RESPONSIBLE DEPARTMENT: Corporate Compliance	SUBJECT: Responding to and Investigating Potential Issues
NUMBER OF PAGES: 3	REPLACES POLICY: 03/2023
EFFECTIVE DATE: APRIL 2024	POLICY ID. ADM-CC

SCOPE:
This policy applies to all employees at Community Memorial Hospital (CMH), Family Health Centers (FHC), and Specialty Clinics.

PURPOSE:
The purpose of this policy is to identify situations in which applicable laws and regulations may not have been followed; to facilitate corrective action as necessary; and to implement procedures to ensure future compliance.

POLICY STATEMENT:
It is the policy of Community Memorial Hospital to establish and implement procedures and systems for promptly responding to compliance issues including complaints, violations of applicable laws, regulations, hospital policies, procedures and standards (including the hospital's Code of Conduct and Corporate Compliance program), investigating potential compliance problems as identified in the course of internal auditing and monitoring, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with State and Federal laws, rules and regulations, and requirements of the MA program. Regardless of the source of the complaint or concern, the hospital takes potential compliance issues seriously and investigates compliance issues promptly.

PROCEDURE:

1) **Receipt of Complaints and Investigation.** See Complaint resolution policy.
   a) **Responsibility.** The Compliance Officer ('CO'), or his/her designee, has primary responsibility for conducting and/or overseeing investigations of potential compliance concerns and/or complaints.
   b) **Reporting.** All affected individuals are required to promptly report issues of suspected or actual noncompliance, and may be subject to discipline for failing to report. The hospital has a strict nonretaliation policy for good faith reporting of suspected or actual compliance issues. (See Hospital's Non-Intimidation/Non-Retaliation and Employee Participation and Discipline Policies).
   c) **Investigation.** The CO or his/her designee shall commence an investigation promptly following receipt of a complaint or the detection of a potential compliance issue. Depending on the issue being investigated, the CO shall report the investigation to the hospital's CEO/President.
      i) The CO may conduct the investigation under the guidance of the hospital's legal counsel as deemed necessary by the CO.
      ii) In the course of the investigation, the CO, or his/her designee, is authorized to perform the following:
         (1) Conduct interviews with any Community Memorial Hospital employee or other person whose activities or work obligations pertain to the potential compliance matter;
         (2) Identify and review relevant documents and materials, including without limitation, bills and claims for services, patient records, business records, email and other forms of communications, and any other document or record necessary for the investigation;
         (3) Seek out individuals, internal or external to the hospital, whose expertise may assist the investigation; and
         (4) Undertake other processes as deemed necessary by the CO to fully investigate the compliance issue raised.

Joint Commission: LD.04.04.01
CMS: 482.11
DOH: 405.2

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d) **Documentation**. The CO, or his/her designee, shall log all complaints in a form and manner as determined by the CO and as required by state law and regulations. The 'intake reporting form' and Compliance 'issues reporting log' spreadsheet on the Risk Management share drive should be utilized for documentation. The documentation will include:
   i) Description of the investigation process including any alleged violations;
   ii) Copies of interview notes and other documents essential for demonstrating that the hospital completed a thorough investigation;
   iii) Any disciplinary action taken and the corrective action implemented.

2) Reports.

a) In addition to documenting on the 'intake reporting form' and 'issues reporting log' spreadsheet, the CO or their designee may prepare a report which summarizes the nature of the problem, concern or complaint. At the discretion of the CO or their designee, such report may be developed under the guidance of the hospital's legal counsel. To the extent relevant, the CO or designee's report shall include the following:
   i) A summary of the investigation process including any alleged violations;
   ii) The relevant facts and identification of involved persons;
   iii) Whether a systems error was involved;
   iv) Whether there is evidence of intentional wrongdoing;
   v) An estimate of potential overpayments, if any;
   vi) Any other information relevant to the investigation.

b) Depending on the nature of the findings, the CO or designee may report the results of the investigation to the Hospital Administration, the Board of Directors or other departments or individuals as necessary to ensure proper mitigation and prevention of future compliance issues.

c) On a periodic basis, the CO shall report a summary of compliance investigations to the Compliance/Revenue Cycle Committee and/or the Board of Directors.

d) Documents generated under this policy shall be maintained in accordance with the hospital's document retention policies and procedures.

3) Response to Investigations.

a) The Hospital's response to an investigation will be determined by the type of noncompliant activity that is suspected and/or verified.

b) The Hospital's response shall be designed to correct the problem promptly and thoroughly, and to implement procedures and systems to prevent recurrence of the problem. To the extent feasible for complaints and concerns that are not made on an anonymous basis, the CO or his/her designee shall respond to the individual who initially raised the compliance issue, within the limits of applicable confidentiality laws and regulations. For those concerns received on an anonymous basis, every effort shall be made to follow up with the writer/caller. This could include but is not limited to; email to the department's DL address (if known), staff meeting/huddle discussion from leadership with notes in minutes, etc.

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c) If the hospital identifies credible evidence or credibly believes that a State or Federal law, rule or regulation has been violated, the hospital shall promptly report such violation to the appropriate governmental entity.
d) In the spirit of the Community Memorial Hospital values, Community Memorial shall self-disclose to any necessary agencies, individuals, companies, any findings of investigations as appropriate. Community Memorial Hospital shall report, repay and address the system/process issues in regards to the appropriate payers or parties during routine internal and external audits. All identified overpayments from Medicare or Medicaid will be reported and returned within 60 days of identification in compliance with federal and state law.
e) Community Memorial Hospital also will investigate and respond to any action or suspected action of retaliation due to the outcome of the investigation.
f) Community Memorial Hospital also will investigate and respond to any action or suspected action of retaliation due to the outcome of the investigation.

DOCUMENTATION: Applies to Hospital-wide

DEFINITIONS:

- **Affected Individuals**: All persons who are affected by the provider's risk areas including employees, chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors and governing and corporate offices

REFERENCES:

- US DHHS, OIG Hospital Compliance Guide, 1998; Supplemental Hospital Compliance Guidance, 2005; NYS OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521.

Approved by:

Jeffery Coakley
President and Chief Executive Officer

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Corporate Compliance Officer

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