AHRC Nassau Compliance Program Policies and Procedures	
SUBJECT: Protocols for Investigations and Implementing Corrective Action, Including Discipline	
APPROVED BY: Board of Directors	**EFFECTIVE: 5/15/23**
Reviewed: 6/5/24, 6/4/25	**PAGE 1 OF 6**

I. POLICY

To be effective and to combat fraud, waste and abuse in the course of operations, a compliance program must institute procedures for investigating compliance issues and implementing appropriate corrective action. Therefore, AHRC Nassau ("Agency") has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to prevent recurrence, and ensure ongoing compliance with federal health care programs requirements (e.g., Medicare and Medicaid). Below are the procedures that the Agency has adopted.

II. PROCEDURE

A. INVESTIGATION

A compliance problem may be uncovered as the result of a report to the Compliance Officer, an internal compliance assurance review, the review of a new regulation or governmental fraud alert, or from another source. Such problems might include, any of the following: errors or inconsistencies in time or task entries; evidence that the Agency is billing for services that were not performed or ordered; that the medical documentation does not adequately support the billing codes selected; or suspect financial relationships with other providers who have a referral relationship with Agency.

Upon receiving a report or otherwise learning of a possible compliance issue, the Compliance Officer will bring such report to the attention of the CEO and Compliance Committee. The Compliance Officer or his/her designee(s) will promptly conduct an investigation and take all necessary and appropriate actions. Such investigations may be undertaken under the supervision and direction of outside counsel, as necessary and appropriate. All Affected Individuals are expected to cooperate in any investigation.

Depending on the nature of the potential compliance issue, an investigation may include interviews with Affected Individuals, documentation reviews and a root cause analysis. The objective of such an investigation will be to determine whether, first, a compliance issue exists or there has been a violation of the Compliance Program (including Agency's compliance policies and procedures, the Code of Conduct or other applicable laws, regulations or requirements). If an issue or violation does exist, then the investigation will attempt to determine its root cause so that appropriate and effective corrective action may be instituted.

If the matter concerns potentially improper or incorrect billing or related issues, the investigation may include, for example, the selection for review of a small, random sampling of claims "in the pipeline" (that is, claims for services that have been performed, documented and coded, but not yet submitted for payment) along with the related supporting documentation. If the review of these claims warrants, the sample will be expanded to additional claims "in the pipeline" so that the extent of any problem may be more accurately assessed. During these reviews, any claims that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding them have been resolved. As appropriate, retrospective claims review may also be conducted. If it is determined at the conclusion of such an investigation that any claims were submitted in error to the government or any other payer, any payments received will be promptly refunded in accordance with applicable law, regulation and/or contractual requirement(s) (see the General Guidelines for Refunding Overpayments, below).

The Compliance Officer or his/her designee(s) will sufficiently document their investigative steps and the resolution/outcome.

The investigation of the compliance issue shall be documented and shall include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that the required provider completed a thorough investigation of the issue.

If credible evidence is identified or there is a credible belief that a State or Federal law, rule or regulation has been violated, it is required that such violation is promptly reported to the appropriate governmental entity. The Compliance Officer shall receive copies of any reports submitted to governmental entities.

B. CORRECTIVE ACTION, DISCIPLINE AND REFUNDING OVERPAYMENTS

1. Corrective Action - Generally. Whenever a compliance issue is uncovered, regardless of the source, the Compliance Officer will ensure that prompt, thorough, appropriate and effective corrective action is implemented. In discharging this responsibility, the Compliance Officer may work in consultation with outside counsel and others, as appropriate to correct the problem. All Affected Individuals are expected to assist in the resolution of compliance issues.

Any corrective action and response implemented must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

Corrective actions may include, but are not limited to, the following:

- Informing and discussing with the offending personnel both the violation and how it may be avoided in the future;

- Providing remedial education (formal or informal) to ensure that there is an understanding of the applicable laws, rules, regulations and/or requirements;
- Conducting a follow-up review to ensure that the problem is not recurring;
- Having personnel go through a cycle or cycles of remedial education and/or focused audits;
- Imposing discipline, as set forth below;
- Suspending billing, in whole or in part, of the services provided by a specific physician/practitioner;
- Refunding any past payments that resulted from any improper bills, to the extent required or otherwise appropriate (see the General Guidelines for Refunding Overpayments, below);
- Self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS, OIG and the New York State DOH and OMIG);
- Modifying or improving Agency's business practices; and/or
- Modifying or improving the Compliance Program to better ensure continuing compliance with applicable Federal and State laws, rules, regulations and/or contractual requirements.

If it appears that a larger, systemic problem may exist, then possible modification or improvement of Agency's compliance, billing and/or other practices will be considered. Such action might include, in addition to that listed above, creating new procedures, or modifying existing procedures, so as to ensure that similar issues will not recur in the future. Possible changes or additions to procedures will be reviewed by the Compliance Officer and will be approved by Agency.

The Compliance Officer will report to the CEO and, depending on the nature of the issue, the Board of Directors regarding which corrective actions have been implemented and whether the compliance problem was corrected within a reasonable amount of time.

2. Discipline. All Agency Affected Individuals are expected to adhere to the Code of Conduct, the Compliance Program, and applicable Agency compliance policies and procedures. If the Compliance Officer concludes, after an appropriate investigation, that there has been a violation, appropriate discipline may be imposed. Discipline may include, but is not necessarily limited to oral warnings, written warnings, education, re-education, suspension and/or

termination from employment and/or affiliation with Agency, suspension of a physician's or practitioner's billing, and/or other appropriate action.

Disciplinary action will be taken, and will be fairly and consistently enforced regardless of the offending Affected Individual's level or position as appropriate for actions including, but not limited to, the following:

- failing to report suspected problems;
- authorizing or participating in non-compliant behavior;
- encouraging, directing, facilitating or permitting either actively or passively, non-compliant behavior;
- refusing to cooperate in the investigation of a potential violation;
- failure to assist in the resolution of compliance issues; and/or
- intimidating or retaliating against an individual for good faith reporting of a compliance violation or other good faith participation in the Compliance Program.

The disciplinary action shall be imposed on an escalating basis and shall consider a variety of factors. Such factors may include, but are not necessarily limited to: (1) the nature of the violation; (2) the time period affected; (3) the amount involved; (4) whether the violation was committed intentionally, recklessly, negligently, or mistakenly; (5) whether the individual has committed any other violations in the past; (6) whether the individual self-reported his or her misconduct; and/or (7) whether (and the extent to which) the individual cooperated in connection with the investigation of the misconduct. Intentional or reckless behavior shall be subject to more significant sanctions. The disciplinary procedure shall conform with collective bargaining agreements, when applicable.

The foregoing is not intended, and shall not be viewed, as a limitation on the Agency's right or ability to impose more than one disciplinary sanction in a particular situation, to impose any other or additional disciplinary sanctions that may be appropriate and permissible in a particular situation, or to take any other actions, measures or sanctions that may be appropriate and permissible in a particular situation.

Any disciplinary action taken and the corrective action implemented shall be documented.

3. Guidelines for Refunding Overpayments.

It is Agency's policy:

- to not retain any payments to which it is not entitled. To that end, reports or other information indicating that an overpayment may

have been received must be immediately brought to the Compliance Officer's attention;

- to exercise reasonable diligence in timely investigating and quantifying any and all potential overpayments; and

- to promptly report, return and explain in writing to the appropriate government agency, contractor or payer (including but not limited to, the New York State Department of Health or the New York State OMIG), any identified overpayments in accordance with applicable legal, regulatory, contractual and/or other requirements or guidance.

Note that governmental and private insurance payers may have different rules concerning when and how identified overpayments must be handled.

For example, under the Federal Affordable Care Act statute (the "ACA"), Medicare and Medicaid overpayments must be reported, returned and explained in writing within 60 days of the date the overpayment is identified. For Medicare Part A and Part B purposes, an overpayment is considered to have been "identified" when a person has or should have, through the exercise of "reasonable diligence," determined that an overpayment has been received and has quantified the amount of the overpayment. "Reasonable diligence" includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining "credible information" about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances. Once an overpayment has been "identified," the person must report, return and explain in writing the overpayment within 60 days.

With regard to Medicaid, Agency will exercise reasonable diligence to determine whether it has received any overpayments and, if so, to quantify the amount of the overpayment. Agency will, as appropriate, report, return and explain in writing any identified Medicaid overpayments within 60 days of identifying the overpayment, to the New York State Office of the Medicaid Inspector General ("OMIG), through its self-disclosure program. The requirements of OMIG's self-disclosure program and related information may be found at: https://omig.ny.gov/provider-resources/self-disclosure.

Any questions regarding when and how potential overpayments are to be addressed by Agency must be immediately brought to the attention of the Compliance Officer, who may consult with outside counsel, as necessary and appropriate.

C. RECORDKEEPING

The Compliance Officer will maintain a record of all investigations, corrective actions and disciplinary actions imposed pursuant to this Policy. Such records shall be maintained for no fewer than ten (10) years from the later of the conclusion of the investigation or the

imposition of the corrective action or disciplinary action(s), or for such longer period of time as may be required by applicable law, regulation or contract.

D. PERIODIC REVIEW OF THIS POLICY

Agency will periodically review this Policy and Procedure (no less than annually) to ensure that it is modified as necessary in order to remain current with applicable law, regulation and guidance, as well as our contractual requirements.