individuals with expertise in the appropriateness of the codes may be needed to review claims before they are submitted. Individuals with expertise in matching CPT, HCPCS, and ICD-9 codes will match the most appropriate CPT/HCPCS/E&M code to the most appropriate ICD-9 code before the claims are submitted. This only occurs if the provider does not make the appropriate ICD-9 mark on the charge slip. The provider or other authorized individual would have to approve the code before submission. Intentionally or knowingly upcoding violates the False Claims Act and/or other civil and criminal laws.

Medicare carriers and fiscal intermediaries have the authority to develop and implement Local Medical Review Policies (LMRPs). LMRPs specify when, and under what circumstances, a services will be considered covered, reasonable, and necessary, and what documentation will support the need for that service. In some cases LMRPs may limit coverage for specified lab tests to specific diagnoses. Compliance policies should ensure that the laboratory, as well as HCMS, can support tests billed to Medicare with documentation obtained from the provider ordering the service, an authorized person on the provider's staff, or other individual authorized by law to order test(s) or services(s).

With regard to code selection, personnel will:

- Contact the ordering provider, authorized person on the provider's staff, or other individual authorized to order tests, to obtain information in the event that such information was not provided.
- Accurately translate narrative diagnosis obtained from the provider or other authorized individual to a billing code.

With regard to code selection, personnel will not:

- Use information provided by the provider or other authorized individual from earlier dates of service
- Create diagnosis information that will trigger reimbursement.

- Use computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the ordering provider or other authorized individual.
- Make up information for claim submission purposes.

These offenses may result in immediate termination of employment.

ENCOUNTER FORM REVIEW AND POLICIES
Encounter forms are reviewed for accuracy of the following information before being keyed, posted, and sent to billing for processing:

- Missing charges.
- Correct fee charges.
- Charges for lab tests that have been sent to an outside reference lab.
- Charges for lab tests performed by the physician's office lab.
- Correct diagnosis codes.
- Correct CPT codes.
- Correct use of modifiers, if indicated.
- Proper linking of ICD-9 and CPT Codes.
- Recalculation of the total if there are several charges.

MISSING PATIENT ENCOUNTER FORMS
The billing staff will review the missing encounter forms daily via surgery schedules, office schedules etc. A "missing encounter form" incident may occur when a patient was cancelled from the schedule, encounter was a "No Charge" or provider did not turn in encounter form for billing. When this occurs, the following steps are taken to ensure that no double or erroneous billing takes place:

- Check to see if the patient actually had an appointment on that date.
- Check the chart for an entry on that date.
- Check the inquiry screen in the computer to see if a charge entry was done on the date in question.
- Check with the provider to see if for any reason the encounter form is being delayed.
- Check the schedule provided (surgical or office) to see if services were provided.
- Once the provider provides the encounter form to the billing office it will processed.
- Follow up on any missing encounter forms. (call the provider directly if after the normal request you do not receive it)

BILLING STATEMENT/ENCOUNTER FORM CORRECTIONS
Incidents of frequent and/or repeated errors found on billing statements or encounter forms will be brought to the attention of the team leader for that specialty and the compliance officer for investigation and corrective action.

Procedure for Correction of Errors on Encounter Forms
If the error is discovered before the claim is submitted, the correction will be made immediately. At no time will we knowingly submit an incorrect claim for reimbursement/billing statement to an insurance company or

patient.

If the error is discovered after the claim has been submitted, the team leader will be notified and advised on what corrective action is necessary. Corrections may include wrong account types, insurance changes, wrong fee charges, incorrect patient name, incorrect provider, wrong total charges, or coding errors. If a refund to the patient or insurance company is indicated, the refund process will begin immediately.

If a charge has been omitted that should be on the encounter form, the patient will be notified of the missing charge and a new encounter form printed with the added charge, unless it is the same day as the date of service. If it is the same day, the charge will be added on the current encounter form and the total will be changed. The patient will still be notified of the change by phone. The added charge will be handled by billing the charges tot he appropriate party. Documentation of the changed encounter form will be made.

Procedure for Correction of Errors on Billing Forms
If a patient informs HCMS of an error on their billing statement, the appropriate information will be taken (patient name, phone number, date of service, and potential error). The patient's encounter form is then reviewed for correct information and comparison with the bill. If necessary you may need to contact provider to compare what the office chart states. If an error has occurred, the bill will be corrected and resubmitted if necessary. The patient will then be contacted and informed of the action taken. Documentation of the outcome is entered into the computer system's note/memo section.

EFFECTIVE TRAINING AND EDUCATION

All employees will be required to attend specific training as part of their new employee orientation and on a periodic basis thereafter, including training in federal and state statues, regulation program requirements, policies of private payers, and HCMS's compliance commitment. All training should emphasize HCMS's commitment to compliance with these legal requirements and policies. Several resources will be used to contribute to these training sessions. Education and training may be accomplished through a variety of means.

Training programs may include sessions highlighting HCMS's compliance program, summarizing fraud and abuse laws and developments, discussing coding requirements, documentation and claim development, claim submission process, billing for CRNA's or other non-physician provider services, reemphasizing patient confidentiality and privacy requirements, and marketing HCMSs that reflect current legal and program standards. The compliance officer will document attendance, the topics covered, and the material distributed at the training sessions. Targeted training will be provided to employees whose actions affect the accuracy of the claims submitted to government and private payers. All employees may be required to attend certain seminars and conferences and are also strongly encouraged to attend other pertinent seminars and conferences on their own time.

Employees involved in billing and coding functions will have, at a minimum, annual training in proper CPT/HCPCS and ICD-9-CM coding. Other topics suggested by the OIG for training are as follows:

- Coding requirements.
- Claim development and submission processes.
- Signing a form for a physician without the physician's authorization.

- Proper documentation essentials.
- Government and private payer reimbursement principles (periodic review of EOB's).
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper translation of narrative diagnosis.
- Billing for services ordered, performed and reported.
- Provider approved amendments to regular forms.
- Proper documentation or confirmation of services rendered.
- Reporting misconduct.
- Legal sanctions for submitting deliberately false or improper bills.

Attendance logs of each employee will be reviewed at employee's annual evaluation.

GENERAL HCMS INFORMATION SOURCES

- Medical Group Management Association
- American Medical Association
- MGMA Connexion Magazine
- American Academy of Professional Coders (AAPC)
- HBMA (Healthcare Billing & Mgmt Assoc)

INTERNET COMPLIANCE RESOURCES

- www.medicaretraining.com
  HCFAs education program to help doctors and other health care providers understand how to properly bill under the Medicare program.
- www.uscode.house.gov/usc.htm
  U.S. House of Representatives Internet Library (Health Care Laws)
- www.dhhs.gov/progorg/oig
  HHS/Office of inspector General. Compliance program guidance for clinical laboratories, hospitals, and other compliance documents.
- www.hhs.gov/oig
  Department of Health and Human Services Office of Inspector General
- www.access.gpo.gov
  U.S. Government Printing Office (for Federal statutes and regulations)
- www.hcfa.gov
  Health Care Financing Administration
- www.hcfa.gov/medlearn
  Medicare training
- www.hcfa.gov/medicare/incardir.htm
  Medical fiscal intermediaries and carriers
- www.hcfa.gov/medicaid/mcontact.htm
  Medicaid state carriers

ENFORCING COMPLIANCE STANDARDS

Violations of any of HCMS's standard policies and procedures, to include compliance program and employee handbook policies, should be reported immediately. Violations that are detected, but not reported or corrected, can seriously endanger the mission, reputation, and legal status of HCMS.

ACCESS TO THE COMPLIANCE OFFICER

An open line of communication between the compliance officer and all employees is a vital part of the compliance program. Written confidentiality statements and non-retaliation policies will be distributed to all employees to encourage communication and the reporting of incidents of potential misconduct. If at any time an employee encounters a situation that simply "does not feel right" and is worried that the action or situation may possible be improper, it is important to discuss the matter with the compliance officer or through an anonymous means. These lines of communication are essential to the success of HCMS's commitment to compliance efforts.

COMPLIANCE WITH APPLICABLE FEDERAL AND LOCAL MEDICARE CARRIER FRAUD ALERTS AND NOTICES

The compliance officer will carefully consider any and all fraud alters and notices issued by any authorized federal agency such as the OIG, HCFA, and local Medicare carrier. If the notice issues an alert for a certain activity, the compliance officer will require that the activity ceases and be corrected, and will take reasonable action to prevent the activity from recurring in the future. Documentation of all actions and changes made to prevent the activity from reoccurring, such as an investigation will be maintained in the appropriate compliance records binder maintained by the compliance officer.

COMPLIANCE NOTICE TO PROVIDERS

HCMS administrator will provide all health care providers and appropriate employees with the Medicare national policies and local medical review policies as they are received, any changes in the payment of or necessary diagnosis for organ/disease related panels (all components must be medically necessary), and the updated Medicare fee schedule. All notices and letters received will be date stamped and marked for immediate attention. All notices will be placed in the appropriate compliance records binder for future reference.

REPORTING COMPLIANCE CONCERNS

Any employee of HCMS who has concerns regarding any office, HCMS or policy, or who perceives what they believe to be an act of misconduct by another employee or individual acting on behalf of HCMS, shall report the concern/violation to their immediate supervisor. However, if the employee is uncomfortable in reporting to the immediate supervisor, the report may be taken to a more senior supervisor or HCMS compliance officer. If the supervisor's/compliance officer's response to the report is unsatisfactory, the employee may report the suspected wrongdoing to the next higher authority, and so on.

HCMS shall provide multiple methods for employees to report (anonymously if desired) suspected policy/procedure violations, as well as to offer suggestions for improvement:

- A “Virtual” Suggestion Box will be available in HCMS Outlook.
- HHS-OIG Hotline is available to employees (800-HHS-TIPS)
- Written/verbal reports will be accepted by the compliance officer during normal HCMS hours.
- Anonymous phone calls from patients or employees may be used to report violations of HCMS policies.

A confidential log will be kept by the compliance officer for these calls.

There will be no retribution to an employee solely for reporting what he or she reasonably believed to be an act of wrongdoing. However, an employee whose report contains an admission of personal wrongdoing cannot be guaranteed protection against disciplinary action. (The fact that the employee volunteered the information will be taken into consideration when determining any disciplinary action.) An employee may also be subject to discipline if HCMS determines that he or she intentionally fabricated the report or wrongdoing, in whole or in part.

INVESTIGATIONS

HCMS will make every effort to keep reports confidential if requested to do so by the employee. Complete confidentiality cannot be guaranteed if HCMS deems it necessary to investigate or take action regarding the report.

Depending on the nature of the violation, the compliance officer (or other designated individual) will conduct an internal investigation. All relevant documents will be reviewed and, if applicable, employee interviews will be conducted. Records of the investigation will contain documentation of the alleged violation, a description of the investigative process, copies of any interview notes, key documents, results of the investigation (disciplinary action taken), and documents of the corrective action implemented.

Any investigation resulting in the determination that a material violation of applicable law has occurred will result in one or both of the following:

- The implementation of a corrective action plan.
- A report to the government and the submission of any overpayments is applicable.

CORRECTIVE ACTIONS

If the compliance officer or any member of the compliance team discovers credible evidence of misconduct/wrongdoing from any source, and after a reasonable inquiry has definite reason to believe that the misconduct may violate criminal, civil, or administrative law (consult your health care attorney), then the compliance officer may report the matter to the appropriate governmental authority. This report must be made within a reasonable period as per the regulatory guidelines. Self-disclosure should not be done without the advice of legal counsel due to the potentially severe criminal penalties, including imprisonment and large civil money penalties and fines.

As previously stated, HCMS will take appropriate corrective action, including the imposition of proper disciplinary action, and prompt identification and restitution of any overpayment to an affected payor.

Failure to repay overpayments within a reasonable period of time would be interpreted as an intentional attempt to conceal the over-payment from the government, thereby establishing an independent basis for a criminal violation with respect to HCMS and any individuals involved.

DISCIPLINE POLICY AND ACTIONS

Intentional or reckless noncompliance will impose significant sanctions on an employee. These sanctions will range from oral warnings to suspension and possibly termination based on the offense. Upon, confirmation of misconduct, the compliance officer will alert the physician director or corporate president as to the offense. The

compliance officer will then decide what disciplinary action to impose on the employee. The consequences of noncompliance will be consistently applied and enforced. All employees, including providers, will be subject to the same disciplinary actions for commission of similar offenses. The compliance officer shall document and note in the employee's file any disciplinary actions taken.

Violations may result in the following disciplinary actions:

- Verbal warning
- Written warning
- Written reprimand
- Probation
- Demotion
- Temporary suspension
- Termination
- Restitution of damages
- Possible referral for criminal investigation

COMPLIANCE AS AN ELEMENT OF EMPLOYEE EVALUATIONS

Employee compliance with all policies and procedures outlined in this program will be an element in evaluating the performance of managers, supervisors, team leaders, and all other employees. Employees will be periodically trained in new compliance policies and procedures as they are changed and added. In addition, all managers and supervisors involved in the sale, marketing, or billing of services will discuss with all supervised employees the compliance policies an legal requirements applicable to their position.

EMPLOYEE VERIFICATION OF ELIGIBILITY

For all new employees who will have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, HCMS administrator will conduct a background investigation, including a reference check, as part of every such employment application. In addition, the application will specifically require the applicant to disclose any criminal conviction or exclusion action. If an applicant who has been convicted of a criminal offense related to health care, or is listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs, will not be hired. If an applicant is hired and later found guilty of such an offense, the employee will be terminated immediately.

Upon implementation of this compliance program, the compliance officer will verify that none of HCMS's current employees or affiliates are on the list of personnel or entities excluded from participating in Federal health care.

Note: "List of excluded individuals/entities" is available at www.hhs.gov/oig.

AUDITING AND MONITORING

The OIG has identified two areas where HCMSs may be vulnerable and at potential risk of noncompliance:

- Medical record documentation, to include identification of reasonable and necessary services.

- Coding and billing.

HCMS will conduct an initial baseline audit of medical record documentation and the coding and billing process to identify areas for improvement. Subsequent audits will be conducted annually or more often if indicated. The baseline audit should reveal:

- HCMS's top ten denials for services provided, and why.
- Any data entry errors.
- Confirmation that all notes and orders are written and signed by the provider.
- Documentation reflects reasonable and necessary medical services.

Appointments/Surgery Schedules
Comparison between the daily printout of scheduled appointments will be made with the providers' list of patient encounter forms.

Medical Chart Review
A medical chart review will be conducted annually, or more frequently if determined necessary. Records selected will include those of patient enrolled in any federal health program. At a minimum, five records from each federal payer from whom the HCMS physician-client received reimbursement. The review will be conducted by the billing supervisor (or compliance officer) and a medically trained employee.

Upon review of a medical chart, note the following:

- Confirm correct patient identification information.
- Complete and legible notes.
- Notation of all treatment.
  Procedures
  Patient education and instructions
  Medications and dosages ordered
  Incident-to services
  Ancillary services
  Medical supplies used
- Past and present diagnosis should be easily accessible.
- Confirm completed information on any forms or flow sheets.
- Appropriate health risk factors should be identified.
- The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.
- Log this patients record as reviewed and the date to avoid repetitive auditing.

THE BILLING AND CODING REVIEW
Regular audits of the coding and billing process will be performed on an annual basis by an internal or external auditor to ensure compliance. The auditor will have knowledge in the areas of federal and state health care statutes and regulations, and program requirements of federal, state, and private insurers. At a minimum, these audits will include in-depth analysis of laws governing kickback arrangements, the provider self-referral prohibition, CPT/HCPCS/E&M coding and billing, ICD-9 & ICD-10 coding, claim development and submission, reimbursement, marketing, reporting, and record keeping. Test utilization reports, cost revenue

analysis, EOBs, as well as any other pertinent reports, should be available to the auditor. Any deviations in these reports will be analyzed to determine if the deviation was caused by improper procedures, misunderstanding of rules, or fraudulent billing problems. If a deviation has occurred for a legitimate reason, the compliance officer will limit or take no corrective action.

The OIG has identified as billing and coding risk areas:

- Billing for items or services that were not rendered or not provided as claimed.
- Submitting claims for equipment, medical supplies, or services that were not reasonable and necessary.
- Double billing, resulting in duplicate payments.
- Knowing misuse of provider identification numbers which result in improper billing.
- Unbundling.
- Failure to properly use coding modifiers.
- Clustering.
- Upcoding the level of service provided.

When refunding an overpayment, HCMS will inform the client and payor of the following information:

- The refund is being made based on a voluntary compliance program.
- A description of the circumstances surrounding the overpayment.
- The methodology by which the overpayment was determined.
- Any claim specific information used to determine overpayment.
- The amount of the overpayment.

Proper completion of the HCFA 1500 form will be closely monitored. Review of these forms should show that:

- The diagnosis code relates to the reason for the services provided.
- Modifiers are used appropriately.
- If HCMS is aware of beneficiary's additional insurance coverage, that information is provided.

The government is particularly concerned with arrangements between the physician and hospitals. The identified potential risk area for review are:

- Financial arrangements with outside entities with whom HCMS may refer federal health care patients.
- Joint ventures with entities supplying goods or services to the physician or its patients.
- Consulting contracts or medical directorships.
- Office and equipment leases or rentals with which the physician refers.
- Any of the above that are not considered financially fair market value and or do not fall within one of the special arrangements as described by government regulations.
- Offering or accepting any gift with more than a nominal value from those who are in a position to benefit from the physician's referrals.

COMPLIANCE RELATED ALERTS, LETTER, NOTICES AND DOCUMENTS

The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA, gave the authority and funding to expand the administrative health care fraud and abuse efforts. HIPAA made health care fraud and abuse both a civil and criminal offense and empowered the administrative agencies to enlarge their investigative efforts.

HIPAA also called for standards for electronic communications of health care information and the protection of the confidentiality of an individual's individually identifiable information.

False Claims Act (FCA)
The Civil False Claims Act (FCA) is often applied to health care fraud cases. Under this act, the prosecution is not required to show that the physician or billing services "intended" to defraud, but only that the physician showed reckless disregard for the truth, knew or should have known that she/he was submitting a false claim. The definition of false claim is very broadly interpreted. If you use electronic billing, it is especially important that coding errors are caught. It is possible that the same coding error multiplied over all the bills submitted could trigger a computer audit. The repeated coding may give the appearance of deliberately repeated inappropriate claims.

DEFINITIONS

ABUSE
A deliberate repeated act of a known improper behavior.

FALSE CLAIMS
Is the intentional misrepresentation of information or coding on a billing claim.

FRAUD
Is the intentional misrepresentation of the truth or a fact. It is very broadly defined by the health care regulations.

JOINT VENTURES
A business arrangement between physicians, physicians and hospitals, physicians and non physicians.

KICKBACK
A payment to a party, as an inducement to buy or influence that party's behavior for their financial gain.

MARKETING
The compliance program will require honest, straight forward, fully informative, and non-deceptive marketing devices for their laboratory and for the medical HCMS as a whole. It must be consistent with and within the limits of the state laws regarding physician advertisements.

REMUNERATION
The reward of getting something in return as a favor or an inducement to do something.

RETENTION OF COMPLIANCE RECORDS
The compliance program will require that all records required either by federal or state law or by the compliance officer are maintained in the appropriate section of the compliance guide. Adequate documentation of any

compliance efforts should be maintained as well.

SAFE HARBOR
This term refers to a designated legally "safe" situation that is not prohibited by the Stark or anti-kickback regulations.