Samaritan Health *830 Washington Street* *Watertown, NY 13601*	**Investigation of Possible Billing Compliance Issues**		**Document No.** 3555
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Business Units:	Medical Center, Samaritan Home Health, Samaritan Keep Home, Samaritan Summit Village Assisted Living, Samaritan Summit Village Skilled Nursing, Centers and Clinics, Samaritan Medical Practice		

This Corporate Compliance Investigation of Possible Billing Compliance Issues Policy is applicable to Samaritan Medical Center (SMC) and its Affiliates: Samaritan Keep Home, Samaritan Medical Practice, Samaritan Summit Village, and Samaritan Home Heath (collectively, "Samaritan").

PURPOSE:

To provide a general outline of the process that Samaritan will use to ensure the integrity of its billing systems, including investigation of reported or suspected billing compliance issues.

POLICY:

Samaritan is committed to investigate any matters that are potentially in violation of federal or state criminal, civil or administrative laws and/or indicate internal billing patterns or operational issues that might affect its right to reimbursement from federal and state health care programs, including Medicare or Medicaid. It is Samaritan's policy to investigate any report or evidence of suspected violations of federal or state laws, rules and regulations or any Samaritan policy with respect to billing compliance.

PROCEDURE:

All persons affected by Samaritan's risk areas, including employees, the chief executive officer of SMC and other senior administrators, managers, and contractors, agents, subcontractors, independent contractors, and governing body and corporate officers of Samaritan, as appropriate ("Affected Individuals") are expected to report any actual or suspected billing compliance issues to a direct supervisor, the Chief Compliance Officer, or a member of the Compliance Oversight Committee or Compliance Core Groups, for further investigation. If there is any question as to the truth or accuracy of the documentation for billing purposes, or if there is material information that is missing, the bill for the services in question should be held until the uncertainties are

resolved. Internal investigations regarding billing compliance issues shall be conducted in accordance with this policy.

If the investigation reveals a routine billing error occurred resulting in an overpayment received from any third party payor, including Medicare, the overpayment will be timely repaid to the affected payor through typical methods of resolution, including but not limited to voiding or adjustment of the amount of claims, or in accordance with applicable payor policies and procedures. Any billing error resulting in an overpayment received from Medicaid should promptly be reported to the Director of Revenue Cycle Operations who will then notify the Chief Compliance Officer and CFO. The Director of Revenue Cycle Operations will ensure the repayment process is completed[1]. Systems will also be put in place to prevent the reoccurrence of such billing errors and resulting overpayments in the future.

If the Chief Compliance Officer determines that a violation beyond an isolated billing error may have occurred warranting further auditing or review, a more detailed investigation will be conducted, which may include, but is not limited to:

- interviews with individuals involved, with knowledge about the billing issue and the facts alleged;
- relevant document and record review; and
- legal research and analysis of applicable laws and regulations and contact with governmental agencies for the purpose of clarification as deemed necessary and appropriate (retention of legal counsel should be considered prior to engaging with governmental agencies).

In the event it becomes necessary to involve legal counsel in an investigation, the notes and records of counsel, as well as any reports connected with the investigation, shall be considered confidential and privileged communications from attorney to client and designated as attorney work product, and may not be released to any outside agency without the prior approval of the Chief Executive Officer and Samaritan's legal counsel.

Overpayments identified as a result of the investigation of a billing compliance issue conducted under this policy that cannot be attributed to a routine billing error will be reported and repaid to state or federal health care programs, including Medicare and Medicaid, or other third party payors, as appropriate, in accordance with Samaritan's *Reporting and Returning Overpayments* policy. Additional reporting to, and cooperation with, governmental authorities, such as the Office of Inspector General of the Department of Health and Human Services (OIG), the Office of the Medicaid Inspector General (OMIG), Medicaid Fraud Control Unit ("MFCU"), and the New York State Department of Health (NYSDOH), as deemed appropriate, may be necessary.

[1] While repayment of simple, routine occurrences of overpayment to Medicaid may be made through the claims voiding and adjustment process, any overpayments must still be reported and explained through submission of a Self-Disclosure Statement.

The Chief Compliance Officer will thoroughly document and report, on a confidential basis, to the Compliance Core Groups, Compliance Oversight Committee, the Audit and Compliance Committee, and SMC's Chief Executive Officer and Board of Trustees of SMC regarding each investigation conducted, as appropriate.

RELATED POLICIES:
Corporate Compliance Plan
Reporting and Returning Overpayments

REFERENCES:
Office of Inspector General
New York State Office of Medicaid Inspector General
New York State Medicaid Fraud Control Unit
Centers for Medicare and Medicaid
Department of Health and Human Services

Revised: 7/27/09, 6/30/13, 3/2018, 2/2022; 3/10/2023

SUMMARY:

DEFINITIONS:

POLICY:

PROCEDURE:

RELATED POLICIES:

RELATED FORMS:

REFERENCES: