



Compliance Program Training Material

This material provides employees with a general understanding of the ENT and Allergy Associates Compliance Program. Training is mandatory for all new employees and will be provided on an annual basis thereafter. A copy of the Summary of the Compliance Plan is also included and all employees are required to read this material.

After reading the following information answer the attached multiple choice questions related to the material. A score of 70% is required for passing. Also sign the Acknowledgement form attached to the Compliance Plan Summary to confirm that you have received it and will read it.

After completing the test, please send it along with the signed Acknowledgement Form, to the Director of Regulatory Affairs at the Corporate office either via interoffice or regular mail:
560 White Plains Road, Suite 500
Tarrytown, New York 10591

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A. Introduction to the Compliance Program

ENT and Allergy Associates, LLP has voluntarily implemented a Corporate Compliance Program to demonstrate a good faith effort to comply with all applicable laws and regulations. Given that there are tremendous federal resources being directed towards investigating alleged “fraud and abuse” in the health care industry, it is prudent to organize, centralize and formalize internal controls and procedures in the interest of protecting our practice from the potential for fraudulent or erroneous conduct.

The existence of an **effective and active** compliance program provides evidence that any improper behavior uncovered was inadvertent and unintentional. As such, the existence of such a plan is a significant factor to be taken into account in ascertaining whether a health care provider has made reasonable efforts to prevent, detect and, if necessary, respond appropriately to any fraudulent behavior. Such a finding is relevant when determining the level of sanctions, penalties and exclusions that the government will seek to impose on the health care provider.

The burden is on us to demonstrate that the Compliance Program is operationally active and effective. This is accomplished by having an active Medical Management Committee dedicated to dealing with compliance related issues, training of all employees regarding the program and a mechanism for reporting any potential issues which is in compliance with guidance provided by the Office of Inspector General. Practices that claim to have a formal compliance program but who fail to demonstrate its implementation will be looked on more unfavorably than practices with no claim of a formal plan.



B. Purpose

This Compliance Program is intended to ensure that ENT and Allergy Associates, LLP develops and implements internal controls and procedures to promote adherence to all applicable federal, state, and local laws, rules and policies regarding payment for health care services including but not limited to coding, billing, documenting, claims submission and improper conduct.

Other purposes of the Compliance Program are:

- ❖ To define the Code of Ethics that states our practice's commitment to compliance with all legal and regulatory requirements.
- ❖ To emphasize organizational commitment to accurate submission of all claims to third parties
- ❖ To promote the detection and reporting of any potential abusive or fraudulent practices in order to expedite appropriate corrective action thereby, reducing the potential of exposure to external scrutiny.

C. Code of Ethics



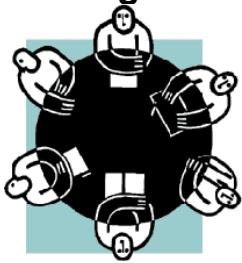
You have been provided with a copy of the Summary of the Compliance Program. You are required to read this information. It sets forth some of the important highlights of the Compliance Plan. The Code of Ethics states our commitment to compliance with all legal and regulatory requirements under which we are governed. This, along with the Standards of Conduct, is the core of the Compliance Program

D. Standards of Conduct

The Standards of Conduct supplement the Code of Ethics. They are the compliance standards and procedures that will reasonably ensure that the prospect of criminal conduct is minimized. The first four standards concentrate on the four risk areas specified by the Office of Inspector General as the focus for anti-fraud and anti-abuse initiatives. The final standard involves general business practice standards.

1. Coding and Billing Standards
 - Coding and billing policies and procedures must reflect current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payer health care program requirements.
2. Reasonable and Necessary Standards
 - Claims are only submitted for services which are reasonable and necessary.
 - Documentation supports the appropriateness of a service that has been submitted to any payer for reimbursement.
3. Documentation
 - Timely, accurate and complete documentation is critical to ensure proper medical treatment and reimbursement.
 - Documentation must be legible.
 - CPT and ICD-9 codes reported should be supported by the documentation in the medical record.
4. Improper inducements, kickbacks and self-referrals.
 - Compliance with anti-kickback and self-referral laws is critical for business ventures, financial arrangements with outside entities, and consulting contracts.
 - Billing policies address anti-kickback and self-referral laws.
5. General Business Practice Standards
 - Ensure that all general business practice standards conform to applicable laws and principles.

E. Oversight



The Compliance Program is overseen by the Medical Management Committee, a subcommittee of the Board of Trustees. This committee oversees both the Compliance Program as well as Quality Assurance. It meets monthly and is extremely active in general chart audits, focused reviews, review of applicable policies and procedures and investigating reported compliance or quality assurance related issues. The Board receives a monthly report from the committee and any *recommendations* for implementation of policies and procedures or for corrective action for identified compliance violations.

Committee members include physician partners and associates as well as an Administrative Liaison.

Compliance Officer: Lee Eisenberg, MD, Medical Director
Englewood, NJ Office: (201) 567/2771
Hackensack, NJ Office: (201) 883-1062

Administrative Liaison: Katie Owens, Director of Regulatory Affairs
Corporate: (914) 333-5896
Cell Phone: (914) 760-1077

Other members Include: Wayne Eisman, MD, President
Jill Zeitlin, MD, Chair of Compliance Committee
Mark Fox, MD
Jeff Jablon, MD
Adam Schaffner, MD

F. Disciplinary Guidelines

The Compliance Program, having been approved by the Board of Trustees, constitutes official practice policy. Adherence to the policies and procedures of the Compliance Program are a material condition of employment.

All workforce members are expected to comply with the Code of Ethics, policies and procedures, contractual obligations as well as relevant federal, state and local laws and regulations. Employees are obligated to report a violation of the aforementioned.

Grounds for discipline include an active violation and failure to report a known or suspected violation of the law or of the Compliance Plan. The level of discipline depends on the nature of the violation. For example, a relatively low risk violation may require retraining in the particular area of concern. However, particularly egregious violations which put the practice at risk may result in termination of employment. The Medical Management Committee reviews all reported instances of potential violations of the Compliance Plan and recommends corrective action and/or sanctions to the Board of Trustees.

Violations can occur when committed for one's own benefit or on behalf of another party. It must be established that the acts were performed knowingly, willfully and intentionally. It should be noted that abusive behavior can evolve into fraud when there is a pattern or routine established.

G. Reporting Potential Compliance Issues

We encourage an open door policy between the physicians and the Medical Management Committee and the practice employees. It is everyone's responsibility to report suspected compliance related issues so that, if necessary, the violation can be corrected effectively and efficiently and before it is exposed to external scrutiny. There are multiple ways for employees to report a potential compliance related issue.



- Employees are encouraged to follow the chain of command by first relaying any concerns to a direct supervisor, manager or other management staff.
- Employees may also report any concern directly to either Human Resources or the Director of Regulatory Affairs.
- The Compliance Hotline provides employees a way to report potential compliance issues anonymously. There will be no attempt to identify a reporter who wishes to remain anonymous. The Compliance Hotline is located in the office of the Director of Regulatory Affairs and it provides the caller with an option to either leave an anonymous message or to ring through to the Administrative Liaison to discuss the issue directly. Please note that any anonymous reports must provide enough specific information to initiate an investigation.

Compliance Hotline Number: (914) 333-5894



Every effort is made to maintain the anonymity and confidentiality of anyone who reports a potential compliance related issue. It is our policy that no employee shall be retaliated against or punished solely on the basis that he or she reports in good faith what he or she reasonably believed to be an act of wrongdoing or a violation of the Compliance Program. However, an employee will be subject to disciplinary action if it is reasonably concluded that the report of wrongdoing was knowingly fabricated by the employee, was distorted or exaggerated, or minimized to either injure someone else or protect the reporter, or directly involves the person reporting the wrongdoing.

In determining what, if any, disciplinary action may be taken against an employee, the employee's own admissions of wrongdoing will be taken into account provided that admission was not previously known to ENT and Allergy Associates or its discovery was not imminent, and that the admission was complete and truthful. An employee whose report of misconduct contains admissions of personal wrongdoing will not, however, be guaranteed protection from disciplinary action. The weight to be given the self-confession will depend on all the facts known to ENT and Allergy Associates at the time it makes its disciplinary decisions.

All reported compliance related issues are investigated. The Administrative Liaison will complete a report detailing the substance of the potential issue. This information will be

relayed to the Compliance Committee and any appropriate Senior Management and an investigation will ensue. The findings will be reported to the Medical Management Committee who will then recommend to the Board of Trustees any sanctions or disciplinary action to be taken. If necessary, legal counsel will be contacted for advice.

H. What is Abuse and Fraud?

HIPAA significantly changed the legal landscape surrounding healthcare fraud and abuse. When it was enacted in 1996 four new criminal healthcare offenses were created: Health Care Fraud, Theft or Embezzlement in Connection with Health Care, False Statements Relating to Health Care Matters, and Obstruction of Criminal Investigations of Health Care Offenses.

It is important to note that these new criminal healthcare offenses apply to fraudulent and abusive activities affecting both public and private payers. Since HIPAA was implemented the government and private payers have significantly increased their efforts to detect alleged health care fraud and abuse. The Compliance Program primarily focuses on our attempt to prevent fraudulent or erroneous claims thereby providing us with some degree of assurance that any basis for any reviews, audits or investigations we face will be unfounded. Therefore, it is important to discuss what constitutes abusive and/or fraudulent billing behaviors.

1. **Abuse defined:**

Abuse involves actions that are inconsistent with sound medical, business or fiscal practices. Abuse directly or indirectly results in higher costs to the Medicare program through improper payments that are not medically necessary. It involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.”



2. **Fraud Defined:**



Fraud is defined by Medicare as an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in the payment of unauthorized benefits. A scheme does not have to be successful to be considered fraudulent. Violations can occur when committed for one's own benefit or on behalf of another party. It must be established that the acts were performed knowingly, willfully and intentionally.

The difference between fraud and abuse is a person's intent. That is, did they know they were committing the crime? It should be noted that what initially looks to be abuse can evolve into fraud when there is a pattern or routine established. This is because once a pattern is established or the behavior becomes routine, an investigator will likely presume that the act is being committed with knowledge.

3. Some examples of fraud and abuse include:

- a. Over-utilization of medically unnecessary services;
- b. Upcoding- reporting more extensive services than actually performed;
- c. Unbundling- reporting services already included in another, more comprehensive, service also being reported;
- d. Balance billing;
- e. Falsification of billing and medical record information;
- f. Kickbacks

I. Auditing and Monitoring

The Medical Management Committee performs audits on each physician at least annually. These audits review whether the documentation in the medical record supports the level of Evaluation & Management code reported as well as the medical necessity for any procedure codes reported.



Physicians receive feedback regarding the findings of the audit as well as any recommendations for improvement. Physicians that require substantial improvement, or who pose a relatively high perceived risk, will be re-audited within a short period of time to ensure that the recommendations have been implemented. The results of the audits are reported to the Board of Trustees.

Additionally, the Committee performs other focused reviews on numerous other coding scenarios. These could be triggered from a report of potentially inappropriate coding behaviors or because a physician is identified as an outlier in his or her utilization of one or more CPT code(s).

J. Government Inquiries

ENT and Allergy Associates will cooperate fully with any government audits and investigations. In order to ensure that our response to subpoenas, summonses, and other requests for medical records is appropriate and timely the following guidelines should be followed:



- Contact the Administrative Liaison immediately and fax a copy of any documentation received;
- DO NOT turn over any documents called for in a subpoena;
- DO NOT discuss the case with the individual who served you with the subpoena;
- DO NOT discuss the subpoena with anyone not directly involved with the matter.

Subpoenas and summonses that are relevant are those in which ENT and Allergy Associates, and/or any of its employees, are named as the defendant. Requests for medical records are relevant when the request is from a Special Investigations or Benefit Integrity Unit or other similar requests or which appear to be more than a general retrospective review. If there is any question regarding how to handle a request, please contact the Administrative Liaison.

Search Warrants

Government investigators are not required to provide forewarning of an investigation. If government agents appear at the door with a search warrant do nothing to interfere with the agents. They are to provide a copy of the search warrant and make sure the search is limited to its content. It is also important to get the name of the agent in charge.

Notify the highest ranking person (physician, PSA) on the premises. They will inform the Administrative Liaison and/or other appropriate member Senior Management and legal counsel will be promptly notified.

Documents are not to be copied on premises. The agents will remove the documents and must provide a correct and complete inventory of all items taken before leaving the premises.

Although personnel may voluntarily speak to government agents if they choose, it is recommended that personnel assert their right to have legal counsel available. It is alright to postpone any conversation with agents until such time that this is accomplished.

K. Exclusion from Medicare or Medicaid

Individuals and entities who are found guilty of submitting false or fraudulent, or otherwise improper claims for Medicare or Medicaid payment face both monetary penalties as well as exclusion from these programs. Exclusion from Medicare or Medicaid means that individual or entity is not permitted to provide services to patients covered by a federally funded healthcare plan; nor are they permitted to receive any payment for services either directly or indirectly related to patient care.

We provide services to both Medicare and Medicaid recipients, and the money we receive for these services is not separated from all other reimbursements (i.e. Oxford, Aetna, etc.). It is impractical for us to pay an excluded individual or entity exclusively with private funds or from other non-federal funding sources. Therefore, we will not employ or contract with any individual or entity that is excluded from Federal healthcare program participation. We ensure this by checking the names of all prospective physicians and employees against the Office of Inspector General List of Excluded Individuals and Entities.