Revive Health Senior Care and Affiliated Skilled Nursing Facilities

Code of Conduct and Corporate Compliance Program

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Compliance Hotline 24/7: (775) 237-3727
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Introduction

This Corporate Compliance Program (“Program”) has been developed for Revive Health Senior Care to ensure that employees, contractors, and vendors understand and comply with appropriate standards of care and demonstrate adherence to legal and regulatory requirements.

The Program focuses on preventing and detecting criminal, civil and administrative violations and promoting quality care. Although both the Program and the Quality Assurance Program address issues related to quality of care, the Program focuses on adherence to federal and state laws and regulations regarding reimbursement for the services delivered, and arrangements with providers of services and supplies to facilities.

The Program is comprised of the following elements, each of which is more fully described in this Program manual:

1. **Code of Conduct** – A statement of the Provider's commitment to compliance with federal and state laws and regulations; as well as compliance to ethical behavior.

2. **Compliance Officer** – An individual in Senior Management whose primary responsibility is ensuring that the Compliance Program achieves its objectives.

3. **Compliance Committee** – An interdisciplinary team created to assist the Compliance Officer oversee the Program. The Committee will meet at least quarterly to discuss internal and external audits, survey issues, policies and procedures and address compliance issues and concerns.

4. **Compliance Training and Education** – Employees attend in-service training upon hire and annually on the Program.

5. **Confidential Disclosure Program** – The mechanism by which employees may confidentially and anonymously share concerns with management.

6. **Disciplinary Actions** – Employees and Contractors are subject to discipline for failing to comply with applicable standards, laws and this program.

7. **Screening of Ineligible Persons** – Employees and contractors are screened prior to employment and on an on-going basis to confirm they have not been convicted of a criminal offense related to the provision of health care services, and have not been excluded from participation in the federal health care programs.

8. **Written Policies and Procedures** – Specific policies and procedures have been developed to ensure our compliance with applicable laws and regulations.

9. **Periodic Audits and Monitoring** – Periodic audits and monitoring techniques are used to confirm compliance goals are maintained and to assist in the elimination of identified problem areas.

This Program, including the Code of Conduct, does not address every situation an employee may face. If you are unsure of the proper protocol to follow in a particular situation, or know of a standard that has been violated, please contact:

- Your Immediate Supervisor;
- The Hotline at: (775) 237-3727;
- Corporate Compliance Officer Identified on the Cover of this Program

Code of Conduct

Revive Health Senior Care has and wants to maintain an excellent reputation for conducting its business activities with integrity, fairness and in accordance with the highest ethical standards, and in compliance with Federal, State and local laws. Employees and our business associates enjoy the benefit of that reputation and are obligated to uphold it in every business activity.

Although no list advocating ethical behavior and cautioning against misconduct, no matter how carefully crafted, could cover every circumstance, the following is Revive Health Senior Care's Code of Conduct which has been designed to protect both Revive Health Senior Care, our business associates and our customers.

Under this Code, each employee and business associate shall:

- Conduct all aspects of Revive Health Senior Care business in an honest, ethical and legal manner and obey the laws of the United States and of every state and locality where the Company does business.

- Conduct all business within the guidelines of the False Claims Act, including the prohibition of filing false claims with the Government (including Medicare and Medicaid programs).

- Conduct work on behalf of Revive Health Senior Care with customers, suppliers, fellow employees and the public with the highest standards of honesty, integrity and fairness.

- Be responsible for his/her actions and their consequences. No-one will be excused from misconduct because another person ordered or asked the employee to participate in misconduct.

- Alert his/her supervisor or a member of Executive Management whenever he/she observes, learns of or suspects any dishonest, destructive or illegal act.

- Respect the rights of all employees to fair treatment and equal opportunity without illegal discrimination or harassment of any type.

- Protect against the unlawful dissemination of confidential information that belongs to Revive Health Senior Care, its residents, suppliers and fellow workers.

- Ensure that all financial transactions and other documentation are handled honestly and recorded accurately. This commitment extends to the reporting and charging of time.

- Avoid Conflicts of Interest, both real and perceived. Conflicts of interest are those outside activities or personal interests that could influence objective decisions made in the performance of responsibilities to Revive Health Senior Care.

- Recognize that even the appearance of misconduct or improper behavior can be very damaging to the company's reputation and act to prevent such appearances.

- Cooperate fully in any investigation of alleged misconduct.

- Understand that there are consequences for violating this Code of Conduct. Consequences for violations include reprimands, demotion and dismissal for employees, and cancellation of services and contracts for business associates.

- Have the right to report, without suffering retaliation, any activity by Revive Health Senior Care that the employee or business associate believes: a) violates any state or federal law; b) violates or amounts to noncompliance with a state or federal rule or regulation; or c) violates fiduciary responsibilities by a corporation to its shareholders, investors, or employees. In addition, employees may and should refuse to participate in any activity that would result in the violation of state or federal statutes, or a violation or noncompliance with a state or federal rule or regulation.

Revive Health Senior Care is committed to preserving the integrity of the work environment. If an employee or business associate is ever in doubt as to whether an activity meets the company's ethical standards or compromises the company's reputation, he/she should discuss this with his/her supervisor, Human Resources or a member of Executive Management. Accordingly, all employees have an obligation to report any violations or possible violations of this Code of Conduct, government laws or regulations or company policy. Employees and business associates are also encouraged to present questions and concerns about compliance issues and company policy.

Employees and business associates have several options for conveying information concerning possible improper conduct and violations. An employee may directly contact their supervisor or Human Resources either in person or via email. Alternatively, an employee may also make reports of alleged violations or concerns about compliance issues to the company's hotline at (775) 237-3727. If an employee wishes to remain anonymous, he/she must request anonymity.

Corporate Compliance Program

Commitment to Compliance

It is the intent of Revive Health Senior Care to comply in good faith and to the best of its ability and knowledge with applicable State and Federal laws, program requirements of Federal, State and private health plans, and ethical business practices. Revive Health Senior Care is also committed to exercising due diligence to prevent and detect criminal conduct. Revive Health Senior Care wants its employees to be fully informed about applicable laws and regulations so they are better able to do their jobs in a compliant manner.

To assure its commitment to compliance, Revive Health Senior Care has developed a Corporate Compliance Program with the following key elements:

- Written Compliance Policies and Procedures
- Responsibility for Corporate Compliance
- Education and Training
- Effective lines of Communication/Reporting Compliance Issues
- Auditing and Monitoring
- Compliance as an Element of Employee Performance/Disciplinary Guidelines
- Responding to Non-compliance and Taking Corrective Action
- Code of Conduct

This Compliance Program is intended to provide the framework for compliance. It is not intended to set forth all of the Revive Health Senior Care's programs and practices. Revive Health Senior Care will continue to modify practices and develop new programs as part of its compliance efforts. This Corporate Compliance Program will be distributed to all Revive Health Senior Care's employees, Directors, and Business Associates as appropriate.

Written Compliance Policies and Procedures

Nursing Home has developed and adopted policies and procedures designed to prevent fraud and abuse, and protect resident rights, while ensuring a high standard of quality care. These policies and procedures will educate employees, physicians, vendors, contractors, and volunteers to Federal and State laws, rules and regulations, as well as Medicare, Medicaid and other payor requirements. They also will identify potential areas of non-compliance and list procedures for reporting problems and adopting changes to prevent further non-compliance. These policies and procedures shall address Revive Health Senior Care's clinical, financial and administrative functions including, but not limited to:

- Quality of Care
- Resident Rights

- Billing and Cost Reporting
- Employee Screening
- Kickbacks, Inducements and Self-Referrals
- Submission of Accurate Claims
- Anti-supplementation
- Medicare Part D
- HIPAA Privacy, Security, and Breach Notification
- Creation and Retention of Records

The Compliance Officer, with the approval of the Compliance Committee and the Executive Management, shall issue written policies and procedures relating to the Compliance Program. Some policies and procedures may be written by the Administrator, the Director of Nursing, or other managers, with the assistance and approval of the Compliance Officer. These policies and procedures will be communicated to Revive Health Senior Care's employees (including management), Directors, contractors, and volunteers, as appropriate. The Compliance Officer and Compliance Committee will assess these policies and procedures and update them as necessary.

Responsibility for Corporate Compliance

The following parties share responsibility for the Corporate Compliance Program:

A. **Compliance Officer** – Executive Management shall appoint a Compliance Officer. The Compliance Officer has the primary responsibility for overseeing the compliance program's implementation, maintenance and improvement and assumes the managerial and administrative tasks involved in establishing, monitoring and updating this program. For a complete list of Compliance Officer responsibilities, please see the *Compliance Officer and Compliance Committee Policy & Procedure*. The Compliance Officer reports to Executive Management. The Compliance Officer has direct access to the Compliance Committee, the Executive Management and Revive Health Senior Care's legal counsel.

B. **Compliance Committee –** The Compliance Committee will advise and assist the Compliance Officer in the development and implementation of the Compliance Program. The Compliance Committee will include:
    a. Nursing Home Administrator
    b. Director of Nursing
    c. Departmental Directors
        i. Business Office
        ii. Social Services
        iii. MDS Manager
        iv. Activities
        v. Dietary
        vi. Environmental Services (Housekeeping/Laundry/Maintenance)
        vii. Staff Development

d. One non-management person from each classification:
    i. Nurse (Either RN or LPN)
    ii. Nursing Assistant

C. **Employees** – Each employee has a duty to**:**
    a. Attend compliance training
    b. Follow Compliance policies and procedures
    c. Seek guidance from supervisor/Compliance Officer regarding compliance questions
    d. Promptly report actual or suspected violations of the Compliance Program. *See Effective Lines of Communication/Reporting Compliance Issues* below.

Failure to adhere to the Compliance Program may result in discipline up to and including termination. *See Disciplinary Action*.

D. **Vendors/Contractors/Business Associates** - Revive Health Senior Care's Compliance Program applies to vendors, contractors and business associates, who will be expected to adhere to it. It is Revive Health Senior Care's goal to incorporate such persons into the compliance program as appropriate, for example, including them in the training, distributing the plan to them and addressing compliance in contracts and agreements.

Education & Training

The Compliance Officer is responsible for ensuring the Compliance Program Policy and Code of Conduct are distributed to all employees, Directors, vendors, contractors, and business associates, as appropriate. When the Compliance Program is first implemented, and as part of new employee orientation, and annually, employees will receive compliance training. Employees will review the Compliance Program Policy and Code of Conduct and be given an opportunity to ask questions. Employees should complete the attached Acknowledgment, which will be kept on file with each individual's personnel file or electronically where the facility stores such forms.

The Compliance Officer will also distribute the Compliance Program and Code of Conduct to volunteers (10+ hours per month) and students (if any), and obtain an acknowledgement from them. The Compliance Program and Code of Conduct will be posted in an inconspicuous location at each facility and on each facility's website, and will be available to residents and families upon request.

Employees will be given annual compliance training. Revive Health Senior Care will also provide periodic training and updates to maintain employee awareness of compliance policies and procedures, including reports of compliance activities and regulatory updates.

Attendance at all training sessions will be documented and retained with each individual's personnel file or electronically where the facility stores such information.

Effective Lines of Communication / Reporting Compliance Issues

1. Questions are encouraged

Employees are encouraged to ask their supervisors or the Compliance Officer any questions they have about compliance. Supervisors who are unable to answer employee compliance questions will seek guidance from the Compliance Officer. When the Compliance Officer is unable to answer compliance questions, he/she will seek guidance from the Compliance Committee, legal counsel and/or executive management.

2. Reporting Non-Compliance

Employees are required to report any and all suspected non-compliance, no matter how minor the issue may seem, so it may be investigated. Reporting may be done the following ways:

- Contacting your immediate supervisor
- Contacting the Compliance Officer
- Calling the hotline: (775) 237-3727. The hotline is available 24/7. The hot-line is also available to vendors, residents and their families, and will be posted throughout the facility.
- Submitting an inquiry at www.revivehealthseniorcare.com/our-ethics.
- Using the anonymous drop box located in the facility's lobby.

All reports will be kept confidential to the fullest extent reasonably possible. Employees may make reports anonymously. When possible, and when the identity of the person making the report is known, Revive Health Senior Care will follow up with the complainant to inform him/her of the results of the investigation.

Employee training will promote the use of the hot-line and drop box to report potential compliance issues. The hot-line number and drop box location will also be listed in some employee communication materials.

Revive Health Senior Care will post the names, addresses, and telephone numbers for the State Survey Agency and any other required numbers in the building as appropriate locations.

3. Non-Retaliation

Employees who ask a compliance question or report potential compliance issues to Revive Health Senior Care or to a government agency will not be subject to retaliation or harassment by Revive Health Senior Care as a result of the report. Concerns about potential retaliation or harassment should be reported immediately to the Compliance

Officer. Any reports of retaliation or harassment will be immediately and thoroughly investigated, and if retaliation or harassment is found, it will be met with disciplinary action, up to and including dismissal.

4. Documentation

The Compliance Officer will keep a log reflecting any compliance issues raised and the results of the investigation of those issues. The Compliance Officer will use this log to update policies and procedures, and improve training, as necessary. All complaints and their disposition will be tracked in the Compliance Program and reported to the Compliance Committee and the Executive Management, as appropriate, and while respecting confidentiality.

Revive Health Senior Care welcomes reports of non-compliance and views these reports as essential to improving our operations. Harassment and retaliation in response to reporting will not be tolerated.

Auditing and Monitoring

A. Baseline Review

Revive Health Senior Care has adopted this new plan and will initially focus on the baseline areas as indicated in the Baseline review. This baseline review will be used to formulate standards and goals, and policies and procedures specific to the risk areas where there may be concerns.

B. Ongoing Review

Revive Health Senior Care establishes a compliance calendar on an annual basis that includes auditing and monitoring activities in each identified area of compliance risk. Audit tools may include but are not limited to: random sampling of records or charts, reviewing written contracts, observing clinical staff, assessing HIPAA documentation, evaluating employee training and discipline records, and reviewing compliance report complaint logs and investigative files. If additional expertise is required, contractors may be used to conduct certain audits. Certain Audits are included in this Manual.

C. Annual Review

The Compliance Officer will coordinate an annual comprehensive audit to evaluate Revive Health Senior Care's performance in all areas of the Compliance Program.

As part of the annual review, the Compliance Officer will recommend changes to current policies and procedures if improvements are needed. Employees will be promptly trained on policy and procedure changes.

In addition to testing each component of the Compliance Program, the annual review will assess the overall effectiveness of the Compliance Program using the following measures:

- Have adequate resources been allocated to compliance initiatives?
- Is there a reasonable timetable for implementation of the compliance measures?
- Have the Compliance Officer and Compliance Committee been vested with sufficient autonomy, authority, and accountability to implement and enforce appropriate compliance measures?
- Do compensation structures create undue pressure to pursue profit over compliance?
- Do employees understand the policies and procedures applicable to their job functions?
- Do employees feel they can report compliance issues without retaliation?
- Is discipline for non-compliance imposed consistently?

D. Audit Procedures

The purpose of compliance monitoring and auditing is to measure performance, identify problem areas, improve processes, and advance compliance with Federal and State laws and regulations, program requirements, ethical standards, and payor rules. Audits will be conducted by appropriate personnel under the direction of the Compliance Officer. The Compliance Officer will document the procedures and findings of each audit and share the results with the Compliance Committee and Executive Management, as appropriate.

If an audit identifies potential compliance issues, the Compliance Officer will handle the matter according to Revive Health Senior Care's policies and procedures for investigating compliance matters. *See Responding to Non-Compliance and Taking Corrective Action Policy and Procedure*. Any weakness or deficiencies identified in the Compliance Program will be promptly corrected. This include promptly repaying any detected overpayments or self-disclosing misconduct to the authorities. Revive Health Senior Care takes these obligations very seriously. The Compliance Officer and Compliance Committee will use the audit results to improve and update the Compliance Program. Employees will be promptly trained on policy and procedure changes.

Compliance as an Element of Employee Performance/Disciplinary Action

Adherence to this Compliance Program is a condition of employment at Revive Health Senior Care. Employees who fail to comply with the Compliance Program will be subject to disciplinary action, regardless of their level or position. Managers and supervisors have a responsibility to discipline employees who violate the Compliance Program in a fair and consistent manner. Managers and supervisors should discuss with employees and contractors the compliance policies relevant to their functions, and the disciplinary consequences for failing to comply. Appropriate disciplinary action will be taken for:

- Participation in or authorization of actions that violate Federal and/or State laws and regulations, the Compliance Program (including the Code of Conduct), or Revive Health Senior Care policies and procedures.
- Failure to report a violation or suspected violation of Federal and/or State laws or regulations, the Compliance Program, or Revive Health Senior Care policies and procedures.
- Actively or passively encouraging, directing, facilitating or permitting non-compliant behavior
- Failure by a violator's supervisor to detect and report a compliance violation, if such failure reflects inadequate supervision or lack of oversight.
- Refusal to cooperate in an investigation of a potential violation.
- Retaliation against an individual for reporting a compliance violation.

The Compliance Officer has no disciplinary enforcement authority; he/she may investigate, evaluate, and make recommendations to the Administrator consistent with Revive Health Senior Care policies and procedures as they apply to employees. The specific disciplinary action will be determined by the Administrator in conjunction with the appropriate supervisor, and in accordance with Revive Health Senior Care's disciplinary sanctions process as set forth in the Employee Handbook. The degree of disciplinary action will range from verbal warning to termination of employment, and will depend upon multiple factors, such as:

- The severity of the violation
- Whether the violation was committed accidentally, negligently, recklessly or intentionally
- Whether the individual has previously committed Compliance Program violations
- Whether the violation was self-reported
- Whether, and the extent to which, the individual cooperated with the investigation of the violation
- Whether the violation constitutes a crime; and if so, whether it is a misdemeanor or a felony
- Whether the violation is unethical
- Whether anyone was harmed by the violation

Disciplinary actions may include the following:

- Verbal warnings
- Written warnings (kept in the employee's HR file)
- Demotion
- Pay Reduction
- Suspension (with or without pay)
- Termination
- Institution of legal actions/reporting conduct to authorities or licensing agencies

In addition to imposing discipline, Revive Health Senior Care will implement other remedial measures as appropriate.

Employees non-adherence to the Compliance Program will be considered as a criterion in performance reviews. Prompt and complete self-disclosure of one's own non-compliance may be considered a mitigating factor in determining discipline or sanctions. Likewise, employees' adherence to the Compliance Program and efforts to advance compliance initiatives in Revive Health Senior Care will be considered as a positive criterion in performance reviews.

Responding to Non-Compliance and Taking Corrective Action

A. Investigating Compliance Issues

All reports of potential compliance violations will be expeditiously investigated by the Compliance Officer to determine whether there is reasonable cause to believe the Compliance Program has been violated. The Compliance Office will conduct an investigation with assistance from Revive Health Senior Care's legal counsel, as appropriate.

Employees should cooperate fully with all Compliance Program investigations. To the extent possible, the inquires and all information gathered will remain confidential and may be subject to various privileges under the law. If the Compliance Officer determines the integrity of the investigation could be compromised by the presence of employees under investigation, those employees will be put on administrative leave until the investigation is complete.

The investigative file should be maintained confidentially. All reports will be investigated unless the information provided by the report contains insufficient information to permit a meaningful investigation. The Compliance Officer will attempt to obtain additional information when possible. If not possible, the Compliance Officer will document the reason an investigation did not take place.

The Compliance Officer will include compliance reports and their results in his/her reports to the Compliance Committee and Executive Management.

A. Corrective Action Plans

If an investigation identifies non-compliance, the Compliance Officer shall have the responsibility and authority to take or direct appropriate action to address the issue, except where discipline requires action of the Nursing Home Administrator. In developing the corrective action plan, the Compliance Officer should consult with the Administrator, legal counsel, Compliance Committee and appropriate clinical and administrative personnel, as appropriate. All compliance issues will be addressed promptly, and on a case-by-case basis. When assessing corrective action, the Compliance Officer will seek advice from Revive Health Senior Care's legal counsel to determine the appropriate course of action. Some non-compliance might require further auditing/internal investigation, and/or returning overpayments or self-disclosing misconduct to the government. Strict timelines may apply.

Possible corrective actions include, but are not limited to:

- Returning overpayments
- Self-reporting to law enforcements, the OIG or other authorities
- Updating the Compliance Program
- Modifying policies and procedures
- Training employees to adhere to policies and procedures

The corrective action plan will be provided to the Administrator and included in reports to the Compliance Committee and Executive Management. The corrective action plan should be designed to ensure not only that the specific issue is addressed, but also that similar problems do not recur.

B. Abuse

All alleged incidents of mistreatment, neglect or abuse (including injuries of unknown origin), and misappropriation of resident property must be immediately reported to the Administrator, and to the authorities within required timelines set by federal or state regulations. Additionally, anything that makes an employee feel uneasy or just doesn't seem right should be immediately reported to a supervisor, department head or the Administrator.

C. Governmental Investigations

It is the policy of Revive Health Senior Care to cooperate fully with federal, state and local regulatory and law enforcement officials; to provide honest and complete answers to their inquiries and to provide them with all information to which they are entitled. The following are specific procedures in cooperating with governmental investigators:

- Subpoenas and other requests for records of the organization made by federal, state or local government or regulatory authorities, attorneys, the media or others should be forwarded to our Legal Counsel for advice on the proper response to the request.
- Subpoenas and other requests for specific patient medical records will be handled in accordance with our organization's medical records policies to ensure compliance with patient confidentiality requirements.
- We will grant immediate access to our facilities and records to properly identified representatives of the U.S. Department of Health and Human Services' Office of the Inspector General and the Medicaid Fraud Control Unit of the state where our facility is located. Contact our Legal Counsel as soon as possible after the arrival of government officials from these agencies. Our Counsel will assist you further.
- Agents or officials from all other government or regulatory agencies seeking access to our facility or records (but not possessing a search warrant) should be directed to our Counsel for assistance with their request.
- Law enforcement or regulatory officials presenting a valid search warrant will be granted access to all facilities. Immediate contact with Legal Counsel is required if this rare, complex exercise ever occurs. Legal Counsel will ensure that senior managers receive appropriate training to cooperate with the execution of a search warrant.
- Under no circumstances will any employee destroy or hide any organization property or records that are requested or sought by government or regulatory officials or inspectors. Notify the Compliance Officer immediately if anyone directs you to destroy or conceal records that are part of an inquiry or investigation.
- If an employee is approached by a government agent or investigator for an interview or to answer a few questions related to our healthcare services, the employee can choose to speak with investigator or can decline to speak to the investigator. **It is a personal choice for each employee to make**. Employees can request that the interview be conducted at another time (such as during work hours or at our work location.) Employees can seek advice or representation assistance from our Counsel before submitting to an interview. We request our associates to consult with our Counsel if approached for an interview, to ensure an understanding of rights and options in the matter. No one in our organization may direct, order or suggest that an employee lie to investigators. If an employee decides to speak with investigators, truthful answers must be provided.

Specific Compliance Areas of Focus – Fraud and Abuse Risk Areas

The following is not meant to be an exhaustive list of the areas that the Corporate Compliance Program will focus on, but rather is meant as a guide of the areas which are typically at risk in

long-term care facilities. The Compliance Officer should keep and maintain documents which evidence which areas are of focus at a given time.

A. Quality of Care

In cases that involve the failure of care on systematic or widespread basis, the facility can be liable for submitting false claims to the government. There is widespread precedent that facilities that routinely and systematically provide poor quality of care cannot and should not be reimbursed for that substandard care. Thus, it is important that the quality of care always be in accord with the applicable standards and regulations. Here are common risk areas which should be monitored:

i. Sufficient Staffing (including competency of staffing and screening of staff backgrounds)
ii. Comprehensive Resident Care Plans
iii. Medication Management
iv. Appropriate use of psychotropic medications
v. Resident Safety and Security

B. Submission of Accurate Claims

Nursing facilities must submit accurate claims to Federal and State health care programs and private insurance companies. Examples of false or fraudulent claims include: claims for items not provided or not provided as claimed; claims for services that are not medically necessary; and claims when there has been a failure of care. Submission of a false claim or causing a false claim to be submitted may subject the healthcare provider, the individual or both to criminal prosecution, civil liability and exclusion from participation in federal, state or private programs. Common and longstanding risks associated with claim preparation and submittal include: duplicative billing; insufficient information; false or fraudulent cost reporting. Additionally, the following are seen as specific areas of risk:

i. Proper reporting of Resident Case-Mix (RUG coding) – Classifying a resident into the correct RUG, through resident assessments, requires accurate and comprehensive reporting about the resident's condition and needs. Inaccurate reporting of data could result in the misrepresentation of the resident's status, the submission of false claims and potential enforcement actions.
ii. Therapy Services – The provision of physical, occupational and speech therapy services is a risk area. Potential problem areas include: a) improper utilization of therapy services to inflate the severity of RUG classifications and obtain additional reimbursement; b) overutilization of therapy services billed for on a fee-for-service basis; and c) stinting on therapy services provided to patient covered under bundled payments.

iii. Screening for Excluded individuals and Entities – No Federal health care program payments may be made for services provided by an individual or entity which is excluded. Procedures must be in place to ensure that no person or entity for which services are provided are on the exclusion lists.
iv. Restorative and Personal Care Services – Nursing facilities must ensure that residents receive appropriate restorative and personal care services to allow them to attain and maintain their highest practicable level of functioning.

C. Federal Anti-Kickback Statute

The Federal Anti-Kickback Statute places constraints on business arrangements related directly or indirectly to items or services reimbursable by Medicare or Medicaid. The statute prohibits the healthcare industry from engaging in certain business practices which may be common in other industries, such as offering gifts or rewards for the referral of new business. The statute is a criminal prohibition against remuneration, in any form, whether direct or indirect, made purposefully to induce or reward the referral or generation of Federal healthcare program business. It prohibits offering or paying anything of value for patient referrals. It also prohibits offering or paying of anything of value in return for purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or order of any item or service reimbursable, in whole or in part, by Medicare or Medicaid. Nursing facilities receive from and make referrals to other providers that accept Medicare and Medicaid, and must endeavor to ensure that these referrals are made in concert with this law. Although liability under the Anti-Kickback Statute ultimately turns on the party's intent, it is possible to identify arrangements or practices that present a significant risk for abuse. For purposes of identifying potential risks, the following questions are useful, but not exhaustive:

- Does the nursing facility (or its affiliates and representatives) provide anything of value to persons or entities in a position to influence or generate Medicare/Medicaid business for the facility?
- Does the nursing facility (or its affiliates or representatives) receive anything of value from persons or entities for which the nursing facility generates Medicare/Medicaid business for someone else?
- Could one purpose of an arrangement be to induce or reward the generation of Medicare/Medicaid business?
- Does the arrangement or practice have a potential to interfere with, or skew, clinical decision-making?
- Does the arrangement or practice have the potential to increase the costs to Medicare/Medicaid or their beneficiaries?
- Does the arrangement or practice have the potential to increase the risk of overutilization or inappropriate utilization?
- Does the arrangement or practice raise patient safety or quality of care concerns?

Keep in mind that there are certain arrangements that the government has identified as safe harbors. The facility and Compliance Officer should consult with legal counsel as to the compliance of certain arrangements when there is doubt.

D. Other Risk Areas

1. Physician Self-Referrals

Commonly referred to as the "Stark Law", nursing facilities should be familiar with the physician self-referral rules. Stark prohibits entities that furnish certain designated health services (DHS) from submitting to Medicare (and Medicare from paying) claims for the DHS if the referral for the DHS comes from a physician with whom the entity has a prohibited financial arrangement. Nursing facility services covered under Medicare Part A are not DHS for the purposes of this law. However, nursing facilities that bill Part B for labs, therapy or other DHS must be aware of the law. Nursing facilities should be especially mindful of relationships with attending physicians that are also owners, investors, medical directors or consultants to other health care providers where residents could be referred for services. Any questions or concerns should be shared with legal counsel.

2. Anti-Supplementation

Nursing facilities are not permitted to "tack-on" to the Medicare or Medicaid rate for any service for which they have accepted the Medicare or Medicaid rate. In essence, the Medicare or Medicaid rate must be accepted as payment in full for any service reimbursed by Medicare or Medicaid.

3. Medicare Part D

Medicare extends voluntary drug coverage to beneficiaries through Part D. Like all Medicare beneficiaries, nursing facility residents have the right to choose which Part D plan they wish to enroll in, if any.

Specific Compliance Policies And Procedures

Screening of Ineligible Persons

Personnel are screened prior to employment and on a monthly basis thereafter against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's System for Award Management (SAM), the U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons list. When applicable, personnel are screened via state lists of individuals and entities excluded from participation in state-funded programs such as Medicaid, to confirm they have not been convicted of a criminal offense relating to the provision of health services or health care items, and have not been excluded, debarred, or otherwise declared ineligible to participate in federal health care programs.

Individuals and entities with which Provider or a facility contracts to provide health care services or supplies are also screened against the foregoing lists at the time of contracting and on a monthly basis. The Human Resources Director/Designee is responsible for and will maintain documentation of the employee screening required upon hire and make such documentation available to the Corporate Compliance Officer. The Corporate Compliance Officer or his/her designee is responsible for and will maintain documentation of monthly screening of individuals and entities with which Provider and facilities contract to provide goods or services.

Arrangements with Health Care Providers Involving Patient Referrals

POLICY: To comply with the federal anti-kickback and physician self-referral (Stark) laws, agreements between Provider and a physician, physician extender, therapy provider, diagnostic services provider, hospital, home health agency, hospice, pharmacy, managed care organization or alliance, or other individual or entity that involves or may involve the referral or transfer of any patient to or by Provider for healthcare services or supplies will be reviewed by legal counsel, at the request of the Corporate Compliance Officer, prior to execution.

PROCEDURE:

A. Arrangements with health care providers to which Provider may refer patients or from which Provider may receive patient referrals will meet the requirements listed below. The list is not exhaustive, but is the minimum required for any such arrangement. Agreements with health care providers will:

    a. Be reviewed and approved by legal counsel prior to execution.

    b. Be in writing and signed by all the parties.

    c. Specify all of the obligations of the parties.

    d. Certify that the health care provider is eligible for participation in the Medicare and Medicaid programs, if applicable, and require that the health care provider notify Provider on an ongoing basis of the imposition of any remedies or sanctions, including termination of Medicare and/or Medicaid program participation imposed by the OIG or a state Medicaid agency, and of the initiation of any audit or investigation of the health care provider by any such agency.

    e. Specify the fee or payment, if any, which will be set at fair market value for the items or services provided.

    f. When taken as a whole, be reasonable in its entirety.

    g. Not take into consideration the value or volume of referrals provided by or to Provider.

    h. Not involve the payment or receipt of remuneration to or by Provider to induce the other party to refer or obtain referrals of patients from Provider.

B. All agreements will be forwarded to the Corporate Compliance Officer who will be responsible for review and initial screening.

C. After initial screening, the Corporate Compliance Officer will forward the proposed agreement to the legal counsel for final review.

D. After the proposed agreement has been approved by legal counsel and the Corporate Compliance Officer, legal counsel will determine an appropriate designee to sign the agreement and ensure the proposed agreement is executed and included in the Provider's records.

E. Exclusion Checks

Prior to entering into an agreement with a provider of health care services and on an ongoing basis, the Corporate Compliance Officer/designee screens the individual or entity against the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's System for Award Management (SAM), the U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons list, and, when applicable, state lists of individuals and entities excluded from participation in state-funded programs such as Medicaid. The Corporate Compliance Officer/Designee maintains documentation of the required screening with the written agreement with the provider.

Billing

POLICY: Provider is committed to prompt, complete, and accurate billing of services provided to patients for payment by patients, government agencies, or other third-party payers. Billing will be made only for services actually provided, directly or under contract, pursuant to the terms and conditions specified by the government or third-party payer and consistent with industry practice.

Provider and its employees will not make or submit any false or misleading entries on bills or claim forms, and no employee will engage in any arrangement, or participate in such an arrangement at the direction of another employee (including any officer of Provider or a supervisor), that results in such prohibited acts. Any false statement on any bill or claim form will subject the employee to disciplinary action by Provider, including possible termination of employment.

PROCEDURE:

1. Information related to billing will be accurately prepared and maintained, including patient records.

2. Only those services rendered will be documented and billed. Services provided will receive accurate billing codes.

3. Patient bills will be itemized and include dates of service.

4. Provider and its employees will specifically refrain from engaging in the following billing practices:
    - Make claims for items or services not rendered or not provided as claimed (such as billing for three hours of therapy when only a few minutes were provided);
    - Submit claims to Medicare Part A for skilled nursing facility residents who are not eligible for Part A coverage, in other words, who do not require services that are so complex that they can only be effectively and efficiently provided by, or under the supervision of, professional or technical personnel;
    - Submit claims to any payer, including Medicare, for services or supplies that are not medically necessary or that were not ordered by the patient's physician or other authorized caregiver;
    - Submit claims for items or services that are not provided as claimed, such as billing.

Medicare for expensive prosthetic devices when only non-covered adult diapers were provided;

- Submit claims to any payer, including Medicare and Medicaid, for individual items or services when such items or services either are included in the facility's per diem rate for a patient or are of the type that may be billed only as a unit and not unbundled;
- Double bill (billing for the same time or service more than once);
- Provide inaccurate or misleading information for use in determining the Resource Utilization Groups, Version IV (RUG-IV), Medicaid level, or other skilled nursing payment or acuity classification scale, score or ranking assigned to skilled nursing facility residents, including but not limited to misrepresenting a resident's medical condition on the minimum data set (MDS); or
- Pay or receive anything of financial benefit in exchange for Medicare or Medicaid referrals (such as receiving non-covered medical products at no charge in exchange for ordering Medicare-reimbursed products).

Deficit Reduction Act of 2015

POLICY: It is the policy of Provider to comply with certain requirements set forth in Section 6031 and 6032 of the Deficit Reduction Act of 2005 ("DRA") with regard to federal and state false claims laws. All Revive Health Senior Care Healthcare employees, board members, officers, contractors, and agents receive training regarding the federal and state false claims statutes and the role of such laws in preventing and detecting, fraud, waste, and abuse in federal healthcare programs.

PROCEDURE:

A. General

Each Revive Health Senior Care Healthcare entity's responsibilities include, but are not limited to:

1. Ensuring that all employees, including board members and management, are provided with the policy within thirty (30) days of commencing employment or contractor status; and
2. Upon hire and on an annual basis, employees will receive training on the federal and state false claims statutes, including preventing and detecting fraud, waste, and abuse in federal healthcare programs.

B. Contents of Policy

1. <u>False Claims Act ("FCA") Laws General Information</u>
Individuals or entities that submit false or fraudulent claims under State Medicaid programs may be civilly liable under the FCA, 31 U.S.C. 3729-3733. Under the FCA, any person who knowingly submits, or causes to be submitted, a false or fraudulent claim for payment or approval under the State Medicaid program may be liable to the Federal Government for up to three times the amount of the Federal Government's damages plus penalties of $5,500 to $11,000 for each false or fraudulent claim.

2. <u>Qui Tam Provision</u>
Under the qui tam provisions of the FCA, private persons, known as realtors, may file lawsuits in Federal court against individuals and/or entities that defraud the Federal Government by submitting false or fraudulent claims under State Medicaid programs. The Department of Justice ("DOJ") is required to investigate the relator's allegations and may intervene and take over the prosecution of the action. If the DOJ chooses not to intervene, the relator has the right to conduct the action. With respect to recoveries in cases in which the DOJ has intervened, the relator is generally entitled to some of the proceeds of the action or settlement of the claim, depending on the extent to which the relator substantially contributed to the case.

3. Whistleblower Protections

   The False Claims Act ("FCA") provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, retaliated against, or in any other manner discriminated against employees who filed a complaint or exercised their rights under the FCA. Additionally, the FCA affords remedies to affected employees which include, but are not limited to, three times the amount of back pay, including, but not limited to, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

4. State False Claims Laws

   Many states have False Claims Acts. It's important to understand that the State False Claims Act will also apply.

Gifts

POLICY: It is the policy of Provider that its employees will not obtain any improper personal benefit by virtue of their employment with Provider, and that Provider will not offer, give, solicit or accept gifts that are or may be viewed as improper inducements or in exchange for the referral of patients or other health care business (e.g., purchase of medical supplies or services).

PROCEDURE:

1. *Receiving Gifts*.

   A. It is acceptable for a facility, **not** an individual employee, to accept a modest perishable gift such as a floral arrangement, box of cookies, candy, or similar food items to be shared by staff members, including a complimentary lunch during an educational presentation. Individual employees may not accept any non-monetary gift from referral sources or vendors, except pursuant to Paragraph 3.C.

   B. Provider and its employees may **not** accept cash or cash equivalents (e.g., gift cards and gift certificates) from referral sources, vendors, other external entities, patients or patients' family members.

   C. Employees may not accept non-monetary gifts from patients or their family members, other than in connection with a holiday during which gift-giving is customary. Any holiday gift offered to or received from a patient or family member should not have a value exceeding $15.00 per item or $75.00 in the aggregate over the course of a year.

2. *Giving Gifts.*

   A. *Cash and Cash Equivalents*. The giving of cash or cash equivalents is **strictly prohibited**.

   B. *Inducement or Reward for Referrals*. Any gift intended to induce or reward referrals or result in the purchase of items or services from Provider is **strictly prohibited**, regardless of the value of the gift. Even if a gift is not intended to induce or reward referrals, gifts of more than nominal value may be viewed as an effort to induce or reward referrals to Provider. To avoid even an appearance of impropriety, any gift to a person in a position to refer business to Provider must be nominal in value and
(1) clearly and completely unrelated to past or future referrals between the parties and (2) unlikely to induce referrals. "Nominal" shall be defined as an individual gift with a value of $50.00 or less. Repeated gifts to the same recipient should be avoided, but in no event shall such gifts collectively exceed an annual aggregate value of greater than $50.00. All intended gifts shall be reported to the Corporate Compliance Officer.

C. *Government Officials*. Gifts, even if nominal in value, may not be offered to any government official.

D. *Gifts to Patients*. Employees may not offer non-monetary gifts to patients or their family members, other than in connection with a holiday during which gift-giving is customary. Any holiday gift offered by an employee to a patient or family member should not have a value exceeding $15.00 per item or $75.00 in the aggregate over the course of a year. All such gifts must be reported to the Corporate Compliance Officer.

3. *Meals and Entertainment*.

A. *Paying for Meals*. Sharing a meal may be a means to communicate important information to an individual who is or may be in a position to refer business to Provider. However, a meal can also be viewed as an inducement or reward for referrals. Paying for a meal with the intent to induce or reward referrals or result in the purchase of items or services from Provider is **strictly prohibited**, regardless of the value of the meal. It is appropriate for occasional meals to be offered as a business courtesy to a person so long as the meal is clearly and completely unrelated to past or future referrals and unlikely to induce referrals and if: (1) the meal is modest as judged by local standards; (2) is not part of an entertainment or recreational event; and (3) is provided along with the communication of important information. Treating the same individual to frequent meals shall be avoided. Provider **must** notify the Corporate Compliance Officer of the following before treating an individual or individuals to a meal: (i) the names and affiliations of guests; (ii) the name of the restaurant or meal provider; (iii) the informational purpose of the meal, together with a brief outline of the topics to be discussed. All meals must be approved by the Corporate Compliance Officer.

B. *Paying for Entertainment*. Paying for entertainment, such as a ticket to a sporting event, concert, golf outing, or banquet is **prohibited**.

C. *Accepting Gratuities*. In limited circumstances, it may be permissible to accept a meal from a current or potential vendor. The purpose of the meal must never be to induce or influence a business transaction. The cost must be modest as judged by local standards and the purpose must be the communication of important information. The invitation must be declined if the occasion appears to be extravagant or if the invitation could be reasonably perceived by anyone as having the intent to influence a business decision by the Provider. In no event shall an employee accept gratuities in the form of entertainment, such as tickets to a sporting event, concert, golf outing, or banquet.

4. *Non-Profit Organization Fundraising Events*. Employees are permitted to attend regional non-profit organization events sponsored by entities in a position to refer business to Provider so long as the event is reasonable and directly supports the other non-profit organization.

5. Any questions concerning this policy or the topics discussed herein should be discussed with the Corporate Compliance Officer.

Health Care Professional Credentialing

POLICY: Health care professionals working in/for Provider health care entities will maintain required licensure, certification, registration and professional liability insurance coverage, as applicable, and must be eligible to participate in federal and state health care programs.

PROCEDURE:

1. Prior to commencing work in Provider facilities, health care professionals are required to provide documentation demonstrating that they possess required licenses, certifications and professional liability insurance and have undergone appropriate screening (e.g., criminal background check, drug testing) confirming their eligibility to provide health care services in Provider facilities.

If the documentation reveals any restrictions or other irregularities, the information is forwarded to the Corporate Compliance Officer for further investigation.

2. Prior to a health care professional commencing work in/for an Provider health care entity and on an ongoing basis, the health care professional is screened against the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's System for Award Management (SAM), the U.S. Department of the Treasury Office of Foreign Assets Control (OFAC), Specially Designated Nationals and Blocked Persons list, and, when applicable, state lists of individuals and entities excluded from participation in state-funded programs such as Medicaid, are checked to verify that they are eligible to participate in federal and state health care programs.

Privacy and Security of Protected Health Information

POLICY: It is the policy of the Provider to maintain the privacy and security of patients' protected health information in accordance with the standards set in the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), and related regulations.

PROCEDURE:

1. The requirements for privacy and security of protected health information are outlined in the corporate HIPAA Manual.

2. New hire and annual compliance training includes a review of HIPAA policies and procedures.

Recordkeeping and Documentation

POLICY: Accurate and complete recordkeeping and documentation is critical to virtually every aspect of Provider's health care operations. It is the policy of Provider that documentation will be timely, accurate, and consistent with applicable professional, legal, and facility guidelines and standards. This includes all aspects of a facility's documentation, including clinical records and billing and payment documentation. Falsification of records is strictly prohibited, including backdating records, with the exception of appropriate late entries duly noted and made consistent with applicable professional and legal standards.

PROCEDURE:

1. Only authorized personnel may make entries into medical records.

2. Entries into the medical record will be dated, timed and signed (unless otherwise specified in applicable guidelines). Signatures are written with the first and last name and credentials, or electronically completed with full name and credentials displayed.

3. All care, planned and provided, will be entered into the medical record. It will be legible and timely.

4. Late entries to the medical record will be entered with the current date and time and the phrase "late entry for…" followed by the date and time being referenced.

5. When incorrect entries are made on any part of the medical record or other facility forms, strike one line through the incorrect entry (so the original entry is still readable) and date and initial that entry. White out/correction fluid or tape will not be used on any part of the medical record.

6. Verbal or telephone orders should be signed within the time period specified by state law.

7. Job-specific recordkeeping and documentation training is provided upon hire and annually.

Refund of Overpayments

POLICY: If inaccuracies are discovered in claims already submitted for payment or reimbursement, the payer will be notified and appropriate action taken to remedy the matter. Providers will refund to any federal government, state agency or private payer any overpayment received in error due to incorrect billing or for services found on audit not to meet coverage requirements.

PROCEDURE:

1. Any individual who determines there may be an overpayment must notify his/her supervisor immediately with the following information:

    - Patient name;
    - Type and amount of overpayment;
    - Date; and
    - Payer.

2. The issue should be researched diligently and discussed with all department managers involved in the service rendered in order to substantiate the overpayment.

3. If it is determined that an overpayment exists, a refund to the appropriate payer should be completed as soon as possible.

4. If an electronic adjustment can be completed, it should be completed as soon as possible.

5. Routine processing errors should be reported to your immediate supervisor and corrected as soon as they are identified using the above procedures.

6. If it is determined there may be a **substantial overpayment** ($5,000.00 or more) **or** one that cannot be refunded through a payer's routine procedures, the Corporate Compliance Officer should be notified to determine, in consultation with legal counsel, how the matter will be addressed.

Vendor Agreements

POLICY: To comply with applicable laws regarding referrals, Provider will not solicit or receive from any vendor, or offer or give to any vendor, anything of value if that vendor is in a position to refer business and/or patients to Provider, or if Provider is in a position to refer business to that vendor. This policy does not preclude the purchase, rental, lease, or other acquisition or provision of reasonable and necessary services or items for fair market value by Provider or its employees.

PROCEDURE:

A. Vendor agreements will meet the requirements listed below when any item(s) or service(s) supplied by the vendor are reimbursable under any state or federal health care program. The list is not exhaustive, but is the minimum required for any such vendor agreement. Vendor agreements will:

1. Be in writing and signed by all parties.

2. Specify the particular services or supplies to be provided.

3. Specify the fee or payment to be made to the vendor, which will be set at the fair market value for such services or supplies and/or be based upon applicable fee schedules or other payment guidelines established by CMS or its designees, the state Medicaid agency or its designees, or other applicable third-party payers, and will not take into consideration the value or volume or referrals provided to or by Provider.

4. Specify that the vendor will submit all bills in accordance with the payment method and amount set forth in the vendor agreement.

5. Have a term of at least one year or will provide that the agreement will not be renegotiated within 12 months of its inception in the event of its termination before the expiration of 12 months.

6. Certify that the vendor currently is eligible for participation in the Medicare and Medicaid programs, if applicable, and require that the vendor notify Provider on an ongoing basis of the imposition of any remedies or sanctions, including termination of Medicare and/or Medicaid program participation imposed by the OIG or a state Medicaid agency, and of the initiation of any audit or investigation of the vendor by any such agency.

7. If the value or cost of the services or supplies to be provided under the vendor agreement equals or exceeds $10,000 over a 12-month period, the agreement will specify that the vendor will, for a period of at least four years after the furnishing of the services and supplies, retain records to verify the nature and extent of the costs of such services and supplies and make such records available upon request by Provider, the Secretary of the U.S. Department of Health & Human Services, the U.S. Comptroller General, or any of their duly authorized representatives (and/or independent auditors); and the vendor will impose similar obligations on any subcontractor it uses to provide the services and supplies under the vendor agreements.

B. All agreements will be forwarded to the Corporate Compliance Officer who will be responsible for review and initial screening.

C. After initial screening, the Corporate Compliance Officer will forward the proposed agreement to the legal counsel for final review.

D. After the proposed agreement has been approved by legal counsel and the Corporate Compliance Officer, legal counsel will determine an appropriate designee to sign the agreement and ensure the proposed agreement is executed and included in the Provider's records.

E. Exclusion Checks

Prior to entering into an agreement with a vendor and on an going basis, the Corporate Compliance Officer/designee screens the vendor against the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's System for Award Management (SAM), the U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons list, and, when applicable, state lists of individuals and entities excluded from participation in state-funded programs such as Medicaid. The Corporate Compliance Officer/designee maintains documentation of the required screening with the written agreement with the vendor.

Contract Review

ASSIGNED TO: Corporate Compliance Officer

FREQUENCY: Annually

PURPOSE: To validate that Provider's agreements with vendors and providers of health care services and supplies conform to the requirements of Provider policies and applicable law.

METHOD:

On an annual basis, the Corporate Compliance Officer/designee reviews a sample of agreements with vendors and providers of health care services to confirm that they meet the requirements of Provider's policies on "Vendor Agreements" and "Arrangements with Health Care Providers Involving Patient Referrals."

Billing: Medicare Part A & Part B (Triple Check)

ASSIGNED TO: Compliance Officer

FREQUENCY: Monthly/Annually

PURPOSE: To confirm that claims submitted for payment are accurate, complete and supported by the required documentation.

METHOD:

1. On a monthly basis, the designated facility staff under the direction of the Compliance Officer reviews the charts of the facility's Medicare residents prior to submitting claims for payment to confirm the documentation is complete and accurate using the Triple Check Audit Form.

2. The Compliance Officer or her/his designee forwards a copy of the results of each prepayment review, including corrective action implemented, to the Compliance Committee.

3. The Compliance Officer maintains audit forms and related documents in a special location.

4. On an annual basis, the Corporate Compliance Officer/designee conducts validation reviews of a random sample of charts reviewed by each facility to determine whether the results of the review are correct.

5. The Corporate Compliance Officer discusses with the facility any differences between the conclusions of their respective documentation reviews, and they institute further corrective action if necessary.

Billing: Medicare Part A (Therapy Documentation)

ASSIGNED TO: Director of Rehabilitation Services

FREQUENCY: Monthly / Quarterly

PURPOSE: To confirm that claims submitted for payment are accurate, complete and supported by the required documentation.

METHOD:

1. On a monthly basis, the Facility Director of Rehabilitation Services will complete five (5) medical record audits on patients who were assigned to the Ultra High RUG category.

2. The Facility Director of Rehabilitation Services will forward the results, including any action plans taken, to the Compliance Officer.

3. On a Quarterly basis, The Director of Rehabilitation Services will identify performance trends and potential billing issues and present these to the Corporate Compliance Officer to determine future training needs and course of action identified.

Billing: Medicare Part B (Therapy Documentation)

ASSIGNED TO: Director of Rehabilitation Services

FREQUENCY: Monthly / Quarterly

PURPOSE: To confirm that claims submitted for payment are accurate, complete and supported by the required documentation.

METHOD:

1. On a monthly basis, the Facility Director of Rehabilitation Services will complete five (5) medical record audits on patients who received therapy reimbursable under Medicare Part B during the previous month to confirm the accuracy and completeness of the documentation.

2. The Facility Director of Rehabilitation Services will forward the results, including any action plans taken, to the Compliance Officer.

3. On a Quarterly basis, The Director of Rehabilitation Services will identify performance trends and potential billing issues and present these to the Corporate Compliance Officer to determine future training needs and course of action identified.

Personnel Documentation Review

ASSIGNED TO: Corporate Compliance Officer

FREQUENCY: Annually

PURPOSE: To validate that Provider health care entities maintain up-to-date documentation relating to professional licensure, certification, registration and professional liability insurance, as applicable, as well as documentation of appropriate pre- employment, pre-promotion, and ongoing screening.

METHOD:

1. The Corporate Compliance Officer/designee reviews the personnel files of randomly selected health care professionals (employees and contractors) at each facility to confirm they contain documentation of current licensure, registration, certification, and professional liability insurance as applicable, required pre-employment and pre- promotion criminal background checks and drug tests, screening against government exclusion lists, and other screening required by state law.

2. If any deficiencies are detected, the Corporate Compliance Officer/designee directs the facility Compliance Liaison or Human Resources Department, as appropriate, to obtain any missing documentation and confirm receipt of the same in writing to the Corporate Compliance Officer within 30 days.