AVOW CARE SERVICES CORPORATE COMPLIANCE

AND ETHICS PLAN

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1095 Whippoorwill Lane, Naples, FL 34105 / TEL 239.261.4404 / FAX 239.262.2429 / www.avowcares.org

Letter to our employees:

Avow enjoys a reputation of integrity and excellence in patient care and service to our community. This reputation is one of our greatest assets as we fulfil our mission to create peace of mind by providing compassionate care and support to those who need us. Everything we are able to achieve depends on the trust our patients and professional associates place with us. The Code of Conduct (the Code) sets the basic principles we must follow to earn and maintain that trust.

Avow expects that all individuals conduct themselves with integrity and in conformance with legal requirements, as well as the organization's policies and procedures. The Code provides our employees, contracted providers, anyone Avow conducts business with and the public with a formal statement of Avow's commitment to the standards and rules of ethical conduct. To ensure that the Code is followed throughout our operations, we have also created a Corporate Compliance Program (the "Compliance Program.)

Please review carefully the materials that follow which outline the Avow Code and the Avow Compliance Program. Included in each section of the Code is a description of Avows' standards of conduct. These standards are minimum requirements. We anticipate that the conduct of the majority of our employees and agents will exceed these minimum standards. Employees are encouraged to ask for guidance when they question whether their activities comply with the ethical and legal requirements.

It is important to remember that we all share the responsibility for assuring ethical behavior in our endeavors. The mere existence of a Corporate Compliance program is not sufficient to withstand federal scrutiny or, more importantly, what our intent for compliance is at Avow. Instead, our licensed health care professionals and all staff and volunteers must demonstrate an ongoing commitment to compliance through a vigilant adherence to the program's standards.

Thank you for all you do to serve our community, clients, and colleagues. You make a difference in the lives of others every day. Please always remember that compliance equals exceptional patient care.

Jaysen F. Roa
President & Chief Executive Officer

Kerri A. Ervin
Chief Compliance Officer

Avow Mission, Vision & Values

Mission

- We create peace of mind by providing compassionate care and support to those who need us.

Vision

- To be our community's choice for support through life's transitions

Values

- Innovation
- Integrity
- Collaboration
- Celebration
- Education

BOARD RESOLUTION AND MESSAGE OF PURPOSE

The Avow Board of Directors authorizes the Corporate Compliance program to detect, prevent, and correct any potential violations of law or regulation. In particular, the Corporate Compliance program will respond to the areas of concern outlined in the Office of the Inspector General's Compliance Program Guidance Individual and Small Group Physician Practices. https://oig.hhs.gov/authorities/docs/physician.pdf

The Board of Directors resolves to allocate sufficient financial resources and personnel resources to ensure the effectiveness of the Corporate Compliance program.

Code of Conduct

Introduction

It is the policy of Avow Care Services that all individuals associated with the practice conduct themselves in an ethical manner and in conformance with all federal and state laws and the policies and procedures of the Employer. To this end, Avow Care Services' Code and Compliance Program have been prepared to provide employees, as well as those with whom Avow Care Services does business and the general public, with a formal statement of commitment to the rules of ethical conduct as spelled out in this Code. [1]

It is imperative that all Avow Care Services' personnel comply with the standards contained in the Code, immediately report any alleged violations thereof to the Compliance Officer and/or Compliance Contact, and assist in investigating any allegations of wrongdoing, to the Compliance Program. It is our policy to prevent the occurrence of unethical or unlawful behavior, to halt such behavior as soon as reasonably possible after its discovery, and to discipline personnel who violate the standards contained in the Code and the Compliance Program.

[1] *See Attachment B "Code of Conduct"*

No code of conduct can cover all circumstances or anticipate every situation. Therefore, should an employee encounter a situation which is not addressed specifically by the Code, he or she should apply the overall philosophy and concepts of the Code to that particular situation, and observe the ethical standards of honorable people everywhere. In addition, Avow Care Services' Compliance Program contains more detailed standards and guidelines which are also applicable. Appendix A is attached to the Compliance Program and contains compliance guidelines specific to the health care industry with which you may need to become familiar.

Ethics

Avow Care Services' policy is to obey the law. Personnel are encouraged to report all that they are doing to achieve their goals, to record all transactions accurately in their books and records, and to be honest and forthcoming with auditors. We require that all employees conduct themselves in an honest and ethical manner, including honest bookkeeping, honest budget proposals, and honest economic evaluation of projects in all aspects of an employee's work. [2]

Conflict of Interest

Avow employees must avoid situations in which their personal interests could conflict, or reasonably appear to conflict, with the interests of Avow. A conflict of interest could exist in any opportunity for personal gain, apart from the normal compensation provided through employment or payment for services rendered.

Dealing with Suppliers and Customers

Conducting business with suppliers and referring providers may pose ethical or even legal problems. The following guidelines are intended to help all personnel to make the proper "ethical" decision.

"Kickbacks" and Rebates

Employees (or their families) may not receive personal kickbacks or rebates in exchange for the purchase or sale of goods or services. "Kickbacks or rebates" can take many forms and are not limited to direct cash payments or credits. In general, if you or your family stand to gain personally through the transaction, it is prohibited. Such practices are not only unethical but are in many cases illegal.

Gifts or Gratuities

Employees may not under any circumstances accept gifts of money nor may they solicit non-monetary gifts, gratuities, or any other personal benefit of any kind from suppliers or patients. Employees may accept unsolicited, non-monetary gifts from a firm or individual doing, or seeking to do, business with us only if the gift is of nominal value, or the gift is primarily of an advertising/promotional nature.

Entertainment

[2] *See Attachment B "Code of Ethics"*

Personnel may not encourage or solicit entertainment from any individual with whom Avow Care Services does business. From time to time, employees may offer or accept entertainment, but only if the entertainment is reasonable, occurs infrequently, and does not involve lavish expenditures.

Overcharging

Insurers and patients shall not be charged for more expensive services or equipment than that actually provided. Examples of overcharging include:

- Billing for more complex or sophisticated (and thus more expensive) services or equipment than actually provided (upcoding);
- Billing for services or individual pieces of equipment customarily provided as part of a package or kit, thereby increasing costs (unbundling);
- Billing two insurers, such as Medicaid and a private insurer, for the same services or equipment; and
- Waiving a patient's co-payment without informing the Government so that the Government believes that our charges are higher than they actually are.

Books and Records

1. Falsification of Records

Federal law requires us to ensure that our books and records accurately reflect the true nature of the transactions represented. It is against our policy for any employee to cause our books and records to be inaccurate.

Examples of false or artificial record entries include the following:

a) Making the records appear as though medical services or equipment was provided to a patient when in fact no such equipment or services was ever provided to that patient;
b) Making the records appear as though one type of medical service or equipment was provided to a patient when in fact a different type of medical service or equipment was provided to the patient;
c) Making the records appear as though a medical service or equipment was provided to one person when, in fact, it was provided to another;
d) Making the records appear as though a medical service or equipment was provided to a patient on a certain date when, in fact, the service or equipment actually was provided on a later date; and
e) The creation of any other records which do not reflect the true nature of the transaction.

Any employee who knows or should know that he or she is making false or artificial record entries shall be subject to disciplinary action, including possible termination.

Employee Relations

Avow Care Services provides equal employment opportunities to individuals who are qualified to perform job requirements, regardless of their race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). There are laws which prohibit discrimination against minorities, sexual harassment, and similar misconduct. Regardless of any legal prohibition, every employee has a right to work in an environment free of harassment or discrimination

based upon race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). All employees shall treat each other with courtesy and fairness and have respect for the dignity of others.

Reports of Wrongdoing

Employee Reporting of Violations

Each employee has a duty to report any suspected violation of the Avow Code of Conduct. If any employee reasonably suspects that any employee, contractor, or agent is involved in any sort of criminal wrongdoing, or has or is violating the guidelines or policies contained in the Code, that employee should immediately report those suspicions directly to the Compliance Officer or Compliance Contact. In the event that an employee feels that a report has been given inadequate attention by the Compliance Officer and/or appropriate Compliance Contact the employee may report to the President/CEO and/or the Board.

Reports of violations by employees may be made without fear of retaliation.

Compliance Program

Introduction

The physicians and employees with Avow Care Services have always been committed to high standards of ethics and integrity. As part of our commitment to integrity, to help us meet the challenges of today's health care environment, and to help our employees to be fully informed so that they do not inadvertently engage in conduct that may raise compliance issues, we have implemented a compliance program. By developing and implementing internal controls and procedures that promote adherence to statutes and regulations applicable to Federal and State health care programs and private insurance program requirements, we can better protect our practice from the potential for fraudulent or erroneous conduct. We recognize our duty to ensure that the claims submitted to Medicare, Medicaid, and any other Federal health care programs are true and accurate to the best of our ability. It is important for all our employees to be aware that Avow Care Services is committed to billing only for services that are actually rendered, coding accurately, documenting medical necessity and appropriateness, and adhering to all payer contracts.

"Ethical conduct" means doing the right thing right.

Benefits of a Compliance Program

The benefits of an effective compliance program include:

- The development of effective internal procedures to ensure compliance with regulations, payment policies and coding rules;
- Improved medical record documentation;
- Improved education for our employees;
- Reduction in the denial of claims;
- More streamlined practice operations through better communication and more comprehensive policies;

- The avoidance of potential liability arising from noncompliance; and reduced exposure to penalties.

The purpose of this program is to provide a formal set of practice policies and procedures that require ethical and lawful conduct by all employees of Avow Care Services. It is the intent of this practice to fully comply with guidelines for the documentation of medically necessary services and prevent claims, to any third party payer, for which proper documentation does not exist. It is also the intention of this policy to provide a mechanism in which employees may effectively communicate, without fear of retaliation, problems with our documentation processes and compliance.

Our "Seven Elements of Compliance" can be outlined as follows:

A commitment to compliance: Each physician and employee of the practice commits to understand the importance of proper documentation in the preparation of claims for medically necessary services to our patients. Further, each person will take personal responsibility for his/her own actions in compliance with the documentation of claims and will report to the designated compliance officer any problems, known or suspected, concerning a lack of proper documentation.

Designated: The Compliance Officer (CO) is designated as the compliance officer; the Director of Patient Accounts is designated as the compliance contact for the practice. Any questions or comments concerning any aspect of this policy, our claims submission processes, billing practices or handling of medical records should be directed to them.

Training and education programs: The practice will offer each employee and physician in-service training and education programs concerning various aspects of compliance with our policies and relevant rules, and guidelines of various third party payers.

Internal auditing and monitoring: We should regularly review our claims development and submission process, from the point of initiating a service for a patient to the submission of the claim for the service. The reviews should be conducted no less than annually and more often as needed. The results of a review may form the basis for identifying training and education needs among staff and physicians. The results of the internal audits and monitoring shall be maintained by the CO.

Maintaining open lines of communications: An environment of open dialogue between all members of the practice shall be maintained. It is the responsibility of the CO to provide information about compliance standards including the results of internal audits to the affected parties. It is the responsibility of each individual to ask questions when they have them and voice complaints or concerns regarding compliance as well. Each person is encouraged to adopt this responsibility, with the knowledge that it is invited and welcomed, in our efforts to fully comply with applicable laws and rules. No person shall be subject to disciplinary actions for complying with this policy.

Internal investigation and enforcement: When an individual is found to have a deficiency in regard to compliance, our primary goal is to provide education and training opportunities. If the non-compliance is deemed to be willful or intentional, the conduct falls within our general guidelines for disciplinary action which could include suspension and/or termination.

Responding to compliance offenses: The CO shall be responsible for initiating a response, either educational or disciplinary, as part of a corrective action to help maintain our commitment to compliance.

While we recognize that mistakes will occur, you have an affirmative, ethical duty to come forward and report erroneous or suspected fraudulent conduct, so that it may be corrected.

Responsibility for the Program

Our Compliance Program is a formal, ongoing program by which we seek to ensure that all appropriate individuals within the practice understand and follow all applicable legal requirements, especially as these relate to professional billing. Primary responsibility for implementing and managing the Program will be assigned to the CO. The Board of Directors has leadership and oversite responsibility for the Program.

Every assignment of responsibility and authority in the Compliance Program is significant. No oral delegation of responsibility or authority should be undertaken.

The Compliance Officer will, with the oversight of the President/CEO, and the Board, perform the following activities:

1. Oversee and monitor the implementation of the Compliance Program.

2. Establish methods, such as periodic audits, to improve the practice's efficiency and quality of services, and to reduce the practice's vulnerability to fraud and abuse.

3. Assist in the review, revision, and formulation of appropriate policies to guide the billing of our professional fees.

4. Assist in the review, revision, and formulation of appropriate policies to ensure compliance with regulatory requirements outside of the area of professional fee billing.

5. Develop methods to ensure that Avow Care Services employees are aware of the Code of Conduct and Compliance Program and understand the importance of compliance.

6. Develop policies to ensure all employees who are hired are fit for the particular position for which they have applied.

7. Ensure that the Health and Human Services (HHS) -Office of Inspector General's (OIG's) List of Excluded Individuals and Entities (http://exclusions.oig.hhs.gov/) has been checked with respect to all employees, medical staff, and independent contractors prior to hire and routinely thereafter.

8. Develop, coordinate and participate in training programs that focus on the elements of our Compliance Program.

9. Review and approve compliance program training materials and programs to ensure they are appropriate.

10. Ensure and document that all new employees receive training with regard to our Compliance Program and proper billing.

11. Assist in developing a procedure to ensure that all billing questions are answered whether from our clinical staff or questions directed to us from our billing department.

12. Review any inquiries regarding billing, or reports of non-compliance that are referred, determine if a compliance issue exists and, if so, develop an appropriate response.

13. Develop and maintain appropriate records of the Program and compliance activities.

14. Develop appropriate corrective action plans to address compliance issues and monitor their effectiveness. Work closely with the billing department to quickly resolve and correct any issues they have brought to our attention.

15. The Compliance Officer will report to and be guided by the President/CEO and the Governing Body.

Board Compliance Oversight Committee

The Board of Directors has established the Compliance Oversight Committee (COC), as a Committee of the Board to directly exercise the Board's oversight of compliance and ethics.

The COC, in the exercise of their oversight responsibility, shall routinely:

- Receive reports from the Compliance Officer (CO) regarding compliance risk, audits, investigations, performance improvement, and quality management;
- Allow the CO to timely present and candidly discuss compliance issues;
- Permit the invocation and preservation of the attorney-client and attorney work product privileges, when appropriate;
- Treat all matters as confidential, especially those which are initially unverified or in the early stages of investigation;
- Annually assess and recommend Board action regarding the sufficiency of funding and support for the Compliance and Ethics Program, including internal and external compliance audit activities;
- Submit quarterly (and as needed) written reports to the Board summarizing compliance and ethics issues and programs;
- Utilize staff in the Compliance Department for administrative assistance in carrying out COC responsibilities.

The COC shall recommend action(s) to the Board of Directors which the COC considers necessary to:

- Develop, implement, maintain, modify, and annually review the Avow Compliance and Ethics Program document;
- Design and implement an effective compliance and ethics program, including monitoring and auditing to collect data sufficient to prevent, detect, report, and eliminate error, waste, abuse, or fraud;

- Develop and implement an effective compliance complaint reporting process;
- Timely respond to compliance complaints, report and return identified overpayments, and self-report internally investigated confirmed violations;
- Implement necessary systemic changes to prevent, detect, report, and eliminate identified error, waste, abuse, and fraud; and
- Align compliance and quality initiatives

Responding to Government Inquiries

Avow Care Services may receive inquiries from government agencies and departments. These inquiries may take the form of letters, telephone calls or personal visits. Avow Care Services will comply with all applicable laws and cooperate with any reasonable request for information from federal, state and local authorities. However, in doing so, it is important to protect the legal rights of Avow Care Services and its employees and agents.

All unusual requests for information from any government branch, agency or department must be forwarded to the CO, who may, where appropriate, consult with legal counsel concerning the request. It is the policy of Avow Care Services to cooperate with government investigations, but it is in the practice's and its employees' best interests to involve legal counsel in this cooperation. If the government is conducting an investigation of certain matters, and investigators wish to interview individuals in connection with the investigation, all employees have certain rights and obligations in connection with such an interview.

Employees may deal directly with government investigators without legal counsel; however, Avow Care Services believes that it is in the employee's best interest to confer with legal counsel prior to doing so. It is also the right of all employees to be interviewed or not to be interviewed by government investigators. However, should an individual choose to be interviewed, she/he must be truthful. If you are contacted by a government official:

- The investigator has the right to contact you and request to speak with you.
- You have the right to choose whether or not to speak with any investigator. In all situations you have the right to consult with legal counsel before you decide whether or not to talk to the investigator.
- The government investigator does not have the right to insist upon an interview, and it is improper for him or her to pressure you in an attempt to obtain an interview.
- If you decide to refuse an interview, you should politely but firmly decline the investigator's request.
- Since you are not required to submit to an interview, if you decide that you are willing to submit to one, you have the right to insist upon any precondition you desire. For example, you may require that the interview be conducted only in the presence of legal counsel. Avow will pay for the cost of an attorney to represent you.
- Regardless of your decision, if you are contacted by a government investigator it is extremely helpful if you immediately contact your supervisor or Compliance Officer as you have every right to tell us about the government contacting you. The agent may request or suggest that you keep the contact confidential, but there is no law that would prevent you from disclosing any detail of your discussion with the agent.
- You may wonder what we would really prefer. The answer is that the decision is truly yours. However, we would strongly encourage you to conduct the interview in the presence of legal counsel.
- Under all circumstances, remember that you must tell the truth to government agents. Failure to do so may, in and of itself, be a violation of the law.
- Lastly, do not destroy any documents or attempt to hide evidence.

No employee shall accept service of a subpoena, search warrant, garnishment, summons or other legal process without prior approval. Please refer to our separate HIPAA policies for the requirements for responding to a subpoena requesting patient identifiable information.

Open Lines of Communication and Reporting Compliance Issues

Every employee is expected to report any activity he or she reasonably believes is in violation of the law, ethical standards, or the policies of Avow Care Services. The employee need not be certain the violation has occurred to report it. Reporting enables the Company to investigate potential problems quickly and to take prompt action to resolve them.

Employees who report possible compliance issues in good faith should not be subjected to retaliation or harassment as a result of the report. Concerns about possible retaliation or harassment should be reported to the President/CEO or the Board.

If you have questions or concerns about an activity which you either know or suspect is illegal, immoral, unethical, or in violation of Avow Care Services policies, you should:

- **Avail yourself of our "open door" policy**. You can take advantage of the open lines of communication between the physicians and compliance personnel. If you are unsure of who to go to, and you are unable or uncomfortable talking to your supervisor, you may go to the CO.

- **Use the confidential Hotline**. You are encouraged to give your name to assist in investigating your report. However, if you remain anonymous, you will be assigned a secret identification number or password so you can receive information on the status of your report. All reports to the Hotline will be documented and reported to the CO for review and referral or investigation if necessary. The Compliance Hotline number is 1-855-348-4998. The Compliance Hotline website is: www.avow.ethicspoint.com.

- **Contact the Compliance Officer**. If you choose, you may contact the Compliance Officer:
  - By telephone at: 239-280-2260
  - By cell phone at: 239-771-0518
  - By website at: www.avow.ethicspoint.com
  - By Navex Global at: 855-348-4998

- **Contact the Compliance Contact.** The Director of Patient Accounts shares the responsibility of monitoring our Compliance Program. You may contact this employee:
  - By telephone at: 239-430-3475

Section 1557 Policy Guidelines

It is the policy of Avow Care Services to provide equal access to individuals regardless of their race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). We will not discriminate based on any of these factors and have, therefore, implemented the Non-Discrimination, Language Access Plan, and Individuals with Limited English Proficiency policies. Interpretation and Assistive Aids Services Policy

It is also our policy that all claims submitted for reimbursement use the proper code for the service provided, that the documentation in the medical record supports the code, that the actual place of service is used, and that the claim is submitted in the name of the appropriate provider. To guide us in meeting this objective, the CO shall, with the assistance of legal counsel if necessary, review existing policies, revise those as necessary, and develop any additional policies that seem advisable. These policies may be changed periodically.

Using the list of potential risk areas developed by the OIG we have conducted an assessment to determine the risk areas where our practice may be vulnerable. The policies included here have been derived from the risk areas we have identified as topics which may affect our practice. All employees must be aware of the risks associated with the operations of a medical practice and are encouraged to bring any additional areas of concern to our attention.

Non-Discrimination Policy

Avow Care Services provides equal access to healthcare to all individuals regardless of race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history) . Employees shall treat all patients with courtesy and fairness and have respect for the dignity of others. All employees will be trained on the practice's non-discrimination policies. If at any time an employee is unsure how to handle a particular patient situation due to the patient's race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history) the employee should contact Compliance Officer (CO) immediately for appropriate guidance. The CO will serve as the Civil Rights Coordinator[3] to ensure compliance with the practice's non-discrimination policies. The Civil Rights Coordinator will investigate all grievances made. ACS Non-Discrimination Policy and Grievance Procedure

Grievance Policy

It is the policy of Avow Care Services not to discriminate on the basis of race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). Avow Care Services has adopted an internal grievance procedure[4] providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Compliance Officer. The Civil Rights Coordinator can be contacted by any of the following means:

- By telephone at: 239-261-4404 or 239-280-2260
- By cell phone at: 239-771-0518
- In person by scheduling a meeting with the Section 1557 Coordinator at:
  1095 Whippoorwill Lane
  Naples, FL 34105

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, gender identity, sexual orientation, age or disability may file a grievance under this procedure. Avow Care

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[3] *Position required by Section 1557 of the Affordable Care Act (42 U.S.C. 18116)*

[4] *See Appendix D Grievance Procedure*

Services will not retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Statement of Non-Discrimination

We are required to post a notice of individual's rights providing information about communication assistance for individuals with limited English proficiency, among other information. This notice must be available in the top 15 non-English languages spoken by individuals with limited English proficiency in our state.[4] For small sized significant communications such as postcards, we must include taglines in the top two non-English languages spoken by individuals with limited English proficiency in our state.[5]

Individuals with Limited English Proficiency

Avow Care Services will provide meaningful access to individuals with limited English proficiency. An individual with limited English proficiency is someone whose primary language is not English and has limited ability to read, write, speak or understand English. This includes the hearing and visually impaired (see policy below on Individuals with Disabilities). Avow Care Services will offer the patient an interpreter to assist in oral communications between the provider and the patient as well as utilize a translator for written, electronic or paper communications.

We may use a qualified bilingual/multilingual staff member who is designated by the practice to provide oral language assistance as part of their current job responsibilities and who has demonstrated that they are proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and is able to effectively, accurately and impartially communicate directly with individuals with limited English proficiency in their primary languages. In the event that there is not a qualified bilingual/multilingual staff member available, we will engage a qualified interpreter.

Definitions

A **qualified interpreter** for an individual with limited English proficiency means an interpreter who via a remote interpreting service or onsite appearance, adheres to generally accepted interpreter ethics principles, including client confidentiality; has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language and is able to interpret effectively, accurately, and impartially, both receptively and expressly to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

A **qualified translator** is a translator who adheres to generally accepted translator ethics principles, including client confidentiality; has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

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[4] See Appendix A for Notice of Non-Discrimination.

[5] See Appendix A for Statement of Non-Discrimination.

Procedures

Staff should be able to offer or inquire whether or not a patient would like an interpreter at all stages of the patient care process. This may include at check-in/registration, telephone conversation with a prospective patient while making an initial appointment, or during the encounter. When the need for an interpreter is identified, the interpreter must be provided in a timely manner.

To be in compliance with The Affordable Care Act as it applies to patients with limited English proficiency, we may not:

- Require an individual to provide their own interpreter
- Rely on an adult accompanying the patient to interpret, except in cases of emergency where no other interpreter is immediately available, or when the patient specifically requests that the adult facilitate communication by interpreting, the adult agrees to provide the assistance, and it is otherwise appropriate under the circumstances
- Rely on a minor child to interpret for the patient, except in cases of emergency
- Rely on staff members who are not otherwise qualified as bilingual or multilingual to interpret
- Rely on staff members who are not otherwise qualified as sign language interpreters

Patients who need an interpreter are not required to accept the interpreter that is offered by the organization. For patients who refuse to use the interpreter offered to them it will be documented in the record that the patient was offered and refused the interpreter services.

Individuals with Disabilities

We are required to take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others. We must provide appropriate auxiliary aids and services, such as alternate formats and sign language interpreters, where necessary for effective communication. We will post a notice of the individual's right to communication assistance. We will make all programs and activities provided through electronic and information technology accessible to individuals with disabilities, unless doing so would impose undue financial or administrative burdens or would result in a fundamental alteration in the nature of the program or activity. We do not use marketing practices that discriminate on the basis of disability.

A qualified interpreter for an individual with a disability is one who adheres to generally accepted interpreter ethics principles, including client confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

Refer to our Interpretation and Assistive Aids Services Policy for additional instructions.

Language Access Plan

The most common non-English language of our patient population is:

1. Spanish

In addition to the spoken language, we also have patients who are hearing impaired and visually impaired.

To help ensure that Avow Care Services staff are aware and sufficiently trained to recognize and accommodate patients with limited English proficiency, at a minimum, the following positions should have some training on our Language Access Plan: front desk, billing department and providers.

We will have the following documents translated as part of our Access Plan for our patients with limited English proficiency:

- New patient paper work
- Notice of Privacy Practices
- Informed consent
- Authorizations and assignment of benefits
- Financial Policy

These documents will be available in English and Spanish. If we implement other documents which we would consider significant (such as forms that are given to all patients), we will have these translated at that time.

When we employ bilingual staff who have demonstrated their fluency in both English and Spanish who also express an interest in serving as a translator, we may offer them medical interpreter duties as part of their job description. For these individuals, unless they had their medical or clinical training in the non-English language for which they would interpret, some formal medical interpreter training should be acquired.

When a translation service or an auxiliary aid or service is requested by a patient, or the need for this service is identified, we will make the appropriate arrangements based on our Interpretation and Assistive Aids Services Policy . When we identify the apparent need for translation and the patient refuses the service offered, we will document in the medical record the patient's refusal of an Avow interpreter.

Coding and Billing

Avow Care Services policies concerning billing are an integral part of this Program.

- It is our policy to bill only for professional services and items actually provided. Examples of improper billing include: when a provider bills Medicare or any other 3rd party payer for a treatment or procedures when no such service was actually performed, such as Evaluation & Management services that were not performed. When in doubt about how to bill a particular service, including the proper code to use, no claim should be submitted until appropriate guidance is obtained.

- Claims for equipment, medical supplies and services provided will be supported by the patient's documented medical condition. Claims should never be submitted that are known to contain inaccurate information concerning the service provided, the charges, the identity of the provider, the date of service, the place of service, or the identity of the patient. All diagnosis codes submitted on a claim will be supported by medical record documentation. We do not submit a diagnosis code that does not accurately reflect the reason for the service "just to get the claim paid." Payments that are received in error will be refunded.

- Duplicative billing occurs when the provider bills for the same item or service more than once or when another party bills a Federal health care program for an item or service also billed by the other provider. For example, a provider might bill two insurers, such as Medicare and a private insurer, for the same

treatment with the intent to be paid in full by both. Proper care must be taken to avoid duplicate billing and to promptly return overpayments.

- Items or services which we know to be non-covered by Medicare, Medicaid or other health programs are not to be billed as if they are covered, unless a denial is needed to submit a claim to a secondary insurance plan. Example: A "routine" visit when medical necessity is not supported.

- The physician's or nonphysician practitioner's provider number is confidential and shall only be shared with those with an operational need to know. There may be a public data base to find a provider's NPI, but the actual Medicare, Medicaid, or other payer identifier is to be protected from misuse by others with malicious intent.

- Billing for multiple components of a service that must be included in a single fee (unbundling) is not allowed. "Unbundling" occurs when a physician or other practitioner bills for separate services which the payer routinely combines into a single procedure and a single payment. In many cases, however, the individual aspects of a global service can, if listed separately, create a larger payment than if the services were "bundled" and reported with one HCPCS code. It is for this reason that Medicare and other payers forbid the unbundling of services in those cases in which a global procedure and fee have been established. While occasional unbundling may be an isolated mistake and treated as such by investigators, routine unbundling is considered to be fraudulent activity justifying harsh penalties. Below is a common example of unbundling.

  a. CPT Code -25 modifier: Should only be used when a significant, separately identifiable evaluation and management service by the same physician is made on the same day as a procedure or other services. The overuse of this modifier is a prime target of Medicare fraud and abuse investigators.

- A modifier, as defined by the CPT-4 manual, provides the means by which we can indicate a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Modifiers are to be used properly.

- "Clustering" is the practice of coding or charging one or two middle level of service codes exclusively. As stated throughout our compliance program documents, codes and charges should always reflect the actual service provided, not an average of the service codes available.

- "Up-coding" is billing for a more expensive service than the one actually performed. Example: billing at a higher level of evaluation and management code than what was actually rendered to the patient or than is medically necessary). Our billing should reflect the proper category and level of service as documented in the patient's medical record.

- It is the responsibility of the billing physician or other health professional to ensure that appropriate documentation supports the medical necessity of the bill being submitted. Staff are to bill only those services that are documented in the patient's medical record. If you have questions about which code is appropriate based on the documentation, always check with the physician or other applicable provider.

- When the physician feels that Medicare may not pay for a particular service, the patient will be provided with an Advanced Beneficiary Notice (ABN) for signature prior to the service being rendered. The ABN will list the service in terms that the Medicare beneficiary is likely to understand and provide the reason it is felt that Medicare may deny payment for the service. We will use the CMS approved ABN form in

place at the time services are to be rendered. A copy of the ABN will be given to the patient for their records. When an ABN is used appropriately, the -GA modifier will be appended to all codes the ABN applies to on the claim submitted to Medicare. We will not routinely give patients an ABN when there is no reason to believe the service could be denied.

- "Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness (Example: administering an injection, drawing blood, follow-up visit by the physician's nurse practitioner or physician assistant). Services performed by someone other than the billing physician for a Medicare beneficiary should meet the following criteria:

    - The services are ones that are commonly provided in an office or physician directed clinic.

    - The services are furnished as an integral, although incidental, part of the physician's professional services in the course of the diagnosis or treatment of an injury or illness. Consequently, the services of a nonphysician practitioner who has seen a new patient may not be billed as 'incident to' the physician. Only follow up visits for established patients being seen for a problem for which the physician has implemented a treatment plan meet the incident to criteria.

    - A valid employment arrangement must exist between the physician/clinic and the employee. The arrangement must provide that the employee is at the physician's direction and control. A nurse practitioner or physician assistant provided by the hospital, at no expense to the physician, does not have a "valid employment arrangement" with the doctor.

    - The supervising physician must be in the office suite at the time services are rendered. "Incident to" is not applicable in the hospital or nursing home, nor in a patient's residence.

- Before assuming a payer follows Medicare Part B "incident to" billing we will make reasonable attempts to the patient's plan for clarification and guidance.

These policies conform to our Code of Conduct and have been developed to help ensure that:

- This office will not charge for services not rendered,
- Documentation of services rendered will be complete and legible,
- Evaluation and Management coding will adhere to established payer guidelines,
- Diagnosis codes reported will be descriptive of the purpose for which a service is performed,
- Modifiers will be used only when justified by the rules, and Medical necessity requirements will be recognized.
- We will validate all coding information by using reputable resources.
- We will not utilize outdated coding resources.
- Medicare, contracted payers, and CPT guidelines will be reviewed on an ongoing basis.

Medical Record Documentation

Timely, accurate and complete documentation is critical to nearly every aspect of a physician practice. Physician documentation is necessary to determine the appropriate medical treatment for the patients and is the basis for coding and billing determinations. It is the policy of Avow Care Services that medical record documentation comply, at a minimum, with the following principles:

- The medical record should be complete and legible. When two practitioners (e.g., physician and ARNP) have both contributed to the service, documentation should be clear as to who provided what portion of the service and each should sign their own unique entry to authenticate the information.

- The documentation of each patient encounter should include, as appropriate, the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and the date and legible signature of the provider of service. The signing provider should be the author of the note.

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred by an independent reviewer or third party. The clinical indication for the service or item should be clearly documented. Past and present diagnoses should be accessible to the treating and/or consulting physician.

- Appropriate health risk factors should be identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis should be documented at each encounter.

- If utilizing documentation templates, only history personally recorded at "today's" encounter and information relevant to the service should be considered in procedure code selection. This is especially important in electronic medical record entries that allow for copy and pasting of a prior encounter's documentation.

- The CPT, HCPCS and ICD-10 codes reported for billing should be supported by documentation in the medical record and the medical chart should contain all required information.

CMS 1500 Form

Proper completion of the CMS 1500 form for submitting claims is an important component of billing professional fees. The following principles are to be adhered to in the completion of CMS 1500 forms:

- The diagnosis code should be supported by documentation of the patient's history and physical examination steps.

- The single most appropriate diagnosis should be linked with the corresponding procedure code.

- Modifiers will be used appropriately.

- Medicare will be provided with all information about a patient's other insurance coverage.

- Forms (Example: superbills/encounter forms, patient registration and history forms) should be reviewed at least annually, and updated as needed, to ensure that accurate and current information is captured for proper completion of the CMS 1500 form.

Kickbacks, Inducements and Self-Referrals

There are a variety of state and federal statutes that govern the business relationships of health care providers such as Avow Care Services. These laws also may prohibit the referral of patients to a health care provider by a physician who has a financial relationship with the provider. The application of these statutes to particular business relationships is often complex.

- Avow Care Services employees responsible for business relationships with persons or organizations outside of Avow Care Services should take steps to ensure that those relationships comply with all applicable legal requirements.

- All business arrangements wherein we refer business to an outside entity should be on a *fair market value* basis.

- Whenever Avow Care Services intends to enter into a business arrangement that involves its making referrals, the arrangement should be reviewed by legal counsel familiar with the applicable state and federal anti-kickback statute and physician self-referral statute.

- Each physician who has a consulting or medical director agreement will abide by the terms of the written agreement and not accept remuneration for services not rendered. The CO should be made aware of all consulting or medical director agreements to help ensure there are no conflicts of interest or other potential issues.

- Prior to waiving a patient's coinsurance, co-pay or deductible, we will expend a reasonable effort to collect the amount, or make a good faith determination that the patient is in financial need.

- Accepting gifts of any kind may influence an employee's independent judgment. Patients, visitors, vendors, contractors, and others may attempt to give you cash as a token of appreciation of your help. While such gestures are often sincere, accepting cash and requesting gifts or gratuities from patients or other sources is strictly prohibited. Gifts of nominal value (example: flowers, candy, ballpoint pens) may be accepted.

- Prior to signing any Home Health Agency plans of treatment (POT) or Certificates of Medical Necessity (CMN) for Durable Medical Equipment, the physician should verify by reviewing the patient's medical record that the information contained in the POT or CMN is accurate.

In general, Avow Care Services' employees shall not enter into any of the following arrangements, regardless of the dollar amount involved, unless the arrangement has been reviewed and passed upon by our legal counsel:

- Any employment agreement with a health care professional
- Any lease with any health care provider.
- Any management agreement with any health care provider.
- Any other contract for services with a health care provider.

- Any joint venture, loan, or investment arrangement with any person or entity in a position to refer or influence the referral of patients to Avow Care Services.
- Any other financial arrangement of any kind between Avow Care Services and any health care provider or professional.
- Any sharing of fees.
- Any pledge or assignment of Medicare or Medicaid receivables.
- Any agreement concerning the referral of patients or the recommendation of any specific health care provider.
- Any purchase of a medical practice.
- Any purchase of other assets from a physician or other health care provider.

Medical Directorships

If Avow Care Services' physicians choose to accept a medical directorship or other consulting arrangement at a nursing home, home health agency, hospital or other health care provider or organization to which we may refer business, they must be prepared to assume substantial professional responsibility for the services that are defined in the agreement. This may include being responsible for the care delivered at the facility. To do this job well, you should be well versed in the functions and activities required in the written agreement, which may include one or more of the following:

- Actively oversee clinical care in the facility;
- Lead the medical staff to meet the standard of care;
- Ensure proper training, education, and oversight for physicians, nurses, and other staff members; and
- Identify and address quality problems through meetings, chart review and/or other activities.
- Development and review of policies

The following requirements and suggestions are the best practices for medical directorship arrangements:

- The agreement must be in writing and signed by both parties for a term of at least one year.
- The agreement must cover all of the services to be provided for the term of the agreement and must specify what services the medical director will provide.
- If the agreement is for services that are periodic or sporadic in nature, the agreement must delineate the time intervals in which the services will be performed and the exact charge for such intervals.
- The aggregate compensation for the services should be set in advance, and must be consistent with fair market value, and not take into account the volume or value of referrals from the physician to the hospital.
- The aggregate services contracted for do not exceed those that are reasonably necessary to accomplish the commercially reasonable business purpose of the services.
- The medical director will maintain and regularly review documentation such as time logs or other accounts of services performed.

- The medical director should be responsible for submitting the time logs or other documentation to the facility/agency prior to receiving payment for the services performed.

Training and Education

All staff, providers and management are required to attend general compliance program training. Physicians and billing personnel are required to participate in training about compliance issues and proper coding and billing. The Compliance Officer will determine who needs training and the type of training that best suits the practice's needs.

- As part of this Program there will be initial, new hire, and annual training.
- New employees will receive training as soon as possible following their start date.
- If a concern develops about a particular billing issue or other compliance issue, the CO may direct that the physician and/or billing personnel attend training sessions on particular issues.
- Components of general compliance training should include:
    - How employees are to perform their jobs in compliance with the standards of the organization and any applicable regulations
    - That compliance is a condition of continued employment.
    - Why we developed a Code of Conduct and a review of the policies and procedures which are part of our Compliance Program.
    - That updated ICD-10, HCPCS and CPT manuals, and carrier bulletins are available to all employees involved in the billing process.
    - Key risk areas in the OIG's compliance guidance and areas of particular OIG interest as identified in the OIG's Work Plan published each year.
    - That following the rules is mandatory.
- Coding and Billing training, as appropriate to the individual's job, should include:
    - Coding requirements
    - Claim development and submission processes
    - Marketing practices that reflect current legal and program standards
    - The ramifications of submitting a claim for physician services when rendered by a non-physician.
    - The ramifications of signing a form for a physician without the physician's authorization
    - The ramifications of altering medical records.
    - 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.
    - Training for physicians regarding avoiding 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 requirements, e.g., "incident to" rules).
- The CO will develop a system to document all training that has occurred and will maintain this documentation as part of our Compliance Program records.

Auditing, Monitoring and Corrective Action

To ensure that our Program is effective and successful, it is evaluated on an ongoing basis to help us determine that our policies and procedures are current, whether individuals are properly carrying out their responsibilities, and that claims are submitted properly. Perhaps the cornerstone of our Compliance Program is the internal review process, in which actual claims are reviewed for compliance with Medicare and other third party payers' rules and regulations. Bills and medical records will be reviewed for compliance with applicable coding, billing and documentation requirements as follows:

- Documentation and billing reviews will be used to determine whether o Bills are accurately coded and accurately reflect the services provided and the place of service.
  - Any overpayments exist
  - Services or items provided are reasonable and necessary.
  - Any incentives for unnecessary services exist.
  - Medical records contain sufficient documentation to support the charge.
  - Records are authenticated by the provider of service.
- While not an all-inclusive list, a documentation and billing review may attempt to answer the following questions:
  - Are the patient and physician both identified in the record?
  - Is each entry dated and signed by the physician?
  - Is the medical record legible?
  - Does the record adequately provide a medical history?
  - Does the record adequately document a review of systems?
  - Does the record adequately document a physical exam?
  - Does the record adequately reflect all conversations held with the patient?
  - Does the record adequately reflect the complexity of all discussions and/or treatments?
  - Is the rationale behind medical decisions adequately recorded?
  - Does the record list all medications prescribed (or samples given), along with prescribed dosages?
  - If the practice actually dispenses medications, does the record contain a listing of the dates on which prescriptions were ordered and picked up, as well as the number of dosages actually dispensed?
  - Has the record been documented, reviewed, and signed within any mandated time limits?
  - Were any referrals to or from the organization documented?
  - Were those referrals legal?
  - Is the coding justified by the medical record?
  - If reimbursement has been received, does reimbursement correspond with the CPT code filed and services provided?
- A baseline review should examine the claim development and submission process, from patient intake through claim submission and payment, to identify elements within this process that may contribute to non-compliance or that may need to be the focus for improvement.
- Periodic reviews should be conducted at least once each year to ensure that the compliance program is being followed and to alert us to any needed modifications to our Compliance Program.
- If problems are identified in a review, additional information or education of employees and physicians or other providers may be conducted. In this instance focused reviews may be conducted more frequently.
- If any of these audits or reviews identify material billing issues, the CO shall promptly report that fact to the President/CEO and/or Board. The situation will be reviewed, with advice from legal counsel when appropriate, to determine what corrective action as appropriate. Corrective action should be designed to ensure not only that the specific issue is addressed, but also that similar problems do not occur in other areas. Corrective action may require that billing be handled in a designated way, that billing responsibility be reassigned, that certain training take place, that restrictions be imposed on

billing by a particular physician or other health professional, that repayment be made, or that the matter be disclosed externally. Corrective action will be documented in writing.

Excluded Persons and Entities

It is illegal for any health care provider who receives government reimbursement to employ, contract, or affiliate with any person or entity that has been excluded from participation in government health care programs.

The U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG) is required to exclude from participation in federal health care programs any individual and entity convicted of any of the following types of criminal offenses: (1) offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The HHS-OIG also has discretion to exclude individuals and entities from federal health care programs for a variety of other reasons, including certain misdemeanor convictions, license discipline, provision of substandard services and defaults on health education loans and scholarships.

No government payment may be made for any health care items or services if those items or services have been furnished, ordered, or prescribed by an excluded individual or entity.

Enforcing Standards

As an employee you should follow our compliance policies every day and use them for guidance in deciding if something is right or wrong. In doing so, you will be conducting yourself in an ethical manner as a vital member of our staff. Importantly, any finding of fraud or abuse must be dealt with swiftly and vigilantly. It is not enough merely to locate the source of the errors, but meaningful corrective action must be taken. In some instances, additional education may be required, while in more serious instances disciplinary action, up to and including dismissal, could be imposed upon the offending individual. Corrective action should be documented in writing and include:

- the problem identified,
- the suggestion of the CO for corrective action,
- whether the CO's recommendation was implemented and,
- if it was not, why it was not and the corrective action actually taken

The operations of Avow Care Services are governed not only by laws and outside requirements, but also by these policies and procedures. We are committed to consistent compliance with all applicable regulatory requirements. As our employee, it is your personal duty and responsibility to comply with all regulatory requirements, professional standards, and our policies and procedures which apply to you. Your compliance is a condition of your continued employment with Avow Care Services. Your failure to comply with these requirements will result in prompt and appropriate disciplinary action which may include:

- An oral warning
- A written reprimand
- Probation

- Temporary suspension
- Termination
- Referral for criminal prosecution

All communication resulting in the finding of non-compliance conduct will be documented in the compliance files and should include:

- The date of incident
- Name of the reporting party
- Name of the person responsible for taking action
- The follow-up action taken

Now you know. You know what is expected of you. You know how to report suspected or known illegal, immoral, unethical, or non-compliant concerns, and that your failure to report will result in disciplinary action. You know that you will not be punished in any way for good-faith reporting, however, reporting situations which you know to be false will not be tolerated.

You also know how committed we are to ethical conduct
and to our value statement of "doing the right things right."

Appendix A - Forms

Employee Acknowledgment Form

Employee Acknowledgement

Our practice has established a compliance program to assure accurate and correct coding and billing practices. I have been advised of and understand the coding, billing, and reimbursement policies as outlined in the program's Manual. I also have been advised and understand that compliance with the coding and billing policies of the practice will be monitored as part of my overall performance evaluation.

_____	_____	_____
Employee (Print name)	Employee Signature	Date

There is a formal mechanism to allow the practice's employees the opportunity to express any concerns regarding coding and billing practices. Practice policy assures no retribution for expressing such concerns. I hereby acknowledge that I have been advised of and understand the practice's reporting mechanism, as outlined in the Compliance Manual, for concerns or complaints regarding coding and billing accuracy.

_____	_____	_____
Employee (Print name)	Employee Signature	Date

Interpreter Services and Training Resources

Training

International Medical Interpreters Association - www.Imiaweb.org
Language Line – www.languageline.com
National Board of Certification for Medical Interpreters – www.certifiedmedicalinterpreters.org The Glades Initiative - http://www.gladesinitiative.org

Interpreting

International Medical Interpreters Association - www.Imiaweb.org
Language Line – www.languageline.com

Notice of Non-Discrimination

In accordance with the ethical standards of the medical profession, Avow Cares, Inc./DBA Avow Palliative Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). Our practice also does not exclude people or treat them differently due to race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history). We offer the following:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please let our practice know.

If you believe that our practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing with:

Compliance Officer
1095 Whippoorwill Lane Naples,
FL 34105

You may also contact the Civil Rights Coordinator by:

- Telephone: 239-261-4404 or 239-280-2260
- Cell Phone: 239-771-0518
- In person by scheduling a meeting with the Section 1557 Coordinator at the above address.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room
509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, or 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.htm

Statement of Non-Discrimination

Nondiscrimination statement for significant publications and signification communications that are small-size:

Avow Care Services, Inc./DBA Avow Palliative Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Top 15 Florida Taglines – Language Assistance Services

Tagline Informing Individuals with Limited English Proficiency of Language Assistance Services
State of Florida

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-239-261-4404

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-239-261-4404

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-239-261-4404

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-239-261-4404

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-239-261-4404.

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-239-261-4404.

Tagalong:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-239-261-4404

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-239-261-4404 (телетайп: 1-239-261-4404.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتص-
(رقم هاتف الصم والبكم: 1-239-261-4404).

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-239-261-4404

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-239-261-4404

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-239-261-4404번으로 전화해 주십시오.

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-239-261-4404

Gujarati:

ચુના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-239-261-4404

Thai:

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-239-261-4404

Appendix: B - Codes

Code of Professional Conduct

- In order to ensure orderly operations and provide the best possible work environment, Avow expects employees to follow rules of conduct that will protect the interests and safety of all personnel. Behaviors that undermine the organization's culture of quality and safety may trigger corrective action. Since it is not possible to list all offensive behaviors that are considered unacceptable in the workplace, the following list (list is not intended to be all-inclusive) provides examples of behaviors that may result in corrective action, including counseling, reprimand, suspension, demotion or termination of employment.
- Violation of any Avow policy, including but not limited to the HIPAA policy and Avow's rules against conflicts of interest and permissible interactions with patients and their families.
- Harassing (verbally or physically acting in an unprofessional manner) a colleague, customer, patient, family member or visitor.
- Falsification of Company records or information, employment records or information, or any other records, including but not limited to patient records, timesheets, mileage reports and so on.
- Misappropriation of medication or any improper handling or disposal of controlled substances.
- Rude, disrespectful or inconsiderate behavior toward any patient, family member or visitor.
- Any act of coercion or undue influence over a patient or a patient's family members.
- Failure to carry out the lawful directives of your supervisor.
- Unsatisfactory job performance, tardiness or absenteeism.
- Reporting for work or working in a condition that renders you unable to safely perform your duties.
- Possessing, distributing, selling, transferring, using or being under the influence of alcohol or illegal drugs while in the workplace. Using illegal drugs (or unlawful use of prescription drugs) at any time.
- Violating any patient or family safety rules.
- Leaving your duties during working hours without authorization.
- Theft or the deliberate or careless damage of Company or personal property, or the property of any employee, patient or visitor.
- Failure to give your full and best efforts during the work day.
- Disorderly or other unlawful conduct on Company time or premises.
- Threat of violence or acts of intimidation toward another employee.
- Use of abusive, foul, or obscene language.
- Unauthorized use, disclosure or removal from Company premises of Company property, records or other materials or the property of other employees or patients.
- Unauthorized use of Avow equipment, time, materials or facilities.
- Sleeping or malingering while on duty.
- No Avow employee will provide a client of Avow any service for which personal remuneration is requested or received.
- No employee will use or attempt to use his/her employment position, Company property, or resource to secure a special privilege, benefit, or exemption for his/herself or others.
- No employee will represent Avow in civic groups, professional memberships, or private gatherings unless authorized to do so by the President or designee.
- Providing any false or misleading information to Avow.

Avow Code of Ethics

I will, during my professional relationship with Avow:

Provide the highest quality of care, in accordance with all applicable laws, regulations and accepted standards of practice.

- I will provide excellent and professional hospice care services to all who qualify, without discrimination based on race, color, sex (including pregnancy, sexual orientation or gender identity), religion, national original. disability, age or genetic information (including family medical history)or ability to pay for services rendered.
- I will support, affirm, and empower patient families who are both providing care and coping with their own grief.

Protect patients' property, right to privacy, confidentiality, health information, and safety.

- I will limit access to information to that which is required to meet the goals of the plan of care and will respect the patient's/family's right to confidentiality and privacy of personal information.
- I will not inquire further into a family's life and affairs than what is necessary within the scope of care and service, but will respect their right to privacy.

Refuse to solicit, accept, offer or give anything of value in exchange for, or related to, patient care and patient referrals.

- I recognize the vulnerability of patients and families, and will thus refrain from accepting personal gifts.
- I will solicit and accept only those referrals for patients who are medically qualified for care and for whom care promises to offer benefits.

Comply with all federal and state laws to prevent, detect, report and eliminate errors, waste, abuse or fraud in Avow programs.

- I will adhere to both the spirit and the letter of the laws governing Avow, and responsibly seek to understand policies, procedures, and practices in order to implement them to the best of my knowledge and ability.
- I will proactively report any compliance questions or concerns I have to my supervisor, compliance officer, or anonymously via NAVEX Global.

Conduct business in a professional and ethical manner.

- I will perform my duties with loyalty, care, respect, and candor in all my dealings with Avow and its constituents.

Promptly report any known or suspected violations of this Code of Ethics, laws, regulations, or Avow's policies and procedures to the Compliance Officer and my supervisor, or anonymously via NAVEX Global at 855-348-4998 or online at www.avow.ethicspoint.com

Appendix C – Grievance Procedure

Grievance Procedure:

- Grievances must be submitted to the Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it should be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of Avow Care Services relating to any grievances that are filed. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator will issue a written decision on the grievance, based on the evidence obtained, no later than 30 days after the date the grievance was filed. This will include a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the President/CEO and/or the Board within 15 days of receiving the Civil Rights Coordinator's decision. The President/CEO and/or the Board will issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at the website for U.S. Department of Health and Human Services, Office for Civil Rights. Complaints must be filed within 180 days of the date of the alleged discrimination.

Avow Care Services will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. These arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator is responsible for making these arrangements.

Appendix D– Internet Resources

Medicare

A complete list of contact information (address, phone number, email address) for Medicare Part A Fiscal Intermediaries, Medicare Part B Carriers, Regional Home Health Intermediaries, and Durable Medical Equipment Regional Carriers can be found on the CMS Web site at www.cms.gov/medicare

Medicaid

Contact information (address, phone number, email address) for each state Medicaid carrier can be found on the CMS Web site at www.cms.gov/medicaid. In addition to a list of Medicaid carriers, the Web site includes contact information for each State survey agency and the CMS Regional Offices.
Contact information for each state Medicaid Fraud Control Unit can be found on the OIG Web site at www.cms.gov/medicaid/fraud/mfs .

Officer of Inspector General – US Department of Health and Human Services www.oig.hhs.gov
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This Web site includes a variety of information relating to Federal health care programs, including the following:
Advisory Opinions
Anti-Kickback Information
Compliance Program Guidance
Corporate Integrity Agreements
Fraud Alerts
Links to Web pages for the:
Office of Audit Services (OAS)
Office of Evaluation and Inspections (OEI)
Office of Investigations (OI)
OIG List of Excluded Individuals/Entities
OIG News
OIG Regulations
OIG Semi-Annual Report OIG
Work Plan

Center for Medicare and Medicaid Services
www.cms.gov

This Web site includes information on a wide array of topics, including the following:
Medicare
National Correct Coding Initiative
Intermediary-Carrier Directory
Payment
Program Manuals
Program Transmittals & Memorandum
Provider Billing/CMS Forms

Statistics and Data
Medicaid
CMS Regional Offices
Letters to State Medicaid Directors
Medicaid Hotline Numbers
Policy & Program Information
State Medicaid Contacts State
Medicaid Manual
State Survey Agencies
Statistics and Data

CMS Medicare Training **(**www.cms.gov/Outreach-and-Education/Medicare-Learning-Networkmln/mlnmattersarticles/index.html**)**

This site provides articles and computer-based training on the following topics:
CMS 1500 Form
Fraud & Abuse
ICD-10-CM Diagnosis Coding
Adult Immunization
Medicare Secondary Payer (MSP)
Women's Health
Front Office Management
Introduction to the World of Medicare Home
Health Agency
CMS 1450 (UB92)
The U.S. House of Representatives Internet Library **(**uscode.house.gov/usc.htm**)**
This site provides access to the United States Code, which contains laws pertaining to Federal health care programs.

Appendix E – OIG's Physician Roadmap

A Roadmap for New Physicians

Avoiding Medicare and Medicaid Fraud and Abuse

U.S. Department of Health & Human Services
Office of Inspector General

Table of Contents

Most physicians strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. Society places enormous trust in physicians, and rightly so. Trust is at the core of the physician-patient relationship. When our health is at its most vulnerable, we rely on physicians to use their expert medical training to put us on the road to a healthy recovery.

The Federal Government also places enormous trust in physicians. Medicare, Medicaid, and other Federal health care programs rely on physicians' medical judgment to treat beneficiaries with appropriate services. When reimbursing physicians and hospitals for services provided to program beneficiaries, the Federal Government relies on physicians to submit accurate and truthful claims information.

The presence of some dishonest health care providers who exploit the health care system for illegal personal gain has created the need for laws that combat fraud and abuse and ensure appropriate quality medical care. This brochure assists physicians in understanding how to comply with these Federal laws by identifying "red flags" that could lead to potential liability in law enforcement and administrative actions. The information is organized around three types of relationships that physicians frequently encounter in their careers:

I. Relationships with payers,

II. Relationships with fellow physicians and other providers, and III. Relationships with vendors.

The key issues addressed in this brochure are relevant to all physicians, regardless of specialty or practice setting.

Fraud and Abuse Laws

The five most important Federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. As you begin your career, it is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal health care programs, or loss of your medical license from your State medical board.

False Claims Act [31 U.S.C. §§ 3729–3733]

The civil FCA protects the Government from being overcharged or sold shoddy goods or services. **It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.** Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or ex-business partners, hospital or office staff, patients, or competitors.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. OIG also may impose administrative civil monetary penalties for false or fraudulent claims, as discussed below.

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (*e.g.*, drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free re expensive hotel stays and meals, and excessive compensation for medical director or consultancies. **In some industries, it is acceptable to reward thos refer business to you. However, in the Federal health care prog paying for referrals is a crime.** The statute covers the payers of kickl those who offer or pay remuneration— as well as the recipients of kickbacks who solicit or receive remuneration. Each party's intent their l under the AKS.

Criminal penalties and administrative sanctions for violating the fines, jail terms, and exclusion from participation in the Feder programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to *bona fide* employees.

For additional information on safe harbors, see "OIG's Safe Harbor Regulations" available at http://oig.hhs.gov/fraud/safeharborregulations.asp.

As a physician, you are an attractive target for kickback schemes because you can be a source of referrals for fellow physicians or other health care providers and suppliers. You decide what drugs your patients use, which specialists they see, and what health care services and supplies they receive.

Many people and companies want your patients' business and would pay you to send that business their way. Just as it is illegal for you to take money from providers and

suppliers in return for the referral of your Medicare and Medicaid patients, it is illegal for you to pay others to refer their Medicare and Medicaid patients to you.

Kickbacks in health care can lead to:

- Overutilization
- Increased program costs
- Corruption of medical decisionmaking
- Patient steering
- Unfair competition

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail. **It is also legal to provide free or discounted services to uninsured people.**

Besides the AKS, the beneficiary inducement statute (42 U.S.C. § 1320a-7a(a)(5)) also imposes civil monetary penalties on physicians who offer remuneration to Medicare and Medicaid beneficiaries to influence them to use their services.

The Government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS. A physician can be guilty of violating the AKS even if the physician actually rendered the service and the service was medically necessary. **Taking money or gifts from a drug or device company or a durable medical equipment (DME) supplier is not justified by the argument that you would have prescribed that drug or ordered that wheelchair even without a kickback.**

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for

physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

For more information, see CMS's Stark law Web site available at http://www.cms.gov/physicianselfreferral/.

Exclusion Statute [42 U.S.C. § 1320a-7]

OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe.

Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. In addition, if you furnish services

to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.

For more information, see OIG's Special Advisory Bulletin entitled "The Effect of Exclusion From Participation in Federal Health Care Programs" available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against OIG's List of Excluded Individuals and Entities. This online database can be accessed from OIG's Exclusion Web site. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

For more information, see OIG's exclusion Web site available at http://oig.hhs.gov/fraud/exclusions.asp.

Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a]

OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation. Some examples of CMPL violations include:

- presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- presenting a claim that the person knows or should know is for an item or service for which payment may not be made;
- violating the AKS;
- violating Medicare assignment provisions;
- violating the Medicare physician agreement;

- providing false or misleading information expected to influence a decision to discharge;
- failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor; and
- making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

I. Physician Relationships With Payers

During residency, you probably are not focused on who pays for your patients' care. Once you start practicing, it is important to understand who the payers are. The U.S. health care system relies heavily on third-party payers, and, therefore, your patients often are not the ones who pay most of their medical bills. Third-party payers include commercial insurers and the Federal and State governments. **When the Federal Government covers items or services rendered to Medicare and Medicaid beneficiaries, the Federal fraud and abuse laws apply.** Many States also have adopted similar laws that apply to your provision of care under State-financed programs and to private-pay patients. Consequently, you should recognize that the issues discussed here may apply to your care of all insured patients.

Accurate Coding and Billing

Payers trust you, as a physician, to provide necessary, cost-effective, and quality care. You exert significant influence over what services your patients receive, you control the documentation describing what services they actually received, and your documentation serves as the basis for bills sent to insurers for services you provided. The Government's payment of claims is generally based solely on your representations in the claims documents.

Because the Government invests so much trust in physicians on the front end, Congress provided powerful criminal, civil, and administrative enforcement tools for instances when unscrupulous providers abuse that trust. The Government has broad capabilities to audit claims and investigate providers when it has a reason to suspect fraud. Suspicion of fraud and abuse may be raised by irregular billing patterns or reports from others, including your staff, competitors, and patients.

When you submit a claim for services performed for a Medicare or Medicaid beneficiary, you are filing a bill with the Federal Government and certifying that you have earned the payment requested and complied with the billing requirements. If you knew or should have known that the submitted claim was false, then the attempt to collect unearned money constitutes a violation. A common type of false claim is "upcoding," which refers to using billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided. Additional examples of improper claims include:

- billing for services that you did not actually render;
- billing for services that were not medically necessary;
- billing for services that were performed by an improperly supervised or unqualified employee;

- billing for services that were performed by an employee who has been excluded from participation in the Federal health care programs;
- billing for services of such low quality that they are virtually worthless; and
- billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.

CAUTION CAUTION CAUTION CAUTION CAUTION CAUTION CAUTION

Upcoding

Medicare pays for many physician services using Evaluation and Management (commonly referred to as "E&M") codes. New patient visits generally require more time than follow-up visits for established patients, and therefore E&M codes for new patients command higher reimbursement rates than E&M codes for established patients. An example of upcoding is an instance when you provide a follow-up office visit or follow-up inpatient consultation but bill using a higher level E&M code as if you had provided a comprehensive new patient office visit or an initial inpatient consultation.

Another example of upcoding related to E&M codes is misuse of Modifier 25. Modifier 25 allows additional payment for a separate E&M service rendered on the same day as a procedure. Upcoding occurs if a provider uses Modifier 25 to claim payment for an E&M service when the patient care rendered was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.

CAUTION CAUTION CAUTION CAUTION CAUTION CAUTION CAUTION

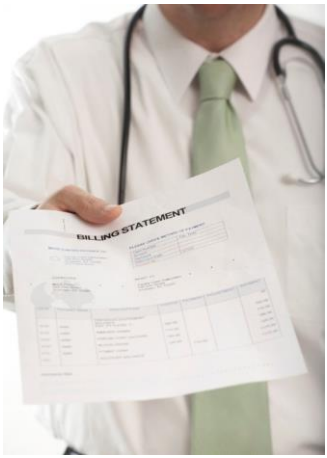
Case Examples of Fraudulent Billing

• A psychiatrist was fined $400,000 and permanently excluded from participating in the Federal health care programs for misrepresenting that he provided therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient, when he had provided only medication checks for 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when in fact a non-licensed individual conducted the sessions.

• A dermatologist was sentenced to 2 years of probation and 6 months of home confinement and ordered to pay $2.9 million after he pled guilty to one count of obstruction of a criminal health care fraud investigation. The dermatologist admitted to falsifying lab tests and backdating letters to referring physicians to substantiate false diagnoses to make the documentation appear that his patients had Medicarecovered conditions when they did not.

• A cardiologist paid the Government $435,000 and entered into a 5-year Integrity Agreement with OIG to settle allegations that he knowingly submitted claims for consultation services that were not supported by patient medical records and did not meet the criteria for a consultation. The physician also allegedly knowingly submitted false claims for E&M services when he had already received payment for such services in connection with previous claims for nuclear stress testing.

• An endocrinologist billed routine blood draws as critical care blood draws. He paid $447,000 to settle allegations of upcoding and other billing violations.


BILLING STATEMENT

Physician Documentation

Physicians should maintain accurate and complete medical records and documentation of the services they provide. Physicians also should ensure that the claims they submit for payment are supported by the documentation. The Medicare and Medicaid programs may review beneficiaries' medical records. **Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients' past medical histories.** It also helps you address challenges raised against the integrity of your bills. You may have heard the saying regarding malpractice litigation: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare and Medicaid billing.

For more information on physician documentation, see CMS's Documentation Guidelines for Evaluation and Management Services available at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp.

Enrolling as a Medicare and Medicaid Provider With CMS

CMS is the Federal agency that administers the Medicare program and monitors the Medicaid programs run by each State. To obtain reimbursement from the Government for services provided to Federal health care program beneficiaries, you must:

1. **Obtain a National Provider Identifier (NPI).** An NPI is a unique health identifier for health care providers. You may apply for your NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

2. **Complete the appropriate Medicare Enrollment Application.** During the enrollment process, CMS collects information to ensure that you are qualified and eligible to enroll in the Medicare Program. Information about Medicare provider enrollment is available at http://www.cms.gov/MedicareProviderSupEnroll/.
3. **Complete your State-specific Medicaid Enrollment Application.** Information about Medicaid provider enrollment is available from your State Medicaid agency.

Once you become a Medicare and/or Medicaid provider, you are responsible for ensuring that claims submitted under your number are true and correct.

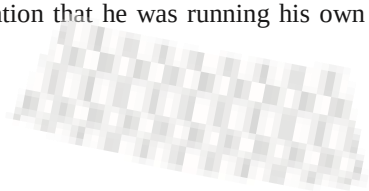
For tips you can share with your patients on how they can protect themselves from medical identity theft, see OIG's brochure entitled "Tips to Avoid Medical ID Theft" available at http://oig.hhs.gov/fraud/IDTheft/OIG_Medical_Identity_Theft_Brochure.pdf.

Prescription Authority

The Drug Enforcement Administration (DEA) is a Department of Justice agency responsible for enforcing the Controlled Substances Act. When you prepare to enter practice, you probably will apply for a DEA number that authorizes you to write prescriptions for controlled substances. You also will apply for your State medical license and any additional credentials your State requires for you to write prescriptions. You must ensure that you write prescriptions only for lawful purposes.

Case Examples of Misuse of Physician Provider and Prescription Numbers

- A physician was ordered to pay $50,000 in restitution to the Government for falsely indicating on his provider number application that he was running his own practice when, in fact, a neurophysiologist was operating the practice and paying the physician a salary for the use of his number.



- An osteopathic physician was sentenced to 10 years in prison and ordered to pay $7.9 million in restitution after she accepted cash payments for signing preprinted prescriptions and Certificates of Medical Necessity for motorized wheelchairs for beneficiaries she never examined. More than 60 DME companies received Medicare and Medicaid payments based on her fraudulent prescriptions.

- An internal medicine physician pled guilty to Medicare fraud and to conspiring to dispense oxycodone, morphine, hydrocodone, and alprazolam. The physician allowed unauthorized and non-medical employees at his pain center to prescribe drugs using his pre-signed blank prescription forms. Prescriptions were issued in his name without adequate physical exams, proper diagnoses, or consideration of alternative treatment options. He paid $317,000 in restitution to the Government.

Assignment Issues in Medicare Reimbursement

Most physicians bill Medicare as participating providers, which is referred to as "accepting assignment." Each year, Medicare promulgates a fee schedule setting the reimbursement for each physician service. Once beneficiaries satisfy their annual deductible, Medicare pays 80 percent of the fee schedule amount and the beneficiary pays 20 percent. Participating providers receive the Medicare program's 80 percent directly from the Medicare program and bill the beneficiary for the remaining 20 percent. Accepting assignment means that the physician accepts the Medicare payment plus any copayment or deductible Medicare requires the patient to pay *as the full payment for the physician's services and that the physician will not seek any extra payment* (beyond the copayment or deductible) from the patient. Medicare participating physicians may not bill Medicare patients extra for services that are already covered by Medicare.

Doing so is a violation of a physician's assignment agreement and can lead to penalties.

The second, less common, way to obtain Medicare reimbursement is to bill as a nonparticipating provider. Non-participating providers do not receive direct payment from the Medicare program. Rather, they bill their patients and the patients seek reimbursement from Medicare. Although non-participating providers are not subject to the assignment rules, they still must limit the dollar amount of their charges to Medicare patients. Generally, non-participating providers may not charge Medicare beneficiaries more than 15 percent in excess of the Medicare fee schedule amount. It is illegal to charge patients more than the limiting charge established for physicians' services.

Excluded providers may not receive Medicare payment either as participating or non-participating providers.

You may see advertisements offering to help you convert your practice into a "boutique," "concierge," or "retainer" practice. Many such solicitations promise to help you work less, yet earn more money. **If you are a participating or non-**

participating physician, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid. It is legal to charge patients for services that are not covered by Medicare. However, charging an "access fee" or "administrative fee" that simply allows them to obtain Medicare-covered services from your practice constitutes double billing.

Case Example of a Physician Violating an Assignment Agreement by Charging Beneficiaries Extra Fees

- A physician paid $107,000 to resolve potential liability for charging patients, including Medicare beneficiaries, an annual fee. In exchange for the fee, the physician offered: (1) an annual physical; (2) same- or next-day appointments; (3) dedicated support personnel; (4) around-the-clock physician availability; (5) prescription facilitation; (6) expedited and coordinated referrals; and (7) other amenities at the physician's discretion. The physician's activities allegedly violated the assignment agreement because some of the services outlined in the annual fee were already covered by Medicare.

II. Physician Relationships With Fellow Providers: Physicians, Hospitals, Nursing Homes, Etc.

Any time a health care business offers something to you for free or at below fair market value, you always should ask yourself, "*Why?*" For example, if a DME supplier offers to give you cash or to pay for your summer vacation, you should suspect that the supplier is trying to induce you to refer your patients to that vendor. If a laboratory offers to decorate your patient waiting room, you should suspect that it is trying to induce you to send your lab business its way.

For more information on physician relationships with:

fellow providers, see OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" available at http://oig.hhs.gov/authorities/docs/physician.pdf;

hospitals, see OIG's "Supplemental Compliance Program Guidance for Hospitals" available at http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf; and

nursing homes, see OIG's "Supplemental Compliance Program Guidance for Nursing Facilities" available at http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf.

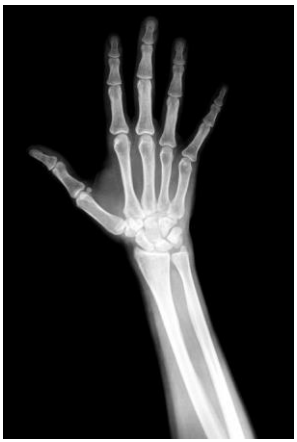
Physician Investments in Health Care Business Ventures

Some have observed that physicians who invest in health care business ventures with outside parties (*e.g.*, imaging centers, labs, equipment vendors, or physical therapy clinics) refer more patients for the services provided by those parties than physicians who do not invest. Maybe this disproportionate utilization partly reflects the physicians' belief in the value of the services or technology, prompting the investments in the first place. However, there also is a risk that the physicians' belief in the value of the services or technology is less a cause than an effect of the investment interest. The physician investors' disproportionate utilization may be motivated partly by the physicians' ability to profit from the use of the ancillary services. These business relationships can sometimes unduly influence or distort physician decisionmaking and result in the improper steering of a patient to a particular therapy or source of services in which a physician has a financial interest. **Excessive and medically unnecessary referrals waste Government and beneficiary money and can expose beneficiaries to harm from unnecessary services.** Many of these investment relationships have serious legal risks under the AKS and Stark law.

If you are invited to invest in a health care business whose products you might order or to which you might refer your patients, you should ask the following questions. If the answer is "yes" to any of them, you should consider carefully whether you are investing for legitimate reasons.

- Are you being offered an investment interest for a nominal capital contribution?
- Will your ownership share be larger than your share of the aggregate capital contributions made to the venture?
- Is the venture promising you high rates of return for little or no financial risk?
- Is the venture or any potential business partner offering to loan you the money to make your capital contribution?
- Are you being asked to promise or guarantee that you will refer patients or order items or services from the venture?
- Do you believe you will be more likely to refer more patients for the items and services provided by the venture if you make the investment?

- Do you believe you will be more likely to refer to the venture just because you made the investment?
- Will the venture have sufficient capital from other sources to fund its ongoing operations?



For more information on physician investments, see:

OIG's Special Fraud Alert entitled "Joint Venture Arrangements" available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html;

OIG's Special Advisory Bulletin on contractual joint ventures available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf; and

OIG's "Supplemental Compliance Program Guidance for Hospitals" available at http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf.

Case Examples Involving Kickbacks for Referrals and Self-Referrals

- Nine cardiologists paid the Government over $3.2 million for allegedly engaging in a kickback scheme. The cardiologists received salaries under clinical faculty services agreements with a hospital under which, the Government alleged, they did not provide some or any of the services. In exchange, the cardiologists referred their patients to the hospital for cardiology services. Two of the physicians also pled guilty to criminal embezzlement charges involving the same conduct.

- A physician paid the Government $203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark law for routinely referring Medicare patients to an oxygen supply company he owned.

Physician Recruitment

A hospital will sometimes provide a physician with a recruitment incentive to induce the physician to relocate to the hospital's geographic area, become a member of its medical staff, and establish a practice that helps serve that community's medical needs. Often, such recruitment efforts are legitimately designed to fill a "clinical gap" in a

medically underserved area to which it may be difficult to attract physicians in the absence of financial incentives. However, as you begin planning your professional future and perhaps receiving recruitment offers, you need to be aware that in some communities, especially ones with multiple hospitals, the competition for patients can be fierce. Some hospitals may offer illegal inducements to you, or to the established physician practice you join in the hospital's community, to gain referrals. This means that the competition for your loyalty can cross the line into illegal arrangements for which *both you and the hospital* can be liable.

Recruitment arrangements are of special interest to graduating residents and fellows. Within very specific parameters specified in the Stark law and subject to compliance with the AKS, hospitals may provide relocation assistance and practice support under a properly structured recruitment arrangement to assist you in establishing a practice in the hospital's community. Alternatively, a hospital may pay you a fair market value salary as an employee or pay you fair market value for specific services you render to the hospital as an independent contractor. However, the hospital may not offer you money, provide you free or below-market rent for your medical office, or engage in similar activities designed to influence your referral decisions. **You should admit your patients to the hospital best suited to care for their particular medical conditions or to the hospital your patient selects based on his or her preference or insurance coverage.** As noted, if a hospital or physician practice seperately or jointly is recruiting you as a new physician to the community, you may be offered a recruitment package. But, you may not negotiate for benefits in exchange for a promise—implicit or explicit—that you will admit your patients to a specific hospital or practice setting unless you are a hospital employee. You should seek knowledgeable legal counsel if someone with whom

you are entering into a relationship requires you to admit patients to a specific hospital or practice group.

Tips for Medical Directors

If you choose to accept a medical directorship at a nursing home or other facility, you must be prepared to assume substantial professional responsibility for the care delivered at the facility. As medical director, patients (both your own patients and the patients of other attending physicians) and their families count on you, and State and Federal authorities may hold you accountable as well. To do this job well, you should:

- actively oversee clinical care in the facility;
- lead the medical staff to meet the standard of care;
- ensure proper training, education, and oversight for physicians, nurses, and other staff members; and
- identify and address quality problems.

Case Examples of Medical Directorship Issues

- A physician group practice paid the Government $1 million and entered into a 5-year Corporate Integrity Agreement to settle alleged violations of the AKS, FCA, and Stark law related to medical directorships with a medical center. Allegedly, the agreements were not in writing, the physicians were paid more than fair market value for the services they rendered, and the payment amounts were based on the value of referrals the physicians sent to the medical center.

- Two orthopedic surgeons paid $450,000 and $250,000 to settle allegations related to improper medical directorships with a company that operated a diagnostic imaging center, a rehabilitation facility, and an ambulatory surgery center. The company allegedly provided the physicians with valuable compensation, including free use of the corporate jet, under the medical directorship agreements, which required the physicians to render limited services in return. The agreements with the physicians allegedly called for redundant services and served to encourage the physicians to refer their patients to the facilities operated by the company.

III. Physician Relationships With Vendors

Free Samples

Some physicians welcome visits from pharmaceutical salespeople, while other physicians prefer not to directly engage with industry representatives. If you decide to make your practice accessible to salespeople, you probably will be offered product samples. Many drug and biologic companies provide physicians with free samples that the physicians may give to patients free of charge.

It is legal to give these samples to your patients for free, but it is illegal to sell the samples.

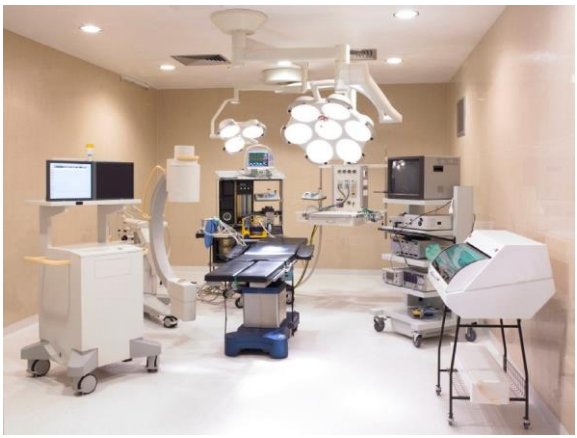
The Government has prosecuted physicians for billing Medicare for free samples. Opinions differ on whether sampling practices ultimately increase or decrease patients' long-term drug costs. If you choose to accept samples, you will need reliable systems in place to safely store the samples and ensure that samples are not commingled with your commercial stock.

Case Example Involving Drug Samples

• Several urologists pled guilty to charges of conspiracy, paid restitution in the tens of thousands of dollars, and received sanctions against their medical licenses for billing Medicare for injectable prostate cancer drugs they received for free from two pharmaceutical companies. The pharmaceutical companies paid $1.4 billion for their part of the alleged scheme to give urologists free samples and encourage them to bill Medicare at an inflated price. The pharmaceutical companies also provided urologists with additional inducements to use their drugs over the competitor's products, including drug rebates, education grants, volume discounts, free goods, and debt forgiveness.

Relationships With the Pharmaceutical and Medical Device Industries

Physician-industry collaboration can produce important medical advances. However, some pharmaceutical and device companies have used sham consulting agreements and other arrangements to buy physician loyalty to their products. Such illegal arrangements induce physicians to prescribe or use products on the basis of that loyalty to the company or to get more money from the company, rather than because it is the best treatment for the patient.



As a practicing physician, you may have opportunities to work as a consultant or promotional speaker for the drug or device industry. For every financial relationship offered to you, evaluate the link between the services you can provide and the compensation you will receive. Test the propriety of any proposed relationship by asking yourself the following questions:

- Does the company *really* need *my* particular expertise or input?
- Does the amount of money the company is offering seem fair, appropriate, and commercially reasonable for what it is asking me to do?
- Is it possible the company is paying me for my loyalty so that I will prescribe its drugs or use its devices?

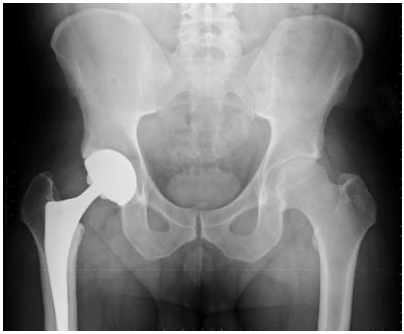
A good discussion that assists in distinguishing between legitimate and questionable industry relationships is located in the OIG's "Compliance Program Guidance for Pharmaceutical Manufacturers" available at http://oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf.

If your contribution is your time and effort or your ability to generate useful ideas and the payment you receive is fair market value compensation for your services without regard to referrals, then, depending on the circumstances, you may legitimately serve as a *bona fide* consultant. **If your contribution is your ability to prescribe a drug or use a medical device or refer your patients for particular services or supplies, the proposed consulting arrangement likely is one you should avoid as it could violate fraud and abuse laws.**

For example, if a drug company offers to pay you and a hundred other "thought leaders" to attend a conference in the Bahamas without requiring preparatory work on your part or information about your expertise in the field (other than the fact that you are a licensed physician), you should be suspicious that the company is attempting to influence you to prescribe its drug.

Case Example of Kickbacks in the Device Industry

- Four orthopedic device manufacturers paid $311 million to settle kickback and false claims allegations that the companies bribed surgeons to recommend their hip and knee surgical implant products. The companies allegedly would award physicians with vacations, gifts, and annual "consulting fees" as high as $200,000 in return for the physicians' endorsements of their implants or use of them in operations. Many of the individual orthopedic surgeons at the receiving end of the kickbacks are the subject of ongoing investigations by the Government. One orthopedic surgeon recently paid $650,000 to resolve allegations that the surgeon accepted payments from device manufacturers to use their hip and knee implants.



Transparency in Physician-Industry Relationships

Although some physicians believe that free lunches, subsidized trips, and gifts do not affect their medical judgment, research shows that these types of perquisites can influence prescribing practices. Recent pharmaceutical company settlements with the Department of Justice and OIG require "transparency" in physician-industry relationships, whether by requiring the pharmaceutical company to provide the Government with a list of physicians whom the company paid and/or by requiring ongoing public disclosure by the company of physician payments. **The public will soon know what gifts and payments a physician receives from industry.**

The Patient Protection and Affordable Care Act of 2010 requires drug, device, and biologic companies to publicly report nearly all gifts or payments they make to physicians beginning in 2013.

Academic institutions also may impose various restrictions on the interactions their faculty members or affiliated physicians have with industry. These and other considerations may factor into your decision about whether you want to conduct industry-sponsored research; serve as a consultant or director for a drug, biologic, or device company; apply for industry-sponsored educational or research grants; or engage in other relationships with industry.

Both the pharmaceutical industry (through PhRMA) and the medical device industry (through AdvaMed) have adopted codes of ethics for their respective industries regarding relationships with health care professionals. Both codes are available online.

Conflict-of-Interest Disclosures

Many of the relationships discussed in this brochure are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may have an obligation to disclose their existence. Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as States, universities, and the National Institutes of Health, and from the Food and Drug Administration (FDA) when data are submitted to support marketing approval for new drugs, devices, or biologics. To "manage" your conflicts of interest, consider the conflicts policies that affect your professional activities, candidly disclose any industry money subject to these policies,

and adhere to restrictions on your activities. If you are uncertain whether a conflict exists, ask someone. You always can apply the "newspaper test" and ask yourself whether you would want the arrangement to appear on the front page of your local newspaper.

Continuing Medical Education

After finishing your formal graduate medical training, you will assume greater responsibility for your continuing medical education (CME) to maintain State licensure, hospital privileges, and board certification. Drug and device manufacturers sponsor many educational opportunities for physicians. **It is important to distinguish between CME sessions that are educational in nature and sessions that constitute marketing by a drug or device manufacturer.** Industry satellite programs that occur concurrently with a society meeting are generally promotional, even if the primary speaker is a physician who is well known in the field. You should be circumspect about a discussion that focuses on a particular brand drug or device, as opposed to all the treatment alternatives for a specific condition.

For example, if speakers recommend use of a drug to treat conditions for which there is no FDA approval or use of a drug by children when FDA has approved only adult use, you should independently seek out the empirical data that support these recommendations. **Note that although physicians may prescribe drugs for off-label uses, it is illegal under the Federal Food, Drug, and Cosmetic Act for drug manufacturers to promote off-label uses of drugs.**

Advertisements and other promotional materials for drugs, biologics, and medical devices must be truthful, not misleading, and limited to approved uses. FDA is requesting physicians' assistance in identifying misleading advertisements through its Bad Ad Program. If you spot advertising violations, you should report them to FDA by calling 877-RX-DDMAC (877-793-3622) or by emailing badad@fda.gov.

If you are invited to serve as faculty for industry-sponsored CME, ask yourself the following questions:

- Does the sponsor *really* need *my* particular expertise or input?

- Does the amount of money the sponsor is offering seem fair and appropriate for the educational value I will add to the presentation?
- Is it possible the sponsor is paying me for my loyalty so that I will prescribe its drugs or use its devices?
- Does the sponsor prepare a slide deck and speaker notes, or am I free to set the content of the lecture?

Compliance Programs for Physicians

Establishing and following a compliance program will help physicians avoid fraudulent activities and ensure that they are submitting true and accurate claims. The following seven components provide a solid basis upon which a physician practice can create a voluntary compliance program:

1. Conduct internal monitoring and auditing.
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication with employees.
7. Enforce disciplinary standards through well-publicized guidelines.

With the passage of the Patient Protection and Affordable Care Act of 2010, physicians who treat Medicare and Medicaid beneficiaries will be required to establish a compliance program.

For more information on compliance programs for physicians, see OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" available at http://oig.hhs.gov/authorities/docs/physician.pdf.

Where To Go for Help

When you are considering whether or not to engage in a particular billing practice; enter into a particular business venture; or pursue an employment, consulting, or other

personal services relationship, it is prudent to evaluate the arrangement for potential compliance problems. The following is a list of possible resources that can help you.

- Experienced health care lawyers can analyze your issues and provide a legal evaluation and risk analysis of the proposed venture, relationship, or arrangement.
- The Bar Association in your State may have a directory of attorneys in your area who practice in the health care field.
- Your State or local medical society may be a good resource for issues affecting physicians and may have listings of health care lawyers in your area.
- Your specialty society may have information on additional risk areas specific to your type of practice.
- CMS's local contractor medical directors are a valuable source of information on Medicare coverage policies and appropriate billing practices. The contact information for local contractors is available at http://www.cms.gov/MLNGenInfo/30_contactus.asp.
- CMS's "Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals" available at http://www.cms.gov/MLNProducts/downloads/physicianguide.pdf, provides an overview of the Medicare program and information on Medicare reimbursement and payment policies.
- The OIG's Web site, available at http://oig.hhs.gov, provides substantial fraud and abuse guidance.
- As discussed above, OIG issues Compliance Program Guidance documents that include compliance recommendations and discussions of fraud and abuse risk areas. These guidance documents are available at http://oig.hhs.gov/fraud/complianceguidance.asp.
- OIG issues advisory opinions to parties who seek advice on the application of the AKS, CMPL, and Exclusion Authorities. Information on how to request an OIG advisory opinion and links to previously published OIG advisory opinions are available at http://oig.hhs.gov/fraud/advisoryopinions.asp.

- CMS issues advisory opinions to parties who seek advice on the Stark law. Information on how to request a CMS advisory opinion and links to previously published CMS advisory opinions are available at http://www.cms.gov/PhysicianSelfReferral/95_advisory_opinions.asp.

What To Do If You Think You Have a Problem

If you are engaged in a relationship you think is problematic or have been following billing practices you now realize were wrong:

- Immediately cease filing the problematic bills.
- Seek knowledgeable legal counsel.
- Determine what money you collected in error from your patients and from the Federal health care programs and report and return overpayments.
- Unwind the problematic investment.
- Disentangle yourself from the suspicious relationship.
- Consider using OIG's or CMS's self-disclosure protocols.

OIG Provider Self-Disclosure Protocol

The OIG Provider Self-Disclosure Protocol is a vehicle for physicians to voluntarily disclose self-discovered evidence of potential fraud. The protocol allows providers to work with the Government to avoid the costs and disruptions entailed in a Government-directed investigation. For more information on the OIG Provider Self-Disclosure Protocol, see http://oig.hhs.gov/fraud/selfdisclosure.asp.

Case Examples of Physician Liabilities Resolved Under the OIG Provider Self-Disclosure Protocol

- A Minneapolis physician paid $53,400 and resolved liability for violating his Medicare assignment agreement by charging patients a yearly fee for services, some of which were covered by Medicare.

- A Florida physician paid $100,000 and resolved liability related to referring patients to a lab owned by his brother.

- A neurosurgery practice paid $10,000 and resolved liability for employing an individual who was excluded from participation in the Federal health care programs.

What To Do If You Have Information About Fraud and Abuse Against Federal Health Care Programs

If you have information about fraud and abuse against Federal health care programs, use the OIG Fraud Hotline to report that information to the appropriate authorities. The Hotline allows the option of reporting anonymously.

Phone:	1-800-HHS-TIPS (1-800-447-8477)
Fax:	1-800-223-8164
Email:	HHSTIPS@oig.hhs.gov
TTY:	1-800-377-4950
Mail:	Office of Inspector General Department of Health & Human Services Attn: HOTLINE P.O. Box 23489

Washington, DC 20026

For additional information about the Hotline, visit the OIG Web site at http://oig.hhs.gov/fraud/hotline/.