SALUS UNIVERSITY

# COMPLIANCE PLAN

**ADOPTED: November 26, 2012**
**AMENDED: January 9, 2013**
**AMENDED: May 20, 2013**
**AMENDED: October 5, 2015**
**AMENDED: October 26, 2015**
**AMENDED: February 27, 2018**

# TABLE OF CONTENTS

# EXHIBITS

# SALUS UNIVERSITY UNIVERSITY COMPLIANCE PROGRAM

## PURPOSE AND SCOPE OF COMPLIANCE PROGRAM

To underscore and enhance the commitment of Salus University ("Salus" or the "University") to legal compliance and University ethics, Salus has established a University Compliance Program (the "Compliance Program" or the "UCP". As used in this document, "Salus" refers to Salus University and all of its affiliates, colleges, divisions and departments, including but not limited to Pennsylvania College of Optometry Foundation, Pennsylvania College of Optometry, Osborne College of Audiology, the College of Education and Rehabilitation, the College of Health Sciences, the Office of Graduate Programs in Biomedicine, The Eye Institute and The Ear Institute. At the heart of the Compliance Program is this document, the "Compliance Plan." This Plan is designed to assist Salus employees, contractors, agents, and students understand their role responsibilities and to foster compliance with federal, state and local laws, and federal health care program and private health plan requirements. The goal is to prevent improper or unlawful conduct or the perception thereof. The Compliance Plan consists of the following items:

- The appointment of a "Compliance Officer" to oversee and run the Compliance Program, with the assistance of a "Compliance Committee," consisting of designated Salus employees with expertise in specific areas of operations;

- The establishment of written policies and procedures to guide Salus employees, contractors, agents, and students in appropriate and ethical business practices, including the establishment of a "Code of Conduct" and certain "Compliance Policies and Procedures";

- The development of mandatory educational and compliance training sessions for Salus employees, and the development of periodic reminders of compliance issues published in memoranda or other written notices;

- The establishment of processes to enable and encourage reporting of potential non-compliance issues or other areas of concern, including through direct access to the Compliance Officer and the establishment of an anonymous reporting mechanism;

- Periodic and ongoing monitoring and auditing to gauge overall compliance efforts and the success of the Compliance Program; and

- The development of a process for corrective action, as necessary, to address issues of non-compliance, required disciplinary actions or policy changes (including the non-employment or non-retention of sanctioned persons).

### *What is a "Compliance Officer?"*

The Compliance Officer is a person who has the responsibility and authority for managing, directing and ensuring the proper functioning of the Compliance Program. Salus' Compliance Officer is listed on Exhibit A to this document.

The Compliance Officer is responsible for the Compliance Program for Salus and will be responsible for a variety of activities, including: overseeing and monitoring the Compliance

Program; establishing methods, such as periodic audits, to improve Salus' efficiency and quality of services, and to reduce Salus' vulnerability to fraud and abuse; periodically revising the Compliance Program subject to approval by the Board of Trustees of Salus University (hereinafter the "Board of Trustees" or "Board") in light of changes in the needs of Salus or changes in the law and in the standards and procedures of Government and private payor health plans; developing, coordinating and participating in a training program that focuses on the components of the Compliance Program, and ensuring that training materials are appropriate; ensuring that applicable federal or state databases of sanctioned providers have been checked with respect to all employees, contractors, agents, students and independent contractors; and investigating reports or allegations concerning possible unethical or improper business practices and monitoring subsequent corrective action and/or compliance.

***What is My Role with Respect to the Compliance Officer?***

Salus takes all reports of non-compliance and wrongdoing seriously. As a general rule, compliance matters must be brought to the prompt attention of the Compliance Officer. One of the purposes of a Compliance Program is to provide a mechanism that allows reporting of any matter that may be unethical, unprofessional, illegal or potentially an issue of non-compliance or wrongdoing, without fear of retribution or embarrassment. With respect to any such matter, every person within Salus will have direct access to, and is encouraged to consult with, the Compliance Officer. You may make a report to the Compliance Officer in any of the following fashions:

- In person;
- By telephone;
- By mail addressed to the "Compliance Officer" (Mark the envelope "Confidential"); or
- By email directed to the email address listed on Exhibit A.

You are not required to provide your name or any other facts that may give away your identity. If you provide your identity, then you will be provided with a file identification number for the reported matter and will be advised when the matter has been addressed and resolved. You will be encouraged to provide as much information as possible to assist with the investigation of the matter. You will also be advised that the Compliance Officer will use best efforts to keep your identity confidential; however, if you do provide your identity, there may be a point in time when your identity may become known or may have to be revealed.

All mailing addresses, email addresses and telephone numbers for compliance reporting are set forth on Exhibit A to this document. A sample "report" form that may be used to make a report to the Compliance Officer may be found at Exhibit B.

# CODE OF CONDUCT

## INTRODUCTION

Salus expects adherence to high standards of operational and personal ethics of all individuals employed by, or doing work for the University.[1].

It is the personal responsibility of all Salus employees, contractors, agents, and students to acquaint themselves with the legal and policy standards and restrictions applicable to their assigned duties and responsibilities, and to conduct themselves accordingly. Over and above the strictly legal aspects involved, all Salus personnel are expected to observe high standards of business and personal ethics in the discharge of their assigned responsibilities. All Salus employees and those doing work for the University must remain in full compliance with all applicable federal, state and local laws and regulations regarding health care regulatory matters, as well as the requirements of governmental and nongovernmental organizations.

All Salus personnel are required to deal fairly, honestly and professionally with patients and their families, regulatory authorities, payors, suppliers and the community at large. Every individual must avoid any action, relationship or situation which could jeopardize or impair the confidence or respect in which the University is held by its patients and the general public.

Salus has an ethical responsibility to its patients/clients and business partners. Ethical care practices and ethical business practices go hand in hand. All employees, contractors, agents, and students of the University have a responsibility to review, understand and abide by the principles set forth in this Code of Conduct.

The Code of Conduct that follows is based not just upon strict compliance with all laws affecting health services at the University and higher education regulations, but on abiding by principles of integrity, honor, and concern for others. This Code of Conduct serves as a reminder of Salus's high ethical standards, and reaffirms the basic standards of professional and business compliance and personal conduct for all University personnel.

It is every person's responsibility to be familiar with this Code of Conduct and to be sensitive to any situations that may violate it. Claims of ignorance, good intentions and bad advice may not be acceptable as excuses for non-compliance. Those of you in supervisory positions have the additional responsibility to verify that the persons whom you supervise understand their obligations to comply with the standards set forth in the Code of Conduct.

[1] All employees and contractors are engaged by the University. This CCP applies to those individuals who work at the University or any University site. For convenience, all such individuals are referred to in this CCP as Salus employees or contractors. All University clinics, unincorporated or separately incorporated, are bound by all Salus policies. If any clinic does not have a specific, stand-alone policy on a particular subject, it follows the applicable institution-wide Salus policy.

## RECORD-KEEPING

Accuracy and reliability in the preparation of all business records is mandated by law. It is of critical importance to the University decision-making process and to the proper discharge of the University's financial, legal and reporting obligations. All bills rendered to patients, their representatives or third parties must accurately reflect the services provided, and the patients' medical records shall properly and accurately record those services. All business records and reports are to be prepared with care and honesty. False or misleading entries are not permitted in the books and records of the University or its clinics. Compliance with accounting procedures and internal control procedures is required at all times. It is the responsibility of all employees to ensure that both the letter and the spirit of organizational accounting and internal control procedures are strictly adhered to at all times. Any employee should advise the Compliance Officer of any shortcomings they observe in such procedures. Every employee at University clinics is expected to record and report all information accurately and honestly. The Compliance Officer will vigorously investigate and respond accordingly to any situation where falsification of records or matters of a similar nature may be involved.

All persons involved in creating, processing and recording financial information, medical charts or billing records, or University documentation or information of any kind, are responsible for the integrity of such items. Every accounting, financial, medical and billing entry should reflect exactly what is described by the supporting information.

Record-keeping policies apply to all aspects of the University's business such as admissions, student financial aid, business and finance. In the context of University clinics, record-keeping policies apply to all records, including but not limited to:

- All clinical/medical records and billing/claims documentation required by federal or state law or the program requirements of Medicare, Medicaid and third party payors; and

- All records necessary to protect the integrity of the University's compliance process and to confirm the effectiveness of the Compliance Program, including records listing the persons responsible for implementing each part of the Compliance Program, evidence of adequate employee compliance training, compliance reports and the University's clinical practices ongoing auditing and monitoring activities, results of investigations conducted as a consequence of a compliance report or inquiry, modifications to the Compliance Program, corrective actions taken, self-disclosures made to government agencies, responses to third party payors to requests for clarification or guidance regarding billing issues, and written notifications given to third party payors or other parties regarding overpayments, contract terminations, and other compliance-related matters.

It is the University's policy to appropriately retain its documentation. Accordingly, University personnel are required to:

- Secure information in a safe place;

- Maintain paper copies (or other backup) of all electronic or database documentation;

- Limit access to any documentation to avoid accidental or intentional fabrication, loss, corruption, damage or destruction of records, or unauthorized access or reproduction; and

- Conform document retention and destruction policies to applicable laws.

All documents that relate to the operation of the Compliance Program, or that may support a claim for reimbursement related to professional medical or clinical services, are to be maintained for a period of ten (10) years, unless required to be maintained for a longer period by applicable law or separate University policy. Records that have satisfied their required period of retention must be destroyed in a manner that ensures the confidentiality of the records and renders the information no longer personally identifiable. University records relating to patient medical information cannot be placed in trash receptacles unless the records are rendered no longer recognizable as a record of University clinics. .

Records that cannot be destroyed include records of matters in litigation or records that have been designated by the University for permanent retention. It is Salus's policy that under no circumstances shall any person ever destroy or alter any records of University clinics or other documents (i) in anticipation of a request for those records or documents from any government agency or court, or (ii) relating to a pending investigation or inquiry regarding a report of a possible billing error or an incident of alleged fraud and abuse or other wrongdoing, except with the prior permission of the Compliance Officer and the approval of the University's legal counsel. In the event of a lawsuit or government investigation, the applicable records that are not permanent cannot be destroyed until the lawsuit or investigation has been finalized. Once the litigation/ investigation has been finalized, the records may be destroyed in accordance with University policy.

You should always check with the Compliance Officer if you have questions about which records may be destroyed.

All records containing Protected Health Information (PHI) shall be handled in accordance with the University's HIPAA/HITECH policies, as amended from time to time.

## CONFIDENTIAL INFORMATION

Confidential information that is not generally available to those outside of the University's clinics is considered proprietary information of the University. This information must be kept confidential, and must be protected against theft, loss or improper disclosure. The confidentiality of student educational records and protection against the disclosure of their personally identifiable information is governed by the Family Educational Rights and Privacy Act (FERPA). The fact that an individual is a patient/client of a University clinic is a matter of confidentiality. University personnel must not discuss, disclose or permit the disclosure of patient/client information or data, systems, finances, pricing and marketing data, salary and wage information, or University policies to any person who does not have a need to know such information for the use and benefit of University or for medical care reasons, or to satisfy regulatory requirements or other appropriate purposes. Former employees of the University remain bound by these rules of confidentiality.

In accordance with federal and state law and University policy (Confidentiality of University Records and Information), confidential records should never be disclosed without appropriate authorization.

All Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA/HITECH) shall be handled in accordance with the University's Health Insurance Portability and Accountability Act (HIPAA/HITECH) policies.

## REPORTING VIOLATIONS AND DISCIPLINE

Violation of the University's Code of Conduct, or any University policy, is a serious matter. Salus personnel are expected to act fairly and honestly in all transactions with the University and with others, and to maintain the high ethical standards of the University at all times. If a situation arises which presents in your mind a potential violation of laws relating to healthcare fraud, claims processing, coding, false claims, physician referrals or the Medicare and Medicaid Anti-kickback law as described herein, the Code of Conduct, or any of the Compliance Policies and Procedures, you are required to contact the Compliance Officer.

If you believe you have information regarding other compliance matters, including but not limited to the inappropriate use of Salus University's assets, officer and employee misconduct, concerns about the University's financial statement disclosures, accounting procedures, internal accounting controls and audit matters, you should follow the Salus University Whistleblower Policy.

You must also contact the Compliance Officer if you are requested to make, accept, authorize or agree to any offer, action or payment that is or may be contrary to any aspect of the University's Code of Conduct or Compliance Policies and Procedures, or if you acquire information that another employee, agent or other person representing the University is engaged in conduct that violates Salus's Code of Conduct or Compliance Policies and Procedures. Discovery of events of a questionable, fraudulent or illegal nature, whether accidental or deliberate, must be reported promptly. A knowing failure to report a violation is itself a violation of the University's Code of Conduct and the Compliance Program.

Salus will not penalize any employee for the good faith reporting of any suspected instance of non-compliance or wrongdoing, regardless of whether or not such non-compliance or wrongdoing ultimately is determined to exist following investigation. However, if the Vice President of Human Resources and Administrative Services, serving in the capacity of the University's Retaliation Complaint Officer (RCO), reasonably concludes that a report of wrongdoing was knowingly fabricated or distorted, either to injure somebody else or to inappropriately protect the reporting employee or other persons, the reporter will be subject to disciplinary action.

Managers and supervisors may be disciplined for failing to adequately instruct their subordinates or for failing to detect non-compliance with applicable policies and legal requirements, where reasonable diligence would have led to the discovery of any problems or violations and given the University the opportunity to correct them earlier. Additional guidance regarding compliance reporting obligations and procedures is set forth in Salus's *Policy No. 5 on Reporting Non-Compliance and Wrongdoing* and in Salus's Whistleblower Policy.

Compliance with the Code of Conduct, the Compliance Policies and Procedures, and other aspects of the University's Compliance Program, is a condition of employment and will be considered in evaluating performance.

Violations of the Code of Conduct, the Compliance Policies and Procedures, or other aspects of the Compliance Program, will result in appropriate disciplinary action, up to and including termination, in accordance with Salus's *Policy No. 4 on Corrective Action and Disciplinary Procedures*.

## NON-HARASSMENT AND NON-DISCRIMINATION POLICIES

All Salus personnel shall comply with Salus's Non-Discrimination and Non-Harassment Policies. Please refer to Salus's Employee Handbook and Human Resources' policies for additional information regarding these policies.

## AVOIDING ABUSE OF TRUST

The University strives to serve the best interests of the public by providing quality service, maintaining a position and reputation as a leading provider of health professions education, research, and health services, and providing full and timely information in response to proper requests. Whether we can achieve these goals depends upon the successful development of the relationships discussed in this Code of Conduct. By conducting our business in accordance with the principles of fairness, decency and integrity set forth herein, we help to build public confidence and avoid abuse of the public's trust.

## USE OF SALUS PROPERTY

Employees must use proper care when using Salus property and equipment. No employee of the University may take University property off University premises without authorization from the Provost (or designee) or the Vice President for Clinical Operations (or designee). No other employee of Salus may authorize such action. Violations of this policy may result in disciplinary action up to and including termination and possible legal action. Furthermore, Salus property and equipment shall be utilized for the specific purpose of fulfilling one's job responsibilities, and not for personal use. This is not to prohibit customary personal use of the University's copy machines, telephones, etc., in accordance with the University's established policies.

At separation of employment, employees are required to return to the University all University property in their possession, including any copies of University documents.

## CONFLICTS OF INTEREST

All University personnel shall comply with the University's Conflict of Interest Policy as such policy may be amended from time to time by the Board of Trustees.

## GIFTS AND ENTERTAINMENT GUIDELINES

It is the University's policy to prohibit its employees from offering or accepting extraordinary business courtesies. In general, a business courtesy is extraordinary if (i) it can be construed as intended to corrupt the judgment of the recipient so as to secure unfair preferential treatment, or (ii) public disclosure of the gift could reasonably be expected to harm the reputation of the University or the other party. It is the policy of the University to conduct its business affairs fairly and impartially in an ethical and proper manner. Integral to this policy is the avoidance of any appearance that the University's decisions are influenced by business courtesies they may be offered from those with whom Salus maintains business relations. Business decisions made by Salus employees should be made on the basis of quality, service, price, and similar competitive factors. Business decisions should not be based on the business courtesies offered by those who are affected by the University's decisions, nor should the acceptance of business courtesies create the appearance that those business decisions are being influenced.

Salus personnel in a position to deal with persons or firms with whom Salus maintains business relationships must be familiar with University policies and procedures regarding the acceptance of business courtesies, and must be sensitive to those circumstances where their offer or acceptance of business courtesies would be improper under this Code of Conduct, or would cause or create the appearance of favoritism in the allocation of University business or adversely affect the reputation of Salus for impartiality or fair dealing. Business courtesies should never be offered or accepted under circumstances where it might appear that the attempt is being made to induce the recipient to grant an unfair competitive advantage or to do anything that is prohibited by law, regulation or University policy.

Business expenditures of an ordinary and customary nature should be included on expense reports and approved under standard University procedures. If you are unsure whether the offer or acceptance of a particular gift or item is permissible under these Gifts and Entertainment Guidelines, you should consult the Compliance Officer.

The University's dealings with government agencies and officials must be conducted legally and morally. You must not seek to influence any government employee's judgment by promising or giving money, gifts or loans, or by any other unlawful inducement. Federal and state laws also prohibit gifts and payments made to government officials, even if they are given with no intent to influence the official.

Any requests made to University personnel by a government or regulatory official for improper payment, or any action taken or threatened by such an official with the intent of obtaining such a payment, must be reported immediately to the Compliance Officer.

## POLITICAL CONTRIBUTIONS

No funds or assets of the University may be used for contributions to any political party, political action committee, organization or candidate, whether federal, state, or local. This prohibition covers not only direct contributions but also indirect assistance or support through buying tickets to fund-raising events or furnishing goods, services or equipment.

The University's policy on political contributions applies solely to the use of University assets, and is not intended to discourage or prevent individuals from engaging in political activities voluntarily and on their own time and at their own expense. No personal contributions are subject to reimbursement by the University, and you must take care, in all cases, to avoid giving the appearance that you are acting or speaking on the University's behalf. Since a person's work time can be considered a contribution, you may not work for any political party or candidate during hours which are being paid for by the University (excluding vacation or personal time).

## DEALING WITH SUPPLIERS, OTHER PROVIDERS AND PHYSICIANS

The University's aim in conducting its purchasing operations is to assure continuing, reliable sources of supply. The University gives all potential suppliers fair and uniform consideration. Factors of race, religion, national origin, gender, other protected characteristics, personal or familial relationship, or friendship play no part in purchasing decisions, which must be based on objective criteria such as price and quality or vendor's reliability and integrity.

Salus expects all vendors to respect its Code of Conduct and Compliance Policies and Procedures. The University also encourages vendors to commit in their contracts with the University to adhere to the provisions of the Code of Conduct and Compliance Policies and Procedures.

University employees, contractors, agents, and students must never solicit or receive payments, gifts or other compensation from suppliers or vendors which are intended to induce purchasing decisions. Similarly, University personnel and students must never offer payments, gifts or similar inducements to obtain new patients/clients or referral sources or to retain existing business, except as otherwise permitted under the section of this Code of Conduct entitled *Gifts and Entertainment Guidelines*.

Appropriate gifts may be given or received on traditional gift-giving occasions provided that they are not intended as inducements to obtain new patients or referral sources or to retain existing business. Although in certain limited situations, as appropriate, the University's clinical practices may take into account a patient/client's inability to pay for services in accordance with established financial policies, all patients/clients must be treated the same fair way.

## FALSE STATEMENTS, SCHEMES TO DEFRAUD AND THEFT

Honesty in dealings with others should be a hallmark of the University. University personnel are expected to be truthful and open in their dealings with others, both within the University's operations and without. Salus employees shall not knowingly and willfully make false statements or conceal a material fact in any communication to the University's business or operations. This includes any misrepresentations made on employment or employee benefit applications, and statements made in connection with investigations and required employee reports.

It is especially important to be honest with government officials. It is the University's policy to cooperate with appropriate government investigations, while at the same time protecting the legal rights of the University, its students and its personnel. However, persons who knowingly and willfully make or cause to be made a false statement, orally or in writing, to a government official not only violate the policy of the University, but also may be committing a criminal offense punishable by fines and imprisonment. It is similarly a violation of University policy to knowingly and willfully conceal or cause to be concealed a material fact called for in a government report, application or other filing. This policy extends to all communications with a federal, state, local or foreign government agency.

University employees, contractors, agents, and students shall not engage in any scheme to defraud the University or any patient/client, customer, supplier, vendor, insurance company or third party payor or any other person or entity with whom or which the University does business, out of money, property or services or to wrongfully withhold or misappropriate the property of others. Any theft, fraud, embezzlement or misappropriation of property or resources must be reported immediately to the Compliance Officer.

## BRIBES, KICKBACKS AND MEDICARE/MEDICAID FRAUD AND ABUSE

University personnel shall not under any circumstances offer, pay, solicit, or receive bribes, kickbacks or other similar compensation, to or from any other source. Accepting or paying bribes or kickbacks is a crime punishable by imprisonment and substantial monetary fines, and could subject both the individual(s) involved and the University to criminal and civil proceedings. To avoid even the appearance of impropriety, University personnel must not engage in personal transactions with, or give gifts to or receive gifts from, patients/clients, suppliers or vendors, or others with whom the University maintains (or is considering entering into) business dealings and with respect to whom they have direct authority and decision-making power on behalf of the University, except as otherwise permitted under the section of this Code of Conduct entitled *Gifts and Entertainment Guidelines*.

Federal health care laws such as the "Medicare and Medicaid Anti-Kickback Statute," which is applicable to patients covered by Medicare, Medicaid and other governmental health care programs, prohibit persons from offering, paying, soliciting or receiving anything of value in return for or to induce, recommend or arrange the referral of an individual or the purchase or lease of a medical product or service. These laws also prohibit persons from offering or paying anything of value to a patient that the person knows or should know is likely to influence the patient to receive a medical item or service from the person or entity making the offer or payment instead of from another provider. Other federal health care laws such as the "False Claims Act" prohibit the filing of claims (and the making of false or misleading statements in support of such claims) for payment under governmental health care programs for a medical item or service that the person knows or should know was not provided as claimed, was false or fraudulent, or was for a pattern of medical items or services that were not medically necessary. Federal health care laws such as the "Stark Law" also prohibit physicians from referring Medicare and Medicaid patients to other health care providers with which the referring physician maintains certain types of financial or business arrangements. The scope of prohibited conduct under the federal health care laws is extremely broad, and legal counsel may be required to determine whether the facts of a particular case involve prohibited conduct. Still, compliance with the federal health care laws is mandatory for all University personnel. If you are aware of any conduct that may violate the federal health care laws, you must bring such matter to the attention of the Compliance Officer.

## ANTITRUST LAWS AND OTHER LEGAL OBLIGATIONS

Under the antitrust laws of the United States and some states, certain agreements (whether explicit or implicit) with competitors, patients/clients, suppliers or others may produce an unreasonable restraint of trade or a substantial lessening of competition. Violations of the antitrust laws may constitute punishable crimes and result in severe personal and civil damages. Examples of misconduct that may be anti-competitive in nature include price-fixing agreements, exclusive selling or buying agreements, certain tying arrangements that condition the purchase or sale of one type of product on the purchase or sale of another, certain mergers and acquisitions, and agreements to divide up markets. Legal counsel may be required to determine whether the facts of a particular case involve prohibited conduct.

While routine exchange of information with competitors may seem to be appropriate and reasonable in many cases, some communications with competitors may be perceived to have the effect of lessening competition. It is Salus policy that the President shall be notified prior to providing information or engaging in any conduct or transactions that may be deemed to be anti-competitive.

General business information about the University's competitors and market is important to allow the University to maintain and improve its competitive position. However, only legal and ethical means should be used to gather information about existing and potential competitors. The exchange of proprietary or other confidential information with competitors (including information on prices, wages, salary ranges or compensation formulas, marketing activities, and acquisition or development plans) shall be made only in accordance with applicable legal parameters regarding the dissemination of such information.

In addition to the antitrust laws, University personnel must conform to all other federal, state and local laws and regulations that apply to the business of the University, wherever it is conducted. If you have questions regarding whether an action is legal, or if you are having difficulty in interpreting or understanding a law or regulation, you should consult your supervisor or the Compliance Officer.

## SECURITIES LAWS

Under the securities laws of the United States and some states, it is illegal to buy or sell stock, bonds, or other securities or investments in certain publicly-traded companies based upon information about such companies and their operations or activities that is not generally known to the investment public (commonly known as "inside information" or "insider trading"). Although the University's clinical operations are not publicly-traded entities, other companies and entities with which the University maintains professional and business relationships, including but not limited to, vendors and other health care facilities, may presently or in the future offer securities or investments for sale to the general public.

Inside information may include such things as information regarding current financial results, possible new services or departments to be opened or closed, marketing plans, new contracts with insurance carriers, managed care plans or other third party payors, or personnel changes. Persons who come into possession of any "material" inside information (that is, information that might be significant to a decision to buy, sell or hold on to stock, bonds, or other securities) regarding the University or entity with which the University or its clinics maintain a professional or business relationship must not: (i) use such information as an opportunity for personal gain; (ii) disclose such information to persons outside the University , including to friends or relatives; or (iii) needlessly discuss such information with persons outside Salus .

Persons who come into possession of material inside information must exercise extreme diligence to maintain the information in confidence, and they must refrain from trading in the securities of any entity to which such information relates before such information is announced to the public and for a reasonable period of time thereafter. Failure to observe these policies may constitute punishable crimes and result in severe personal and civil damages. If you are aware of any conduct that may violate the securities laws, you must bring such matter to the attention of the Compliance Officer.

## COPYRIGHT AND INTELLECTUAL PROPERTY LAWS

Federal and state laws protect intellectual property. Intellectual property includes copyrights, trademarks and service marks, patents, and trade secrets. To protect the University's rights, the use of all of such intellectual property by University personnel must be in accordance with all applicable laws that govern the use of material and/or information which may be the subject of a trademark, copyright or patent, or which may be treated as a trade secret. In addition, University personnel must not infringe the legal rights of third parties (including former employers or competitors) with respect to trademarks, copyrighted works, patents and trade secrets owned by such third parties.

Photocopying and dissemination of material contained in books, newsletters, medical journals and other periodicals, and unauthorized duplication of computer software, can result in substantial University and personal liability for copyright infringement. However, the "fair use" doctrine potentially can justify some copying of written material for purposes such as criticism, comment, news reporting, teaching, scholarship or research, and there are other alternatives available to avoid or minimize the exposure for copyright infringement. An important factor to consider in determining whether there has been a "fair use" of otherwise protected materials is the amount and substantiality of the portion being used in relation to the copyrighted work as a whole. It is the University's policy that all employees, contractors, agents, and students must comply with all pertinent copyright laws, and must respect and support patents, trademarks, service marks, and other forms of intellectual property such as software licensing agreements.

## WIRETAPPING, EAVESDROPPING, SURREPTITIOUS RECORDING AND COMPUTER ACCESS

In addition to the University's USE OF ELECTRONIC COMMUNICATIONS policy as it may be amended from time to time, the University shall follow the policies and procedures set forth below:

It is the policy of the University to comply fully with all federal and state laws governing wiretapping, eavesdropping, or other forms of electronic surveillance. It is a violation of the law for University personnel to use any electronic, mechanical or other device to intercept the contents of a telegraphic, telephonic, facsimile, text messaging, electronic mail or other electronic communication, unless one (or in certain jurisdictions such as Pennsylvania, all) of the parties to the communication consents to the interception. This includes, but is not limited to, the use of telephone extensions to overhear other persons' conversations. The law may be violated merely by listening in on somebody else's conversation, even if no notes are taken and no recordings are made.

Persons who engage a telephone extension while another individual is using that extension must: (i) have received express permission from all persons on the line or be aware that all persons on the line have given blanket permission to listen to their telephone calls; (ii) identify themselves so that the participants in the conversation will understand that someone is listening to the conversation; or (iii) hang up immediately. It also is the University's policy to prohibit the use of any device on University property or in connection with University business to make any sound or visual recording of another person, unless all persons being recorded are aware of the recording and consent to it.

Federal law also makes it a crime to intentionally access a computer, without authorization, and obtain information restricted by virtue of the national defense, information in a federal agency's computers, or information in financial institutions. It also is a violation of law to access or tamper with any computer used in interstate commerce, without authorization, if such access is done with the intent to defraud or to damage the computer, the program or computerized information. All electronic (e-mail/internet/world wide web) communication systems operated by the University, as well as information stored, downloaded, transmitted, received, or contained in such systems, are the property of University. These systems are to be used solely for job-related purposes (except for customarily permitted personal uses).

The University reserves and intends to exercise the right at any time to review, audit, intercept, access, and disclose all materials created, received or sent over such systems. No individual user shall have any expectation of privacy from such access or monitoring of University communication systems. Notwithstanding the University's right to retrieve and read any e-mail/internet/www communication, link or message, such items should be treated as confidential by other persons and accessed only by the intended recipient.

University personnel shall refrain from using University communication systems to solicit others for commercial ventures, religious or political causes, outside organizations, or other non-business matters. Moreover, the University's e-mail system shall not be used to create any offensive or disruptive messages, or to send (upload) or retrieve (download) copyrighted materials, trade secrets, proprietary business or financial information or similar materials, without the prior approval of the Compliance Officer. Nothing contained in this University Compliance Plan is intended to interfere with employee rights to communicate about terms and conditions of employment, at appropriate times and in conformance with applicable law.

## RESPONDING TO REQUESTS BY GOVERNMENTAL OR REGULATORY AUTHORITIES

The University's policy is to cooperate with all reasonable requests from any governmental agency concerning the University's operations. This includes requests from Medicare/Medicaid agencies such as the Centers for Medicare and Medicaid Services ("CMS"), the Office of Inspector General (the "OIG") of the United States Department of Health and Human Services ("HHS"), and requests from the Federal Bureau of Investigation ("FBI"), the Department of Justice ("DOJ"), the United States Attorneys' Office, the State Attorney General's Office, and state agencies on health, senior services, public welfare, and insurance.

Employees of the University shall notify the Compliance Officer prior to responding to any requests for information that are outside of the ordinary scope of routine reports which are regularly made to governmental authorities listed above. If you are served with a subpoena, summons, complaint, search warrant, or other legal document, call the Compliance Officer and/or the appropriate University Vice President. .

Requests from the Equal Employment Opportunity Commission ("EEOC"), the Pennsylvania Human Relations Commission (PHRC), or the Occupational Safety and Health Administration ("OSHA") should be referred to the Vice President of Human Resources and Administrative Services who will subsequently notify the President.

### A. Subpoenas

If a law enforcement agent, investigator, or other governmental authority appears in person - whether in the office, at home, or elsewhere - and seeks information from you involving University operations or requests information through a subpoena, you should be advised of the following rights:

- You have the right and the responsibility to request credentials of the agent or investigator for identification purposes;
- You have the right to speak or decline to speak, as all such conversation is voluntary;
- You have the right to consult with an attorney before deciding to be interviewed; and
- If you agree to be interviewed, you can insist that an attorney or other person (including a representative of the University) be present, you can choose the time and place of the interview, and you can terminate the interview at any time.

DO NOT turn over documents called for in a subpoena until instructed by the Compliance Officer or the University's legal counsel.

### B. Search Warrants

If a law enforcement agent, investigator, or other governmental authority arrives to execute a search warrant on University property, the following steps should be taken:

- DO NOT interfere with the agents in their search;
- Demand a copy of the search warrant and the business card (or name) of the agent in charge, including the office or agency that he/she represents;
- Be sure the highest ranking employee of the University on the premises is informed of the situation; and
- Call the appropriate University Vice President and/or the Compliance Officer.

- Next, the highest ranking employee of the University on the premises) should take the following steps:

- Review the search warrant or other legal authority under which the agents assert the right to search University premises or seize documents, equipment or records, noting the specific areas of the premises and items designated for the search and seizure;
- Ask for the name and telephone number of the supervising governmental attorney;
- Inquire into what the agents are seeking, and attempt to ascertain the nature of the inquiry and the alleged violations that are the basis for the investigation (treating the agents courteously throughout the entire visit);
- Ensure that only those items referred to in the search warrant are taken (voicing objection if the agents stray outside the physical space identified in the warrant or attempt to seize items that are not referred to in the warrant);
- Urge the other employees to remain calm, and to the extent possible, ensure that the presence of the agents does not unduly interfere with the ability of University employees to carry on their essential job functions, assessing the advisability of sending non-essential employees home;
- Advise the other employees not to make small talk with the agents, and ensure that University employees understand their obligation not to obstruct the investigation (although they are not required to explain University operations, bookkeeping, records, or what any document means), as well as their right to refuse to be interviewed by the agents or to be interviewed only in the presence of legal counsel or other persons (including University representatives) or at another time and place, if they so choose;
- Accompany the agents while they remain on University property, making notes of areas searched and the general description of items seized;
- As applicable, identify for the agents any documents sought that fall under the attorney-client, attorney work product, or self-evaluation privileges;
- As applicable, attempt to convince the agents to take only computer files, not the entire computer hardware;
- At the close of the search, obtain an inventory and receipt of any items seized by the agents (and compare the list of seized documents and items on the government's receipt with the list created internally during the course of the search); and
- Request the opportunity to make copies of all documents to be taken off the premises by the agents, especially those essential to ongoing operations.

**C. Informal Contacts with Government Agents/Investigators**

All contacts with anyone claiming to represent any local, state or federal agency shall be immediately reported to the Compliance Officer. In complying with this policy, keep the following in mind:

- It is not uncommon for investigators to arrive unannounced at somebody's home, and then try to make the person feel guilty if they do not consent to an interview. Occasionally, the investigator will try to suggest that you must speak with him or her "or else." Nobody is required to submit to questioning by a government agent or investigator. Beware of any agent who says that you have nothing to worry about or who suggests that by talking to him or her, things will be better for you. Agents and investigators do not have the authority to promise anything to a witness. Only a

government attorney, working with your attorney, can make promises binding on the government.

- If someone claiming to represent the government contacts you at work or at your home, you should follow these steps:

    - Ask for identification and a business card;
    - Determine why the individual wants to speak with you; and
    - If you prefer, tell the individual that you do not wish to speak with him or her, or that you want to make an appointment for a date and time in the future. Do not be intimidated by a claim that there should be no delay because "honest people have nothing to hide."

After the investigator or agent leaves, contact the Compliance Officer and/or the Office of the President.

**D. Contacts with Non-University Employees**

Unless it is part of a person's written job description to have contact with the following categories of individuals, all University personnel are governed by the following rules:

i. Contact with the Media.

All contacts with the media MUST be referred to the Director of Communications, the appropriate University Vice President, the Chief of Staff, or for matters involving labor and employment issues, the Vice President of Human Resources and Administrative Services. You should politely, but firmly, decline to engage in any discussion with media representatives, no matter how seemingly harmless.

Reporters are skilled at extracting information, often pretending to know more than they really do or claiming to have already talked to someone inside the organization. Do not confirm, deny, or otherwise discuss information related to the University with anyone from the media unless directed to do so by the Director of Communications, appropriate University Vice-President, Chief of Staff, or the Vice President of Human Resources and Administrative Services.

ii. Contact with Attorneys.

All contacts with anyone claiming to be an attorney should be immediately referred to the Chief of Staff or the appropriate University Vice-President. The University may become involved in legal disputes and litigation. Attorneys representing those with interests contrary to the University may try to contact University personnel directly in an effort to obtain information. You should politely, but firmly, refuse to discuss anything with the attorney. Instead, refer the attorney to the appropriate University Vice-President or University Chief of Staff. .

The University realizes that, as a health care provider, it may receive requests and subpoenas for medical records from attorneys for use in connection with litigation, claims, and disputes that do not involve a University clinical practice as a party. University personnel should respond to such routine document requests in accordance with the University's records policies, but in order to maintain control over contacts with attorneys, the request must be reported as required above.

## HEALTH, SAFETY AND HAZARDOUS MATERIALS

The health and safety of Salus personnel is a primary concern and responsibility of the University. The University is committed to providing a safe and healthy working environment. All Salus personnel are responsible for performing their jobs in compliance with federal, state and local laws affecting health and safety conditions of the workplace, including the rules and regulations of the Occupational Safety and Health Administration (OSHA), state laws and licensing requirements, any applicable accrediting standards, and the health and safety policies established by the University.. Using good common sense and following health and safety regulations can keep accidents, to you and others, at a minimum. Salus personnel who improperly or carelessly endanger themselves, other University personnel, or patients/clients will be subject to discipline.

It is in the best interest of the University, its employees, students, and patients/clients that all employees are able to work to the best of their capabilities, and that employees and students are not exposed to the hazards which arise when drugs or alcohol are present in the workplace. Therefore, the University will not tolerate the possession, use or sale of alcohol, controlled substances, or any illegal drug on University premises, or the impairment of job performance arising from the use of these substances at any time. However, after-hours social functions which offer alcoholic beverages in moderation may be permitted on University premises if approved through University policy. The University encourages employees who are impaired by the use of drugs, alcohol or other substances to obtain treatment voluntarily, and where appropriate, the University, through Salus's Vice President of Human Resources and Administrative Services, may help monitor the condition of persons with a history of impairment in order to maintain the safety of other employees, students and patients/clients.

University personnel must fully comply with all federal, state, and local environmental laws, including but not limited to, those relating to controlled dangerous substances, and control of infectious disease.

**Part II of the Salus University Compliance Program defines the policies that provide the basis of the University's culture of compliance. Polices 1 through 7 are policies that apply to all University staff. Polices 8 through 19 are policies applicable to clinical providers and the clinical operations of the University.**

## POLICY No. 1

## DUTIES OF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

An individual appointed by the Board of Trustees upon recommendation of the President shall serve as the Compliance Officer and shall have the responsibility and authority for managing, directing and ensuring the proper functioning of the Compliance Program. The Compliance Officer shall be a person with sufficient integrity, credibility and standing within the University to warrant the confidence of the Board and the President and the trust and respect of Salus employees who must be comfortable in reporting matters to the Compliance Officer. The Compliance Officer must have direct access to the President and the Board. In light of the important and sensitive nature of his or her duties and responsibilities, the Compliance Officer should be a person of demonstrated tact and good judgment.

The Compliance Officer shall confer generally with University employees about matters relating to the Compliance Program, and shall report to the President and the Board of Trustees with respect to any deficiencies identified or improvements needed in the Compliance Program. The Compliance Officer shall report to the Board and the President on at least an annual basis, or when compliance matters arise which require its attention.

The Compliance Officer shall be accessible to every person within the University with respect to any and all ethics and compliance issues. The Compliance Officer shall be responsible to do or oversee the performance of the following activities:

- Ensure that all Salus employees are made aware of the Compliance Program, (and receive a copy or have access to a copy of the Compliance Plan, including the Code of Conduct and the Compliance Policies and Procedures that are applicable to their specific job responsibilities), and that all University personnel sign a statement acknowledging their understanding of the Compliance Program requirements and their obligation to abide by these requirements and to report potential compliance concerns to the Compliance Officer.

- Coordinate with Human Resources to make reasonable inquiry into the status and background of existing and potential University personnel so as to avoid the University knowingly employing or retaining persons who are excluded from or ineligible for participation in federal health care programs.

- Monitor developments relating to compliance, including changes in applicable laws, regulations and standards of conduct, and periodically distribute to affected Salus personnel memoranda, news articles or other relevant informational materials that explain compliance requirements, report changes in requirements or industry standards, or otherwise are relevant to compliance responsibilities.

- Revise, update, supplement, archive and maintain a centralized chronological repository of the University's Compliance Plan, including the Code of Conduct and the Compliance Policies and Procedures, as necessary, in order to ensure compliance with applicable laws, regulations and compliance standards and to reflect new laws, regulations and compliance standards. (A complete copy of these items should be maintained in the Compliance Officer's office or other centralized location.)

- Distribute pertinent policy manuals and compliance materials, including revisions and supplements, to appropriate employees for their use, and develop and monitor attendance at educational and compliance training sessions and in-service programs for Salus personnel, including compliance orientation for new personnel, geared toward promoting compliance throughout the University.

- Maintain effective mechanisms for University personnel to report potential non-compliance issues and wrong doing, disseminate information regarding these reporting mechanisms throughout the University, and respond appropriately to employee questions and external inquiries regarding ethics and compliance issues.

- Oversee internal quality monitoring and reviews, and periodic monitoring and auditing by external consultants, when deemed appropriate, to ensure that the Compliance Program is operating at a high level of effectiveness.

- Review and investigate reports of potential non-compliance or wrongdoing, establishing corrective action plans in consultation with the Board, when necessary.

- Develop procedures for obtaining legal advice on proposed transactions or activities that may raise questions under applicable laws or regulations or may involve ethics or compliance issues, and consult with Salus' legal counsel, as appropriate, on individual reports of non-compliance to ascertain legalities of issues and disclosure obligations and to preserve attorney-client privilege to the fullest extent available.

- Report to the President and the Board when compliance matters arise which require its attention, prepare written reports upon request detailing actions taken during the year to ensure compliance with the Compliance Program and any recommended changes to the Compliance Plan, the Code of Conduct or the Compliance Policies and Procedures that would enhance overall compliance efforts.

- Maintain a "log" of all compliance reports, identifying each report sequentially, and noting all investigations, actions and changes in policy that result from the report.

Salus University's Risk and Compliance Committee ("the Committee") provides support to University leaders and managers by providing senior level guidance relative to significant regulatory compliance matters that have been brought to its attention, particularly when overlap exists among functional areas or it is unclear which unit is responsible for managing a particular compliance requirement. The Committee meets quarterly (or more frequently if required), and reports to the University President. The Committee membership includes the following: the University's Compliance Officer (chairperson), Provost, Vice-President of Human Resources and Administrative Services, Vice-President for Clinical Operations, Vice-President for Business Administration and Finance, Dean of Student Affairs, Chief Information Officer and Associate Dean for Student Financial Affairs.

The University's clinical operations shall have a Clinical Compliance Committee, which shall be a sub-committee of the University's Risk and Compliance Committee, comprised of representatives from appropriate clinical and administrative areas to assist the Compliance Officer in carrying out the purposes of the Compliance Program. The Clinical Compliance Committee members should have broad backgrounds and experience levels and expertise in operations, monitoring quality, service delivery and legal/regulatory compliance. The Clinical Compliance Committee shall meet as specified by the Compliance Officer in order to discuss compliance issues, including monitoring and auditing activities.

The Clinical Compliance Committee assists in the development, implementation and monitoring of the University's Clinical Compliance Program. The Committee's functions include: monitoring changes in the health care environment, including regulatory changes with which Salus clinical providers must comply and identifying the impact of such changes on specific risk areas; and recommending the revision of policies and procedures, as needed, so that such policies support the Code of Conduct.

Members of the Clinical Compliance Committee shall be appointed by the Vice-President for Clinical Operations except as indicated. Members of the Clinical Compliance Committee shall include the Vice-President for Clinical Operations, one manager/administrative staff member, and at least one clinical provider from each Salus clinical discipline. The Vice-President for Clinical Operations shall chair the Clinical Compliance Committee.

Effort should be made to include members on the Clinical Compliance Committee who have knowledge and expertise in: (i) billing, finance and reimbursement; (ii) operations, administration, strategic planning and marketing; (iii) clinical, quality assurance, utilization review and patient care matters; (iv) contractual, managed care and third party payor matters; and (v) employment, personnel and human resources. As appropriate, each member of the Clinical Compliance Committee should assume responsibility for developing compliance initiatives, subject to the approval of the Vice-President for Clinical Operations, and implementing compliance monitoring and auditing activities within the Committee member's particular clinic, department, or area of expertise within Salus.

## POLICY No. 2

## COMPLIANCE MONITORING AND AUDITING

Monitoring and auditing functions enable the University to review systematically the effectiveness of the Compliance Program and target additional training efforts in order to ensure that the University's business practices and operations are (and remain) in compliance with existing University policies and applicable federal, state and local laws and regulations.

There are three (3) concurrent monitoring and auditing processes in place under the Compliance Program: (i) self-monitoring; (ii) internal audit reviews; and (iii) external reviews.

### A. Self-Monitoring

As part of an employee's performance review, each person shall be questioned as to his/her awareness of any potential compliance issues, and his/her attendance at compliance training and educational sessions and in-service programs held during the preceding review period. University employees shall be asked to certify their familiarity and compliance with the Compliance Program, including the Code of Conduct and all Compliance Policies and Procedures that are pertinent to their job responsibilities, and to certify that they have not engaged in, nor are aware of, any practices, activities or incidents that would deviate from the requirements of the Code of Conduct or any Compliance Policies or Procedures. Adherence to the requirements of the Compliance Program shall be a consideration in the annual evaluation of all University personnel. Similar inquiries and certifications shall be made of, and sought from, departing Salus personnel at scheduled exit interviews by the Vice President of Human Resources and Administrative Services.

### B. Internal Audit Reviews

Internal audit reviews shall be undertaken to address typical areas of risk associated with initiatives under the Compliance Program. The Compliance Officer, with the assistance of the University's Risk and Compliance Committee and the Clinical Compliance Committee, shall be responsible for directing employees to conduct appropriate compliance reviews throughout the University. All compliance review approaches and audit methodologies shall be approved by the Compliance Officer, and may be modified by the Compliance Officer at any time if they are determined to be ineffective or too limited in scope. As appropriate, members of the University's Risk and Compliance Committee shall be primarily responsible for compliance audits arising within such Committee member's particular area of knowledge or expertise. An internal assessment should focus both on the day-to-day University operations, as well as its clinical operations, including its adherence to the rules governing claims development, billing and relationships with third-parties.

Areas to be addressed by internal employees, under the direction of the Compliance Officer and the Compliance Committee, may include as follows:

- Specific areas of University operations that relate to initiatives under the Compliance Program as designated by the Compliance Officer or the Compliance Committee;

- Areas for study that have come to light as the result of reports made through the voluntary reporting mechanisms under the Compliance Program or through the

compliance surveys and disclosure statements received during the annual employee performance reviews and exit interviews;

- Areas for study identified by the internal employees as the result of its audit activities, with the concurrence of the Compliance Officer, and any other areas for which the Compliance Officer has requested review; and

- Appropriate follow-up study on violations previously reported under the Compliance Program in order to determine the adequacy of corrective actions taken.

Monitoring techniques that will be used by the Committee include, but are not limited to:

- Compliance audits focused on those areas within the University that have potential exposure to government enforcement actions.

- Benchmarking which provides operational snapshots from a compliance perspective that identify the need for further assessment, study, or investigation.

- Periodic reviews in the areas of Compliance Program dissemination, communication of University compliance standards and Code of Conduct, and adequacy of compliance training and education to ensure that the Program's compliance elements have been satisfied. The review process will be conducted through on-site interviews and surveys of key management operations. .

- Subsequent reviews to ensure that corrective actions have been effectively implemented.

As appropriate, warning indicators of potential compliance concerns in the University's clinical operations should be reviewed, including: (i) significant changes in the types of claim rejections and/or reductions; (ii) correspondence from the Medicare carrier and/or commercial insurance carriers challenging the medical necessity or validity of claims; (iii) illogical patterns or unusual changes in the pattern of CPT code utilization; or (iv) high volumes of unusual charge or payment adjustment transactions.

Internal audits may include such techniques as: on-site reviews, mock surveys and/or investigations; interviews with personnel involved in management, operations, billing, marketing and patient-care related activities; testing University personnel on their knowledge of pertinent University policies, health care laws and third party payor reimbursement criteria; review of written materials prepared by different departments or divisions within the University, assessment of existing contractual and business relationships involving the University; and trend analysis studies that spot deviations in specific areas over a given period, including deviations from any prior baseline audits or assessments that have been performed. The internal audit staff should be permitted to review all areas of the University operations and to have access to all personnel relevant to the discipline being audited.

The protocol for Medicare Chart Audits is attached hereto as Exhibit D, <u>but may be modified at any time if it is determined to be ineffective or too limited in scope</u>.

**C. External Reviews**

External legal counsel, accountants, auditors and other consultants or professionals may be retained for purposes of monitoring and auditing activities under the Compliance Program,

but only upon the express prior approval of the President or the affirmative action of the Board of Trustees. As appropriate, the President and/or the Board should consult with the University's legal counsel prior to engaging any external accountants, auditors or other consultants in order to discuss the preservation of the attorney-client privilege to the fullest extent available.

## POLICY No. 3

## COMPLIANCE TRAINING AND CONTINUING EDUCATION

As part of the orientation provided to all Salus personnel, the University will provide instruction and training regarding the Compliance Program, including the University's Code of Conduct and the Compliance Policies and Procedures that are pertinent to each person's job responsibilities. This instruction and training will be scheduled by the Compliance Officer (in conjunction with the Human Resources staff), and should be performed within thirty (30) days of the employee or contractor's hire or contract date. Attendance at these orientation sessions is mandatory and shall be monitored by the Compliance Officer.

In addition to compliance orientation for new personnel, the University is committed to providing ongoing education and training under the Compliance Program for existing employees. A minimum of one (1) annual educational or training session or in-service program shall be offered to all Salus personnel. Additional targeted training also may be provided to those persons who create greater legal exposure to the University by virtue of their job responsibilities (e.g., billing, coding and marketing employees, managers and supervisors, etc.). The Compliance Officer also may disseminate information regarding pertinent external conferences and seminars to appropriate University personnel.

To accommodate the training program requirement, optometry faculty members/clinical providers will receive assignment time allocations on their Faculty Assignment Sheets for Patient Record Audit Sessions (4-2 hour sessions) and Clinical Coding Training (4-1 hour sessions) beginning in FY 2012-2013. Faculty members/clinical providers in other program areas will receive assignment time allocations based on the volume of the clinical claims for their respective disciplines.

It is expected and required that University personnel will comply with the educational and training sessions, conferences, web-based programs, and/or seminars for which their attendance has been specified as mandatory. Failure to comply with training requirements will result in disciplinary action.

Examples of topics likely to be covered during the University's internal sessions and programs include:

- Federal and state statutes, regulations and guidelines applicable to University's academic and research programs and clinical services;
- Accreditation requirements;
- CMS manual instructions;
- Carrier medical review policies;
- Private payor policies;
- Medical record audits for coding compliance; and
- The University's Code of Conduct and Compliance Policies and Procedures.

Managers of specific departments may be asked to assist in identifying areas that require compliance training and in carrying out such training.

In addition, the University will provide training to those individuals involved in policy-making, coding, billing and claims submission on topics such as:

- Specific government and private payor reimbursement principles;
- Proper documentation of items and services rendered, including the correct application of CPT coding rules and guidelines;
- Improper alterations to documentation (e.g., medical records, certificates of medical necessity, etc.);
- Compliance with federal, state and private payor standards;
- The legal sanctions for submitting deliberately false or reckless billings; and
- Duty to report misconduct.

The University will provide training to those individuals involved in sales and marketing activities on topics such as:

- General prohibition on paying or receiving remuneration to induce referrals;
- Routine waiver of deductibles and/or coinsurance;
- Disguising referral fees as salaries or other payments;
- Offering free items or services to induce referrals;
- High pressure marketing of non-covered or unnecessary services;
- Improper patient solicitation; and
- Duty to report misconduct.

Compliance training sessions should allow participants to ask questions regarding ethics and compliance issues and identify resources within the University that can answer subsequent questions that may arise. In addition to University sponsored compliance training sessions, appropriate University personnel should attend professional education courses sufficient to ensure that they remain current with changes within their field of expertise. The Compliance Officer shall maintain copies of all attendance logs and materials disseminated at compliance training sessions.

All Salus personnel shall be provided access to the University's Compliance Plan, including the Code of Conduct and the Compliance Policies and Procedures, and any other documents that are pertinent to their job responsibilities, along with appropriate updates of these items. Within a reasonable period of time following distribution of the Compliance Plan, each person shall be required to sign and return to the Compliance Officer a copy of the *Compliance Plan Awareness Certification Form,* a copy of which is attached as Exhibit E to the Compliance Plan, certifying the person's receipt of and familiarity with the Compliance Plan and the person's commitment to report any potential compliance concerns in accordance with the procedures established under the Compliance Program.

The Compliance Officer should undertake and oversee regular efforts to ensure that University personnel are aware of the voluntary reporting aspects of the Compliance Program, including through: (i) communication to University personnel at the commencement of the Compliance Program; (ii) discussion and printed information distributed during orientation for new Salus personnel; (iii) discussion and printed information distributed to University personnel during compliance training and educational sessions; (iv) discussion during annual performance reviews; and (v) the posting of Compliance Program notices in prominent locations throughout the University.

The Compliance Officer shall establish standards for provider education and training, the current version of which is attached hereto as Exhibit F.

## POLICY No. 4

## CORRECTIVE ACTION AND DISCIPLINARY PROCEDURES

It is the policy of the University to ensure that all reasonable steps are taken to facilitate compliance with applicable federal, state and local laws and regulations, including but not limited to, those involving the Medicare and Medicaid programs. Toward that end, the enforcement of the Compliance Program is meant to prevent, detect and deter instances of non-compliance and wrongdoing.

It is also the policy of the University that the standards of conduct set forth in the Compliance Plan, including the Code of Conduct and the Compliance Policies and Procedures, shall be consistently administered through appropriate review, remediation and, where appropriate, personnel mechanisms. If a violation of any applicable law, regulation or standard of conduct relating to federal or state health care laws, regulations, or third party reimbursement is detected, the University shall take all reasonable steps to respond appropriately to the violation and to prevent further similar violations from occurring including, where appropriate, through modifications to the Compliance Program.

With regard to misconduct or violations which do not directly implicate federal or state health care laws or third party reimbursement, the President, with the assistance of the Vice President of Human Resources and Administrative Services, shall take such actions, or where applicable, remand such cases to the appropriate committee, for the adjudication of alleged professional misconduct, violations or lack of fitness as a teacher, researcher or clinical educator, in accordance with University, Faculty and Human Resources policies.

It is further the University's policy that if it learns: (i) of a material violation of any applicable health care law or regulation that is not known to the relevant governmental agency but is reasonably likely to be of interest to that agency; or (ii) that any statement previously made by or on behalf of the University to any governmental agency is subsequently found to be false or incorrect in any material respect, then, upon the advice of counsel, the University shall, when appropriate, voluntarily and promptly (after internal investigation) self-report the matter to that agency. Nothing under this policy or under the Compliance Program generally shall be deemed to require a waiver of any right, privilege or immunity conferred upon the University by state or federal law.

Salus expects the performance by all of its personnel under the Compliance Program to be professional, reflecting good judgment in education of students, care of patients and maintenance of the institution and didactic programs. University personnel who disregard the requirements of the Compliance Program shall be subject to appropriate personnel action, which may range from remediation to cessation of the University's clinical responsibilities or employment or contractual engagement by Salus depending on the severity of the violation and the willfulness or intentionality of the underlying conduct. Claims of ignorance, good intentions, or bad advice shall not be acceptable excuses for misconduct on the part of University personnel.

Upon the completion of an appropriate investigation of any issues of potential non-compliance or wrongdoing on the part of Salus personnel (conducted by or under the direction

of the Compliance Officer and the University's Risk and Compliance Committee), appropriate action shall be determined and implemented by the President in consultation with the Compliance Officer who, following receipt of relevant input from the Compliance Committee where appropriate, shall make a non-binding recommendation of appropriate action to the President. Any instances of employee misconduct shall be appropriately documented in the employee's performance review and personnel file, and may be considered when determining his/her compensation level, promotion and retention.

Where remedial actions and additional training are ineffective, alternative sanctions may include, but are not limited to: verbal reprimand or censure; written warning in the personnel file; probation; suspension; removal from clinical provider responsibilities; suspension of clinical privileges for one or more reasons described by the Clinical Privileging Protocol; ineligibility for promotion; or the initiation of proceedings seeking dismissal in accordance with applicable Human Resources policies, Faculty policies or collective bargaining agreements; and referral to governmental authorities. In the event of a provider's breach of his letter of appointment or independent contractor agreement, or either intentionally or with wanton disregard of the consequences engaging in fraudulent billing practices which directly result in Salus sustaining a monetary loss or incurring a monetary penalty on account of such conduct, such violations also may subject the provider to a claim by Salus for reimbursement for any losses or damages directly resulting from their violation (subject to any defenses they may seek to assert). Disciplinary actions will be consistent with any applicable contractual arrangements, including collective bargaining agreements, and/or disciplinary policies and procedures set forth in Salus's Employee Handbook and Academic Policies, Procedures and Guidelines. Nothing contained in this University Compliance Plan shall be construed as a limitation on Salus's rights.

University personnel who are subjected to sanctions, which may include being placed on probation for misconduct under this policy, shall receive appropriate counseling, training and compliance monitoring as directed by the Compliance Officer and the Compliance Committee.

As appropriate, if an audit or investigation reveals a systemic billing, coding, claims submission or other problem, the Compliance Officer and the Compliance Committee shall draft a corrective action plan, with the advice and assistance of the University's legal counsel. A sample format for a Corrective Action Plan is attached hereto as Exhibit G.

When a compliance issue that has been identified requires remedial action, the Compliance Officer, with input from the appropriate Vice President (or his/her designee), and if appropriate the Dean or program director in the case of faculty or students, or the Department Head in the case of administrative/clerical personnel, should develop a corrective action plan which specifies the responsible parties, the tasks to be completed, and completion deadlines.

A corrective action plan should ensure that the specific issue is addressed and that similar problems will not occur in other areas or departments, to the extent possible. Corrective action plans may require that compliance issues be handled in a designated way, that relevant training takes place, that restrictions be imposed on particular employees, or that the matter be disclosed to the applicable third party payer.

Where an employee or contractor has received notice of non-compliance with the University Compliance Program, has not provided a response satisfactory to the University Compliance Officer and corrective action plans have not been successful, sanctions in accordance with University policies and procedures, including but not limited to the Academic Policies, Procedures and Guidelines and any applicable collective bargaining agreements, will be

recommended. Providers holding academic or clinical appointments may also be sanctioned in accordance with expectations associated with maintaining their appointment and the conditions of faculty employment.

In appropriate circumstances, the failure to become or remain in compliance with the University's Code of Conduct and direction by the Vice President for Clinical Operations or other appropriate University Representative may result in the suspension of clinical privileges for one or more reasons described by the Clinical Privileging Protocol with corresponding effect on employment or independent contractor status. Clinical providers who disagree with the determination of the Vice President for Clinical Operations regarding clinical privileges may utilize the applicable procedures described in the respective Clinical Privileging Protocol to challenge such determination or any other applicable sections from University policies that relate to the conditions of faculty employment.

## POLICY No. 5

## REPORTING NON-COMPLIANCE AND WRONGDOING

### A. Employee Reporting

The University takes all reports of non-compliance and wrongdoing seriously. The purpose of voluntary disclosure under the Compliance Program and related policies is to provide a mechanism to allow the reporting of any matter that may be unethical, illegal or potentially an issue of non-compliance or wrongdoing without fear by the reporting employee of retribution or embarrassment. With respect to any such matter, every person within the University has direct access to and is encouraged to consult with the Compliance Officer.

Any University employee who is requested to make, accept, authorize or agree to any offer, action or payment that is or may be illegal or contrary to any aspect of the University's Compliance Program shall promptly report such information to the Compliance Officer. Furthermore, any University personnel who acquires information that another employee, agent or other person representing the University is engaged in conduct that is illegal or in violation of laws relating to healthcare fraud, claims processing, coding, false claims, physician referrals or the Medicare and Medicaid Anti-kickback law as described herein, the Code of Conduct, or any aspect of the University's Compliance Program, shall also promptly report such information to the Compliance Officer. The knowing failure to report an instance of non-compliance or wrongdoing is itself a violation of the Compliance Program.

If you believe you have information regarding other compliance matters, including but not limited to the use of the University's assets, officer and employee misconduct, concerns about the University's financial statement disclosures, accounting procedures, internal accounting controls and audit matters, you should follow the University's Whistleblower Policy as amended from time to time.

Persons who report potential compliance concerns are not required to disclose their names or to provide other facts that may give away their identity. If the reporting person does provide his/her identity, then he/she will be provided with a file identification number for the reported matter and will be advised when the matter has been addressed and resolved. Reporting persons are encouraged to provide as much information as possible to assist with the investigation of the matter. The Compliance Officer and the University will use best efforts to keep the identity of reporting persons confidential; however, if you do provide your identity, there may be a point in time when the identity of the reporter may become known or may have to be revealed.

All mailing addresses and telephone numbers for compliance reporting are set forth on Exhibit A to the Compliance Plan. A sample "report" form that may be used to make a report to the Compliance Officer may be found at Exhibit B to the Compliance Plan.

It is the University's policy that no person shall suffer any penalty or retribution for the good faith reporting of any suspected instance of non-compliance or wrongdoing, regardless of whether or not such non-compliance or wrongdoing ultimately is determined to exist following investigation. However, if it is determined that a report of wrongdoing was knowingly fabricated or distorted, either to injure somebody else or to inappropriately protect the reporting employee or other persons, the reporter will be subject to disciplinary action.

## B. Compliance Investigation and Log

The Compliance Officer shall maintain a "log" of all reports regarding compliance matters. These reports shall be assigned a sequential file identification number by the Compliance Officer for the specific year, and shall be used for new or additional information on the same matter. The Compliance Officer shall conduct (or direct) an appropriate investigation of each compliance report, making an appropriate recording in the log of the results and the specific actions taken after completion of the investigation. The specific facts and circumstances surrounding the report should be kept confidential, and any discussions regarding the identified compliance concerns should be limited to those parties with a "need to know" during the investigation, including the investigated person.

A sample Incident Report is attached hereto as Exhibit C.

The Compliance Officer's log should include the following information with respect to each reported compliance matter:

- Sequential file identification number, date report of potential compliance matter is received, whether the reporter has identified himself/herself and has been advised of the file identification number, and description of the concern or incident;

- Identification of person designated as being primarily responsible for investigating the compliance matter, and identification of any outside counsel or external consultants retained to assist in evaluation and investigation of the matter;

- Current status of the investigation, as periodically updated;

- Date matter is resolved and type of resolution, including corrective action taken, where appropriate; and

- Date matter is reported to the President and/or Board of Trustees, or reason why not reported.

## POLICY NO. 6

## RETALIATION

It is the University's policy that no retaliation shall be taken against any individual who, in good faith, reports any incident of potential fraud or other possible violation of this Compliance Plan or Federal or State statutes or regulations solely on the basis of such good faith reporting.

The University recognizes that assertions of fraud and abuse by employees or agents who may have participated in illegal conduct or committed other malfeasance raise numerous complex legal and management issues that should be examined on a case-by-case basis. The Compliance Officer shall work closely with legal counsel, who can provide guidance regarding such issues. However, the recommendation to the Board of Trustees of any action to be taken against a reporting individual who has participated in such conduct shall be determined solely by the Compliance Officer, with the final action to be taken against any such individual to be determined by the Board of Trustees.

***Nothing in this Compliance Plan is intended to guarantee future employment for any period or to modify the status of any employee-at-will.***

## POLICY No. 7

## EMPLOYEE SCREENING

It is the University's policy (see policy on Background and Employment Verification Checks) to conduct a reasonable and prudent background investigation and reference check before hiring those employees who have access to patients or their possessions, or who have discretionary authority to make decisions that may involve compliance with the law. Prior to hiring such individuals, the University requires that such persons disclose any prior criminal convictions, exclusions from participation in the federal health care programs (Medicare, Medicaid, etc.), or professional licensure sanctions in accordance with applicable Human Resources policies. The University also requires that persons who provide services to the University, but who are not employees of the University (e.g., temporary agency personnel), make similar written disclosures. Substantial discretionary authority shall be delegated only to individuals whom the University reasonably believes will not engage in improper activities.

The University also prohibits the continued employment of, or contracting with, persons who have been convicted of criminal offenses related to health care services or who are debarred, excluded, or otherwise ineligible for participation in federal health care programs. In addition, if the University receives notice that an employee or contractor currently is charged with a criminal offense related to the delivery of health care services or is proposed for exclusion during his or her employment or contract period, the University will take all appropriate actions to ensure that the responsibilities of that employee or contractor do not adversely affect the quality of care or services rendered to any patient or the accuracy of any claims submitted to any federal health care program. If resolution of the matter results in conviction, debarment, or exclusion, Salus will terminate its employment or contract arrangement with the employee or contractor.

The University shall not knowingly contract or enter into any business relationship with, or purchase any equipment or supplies from, any individual or entity who or which is debarred, suspended or otherwise excluded from or ineligible for participation in the federal health care programs, or who or which has been convicted of a criminal offense related to health care, as the University's dealings with such sanctioned individuals or entities could jeopardize the University's ability to participate in governmental programs and could subject Salus to substantial civil monetary penalties. To carry out this policy, it is the intention of the University to make reasonable inquiry into the status of existing and potential contracting parties and business partners, as appropriate.

As part of the routine background check of employees and contractors, the University may:

- Investigate the background of employees and contractors by checking with all applicable licensing and certification authorities to verify that requisite licenses and certifications are in order;

- Require all employees and contractors to certify (e.g., on an employment application or similar form) that they have not been convicted of a criminal offense that would preclude employment by an entity that receives reimbursement from a federal health care program, and that they are not excluded from participation in the federal health care programs;

- Require temporary employment agencies to ensure that temporary staff assigned to Salus clinical practices have undergone background checks that verify that they have not been convicted of an offense that would preclude employment by the University;

- Check appropriate databases (and retain search results) to verify that employees and contractors are not excluded from employment by an entity that receives reimbursement from a federal health care program, including: (i) the Office of Inspector General's ("OIG") List of Excluded Individuals and Entities (formerly known as the Cumulative Sanctions Report), which is available on-line at http://www.exclusions.oig.hhs.gov; (ii) the General Service Administration's ("GSA") List of Parties Excluded from Federal Procurement and Non-Procurement programs, which is available on-line at https://www.epls.gov/ or from the GSA website at http://www.gsa.gov; and

- Require current employees and contractors to report to the Compliance Officer if, subsequent to their hiring, they are convicted of an offense that would preclude employment by an entity that receives reimbursement from a federal health care program, or are excluded from participation in any federal health care program.

# POLICY No. 8

## MEDICAL RECORD DOCUMENTATION

Timely, accurate and complete documentation is important to clinical patient care. This same documentation serves as a second function when a bill is submitted for payment, namely, as verification that the bill is accurate as submitted. Therefore, one of the most important physician / provider practice compliance issues is the appropriate documentation of diagnosis and treatment. A provider's documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

### A. Medical Record Documentation

In addition to facilitating high quality patient care, a properly documented medical record verifies and documents precisely what services were actually provided. The medical record may be used to validate: (a) the site of the service; (b) the appropriateness of the services provided; (c) the accuracy of the billing; and (d) the identity of the care giver (service provider). Medical records shall meet the following guidelines:

- The medical record shall be complete and legible, with the responsible provider's signature and date affixed within a timely matter;

- The documentation of each patient encounter shall include the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer;

- If not documented, the rationale for ordering diagnostic and other ancillary services shall be easily inferred by an independent reviewer or third party who has appropriate medical training;

- CPT and ICD-9/10-CM codes used for claims submission shall be supported by documentation and the medical record;

- Appropriate health risk factors shall be identified; and

- The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis is documented.

The CPT and ICD-9/10-CM codes reported on the health insurance claims form should be supported by documentation in the medical record and the medical chart should contain all necessary information. Additionally, CMS and the local carriers should be able to determine the person who provided the services. These issues can be the root of investigations of inappropriate or erroneous conduct, and have been identified by CMS and the OIG as a leading cause of improper payments.

## B. CMS 1500 Form

Practice personnel shall monitor closely the proper completion of the CMS 1500 form. Such forms shall include:

- link the diagnosis code with the reason for the visit or service;
- use modifiers appropriately;

- provide Medicare with all information about a beneficiary's other insurance coverage under the Medicare Secondary Payor (MSP) policy, if the clinical practice is aware of a beneficiary's additional coverage.

## POLICY No. 9

## CODING, BILLING AND SELECTION OF CPT CODES

A primary component of the University's clinical compliance effort is to identify those areas that may subject Salus to the risk of submitting false or fraudulent claims. Central to this effort is billing and coding. The Compliance Officer is responsible for ensuring the University maintains up-to-date coding and billing policies and that these policies are followed. The University shall maintain written standards/procedures and/or have resources that are available to guide all coding and billing personnel with respect to the current reimbursement principles. Clinical faculty and consultants will have access to all billing, coding and local medical review policies in either written or electronic form. Coding and billing must be based on and supported by adequate medical record documentation.

At no time shall any person who has input into the University's billing and claims submission process, change, modify or cause to be altered any billing or claims information without supporting documentation in the applicable medical record justifying such change, modification or alteration. No coding of any nature is to be modified for the sole purpose of obtaining payment without regard to the actual nature of the services or supplies provided (e.g., upcoding). No payment on behalf of the University shall be approved or made with the intention or understanding that any such payment is to be used for any purpose other than that described by documents supporting the payment. It also is the policy of the University that any late entries, marginal notes or corrections in patient medical and clinical records shall be appropriately noted and explained. At no time shall a patient medical or clinical record be deleted or altered to conceal information or for fraudulent purposes. All record entries must be signed and dated at the time of entry.

The following risk areas associated with billing and claims submission have been among the most frequent subjects of investigations and audits by the Office of Inspector General (the "OIG"). Absent extraordinary and permissible circumstances, the existence of which shall be determined by the Compliance Officer on a case-specific basis, the following suspect practices (which are grouped for convenience by those practices most frequently associated with Providers and with Non-Providers) shall be prohibited by the University at all times:

Providers

- Billing for items or services not provided;
- Billing for services that the University believes may be denied (without the proper modifier);
- Billing patients for denied charges without a signed written notice;
- Billing for items or services not ordered;
- Upcoding;
- Refusing to submit a claim to Medicare for which payment is made on a reasonable charge or fee schedule basis;
- Reassigning a code that has been originally assigned by the responsible provider, except in accordance with internal audit policies;
- Failure to monitor medical necessity on an on-going basis;
- Altering medical records;
- Manipulating the patient's diagnosis in an attempt to receive improper payment;

- Failing to maintain medical necessity documentation;
- Cover letters that encourage physicians to order medically unnecessary items or services;
- Routine waiver of deductibles and coinsurance;
- Providing incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, skilled nursing facilities, home health agencies or others) that may violate the anti-kickback statute or other similar federal or state statute or regulations;
- Compensation programs that offer incentives for items or services ordered and revenue generated;
- Suspect joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other;
- Billing for items or services furnished pursuant to a prohibited referral under the Stark physician self-referral law;
- Misrepresenting a person's status as an agent or representative of Medicare;
- Knowing misuse of a provider number, which results in an improper billing; and
- Failing to meet individual payer requirements

Non-Providers

- Billing for items or services not provided;
- Billing for services that the University believes may be denied;
- Billing patients for denied charges without a signed written notice;
- Billing for items or services not ordered;
- Using a billing agent whose compensation arrangement violates the reassignment rules;
- Upcoding;
- Unbundling items or supplies;
- Resubmission of denied claims with inaccurate information in an attempt to be improperly reimbursed;
- Refusing to submit a claim to Medicare for which payment is made on a reasonable charge or fee schedule basis;
- Reassigning a code that has been originally assigned by the responsible provider, except in accordance with internal audit policies;
- Inadequate management and oversight of contracted services, which results in improper billing;
- Altering medical records;
- Manipulating the patient's diagnosis in an attempt to receive improper payment;
- Inappropriate use of place of service codes;
- Cover letters that encourage physicians to order medically unnecessary items or services;
- Routine waiver of deductibles and coinsurance;
- Providing incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, skilled nursing facilities, home health agencies or others) that may violate the anti-kickback statute or other similar federal or state statute or regulations;
- Compensation programs that offer incentives for items or services ordered and revenue generated;

- Suspect joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other;
- Billing for items or services furnished pursuant to a prohibited referral under the Stark physician self-referral law;
- Misrepresenting a person's status as an agent or representative of Medicare;
- Knowing misuse of a provider number, resulting in an improper billing;
- Failing to meet individual payer requirements;
- Failing to refund overpayments to a health care program;
- Failing to refund overpayments to patients; and
- Employing persons who have been excluded from participation in federal health care programs.

**All Salus employees and consultants, whether Providers or Non-Providers, are legally prohibited from engaging in any and all activities listed above regardless of those most frequently associated with either the Provider or Non-Provider grouping.**

It is the University's policy that, from time to time, a random sampling of claims (or certain codes) be performed by individuals with technical expertise in billing and coding matters before such claims for reimbursement are submitted to the affected payor. University personnel who have questions regarding the appropriate CPT billing code to be used in a given circumstance should consult one of the coding specialists whose duties include responding to provider coding questions. As applicable, "local medical review policy" established by the pertinent Medicare carrier shall be consulted and followed with respect to billing and coding matters.

## POLICY NO. 10

## REFUND OF OVERPAYMENTS

Any overpayments discovered by the University should be returned promptly to the affected third party payor or patient no later than sixty (60) days after discovery. The refund should be accompanied by documentation setting forth the following information: (1) a statement that the refund is being made pursuant to University's voluntarily implemented Compliance Program; (2) a description of the complete causes and circumstances surrounding the overpayment; (3) the methodology by which the overpayment was determined; (4) the amount of the overpayment; (5) any claim-specific information reviewed as part of the University's self-audit that was used to determine the overpayment (e.g., beneficiary health insurance claims number, billing claim number, date of service, payment date, etc.).

Legal counsel should be consulted in connection with overpayments that, by virtue of their frequency or magnitude or other case-specific circumstances, may implicate potentially serious compliance issues, in which case compliance with formal voluntary disclosure protocols may be recommended.

## POLICY NO. 11

## REASONABLE AND NECESSARY SERVICES

Claims may be submitted only for items and services that are documented as reasonable and necessary in the particular case. Appropriate documentation to support the medical necessity of an item or service shall be maintained in accordance with the University's record-keeping policies.

## POLICY No. 12

## VALID PROVIDER NUMBERS

The University will not bill any federal, state or private third party payer health care plan without first obtaining the necessary billing numbers, and all billing numbers will be utilized correctly at all times.

## POLICY NO. 13

## ASSIGNMENT

The University will not charge Medicare beneficiaries more than the amounts allowed under the Medicare fee schedule, including coinsurance and deductibles. If the beneficiary pays the University prior to submission of a claim, the University should ensure it is not charging the beneficiary more than the coinsurance on the allowed amount under the fee schedule. In the event that the University collects excess payments from a Medicare beneficiary, mechanisms shall be in place to promptly refund the overpayment to the beneficiary. University personnel should be knowledgeable about the Medicare rules and instructions for accepting assignment and receiving direct payment from beneficiaries for items or services.

## POLICY NO. 14

## NON-COVERED SERVICES AND ADVANCE BENEFICIARY NOTICES

In the event that the University believes that a claim submitted to Medicare will be denied on medical necessity grounds, it must inform the patient of this fact prior to furnishing the item or service. In this situation, Salus should ask the Medicare beneficiary to sign a written notice (sometimes referred to as an "advance beneficiary notice" or "ABN"). The written notice must clearly identify the particular item or service, must state that the payment for the particular item or service likely will be denied, and must give the reasons for the belief that payment is likely to be denied. It is the beneficiary's decision whether to sign the notice. If the beneficiary does sign the written notice, the University should: (1) include the appropriate modifier on the claim form; (2) maintain the written notice in its files; and (3) be able to produce the written notice upon request.

Routine notices to Medicare beneficiaries that do no more than state that denial of payment is possible, are not considered acceptable evidence of written notice. Notices should not be given to Medicare beneficiaries unless there is some genuine doubt regarding the likelihood of payment as evidenced by the reasons stated on the written notice. Giving notice for all claims, items or services is not an acceptable practice.

In instances where a claim is being submitted to Medicare in order to receive a denial from the Medicare carrier (allowing the patient to submit the denied claim for payment to a secondary payor), the University must place, somewhere on the claim form, the following statement or the appropriate modifier:

> "THIS CLAIM IS BEING SUBMITTED FOR THE PURPOSE OF RECEIVING A DENIAL, IN ORDER TO BILL A SECONDARY INSURANCE CARRIER."

In the event the Medicare carrier pays the claim even though the service is non-covered, and even though the University did not intend for payment to be made, the University will promptly communicate this fact to the Medicare carrier and refund the amount paid and indicate that the service is not covered (in the absence of contrary instructions from the carrier at such time).

## POLICY NO. 15

## PROFESSIONAL COURTESY

The term "professional courtesy" is used to describe a number of analytically different practices. The traditional definition is the practice by a provider of waiving all or a part of the fee for services provided to the provider's office staff, other physicians, and/or their families. In recent times, "professional courtesy" has also come to mean the waiver of coinsurance obligations or other out-of-pocket expenses for physicians or their families (i.e., "insurance only" billing), and similar payment arrangements by hospitals or other institutions for services provided to their medical staffs or employees. While only the first of these practices is truly "professional courtesy," in the interests of clarity and completeness, the OIG has addressed all three.

In general, whether a professional courtesy arrangement runs afoul of the fraud and abuse laws is determined by two factors: (i) how the recipients of the professional courtesy are selected; and (ii) how the professional courtesy is extended. If recipients are selected in a manner that directly or indirectly takes into account their ability to affect past or future referrals, the anti-kickback statute -- which prohibits giving anything of value to generate Federal health care program business -- may be implicated. If the professional courtesy is extended through a waiver of copayment obligations (i.e., "insurance only" billing), other statutes may be implicated, including the prohibition of inducements to beneficiaries, section 1128A(a)(5) of the Act (codified at 42 U.S.C. 1320a-7a(a)(5)). Claims submitted as a result of either practice may also implicate the civil False Claims Act.

The following are general observations about professional courtesy arrangements to consider:

1. A provider's regular and consistent practice of extending professional courtesy by waiving the entire fee for services rendered to a group of persons (including employees, physicians, and/or their family members) may not implicate any of the OIG's fraud and abuse authorities (i.e., the anti-kickback statue or the Civil Monetary Penalties law) so long as membership in the group receiving the courtesy is determined in a manner that does not take into account directly or indirectly any group member's ability to refer to, or otherwise generate Federal health care program business for, the provider.

2. A provider's regular and consistent practice of extending professional courtesy by waiving otherwise applicable copayments for services rendered to a group of persons (including employees, physicians, and/or their family members), would not implicate the anti-kickback statute so long as membership in the group is determined in a manner that does not take into account directly or indirectly any group member's ability to refer to, or otherwise generate Federal health care program business for, the provider.

3. Any waiver of copayment practice, including that described in the preceding bullet, does implicate section 1128A(a)(5) of the Act if the patient for whom the copayment is waived is a Federal health care program beneficiary who is not financially needy.

The legality of particular professional courtesy arrangements will depend on the specific facts presented, and, with respect to the anti-kickback statute, on the specific intent of the parties. The University shall consult with an attorney if it is uncertain about its professional courtesy arrangements.

## POLICY NO. 16

## ROUTINE WAIVER OF DEDUCTIBLES AND CO-INSURANCE

Routine waivers of deductibles and coinsurance may result in false claims, and/or violations of the anti-kickback statute or regulations. The OIG has concerns when providers routinely waive deductibles and coinsurance. When providers forgive financial obligations for reasons other than genuine financial hardship of a particular patient, they may be inducing the patient to use items or services that are unnecessary, simply because they are free. Such usage may lead to over-utilization.

It is the University's policy that it will waive Medicare deductibles and coinsurance amounts only in cases of documented financial need. In cases where there is not documented financial need, the University will make a good faith effort to collect deductibles and coinsurance.

In addition, it is against University policy for personnel to:

- Advertise an intent to waive deductibles or coinsurance for Medicare beneficiaries;
- Advertise an intent to discount services for Medicare beneficiaries; or
- Give unsolicited advice to Medicare beneficiaries that they need not pay.

## POLICY No. 17

## FRAUD AND ABUSE PREVENTION

The Office of Inspector General (the "OIG") and the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services ("HHS") and other governmental agencies charged with the responsibility for enforcement of federal health care laws have emphasized the importance of voluntarily developed and implemented compliance programs, such as the University's Compliance Program.

The OIG and other regulatory agencies recognize that voluntary compliance programs can be a significant factor in reducing and preventing instances of fraud, abuse and waste under governmental health care programs such as the Medicare and Medicaid programs, particularly in connection with reimbursement matters where claims and billing operations are subject to extensive governmental regulation.

The Compliance Program is intended to assist the University in improving overall quality and preventing instances of non-compliance with applicable health care laws, while developing a central coordinating source for information and guidance on applicable laws, regulations, standards of conduct and conditions of participation in governmental health care programs.

Although a primary impetus behind the Compliance Program is to prevent and detect instances of non-compliance in connection with applicable health care laws and particularly those involving the Medicare and Medicaid programs, the University is committed to full compliance with all pertinent federal, state and local laws and regulatory guidelines, whether they relate to health care matters or not. Accordingly, the responsibilities and obligations established under the Compliance Program, such as the duty to report to the Compliance Officer any instance of suspected non-compliance or wrongdoing, apply to all laws and regulations applicable to the University and all areas and aspects of University operations.

There are numerous federal and state health care laws that are applicable to different aspects of the University's operations. Some of the more relevant health care laws, for which persons and entities found to violate them may be subject to substantial criminal and civil penalties, include the following:

- *Anti-Kickback Law (also referred to as the Medicare and Medicaid Anti-Kickback Statute)* – This law prohibits anyone from knowingly and willfully offering, paying, soliciting or receiving anything of value in return for or to induce, recommend or arrange the referral of an individual or the purchase or lease of a product or service covered under Medicare, Medicaid or another governmental health care program. A similar law also applicable to Medicare, Medicaid and other governmental health care programs prohibits anyone from offering or paying anything of value to a patient that the person knows or should know is likely to influence the patient to receive a medical item or service from the person or entity making the offer or payment instead of from another provider.

- *False Claims Laws (including the False Claims Act)* – These laws prohibit anyone from knowingly presenting or causing to be presented any claim for payment under Medicare, Medicaid or another governmental health care program for a medical item or service that the person knows or should know was not provided as claimed, was false or fraudulent, or was for a pattern of medical items or services that were not medically necessary.

Similar laws prohibit false claims made to other third party payors including private insurance companies.

- *False Statements Law* – This law prohibits anyone from knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in any application for benefits or payment or in determining rights to benefits or payment under Medicare, Medicaid or another governmental health care program. Similar laws prohibit false statements made to other third party payors including private insurance companies.

- *Anti-Referral Laws (also referred to as the Stark I and II Physician Self-Referral Laws)* - Among other things, these laws prohibit a physician from referring a Medicare or Medicaid patient to a health care provider for such Medicare or Medicaid patient, if the physician or an immediate family member has an ownership or investment interest in, or financial or compensation arrangement with, the health care provider, unless one of certain limited exceptions applies. Analogous State laws may prohibit similar self-referral conduct with respect to non-Medicare and Medicaid patients depending on the State in which the physician and patient are located.

- *Health Care Fraud* – This law makes it a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud any health care benefit program, or to obtain money or property from a health care benefit program through false representations. This applies not only to federal health care programs, but also to most other types of health care benefit programs. Additionally, Pennsylvania law provides "With respect to an insurance benefit or claim, a healthcare provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct."

- *Theft or Embezzlement in Connection with Health Care* – This law makes it a crime to knowingly and willfully embezzle, steal or intentionally misapply any of the assets of a health care benefit program. This law applies not only to Federal health care programs, but also to most other types of health care benefit programs.

- *False Statements Relating to Health Care Matters* – This law makes it a crime to knowingly and willfully falsify or conceal a material fact, or make any materially false statement or use any materially false writing or document in connection with the delivery of or payment for health care benefits, items or services. This law applies not only to Federal health care programs, but also to most other types of health care benefit programs.

- *Obstruction of Criminal Investigations of Health Care Offenses* – This law makes it a crime to willfully prevent, obstruct, mislead, delay or attempt to prevent, obstruct, mislead or delay the communication of records relating to a Federal health care offense to a criminal investigator. This law applies not only to Federal health care programs, but also to most other types of health care benefit programs.

- *Civil Monetary Penalties Law* – This law is a comprehensive statute that covers an array of fraudulent and abusive activities and is very similar to the False Claims Act. The

statute prohibits a health care provider from presenting or causing to be presented, claims for services that the provider "knows or should know" were:

- Not provided as indicated by the coding on the claim;
- Not medically necessary;
- Furnished by a person who is not licensed as a physician (or who was not properly supervised by a licensed physician);
- Furnished by a licensed physician who obtained his or her license through misrepresentation of a material fact (such as cheating on a licensing exam);
- Furnished by a physician who was not certified in the medical specialty that he or she claimed to be certified in; or
- Furnished by a physician who was excluded from participation in a Federal health care program to which the claim was submitted.

Under this law, it is also unlawful to:

- Offer remuneration to a Medicare or Medicaid beneficiary that the person knows or should know is likely to influence the beneficiary to obtain items or services billed to Medicare or Medicaid from a particular provider; or

- Employ or contract with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program.

Any of the University's personnel who believe or have reason to believe that Salus or any University employees, contractors, agents, or students have violated (or are about to violate) any of the above-described health care laws shall immediately report such information to the Compliance Officer.

## POLICY NO. 18

## ANTI-KICKBACK AND SELF-REFERRAL CONCERNS

The University will comply with all federal and state laws, including the anti-kickback statute and the Stark physician self-referral law. These laws state:

- *Anti-Kickback Law (also referred to as the Medicare and Medicaid Anti-Kickback Statute)* – This law prohibits anyone from knowingly and willfully offering, paying, soliciting or receiving anything of value in return for or to induce, recommend or arrange the referral of an individual or the purchase or lease of a product or service covered under Medicare, Medicaid or another governmental health care program. A similar law also applicable to Medicare, Medicaid and other governmental health care programs prohibits anyone from offering or paying anything of value to a patient that the person knows or should know is likely to influence the patient to receive a medical item or service from the person or entity making the offer or payment instead of from another provider.

- *Anti-Referral Laws (also referred to as the Stark Physician Self-Referral Laws)* - Among other things, these laws prohibit a physician from referring a Medicare or Medicaid patient to a health care provider for such Medicare or Medicaid patient, if the physician or an immediate family member has an ownership or investment interest in, or financial or compensation arrangement with, the health care provider, unless one of certain limited exceptions applies. Analogous State laws may prohibit similar self-referral conduct with respect to non-Medicare and Medicaid patients depending on the State in which the physician and patient are located.

The University will ensure that its contracts and arrangements with actual or potential referral sources (e.g., physicians) are reviewed by counsel and comply with all applicable statutes and regulations, including the anti-kickback statute and the Stark physician self-referral law.

The University will not submit or cause to be submitted health care program claims for patients who were referred to University clinics pursuant to contracts or financial arrangements that were designed to induce such referrals in violation of the anti-kickback statute or similar federal or state statute or regulations, or that otherwise violate the Stark physician self-referral law.

The University will not offer a physician or other referral source more than fair market value for space rented to store items or supplies (i.e., consignment closets).

The University will not offer or provide gifts, free services, or other incentives or things of value to patients, relatives of patients, physicians, home health agencies, nursing homes, hospitals, contractors, assisted living facilities, or other potential referral sources for the purpose of inducing referrals in violation of the anti-kickback statute or similar federal or state statute or regulations.

## POLICY NO. 19

## UNLAWFUL ADVERTISING

It is the University's policy to engage in honest, straightforward, fully informative and non-deceptive marketing. The University will not engage in any marketing activity that either explicitly or implicitly implies that Medicare beneficiaries are not obligated to pay their coinsurance or can receive "free services." The University will not promote items or services to patients or physicians that are not reasonable or necessary for the treatment of the individual patient.

The University will not use any symbols, emblems or names in reference to Social Security or Medicare in a manner that it knows or should know would convey the false impression that an item is approved, endorsed or authorized by the Social Security Administration, CMS or the Department of Health and Human Services, or that the University has some connection with, or authorization from, any of these agencies.

It is the University's policy that all advertising and marketing activities shall be reviewed for compliance with the standards set forth above in advance by the Compliance Officer.

# GLOSSARY OF TERMS

ABN – Advance Beneficiary Notice
UCP – University Compliance Plan
CPT – Current Procedural Terminology
CMP - Civil Monetary Penalties Law
CMS - Centers for Medicare and Medicaid Services
DOJ – United States Department of Justice
EEOC - Equal Employment Opportunity Commission
FBI - Federal Bureau of Investigation
GSA - General Service Administration
HHS - United States Department of Health and Human Services
HIPAA - Health Insurance Portability and Accountability Act
ICD-9/10-CM - International Classification of Diseases, Clinical Modification
MSP - Medicare Secondary Payor
OSHA - Occupational Safety and Health Administration
OIG - Office of Inspector General of the Department of Health and Human Services
PHRC - Pennsylvania Human Relations Commission
PHI - Protected Health Information
RCO – Salus University's Retaliation Complaint Officer

## EXHIBIT A

## LISTING OF COMPLIANCE OFFICER AND REPORTING MECHANISMS

**COMPLIANCE OFFICER:** **Mr. Brian Zuckerman**

**TELEPHONE NUMBER:** **215-780-1281**

**EMAIL ADDRESS:** **BZuckerman@salus.edu**

**TO REPORT ANONYMOUSLY**: (by phone or online anonymously)

844-570-SAFE
Hotline code: 791755

www.safewhistle.com
Web code: 1QJkNA

**EXHIBIT B**

I.D.# _____
(to be completed by
Compliance Officer)

**REPORT OF POTENTIAL COMPLIANCE ISSUE***

(*This form may be used by University personnel or others to report potential compliance issues)

Name of Reporting Person (*optional*):_____

Position Held by Reporting Person (*optional*):_____

Telephone Number (day or evening) of Reporting Person
(*optional*):_____

Date of this Report:_____

1. Please describe the potential compliance issue, including the name(s) of the person(s) involved and, if known, the date(s) of the relevant incident(s):_____
_____
_____
_____

2. Please describe when and how you became aware of this activity:_____
_____
_____

3. Please describe any evidence that exists to prove the improper conduct or other means available to verify relevant incident(s):
_____
_____
_____

4. Please list any other person(s) inside or outside of the University who may be able to verify the relevant incident(s):
_____
_____

5. Have you discussed the relevant incident(s) with any other person(s) inside or outside of the University? Yes ____No __. If "Yes," please list the identity of such person(s):
_____
_____

6. Would you be willing to discuss the potential wrongdoing with the University's Compliance Officer or legal counsel? Yes _____No ___.

**EXHIBIT C**

**SAMPLE**

**COMPLIANCE INCIDENT REPORT**

Report Number/Reference: _____

Receiving Date: _____

Time: _____

Date Violation Occurred:_____

Report Received: By _____ Position:_____

Reporting Individual: _____ Position:_____

Individuals and/or Department Involved:

_____

_____

_____

Description of Incident:

_____

_____

_____

_____

_____

Type of Violation:

Dishonesty and/or Fraud: _____

Billing: _____

Antitrust: _____

Other: _____

Report Completed By: _____ Date_____

Compliance Officer _____

[Name]

Contacted by _____on _____ [Date]

**Date of Last Revision: _____**

## EXHIBIT D

## PROTOCOL FOR MEDICARE CHART AUDIT [(1)]

**Background:** The purpose of auditing the medical records of federal payor patients is to ensure that all clinical providers are following best practices in coding and billing. At all times, the chart documentation of the provider must support the code or level billed to the federal payor. The Vice-President for Clinical Operations will coordinate, schedule, and provide oversight for all audits. Audits will be conducted according to the outlined protocol. The Compliance Consultant will oversee the process.

To ensure consistency of care and compliance with best practices in coding and billing, a defined sample of federal payors (Medicare, Medicaid, Tricare, Veterans care) will be audited for each provider. Constructive education, feedback, and training will be provided to ensure compliance and accuracy with federal payor guidelines for coding and billing and supportive health record documentation.

**Protocol for Federal Payor Chart Audits:**

- The criteria used for chart audits are based upon the Centers for Medicare and Medicaid Services Documentation Guidelines for Evaluation and Management Services.

- Based upon the results, if the provider has achieved 75% accuracy for one level differences and 95% for two level differences for the past six months ("acceptable accuracy rate"), the provider will revert to annual auditing. These accuracy percentages will apply to all CPT and ICD-10 codes.

- If a provider is new to Salus University and/or has not been previously audited, 100% of their federal payor claims will be reviewed for a period of six months.

- The audit process will differ depending upon the error rate and historical performance and is as described in the sections below as "annual auditing" or "continuous auditing".

- Each claim determined to have any failure will be logged and any errors identified will be corrected prior to billing, if performed prospectively. In those cases where retrospective auditing is completed, Salus will reprocess the claim or refund, as needed.

- A second auditor, provided by the Compliance Consultant, will be available for review if the provider believes any claim has been audited incorrectly. If the second auditor agrees with the provider, the initial revisions to the claim will be removed. If the second auditor agrees with the first auditor, no further review is necessary and the initial revisions will remain.

*Annual Auditing*

- The Compliance Consultant will determine the number of claims to retrospectively review based on a statistically valid sample. This sample, at a minimum, a two-sided confidence interval at 90 percent confidence level and 25 percent precision rate. Based on the overall sample size, the number of claims to review per provider will be determined. At a minimum, ten claims will be reviewed per provider. If a provider has fewer than 10 claims, all claims will be audited for the year.

- The annual audits will be scheduled throughout the year (in quarterly cohorts). The purpose of this is to quickly identify any systematic issues.

- Each claim audited during the audit period will have an equal chance of selection. Claims will be randomly selected for audit for providers having more than 10 claims per year. The results of all audits will be shared with the Vice-President for Clinical Operations and the Compliance Officer.

*Ongoing Auditing*

- If the provider has an error rate exceeding the acceptable accuracy rate, as defined above, the provider will be placed on "continuous auditing". This will be prospective auditing of 100% of the provider's federal claims. This applies to both the annual audit and those that, based on the initial review, have not met the acceptable accuracy rate. The Compliance Officer and the Vice-President for Clinical Operations will determine the most appropriate education plan within two weeks from data dissemination. This is considered the provider's first warning.

- Providers are encouraged to review any failing claims as quickly as possible with the Coordinator of Clinical Coding Compliance or his/her designee.

- The provider's accuracy rate will be reviewed again after six months of ongoing auditing. If after a six-month timeframe, the error rate is still unacceptable, this will be considered their second warning and ongoing auditing will occur for an additional six months. At this point, a corrective action plan will be implemented by the Vice-President for Clinical Operations in consultation with the Compliance Officer.

- If error rates are still not acceptable, the Vice-President for Clinical Operations will advise the provider that a specific corrective action plan has not been successfully completed and he/she may be removed from clinical provider responsibilities or that provider's clinical privileges may be suspended until successful remediation has been achieved. The Compliance Officer, the Director of Human Resources, the Dean of the College of Optometry, the Vice-President for Academic Affairs, and the President will be notified.

- If the provider fails the ongoing auditing process twice within a timeframe of eight consecutive quarters, their claims will be reviewed at 100 percent pre-claim submission for six months after the second failure occurrence; the process of "ongoing auditing" with a corrective action plan as described above will apply.

*Reporting and Education*

The Vice-President for Clinical Operations or his designee will distribute audit results to providers within two weeks of completion of a provider's audit. Results will be communicated via spreadsheet report that includes that individual provider's cumulative results as well as specific claim data for the audited time frame.

Providers will receive education twice a year. This education will be recorded. The external auditor will be made available for questions. Annual coding education will be more detailed and cover any applicable annual updates. This will also be recorded.

*Provider Petition*

- Clinical providers may request to return to clinical care responsibility through a written petition to the Compliance Officer. The petition should include the rationale and the suggested time line for the return to clinical care responsibilities based upon their successful completion of their corrective action plan. The provider should demonstrate that significant coding and documentation education has occurred through all available internal and external sources. The Compliance Officer will review the petition, as well as the related history and details associated with the removal from clinical care, including audit results, attendance record at mandatory education and training sessions, and other related information. The Compliance Officer will make a recommendation to the Vice-President for Clinical Operations within one month from the date of the provider's petition.

- The Vice-President for Clinical Operations will review the recommendation and notify the faculty provider if he/she has accepted the recommendation from the Compliance Officer within two weeks.

- Clinical faculty providers who disagree with the determination of the Vice-President for Clinical Operations regarding the return to clinical care responsibilities may utilize the applicable procedures described in the Faculty Grievance Policy to challenge such determination. All non-faculty providers should follow the process outlined in the Clinical Privileging Policy starting with Section VI.

- If a provider exhibits a pattern of repeated audit failures, even if not for continuous audit periods, the auditing protocol will be modified to address these concerns. In addition, nothing contained in this discussion of the federal payor audits shall be interpreted to limit the right to implement additional compliance monitoring and auditing, or to take other corrective or disciplinary action, as it deems necessary based on relevant facts and circumstances.

(1) Although Medicare is our predominant federal payor, sample claims from other federal payors will be audited for consistency and accuracy according to the outlined protocol.

*Updated 2/27/18*

## EXHIBIT E

## COMPLIANCE PROGRAM AWARENESS CERTIFICATION FORM

(*To be completed by all University personnel upon distribution of the Compliance Plan, and by all new employees, contractors, agents, students and contractors)

I hereby certify that I have received and reviewed a copy of Salus University's Compliance Plan, including the University's Code of Conduct and Compliance Policies and Procedures, and that I understand it is my responsibility to comply with the provisions contained in these documents and my responsibilities under the University's Compliance Program.

I also hereby agree that I will promptly report any matter that may be unethical, illegal or potentially an issue of non-compliance or wrongdoing with any of the University's published policies or with applicable Medicaid or Medicare requirements or other pertinent laws or regulations, in accordance with the procedures set forth in the Compliance Plan.

I also hereby certify that, as of the present date, I am in full compliance with all policies, procedures and rules of conduct established by the University and communicated to me, including but not limited to, those contained in the University's Code of Conduct and Compliance Policies and Procedures.

_____ _____

Date Signature

_____

Print Name

## EXHIBIT F

## ANNUAL SALUS PROVIDER COMPLIANCE EDUCATION AND TRAINING

1. Each clinical discipline will have a designated coding compliance coordinator. The coding compliance coordinator will define the annual compliance training curriculum for their specialty, based on the needs of their providers to maintain the highest level of compliance.

2. The coding compliance coordinator will be responsible for providing training at least annually, with more frequent training required for providers who do not meet the compliance standards. The annual training will include, at a minimum:

- Updates to the code sets (ICD and HCPCS)
- Practice updates relating to the University Compliance Program
- Regulatory and policy updates
- Trends in auditing results

3. The coding compliance coordinator will ensure clinical records are audited for compliance on an ongoing basis, and provide feedback to the individual providers on a quarterly basis. The coding compliance coordinator will determine the best technique for auditing and compiling the audit data based on auditing resources and volume of work to be audited. Audit techniques most commonly used will be either (i) centralized audit by a committee/team of auditors, (ii) audit by a single trained auditor, or (iii) audit using a structured peer review process. Failure to meet compliance standards is addressed in the plan under Policy 4: Corrective Action and Disciplinary Procedures.

4. Attendance at all training and audit session will be monitored and documented. Failure to attend required training and audit sessions will result in the suspension of clinical privileges, and may ultimately impact the non-compliant provider's employment by Salus University.

5. All providers, including full-time, part-time and part-time intermittent employees and contracted clinical consultants, are expected to comply with all compliance training requirements. Failure to do so may result in adverse employment action or the termination of an independent contractor's services.

## EXHIBIT G

**SAMPLE**

## CORRECTIVE ACTION FORM

**Note**: To be completed by Compliance Officer

Date report received:_____

Referred for investigation to:

_____

_____

Date investigative report received: _____

Investigative Results: (Attach if appropriate)

_____

Action taken and date: (Attach report if appropriate)

_____

_____

_____

_____

Persons who reported violation notified: Yes _____No ____

Date: _____ Individual's name: _____

_____

Compliance Officer (Signature) Date