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IX. FORMS
I. INTRODUCTION

A. Purpose

This compliance program is intended to develop and implement internal controls and procedures that promote adherence to statutes and regulations applicable to the Federal health care program and private insurance program requirements. Further, this program will strengthen efforts to prevent and reduce improper conduct and provide quality care to patients. This compliance plan seeks to address and implement the following:

1. Establishment of compliance standards through the development of a code of conduct and written policies and procedures.

2. Assignment of a Compliance Officer to monitor compliance efforts.

3. Conduct comprehensive training and education on practice ethics, policies and procedures.

4. Conduct internal monitoring and auditing focusing on high-risk billing and coding issues through performance of periodic audits.

5. Develop accessible lines of communication, such as staff meetings regarding fraudulent or erroneous conduct issues and community bulletin boards to keep practice employees updated regarding compliance activities.

6. Enforcement of disciplinary standards to ensure employees are aware that compliance is treated seriously and violations will be dealt with consistently and uniformly.

7. Appropriate response to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities.
II. POLICIES AND PROCEDURES

A. Code of Conduct

STATEMENT OF PURPOSE
The YOUR PRACTICE NAME is a full service Podiatry practice. Our purpose is to provide the highest quality of medical care to our patients with an extraordinary level of care and services. The single most important attitude you can bring to YOUR PRACTICE NAME is the desire to be of service. To that end, all employees will:

1. Work the required hours as determined necessary to meet the needs and objectives set forth by the practice Statement of Purpose.

2. Perform all tasks assigned, requested, needed or essential to the attainment of the practice Statement of Purpose.

3. Dress and act in a highly professional manner in accordance with the policies developed by YOUR PRACTICE NAME

4. Treat all patients, their families or escorts, insurance company representative, co-workers and any others that you come into contact with in a highly friendly and courteous manner which reflects the intent and direction of the practice Statement of Purpose.

5. Act in a manner that will promote the cohesive teamwork of the YOUR PRACTICE NAME staff and treat every staff member, patient and guest as you would expect to be treated.

6. Maintain the highest level of decorum consistent with the furtherance of the practice Statement of Purpose. The use of any profanity, vulgarity, intimidation, harassment or uncooperative behavior are grounds for termination.

7. All information entrusted to you regarding patients, doctor(s), fellow employees or any office matter is to be treated as entirely confidential and not be discussed.

8. Maintain billing standards for services actually rendered, coded accurately, documented for medical necessity and appropriateness with adherence to all payer contracts.
9. Standards of conduct will be enforced and any negligence, carelessness or misconduct will result in counseling or termination or both.

B. Policies and Procedures

YOUR PRACTICE NAME shall enforce and incorporate the Code of Conduct into all standard operating policies and procedures. Written polices and procedures will be given to all employees in the form of a Policy Manual. These procedures and policies will be updated and revised as necessary to meet the requirements of an effective compliance plan.

1. Employee Hiring and Retention

a. **Standard:** All coders are required to pass a skill competency test prior to employment. Upon employment and yearly, thereafter, all coding staff shall complete the training and education necessary to maintain up-to-date coding compliance as required by government and insurance regulations. This includes:

   1. Carrier Updates
   2. Compliance & Fraud Alerts
   3. HCFA directives
   4. OIG Bulletins and Informative documents

   The above updates, alerts, directives and bulletins will be maintained and available for review to all employees of the YOUR PRACTICE NAME. Distribution of these resources will be documented.

b. **Encounter forms and Clinical Forms:** The creation and maintenance of encounter forms, registration forms, history and physical forms and shall be done annually or more often, as necessary.

c. **Coding Responsibilities:** All coders shall demonstrate billing competency with minimal rate of errors. Continued above average or repetitive error rates will require additional education or termination as deemed necessary.
d. **Correct Coding Initiatives:** The CCI Edits will be used to implement correct coding skills and to determine bundled services for billing purposes.

e. **Communication:** All coders shall demonstrate an ability to communicate with patients regarding the coding and billing of services provided by the YOUR PRACTICE NAME.

f. **General Marketing and Patient Quality of Care:** Strict adherence to the Code of Conduct and policies and procedures as outlined in the employment manual and the compliance plan for the YOUR PRACTICE NAME are required and monitored by the Compliance Officer.

C. **Risk Areas**

Risk areas for coding and billing will be monitored and reviewed annually by the Compliance Officer. The following risk areas are identified for the YOUR PRACTICE NAME: 1) Coding and Billing; 2) Reasonable and Medically Necessary Services; 3) Documentation Requirement of the Medical Record and the HCFA 1500 Claim Form; 4) Kickbacks, Inducements and Self-Referrals.

1. **Coding and Billing:**
   
   Current reimbursement principles as outlined in the CPT and ICD books, as well as, federal, state or private payer health care programs shall be used to ensure proper coding and billing standards are met. Medical record documentation shall reflect medical necessity for services provided with particular attention to diagnosis and an appropriate level of coding reflected for evaluation and management services. Rejected claims shall be reviewed against procedure and diagnosis to facilitate a reduction in billing errors. The following risk areas are identified:

   a. Billing for services or items not rendered or not provided.

   b. Submission of claims for medical supplies and services that are not deemed reasonable and necessary.

   c. Submission of claims for medical supplies and services that are not deemed reasonable and necessary.
d. Duplicate billing.
e. Submitting claims for non-covered services, as if covered.
f. Willful misuse of provider identification numbers, resulting in improper billing.
g. Billing for unbundled services.
h. Failure to use coding modifiers.
i. Up-coding the level of service provided.

2. Reasonable and Medically Necessary Services:

Only claims for services and treatment believed to be reasonable and medical necessary shall be submitted for payment. Appropriate documentation shall be maintained in the medical record to support the appropriateness of services and treatment provided.

3. Documentation:

a. Medical Record documentation will verify and precisely reflect the services provided to each patient. It will be used to validate: a) the site of service; b) the appropriateness of the services provided; and c) the accuracy of the billing. The following minimum principles will be complied with:

- The medical record shall be complete and legible.

- The medical record shall document the date and reason for the encounter, any relevant history, examination with findings, prior diagnostic test results, assessment, clinical impression and/or diagnosis, plan of care and legible identity of the observer.

- The rationale for ordering diagnostic and/or other ancillary services shall be documented or easily inferred by an independent reviewer or third party.
Past and present diagnoses shall be accessible to the treating and/or consulting physician.

- Appropriate risk factors shall be identified. The patient’s progress, his or her response to and any changes in treatment and any revision in diagnosis shall be documented.

b. The HCFA 1500 Claim Form will be monitored to assure proper completion with particular review to the following areas:

- The diagnosis code is linked to the examination and record of personal history obtained.
- The most appropriate diagnosis code is linked to the procedure performed.
- Modifiers are used appropriately.
- The claim form accurately reflects information provided by the patient regarding all insurance coverage policies held and filing requirements.

4. Kickbacks, Inducements and Self-Referrals

The YOUR PRACTICE NAME shall receive no remuneration for referrals in compliance with the anti-kickback statute and the physician self-referral law. In addition, waiving of coinsurance, co-pay or deductibles without a good faith determination of patient financial hardship is strictly prohibited. All financial hardship cases shall meet the criteria established by the YOUR PRACTICE NAME for economic hardship.

D. Retention of Records

The Compliance Officer assigned by the YOUR PRACTICE NAME shall maintain an updated record of compliance-related activities, included, but not limited to: compliance meetings, educational activities and attendance, internal audit results, documenting violations and resulting remedial action.
Retention of medical records shall meet Federal and State regulatory requirements and shall include the following types of documents:

- All records and documents required for participation in Federal, State and private payer health care programs.

- All records generated by the YOUR PRACTICE NAME and used for purposes of tracking charges, payments and insurance claims filing.

- All records maintained for the express purpose of demonstrating and tracking efforts to maintain the integrity of the compliance process.

- All carrier-updates, manuals, books, inquiries and responses from carriers and educational seminars conducted and/or attended.

Records shall be retained for a period of time as specified by Federal and State statutes. The confidentiality of the records will be maintained at all times and efforts to insure against loss, destruction, unauthorized access, unauthorized reproduction, corruption or damage shall be undertaken.

In the event the practice is sold or closed, copies of the medical record will be made available at the request of patients, transferred to the physician of their choice or maintained by the physician purchasing the medical practice.

III. COMPLIANCE OFFICER

The YOUR PRACTICE NAME has designated the Administrator as the Compliance Officer. The Compliance Office will assign compliance functions and duties to designated employees to assist in the responsibilities of the compliance plan. The primary responsibilities of the Compliance Officer include the following:

- Overseeing and monitoring the implementation of the compliance program.

- Performing periodic audits to monitor and improve the practice’s efficiency and quality of services and to reduce the practice’s vulnerability to fraud and abuse.
• Periodically revising the compliance program in light of changes in the needs of the practice or changes in the law and in the policies and procedures of Government and private payer health plans.

• Developing, coordinating and participating in training programs that focus on the elements of the compliance program and assure appropriate and accurate training materials.

• Ensuring that the HHS-OIG’s list of Excluded Individuals and Entities and the General Services Administration’s List of Parties Debarred from Federal Programs have been checked with respect to all employees, medical staff and independent contractors.

• Ensuring that employees and physicians know, and comply with, pertinent Federal and State statutes, regulations and standards.

• Investigating any report or allegation concerning possible unethical or improper business practices and monitoring subsequent corrective action and/or compliance.

IV. STAFF TRAINING AND EDUCATION

Staff training and education shall be provided by the YOUR PRACTICE NAME on a continuing basis for all coding and billing personnel. This shall be accomplished through in-service training, updates provided by carriers, seminars and teleconferences. Coding and billing training shall include the follow key areas:

• Coding requirements

• Claim development and submission processes

• Marketing practices that reflect current legal and program standards

• The ramification of submitting a claim for physician services when rendered by a non-physician
• Signing a form for a physician without the physician's authorization

• Proper documentation of services rendered

• How to report misconduct

• Proper billing standards and procedures and submission of accurate bills for services or items rendered to Federal health care program beneficiaries

• The personal obligation of each person involved in the billing process to ensure claims are properly and accurately submitted

• The legal sanctions for submitting deliberately false or reckless billings

• Informing physicians that they cannot receive payment or any type of incentive to induce referrals and that claims should not be submitted for physician services when those services are rendered by a non-physician (unless they follow the applicable Federal health care program requirements, e.g., “incident to” rules).

In addition to the billing and coding training, YOUR PRACTICE NAME will provide up-to-date CPT and ICD-9 Manuals.

Continuing education shall be provided as needed but no less than annually for experienced employees. New employees will receive training during the first three months of their employment under an experienced employee.

V. AUDITING AND MONITORING

An on-going evaluation process to evaluate the effectiveness of the compliance plan and accuracy of the practice’s standards and procedures is implemented by the YOUR PRACTICE NAME. This self-audit will include the following:

• Billing and coding accuracy to reflect the services provided

• Services and items provided are reasonable and necessary

• No incentives for unnecessary services exist
• Sufficient documentation in the medical records to support the charge

A random selection of charts shall be reviewed annually to insure the above measures have been followed. If problems are identified, a focused review will be conducted on a more frequent basis. If audit results reveal areas needing additional information or education of employees and physicians, these areas will be incorporated into the on-going training and educational process. This action shall be undertaken within sixty days from the date the original problem is identified.

VI. COMMUNICATION

An “open door” policy of communication is adopted by the YOUR PRACTICE NAME to assure compliance standards have been met. This shall include the following:

• The requirement that employees report conduct that a reasonable person would, in good faith, believe to be fraudulent or erroneous

• An anonymous letter to the compliance office for effective reporting of fraudulent or erroneous conduct

• Provisions in the employee policies and procedures manual that state a failure to report fraudulent or erroneous conduct is a violation of the compliance program

• Assurance of confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation

• Assurance of no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be fraudulent or erroneous

VII. ENFORCEMENT OF COMPLIANCE STANDARDS

Violations of the YOUR PRACTICE NAME Compliance Plan will result in disciplinary actions. These actions may include: warnings (oral); reprimands (written); probation; demotion; temporary suspension; discharge of employment; restitution of
damages; and referral for criminal prosecution. Non-compliant conduct will be documented in the employee record with the follow-up action taken. The YOUR PRACTICE NAME will conduct checks to make sure all current and potential practice employees are not listed on the OIG or GSA list of individuals excluded from participation in Federal health care of Government procurement programs.

VIII. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION INITIATIVES

Upon receipt of reports or reasonable indications of suspected noncompliance, the compliance officer shall investigate the allegations to determine whether a material violation of applicable law or the requirements of the compliance program has occurred. If so, decisive steps to correct the problem will be taken, including the return of any overpayments, a report to the Government and/or law enforcement authorities and corrective measures to insure no further violation occurs.

Prompt identification of any overpayment shall be made within sixty days and returned to the affected payer.

It is recognized that any violation that has occurred and was not immediately detected may require modification of the compliance plan. A periodic review on an annual basis to review and modify this compliance program shall be undertaken to identify any flaws.
The undersigned hereby acknowledges receipt of the documentation of YOUR PRACTICE NAME Compliance Program including the Compliance Program Manual, the Personnel Policy Manual, and the OSHA Manuals. The undersigned has read and understands the policies and rule and agrees to follow all the policies and procedures set forth in this manual. Failure to comply with the policies of Pinnacle Family Medicine, PA could result in disciplinary action including termination.

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