Pro EMS Solutions

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Introduction

The following policies and forms are part of our Compliance Program. The policies are to be followed and the forms are to be used to foster our organization's compliance with statutes, regulations and policies relating to compliance with Medicare Program requirements. In some instances, the policies and forms also have a broader application.

Policy #001 Patient Care Report Documentation

Purpose

To capture a complete picture of the ambulance service provided for a patient, ensure appropriate billing, and prevent FCA and other federal violations.

Policy

All PCRs must be complete and thorough, and must accurately and objectively address the patient's condition at the time of transport. Documentation must cover all key elements necessary to fully document the patient assessment and care provided, as well as to allow the billing staff to make appropriate determinations as to the medical necessity and other requirements needed to ensure proper reimbursement for the services we provide.

Procedure

The PCR should contain the information necessary to accurate describe the services provided. The PCR should be concise, thorough and accurate and include an unbiased, objective description of information received, observations, and the ambulance service provided. The information contained in the PCR must be complete, accurate and never misrepresent the patient's actual condition. There must be sufficient documentation in the PCR to determine if the patient's medical or physical condition was such that other means of transportation other than an ambulance was appropriate for the patient.

All sections of the PCR must be completed in their entirety and should include information such as: dispatch instructions, the patient's condition and chief complaint, the patient's relevant medical history, the services provided to the patient, the pick-up and destination location, and the loaded mileage.

The PCR should not be used as a medium to express concerns or otherwise document potential problems to management and others. The PCR should document the objective findings related to patient assessment, patient care, and the ambulance service provided. Other forms and documents should be used (e.g., incident report, complaint reporting form, etc.) to document concerns, risks, issues or complaints.

Policy #002 Review and Amendment of Patient Care Reports

Purpose

PRO EMS SOLUTIONS will maintain a strict quality assurance procedure to ensure that the accuracy and clarity of our patient care documentation is at the highest possible level.

Policy

Substantive amendments to the PCR will be made only by the original author of the PCR or another member of the crew that provided the ambulance service. Demographic information (e.g., patient name, Social Security Number, address, health insurance information) may be corrected or added by billing personnel.

Procedure

1) An ambulance crew will complete a PCR as promptly as possible following completion of the call (and, if possible, prior to the completion of the shift). The PCR should be completed by the primary caregiver. A PCR may not be completed by personnel other than the crew that participated in the call. Amendments may be made as set forth in this policy.

2) Crewmembers who provided the ambulance service will check the PCR for accuracy prior to submitting the PCR and other paperwork for billing.

3) PCRs will undergo quality assurance review as part of the billing process and prompt feedback will be given to the author of the PCR where it is apparent that there is an error, or missing information on a PCR.

4) Addenda and corrections will be requested by returning the PCR to the author for any substantive amendments. Requests for addenda and corrections will be made only to ensure completeness and accuracy of the medical record or to correct clearly erroneous or conflicting information.

5) A crew member may make corrections or additions to the PCR after submitting if information was inadvertently omitted prior to submission

or additional information regarding the patient's care or condition was acquired after submission.

6) All amendments must be truthful and initialed and dated by the crewmember who makes the amendment. If using electronic PCR software, automatic tracking of amendments may suffice as "initialing and dating". The crewmember making the amendment must have direct knowledge of the matter addressed by the amendment.

Policy #003 Physician Certification Statements

Purpose

To satisfy a regulatory requirement that requires a properly completed Physician's Certification Statement (PCS) for most non-emergency transports of Medicare beneficiaries.

Policy

PRO EMS SOLUTIONS personnel will obtain a properly completed and signed PCS for any non-emergency transport for which a PCS is required. Billing personnel will confirm that a PCS is obtained and properly completed and signed by an authorized signer before billing Medicare for any non-emergency transport for which a PCS is required to support the claim. Or when a required PCS was not obtained for a non-scheduled, non-repetitive transport, billing personnel will ensure the appropriate steps are taken to verify an attempt to obtain a PCS.

Procedure

1) Billing personnel will ensure that there is a PCS for a non-emergency ambulance service unless other documentation reviewed by them establishes that the ambulance transport was an unscheduled transport of a beneficiary who at the time of the transport was residing either at home or in a facility and who was not under the direct care of a physician.

2) Billing personnel will ensure that the PCS includes:

    a. Identification of the beneficiary, and date of transport or notation that the PCS is for scheduled repetitive transports and dated within 60 days of the date of transport.

    b. Specific information regarding the patient's condition which substantiates the certified medical necessity for an ambulance transport.

    c. A certification by a qualified person that other means of transportation were medically contraindicated.

    d. Signature of the qualified person and date the document is signed and that the person signing the PCS is identified, in accordance with the signature verification requirements as outlined in

Medicare Transmittal 327 of 2010, and the Medicare Program Integrity Manual, Chapter 3, Section 3.2.2.4.

e. A qualified person is the attending physician for scheduled, repetitive transports. For all other transports for which a PCS is required, a qualified person includes the attending physician or where the physician is unavailable, a physician assistant (PA), registered nurse (RN), discharge planner, clinical nurse specialist, or nurse practitioner (NP) as long as that person is employed by either the attending physician or the facility from which the beneficiary is being transported and has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the ambulance service is furnished.

3) In the event a PCS was not obtained prior to or at the time of transport, or if the PCS is incomplete, efforts can be made to obtain a signed PCS for 21 days after the date of transport for non-scheduled, non-repetitive transports, A PCS obtained after the date of service can still be valid, as long as the PCS relates to the patient's condition on the actual date of service.

a. If a PCS is not obtained within 21 calendar days following the date of the service, billing personnel will document the attempts to obtain the PCS with either a signed return receipt from the U.S. Postal Service or other similar service or the U.S. Postal Service Certificate of Mailing form approved by Medicare and then submit the claim to Medicare using the certified mailing record in lieu of the signature on the PCS.

4) Billing personnel will review the PCS form submitted with the PCR and other documentation to ensure that the above requirements have been satisfied.

Policy #004 Internal Audits

Purpose

To verify that claims are properly coded to be submitted for payment or that proper payment was made for submitted claims, and to determine if appeals for denials or refunding of overpayments may be required.

Policy

In accordance with the auditing and monitoring standards, to promote a positive compliance atmosphere, and to detect and prevent violations of the law, Medicare Program requirements, and our policies and procedures, PRO EMS SOLUTIONS will conduct periodic audits and reviews of claims and other Medicare requirements to ensure that proper coding and billing of services are being performed and that proper reimbursement is being pursued and received. Samples of pre- and/or post-submission claims will be audited to verify accuracy, check for any possible errors, and ensure that all Medicare coverage criteria are met.

Procedure

1) On a monthly basis, claims will be selected and internally reviewed and audited for accuracy ("self-audit"). Claims will be chosen randomly, using random number generators (e.g., OIG's "RAT STATS") where possible.

   a. Upon review of claims that have not yet been billed, a determination will be made as to whether each claim can be submitted for payment as prepared, or whether additional documentation is required, corrections must be made to address errors, or it cannot be billed at all. In each case, compliance with all Medicare coverage criteria should be evaluated.

   b. Upon review of claims which have been paid, a determination will be made as to whether the claim was appropriately billed and paid, and whether an overpayment or underpayment exists. In each case, compliance with all Medicare coverage criteria should be evaluated. A denied or "downcoded" claim will be further reviewed and a decision made as to whether the claim should be appealed.

   c. Information for each claim will be reviewed (including a review of the CMS 1500 claim form (or its electronic equivalent), the electronic remittance advice, the PCR, the PCS (if applicable), the CAD notes (or other dispatch instructions or information) if available, and all other available and relevant information.

d. The self-audit process will ensure that claims for ambulance transports of Medicare beneficiaries meet the requirements for a "covered transport" in accordance with CMS Manual 100-02 ("Medicare Benefit Policy Manual"), Chapter 10 ("Ambulance Services"), CMS Manual 100-04 ("Medicare Claims Processing Manual"), Chapter 15 ("Ambulance"), 42 CFR 410.40, 42 CFR 410.41, and 42 CFR 414.605 *et seq.*

2) In order to assess these criteria, we will use our Ambulance Claims Review Spreadsheet to assist in performing a thorough review, which will be able to concisely demonstrate problem areas, and provide input for future corrective actions. Below is a table further describing the general categories on the spreadsheet and a brief explanation as to what to consider when assessing each area.

Patient Name	Verify that patient's name is spelled correctly and will be/was recognized by Medicare.
Date of Service	Ensure that the dates reported on the various forms (PCR, PCS, dispatch records, claim, etc.) are consistent and correct.
Was Medical Necessity Met?	Determine if the documentation reveals the medical or physical reason the patient needed an ambulance transport, and that other forms of transport were contraindicated.
Was the Transport Reasonable?	Determine if the patient required transport from the origin point to the destination point. Ensure that the service could not have been provided at less cost at the point of origin and that the destination was the closest appropriate destination.
Was There an Immediate Response?	For emergency transports, verify that there was a 911 dispatch or equivalent and that there was minimal delay between the dispatched and enroute times. If the time between dispatch and arrival is lengthy, verify

	that the PCR contains information explaining the delay and how the crew acted as quickly as possible to respond.
Are Modifiers Correct?	Verify that proper modifiers were used, including origin and destination modifiers, and possible payment related modifiers (GY, GA, GZ, etc.).
Does Destination Appear Appropriate?	Confirm that the destination facility is a covered destination, appropriate (to meet reasonableness standards) and that it is the closest appropriate facility to meet the patient's needs.
Was Loaded Mileage Recorded?	Check to make sure that mileage was recorded on the PCR (from the point of pickup to the destination in tenths), and that only loaded mileage was billed on the claim form.
Was Patient Signature Obtained?	Confirm that a patient signature has been captured, or, where appropriate and permitted, that a representative signature has been obtained, or a lifetime signature is on file.
Was Zip Code Recorded?	Verify that the zip code of the point of pick–up is recorded.
What Service Level was Billed?	Determine whether the service level (base rate HCPCS code) was appropriately recorded, based on the information available, and was based upon the totality of facts and circumstances.
Does the Service Level Billed Appear Correct?	If the claim is not yet paid, verify that the level of service to be billed is proper. If already paid, make sure that the right service level code was used and that payment is consistent with the trip documentation. Verify coding based upon both the level of service billed considering dispatch type (E or NE) and services provided (ALS, BLS, etc.)
Is the Crew Appropriate for Level of Service	Verify that the composition of the crew is adequate for the level of service billed or to be billed. The legible name of each crew member,

	accompanied by their certification level should appear on the PCR and, if billed or to be billed ALS, the crew member who assessed the patient or provided interventions needs to be identified.
Comments	Insert relevant comments, related to any of the review areas, or any other issues that may arise, including whether an overpayment or underpayment may exist.

Policy #005 Identifying and Refunding Overpayments

Purpose

To prevent retention of improper payments, and to avoid fraud and abuse or the appearance of improper payments.

Policy

All improper or inadvertent overpayments that are self-identified will be promptly returned upon identification of the overpayment, but in no case will an overpayment be refunded more than 60 days after the date it was identified. Overpayments identified by payers will be investigated internally and responded to in an appropriate manner.

Procedure

1) Remittance advice and payments will be reconciled with submitted claims to determine whether payment was made in accordance with how the claim was billed. All patient accounts will be reconciled.

   a. Billing personnel (other than the person that prepared and submitted the claim) will compare the billed amounts with the received amount to fully reconcile all claims. This helps prevent overpayments, underpayments, and the accumulation of large amounts of accounts receivable.

   b. Accounts that have been properly paid in full may be considered "closed."

   c. If a duplicate payment is made upon any account, an assessment will be made to determine which payer is "primary." Payments made by a secondary payer for which the payer is not responsible will be reimbursed.

   d. Upon discovery of payment from any payer that is not responsible for payment, the overpayment (or improper payment) will be refunded, and an appropriate payer will be subsequently billed.

2) Where overpayments are discovered, and where overpayment forms exist, appropriate repayment forms and explanatory letters (where required) will be utilized to explain the reason for the repayment. For example:

a. Payment may have been made at the wrong level of service.

b. Payment may have been made where it was improper (e.g., medical necessity not met, no proper assignment of benefits, etc.)

3) If a payer identifies an overpayment and issues a demand notice, billing personnel in coordination with the Compliance Officer will review the request to determine if an overpayment does indeed exist. Pro EMS Solutions will contest the overpayment demand or initiate a refund promptly in accordance with the timeframe established in the letter or with typical payer practices.

4) In the case of an overpayment demand or self-identified overpayment that could potentially be large in scale or implicate the need for the OIG Self Disclosure Protocol, the Compliance Officer will consult with legal counsel and make a decision on how to proceed on a case-by-case basis.

Policy #006 Financial Hardship Waivers

Purpose

To objectively evaluate the financial ability of patients to make payments for their ambulance services, and make appropriate decisions as to when a hardship reduction or waiver may be appropriate.

Policy

Write-offs, waivers of payments, and other discounts will be made on a discretionary basis, taking such considerations as financial hardship and ability to pay into account.

Procedure

1) Patients will be billed promptly for any balance due including legally required cost sharing amounts. Billing the patient and attempts to collect co-payment and deductible amounts (after insurance has paid) from the patient may be waived in the following circumstances:

   a. If the patient participates in a membership or subscription program where the patient made a contribution in advance, the contributions collectively are designed to "cover" any cost-sharing amount that would be otherwise due by the subscribers, and the subscription program is actuarially sound.

   b. If the patient is a bona fide resident of a community where there is a municipally-run ambulance service operation and cost-sharing amounts are waived based upon taxes, or other payments made for ambulance services provided by the municipality for the purpose of "covering" cost-sharing amounts.

   c. If the patient is a bona fide resident of a community where there is a private ambulance service provider serving the community, and the municipality makes a payment to the private ambulance service provider for the purpose of "covering" the cost-sharing amounts that would otherwise be the patient's responsibility.

2) Attempts to collect co-payments or deductible amounts or payment in full from the patient may be revised in the following circumstance:

   a. If the patient or patient representative advises us that the patient is suffering a financial hardship and is unable to make payments we will ensure that insurance benefits have been maximized and offer a payment installment plan.

b. If a patient is unable to maintain even a minimal repayment plan and claims financial hardship, we will conduct a Financial Hardship Assessment

3) If financial hardship does not apply, the patient must make routine installment payments on their account. If promised payments are not made, the patient may be referred to a collection agency in accordance with client policy.

4) Grant waiver of payment if assessment yields evidence of financial hardship sufficient to a grant waiver.

5) A patient is eligible to be declared a "Financial Hardship" case and may be eligible for discounted services if the patient's household income is at or below the income levels established by HHS in its annual guidelines. See: http://aspe.hhs.gov/POVERTY/index.cfm.

6) Only the personnel designated by PRO EMS SOLUTIONS management may approve a financial hardship case. Personnel will gather as much information as possible from the patient and present this information to the Billing Manager for processing. A patient's financial and insurance status is subject to change. The fact that a patient qualifies for financial hardship treatment at one time does not mean that the patient will qualify for financial hardship treatment in the future. Past showing of financial hardship will not preclude attempts to collect on future services provided if financial hardship ceases to exist or is at a level that warrants patient discounted payments.

7) Personnel will use the following Financial Hardship Request Form.

Ambulance Billing and Financial Hardship Policy

Purpose

To establish a policy of compliant and compassionate billing that allows waiving of ambulance transport fees based on established Federal and State guidelines. The charges for EMS transport billing may be reduced or waived, based on the patient's residency and/or upon financial hardship, as determined by the guidelines established by the municipality.

Procedures

I. **Billing of Patients**

Patients will fall into one of the following categories for billing purposes:

Insured through commercial health insurance, Medicare and Medicaid

The appropriate health insurance carrier will be billed by Pro EMS Solutions. If the patient can demonstrate financial hardship, they may request to be considered for a payment plan or financial hardship waiver.

- **ALL TOWN RESIDENTS who have any applicable insurance co-payments will have this charge waived due to the assumed payment of City/County real estate and/or personal property taxes. A narrative will be submitted with all commercial insurance claims stating: "Municipal resident patient cost-sharing obligations may be waived." Deductibles will be billed to the patient.**

- **NON-RESIDENTS will be billed for deductibles and co-payments.**

No Insurance

A bill will be sent to ALL PATIENTS transported. If the patient has the ability to pay, then payment is expected in full. If the patient can demonstrate financial hardship, they may request to be considered for a payment plan or financial hardship waiver.

Bill generated/No collection

There are instances when a bill is generated in which the municipality would be merely transferring funds from one department's budget to another to satisfy the bill, for example when an on-duty employee is transported to the hospital for a compensable worker's compensation injury. In these instances, there would be no requirement to pursue payment of the bill. Pro EMS Solutions would update its records to reflect this adjustment.

Contractual Write-Offs/Balance Billing

The bills that Medicaid, Medicare and commercial insurance companies pay on behalf of an insured individual are sometimes adjusted to pay only a portion of the billed amount. This adjustment referred to here as a “contractual write off” is usually due to laws governing the payment amount or through payment reductions agreements between commercial insurance companies and Pro EMS Solutions in return for prompt reimbursement and/or full payment. The contractual write offs are not considered unpaid balances that would require pursuit of the amount from the insured individual. Patients will not be billed for payment of contractual write offs.

If a commercial insurance unilaterally reduces an out of network bill below the usual and customary charge, Pro EMS Solutions will attempt to negotiate with the payer. In many cases, the payer may require the patient to appeal/negotiate. If the payer refuses to negotiate and/or pay the usual and customary charge, or the patient refuses to appeal to their commercial insurance, the total bill will be reduced to 325% of the Medicare rate of reimbursement at the time of the transport and the patient will be billed for the balance after insurance.

If the patient has a financial hardship the Financial Hardship Determination process will be followed.

II. Financial Hardship Determination

ALL PATIENTS who are unable to pay their co-pays, deductibles or who are uninsured and unable to make payments may request a financial hardship review of their transport charge.

Patients, or their designee, should complete the Hardship Waiver Form whenever possible. Pro EMS Solutions may also identify and document financial hardships.

Patients who attest that their household income is not in excess of 500% of the Federal Poverty Level (FPL) will be eligible for elimination of any balance due.

Patients who attest to any of the following circumstances will be presumptively eligible for elimination of any balance due:
1. State-funded prescription programs
2. Homeless or received care from a homeless clinic
3. Participation in Women, Infants and Children programs (“WIC”)
4. Food stamp eligibility
5. Subsidized school lunch program eligibility
6. Eligibility for other state or local assistance programs that are unfunded
7. Low income/subsidized housing is provided as a valid address
8. Patient is deceased with no known estate
9. Patients enrolled in limited-service Medicaid programs or Free Care
10. Patients with non-participating out-of-state Medicaid insurance plans

Patients who do not fall within any of the above parameters may submit a written narrative of their financial hardship. Reduction or elimination of the transport charge will be at the discretion of Pro EMS Solutions.

The Hardship Waiver Form can be requested by contacting Pro EMS Solutions 617.492.8484. The completed form should be forwarded to Pro EMS Solutions, 31 Smith Place, Cambridge, MA 02138 or faxed to 617.812.4770. Pro EMS Solutions will review the form. If approved, the account will be noted and the completed form will be attached when available.

III. Collection Agency Referrals

PATIENTS (residents and non-residents) who receive direct payment from their insurance and fail to timely submit that payment to satisfy applicable ambulance transport fees will be referred to a collection agency and WILL be subject to being reported to credited bureau.

PATIENTS (residents and non-residents) who do not respond to multiple attempts to contact them through invoices and telephone calls will be referred to a collection agency and WILL NOT be subject to being reported to Credit Bureau. The balance due will be written off at that time and will be reinstated if there is a payment.

PATIENTS with a balance after insurance of $200 or greater who do not respond to multiple attempts to contact them through invoices and telephone calls will be referred to a collection agency and WILL NOT be subject to being reported to Credit Bureau.

PATIENTS with a balance after insurance less than $200 who do not respond to multiple attempts to contact them through invoices and telephone calls will have the balance written off as a Bad Debt.

Policy #007 Excluded Parties/Background Checks

Purpose

To collect exclusion and other background information about individuals and entities who provide or seek to provide services for PRO EMS SOLUTIONS to enable PRO EMS SOLUTIONS to comply with federal health care program requirements and otherwise make employment and contract decisions.

Policy

All personnel and will be subject to background screening. PRO EMS SOLUTIONS will not employ or do business with individuals or entities who have been convicted of health care fraud or listed by a federal agency as excluded, debarred or otherwise ineligible to participate in federal health care programs.

Procedure

1) We will utilize the Office of Inspector General's List of Excluded Individuals/Entities ("LEIE") to determine if an individual or entity has been excluded from participation in federal health care programs. For individuals, both current and maiden names or any other prior legal names will be checked.

2) Individuals seeking to work for us and entities seeking to contract with us will be required to disclose exclusion from a federal health care program, debarment by a federal agency, any criminal conviction, and any civil monetary penalty assessed against the individual or entity for conduct involving a federal health care program.

3) We will screen all individuals seeking to work for us and entities seeking to contract with us against the LEIE prior to making an employment or contract decision.

4) Our personnel and contractors, upon receiving notice of being excluded from a federal health care program, debarred by a federal agency, convicted of a criminal offense, or assessed a civil money penalty for conduct involving a federal health care program, will be required to immediately disclose that information to us.

5) We will check the LEIE on a monthly basis to determine whether any of our personnel or entities with which we contract have been excluded from a federal health care program.

6) We will require our contractors to check the LEIE on a monthly basis to determine whether any of their personnel have been excluded from a federal health care program and to alert us promptly if an excluded individual is involved in any way with providing services to us, directly or indirectly, under the contract.

7) We will not allow an individual who is excluded from a federal health care program to work for us in any capacity that directly or indirectly involves the provision of service payable by a federal health care program. This includes, without limitation, field personnel, billers, coders, and administrative and management personnel.

8) We will take disciplinary action against any of our personnel who fail to immediately notify us of exclusion from a federal health care program, debarment by a federal agency, a criminal conviction or a civil monetary penalty assessed against the individual for conduct involving a federal health care program.

Policy #008 Licensure/Certification Checks

Purpose

To ensure compliance with Medicare and applicable state ambulance staffing and vehicle requirements.

Policy

Pro EMS Solutions contractually requires that all Agencies verify that personnel who serve as EMS provider members of ambulance crews have their licensure/certification (hereafter "licensure") status verified to ensure current licensure at the EMS provider level for which they are being used.

Procedure

Contractually require verification of the licensure status of all personnel, both career and volunteer, who serve as EMS provider members of an ambulance crew.

Policy #009 Risk Identification and Response

Purpose

To identify possible compliance risk areas and ensure proper controls are in place to prevent compliance problems in an effort to avoid a government investigation or other negative consequences for PRO EMS SOLUTIONS.

Policy

On a routine basis, we will perform a risk assessment which will include a review of potential risk areas identified by the OIG as well as other potential risks identified by the Compliance Officer as relevant to the organization in order to ensure that we are maintaining compliance with statutes, regulations and other requirements applicable to our ambulance service operations and that our compliance efforts are properly focused and effective.

Procedure

1) During the initial development of the Compliance Program, and at least annually thereafter, the Compliance Officer will conduct a risk assessment of PRO EMS SOLUTIONS. The risk assessment may be conducted with the assistance of legal counsel or consultants who have experience with compliance risks impacting ambulance services.

2) The risk assessment will include an evaluation of the risk areas identified by the OIG in its Compliance Program Guidance as well as other OIG publications and any other risk areas impacting PRO EMS SOLUTIONS as identified by the Compliance Officer. The Compliance Officer may consider laws, regulations, policies and conduct as well as complaints or concerns reported by personnel, prior audits or lawsuits, and external audits and reviews among other factors when identifying areas of risk.

3) As part of the risk assessment, the Compliance Officer may evaluate PRO EMS SOLUTIONS's policies and procedures, employee training, employee knowledge, the claims submission process, documentation practices, management structure and commitment to compliance, contractual arrangements, and technology relied upon in the claims submission process to identify areas where PRO EMS SOLUTIONS may be exposed to compliance risk.

4) After identifying potential risks, the Compliance Officer will evaluate all of the identified potential risks along with the systems and controls PRO EMS SOLUTIONS currently has in place to combat those risks. Compliance program efforts will be focused on the areas with greatest potential risk to PRO EMS SOLUTIONS and those areas where PRO EMS SOLUTIONS needs to improve systems and controls.

5) The Compliance Officer may choose to implement a Corrective Action Plan to address some of the identified risks to ensure risks are properly mitigated.

Policy #010 Personnel Rights in a Government Investigation

Background

Government attorneys, agents, and investigators ("government representatives") frequently conduct investigations and inquiries in order to monitor compliance with government regulations and laws. As a result, PRO EMS SOLUTIONS personnel may be contacted by a government representative in the course of an investigation. This does not mean that any laws have been violated or that the government representative believes that any laws have been violated; it could simply be part of a routine inquiry. Personnel may be contacted either at work or away from work during off hours, or be visited at home, at work, or at some other location.

Purpose

To ensure that personnel understand their rights and their responsibilities to PRO EMS SOLUTIONS when approached by a government representative during an investigation and to ensure that the information and documents PRO EMS SOLUTIONS provides during an investigation are honest and accurate.

Policy

All personnel are expected to understand their rights in a government investigation and to deal with a government investigation in accordance with the procedures set forth in this policy.

Procedure

1) Personnel have certain rights and obligations of which they should be aware in the event they are contacted by a government representative during the course of an investigation. Personnel have the following rights:

    a. While personnel are free to talk with government representatives, they are under no obligation to do so.

    b. Personnel have a right to decline to be interviewed by a government representative.

    c. Government representatives cannot require personnel to be interviewed or make a statement.

d. Unless given permission, government representatives cannot enter the homes of personnel without a search warrant.

e. Just as personnel are free to decline to speak with a government representative, they also have a right to choose to speak with a government representative. If personnel choose to be interviewed or make a statement, they are to respond to questions truthfully.

f. If personnel are contacted by a government representative who wants to conduct an interview, they may inform the government representative that they wish to have an attorney present for any interviews or statements (if that is in fact their wish), or that they wish to first confer with PRO EMS SOLUTIONS'S Compliance Officer or management, and it is their right to do so.

g. If the government representative seeks to interview personnel, they have the right to inform the government representative to contact PRO EMS SOLUTIONS's Compliance Officer for the purpose of scheduling the interview at a mutually convenient time when legal counsel can be present.

2) If a government representative asks to see or make copies of any PRO EMS SOLUTIONS documents, including call records, PCRs, computer disks, hard drives, printouts, faxes, PCSs, etc., personnel should understand that these are PRO EMS SOLUTIONS records and inform the government representative that he or she must contact our Compliance Officer. If the representative refuses to do so, personnel should immediately contact the Compliance Officer and so advise.

3) In the event the government representative has a search warrant, the representative is permitted to enter and inspect the premises described in the warrant and obtain all documents or other evidence within the scope of the search warrant. Personnel should advise the government representative that they want to contact the Compliance Officer before the representative executes the search warrant and do the following:

a. IMMEDIATELY contact the Compliance Officer.

b. DO NOT interfere or prevent the person from executing the warrant if the representative elects to execute the search warrant without waiting, but advise the Compliance Officer that the representative is executing the search warrant.

c. DO NOT make any statements to the government representative while the government representative is executing the warrant.

d. DO monitor the government representative while the representative is performing the search or executing the warrant.

e. DO take notes as to the areas searched and documents or other evidence seized by the government representative during the course of their visit.

f. DO attempt to make copies of any documents that are seized. Personnel may not have a right to copy documents being taken in response to a warrant, but should make a request of the government representative to permit you to do this. If the request is refused, allow the representative to continue to do their work uninterrupted.

h. DO NOT lie or make a false statement to a government representative at any time.

3) In the event personnel are served with subpoena *duces tecum* for records for PRO EMS SOLUTIONS (this is a subpoena for PRO EMS SOLUTIONS documents or other records or items), that is not the same as a search warrant and does not entitle the representative to immediate access to the records covered by the subpoena. The subpoena should specify a date by which the covered items are to be produced. Personnel should advise the government representative the subpoena will be provided to management for processing. If personnel receive the subpoena by mail, provide it to the Compliance Officer. In either event, immediately apprise the Compliance Officer of the service of the subpoena and provide the subpoena to the Compliance Officer.

4) After a government investigation has been initiated, and while it is ongoing, DO NOT destroy or dispose of any documents or records in any form that may have any relationship to a government investigation.

Policy #011 Complaint and Concern Reporting

Purpose

To promote the reporting of compliance concerns or potential violations of the law to the Compliance Officer as soon as possible so that the matter can be promptly considered and addressed.

Policy

All personnel will report good faith compliance concerns or suspected compliance violations without fear of retaliation.

Procedure

Personnel will report any concern about conduct they believe to be improper including, but not limited to, conduct in violation of our Code of Conduct or any conduct that could be seen as violating the principles or standards of our Compliance Program.

1) Concerns are to be brought to the Compliance Officer's attention as soon as possible after the incident or behavior occurs that causes concern or constitutes the perceived improper conduct.

2) As a general rule, personnel should bring concerns to their immediate supervisor. If the concern is compliance related or if for any reason, personnel do not feel comfortable in reporting the concern to an immediate supervisor, report the concern to the Compliance Officer instead. Personnel have the discretion to report any concern about our operations or personnel conduct to the Compliance Officer, whether or not they also report the concern to an immediate supervisor.

3) Reports may be made in writing, but it is not required that concerns be placed in writing to be treated seriously. Any concern that could affect our compliance with the law will be investigated, even if it is not put in writing.

4) Reports can be made directly to the Compliance Officer by emailing compliance@proems.com or calling (844) 990-0002.

5) The reporting process we have in place may also be used to anonymously report compliance concerns.