HOSPITAL

COMPLIANCE PROGRAM MANUAL

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COMPLIANCE PROGRAM

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THE HOSPITAL

COMPLIANCE PROGRAM

Introduction

Agencies and departments of the U.S. Government have publicized a number of instances of fraud, abuse and waste in federally funded health care programs including Medicare and Medicaid. The Board of Directors of Hospital and the administrators of the Hospital recognize the seriousness of the issues raised by the Government and recognize that failure to comply with applicable laws and regulations could threaten the Hospital's continuing participation in these health care programs.

The Board, therefore, has directed that The Hospital undertake an integrity program in order to continue the Hospital's commitment to high standards of conduct, honesty and reliability in its business practices. This integrity program is called a Compliance Program. The purpose of the Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in The Hospital in connection with federally funded health care programs and private health plans. There are several parts to the Compliance Program, each of which is important. The Program applies to all employees. "Employees" means the Administrator, associate and assistant administrators, department directors and managers, supervisors and any other person or individual hired by and in the paid service of The Hospital.[1]

I.
STANDARDS OF CONDUCT

All of The Hospital's business affairs must be conducted in accordance with federal, state

[1]Attached for additional information and guidance is a copy of The Office of Inspector General's Compliance Program Guidance For Hospitals (1998).

and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness and integrity. Employees should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of The Hospital and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances. To further these overall goals, a number of policies or standards of conduct have been adopted by the Hospital.

A. EMPLOYEE HANDBOOK. The handbook given to each employee sets out several types of conduct, which are unacceptable. These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other HOSPITAL records.

2. Dishonesty.

3. Unauthorized alteration or destruction of Hospital records including patients' charts.

4. Coding or billing which violates Medicare or Medicaid rules or regulations or other federal rules or regulations.

5. Behavior detrimental to the operation of the Hospital.

Other unacceptable conduct may be found in the handbook.

B. CONFLICT OF INTEREST. In order to perform their duties with honesty and fairness and in the best interest of The Hospital, employees must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which the Hospital obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the Hospital and from using Hospital property for personal or private purposes. Conflicts also

may arise in other ways. If an employee has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from the Compliance Officer, Director of Human Resources or the employee's manager. The Hospital's policy on and prohibiting conflicts of interest may be found in Policy Number _____. A copy may be obtained from THE HOSPITAL Intranet under the Blue Book policies.

C. CONFIDENTIALITY OF INFORMATION. A patient's health care record is the property of The Hospital and shall be maintained to serve the patient, necessary health care providers, the institution and third party payors such as Medicare in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health care record belongs to the patient and the patient is entitled to the protection of that information as mandated under the Health Insurance Portability and Accountability Act also known as HIPAA . All patient care information is regarded as confidential and available only to authorized users such as treating or consulting physicians, employees who may be providing patient care and to third party payors in order to facilitate reimbursement. The operations, activities, business affairs and finances of the Hospital should also be kept confidential and discussed or made available only to authorized users.

D. WORKPLACE ADMINISTRATIVE SEARCHES. To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing employees with a safe working environment, to assist in the effective operation of the Compliance Program and to supplement the Drug and Alcohol Policy, supervisors may conduct unannounced administrative searches of Hospital premises, offices, work areas, property and equipment and the contents of such property and equipment. No employee should have any expectation of privacy in Hospital property or in their offices or work areas including lockers, desks, cabinets, drawers, shelves or trash cans or in folders, envelopes or packages located on Hospital premises. Personal possessions or materials

should not be brought to work if they are of a sensitive or confidential nature. The Hospital's policy on Workplace Administrative Searches is Policy Number _____. A copy may be obtained from the THE HOSPITAL Intranet under the Blue Book policies. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

E. FRAUD AND ABUSE. Employees shall refrain from conduct, which may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment or excessive payment for any service.

F. BUSINESS ETHICS. Employees must accurately and honestly represent the Hospital and should not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

G. FINANCIAL REPORTING. All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to Hospital policy, it may be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

H. PROTECTION OF ASSETS. Hospital will make available to employees assets and

equipment necessary to conduct Hospital business including such items as computer hardware and software, billing and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment. Employees should strive to use Hospital's assets in a prudent and effective manner. Hospital property should not be used for personal reasons or be removed from The Hospital without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly or has an inaccurate calibration should immediately report the problem to his or her supervisor.

I . ANTI-COMPETITIVE CONDUCT. The Hospital will not engage in anti-competitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

J. CREDIT BALANCES. The Hospital will comply with Federal and state laws and regulations governing credit balance reporting and refund all overpayments in a timely manner.

K. FINANCIAL INDUCEMENTS. No employee shall offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction or any person in a position to benefit The Hospital or the employee in any way. Employees are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts and

allowances are customary and acceptable business inducements provided that they are approved by Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to whom the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

L. ADDITIONAL STANDARDS. The Hospital has adopted a number of other hospital-wide policies and procedures. Employees may obtain copies the THE HOSPITAL Intranet web page under Blue Book policies. Additional standards and policies may be applicable only to particular departments and copies may be obtained from supervisors or directors in those departments. It is particularly important that coding, billing and submission of claims to Medicare, Medicaid and other third party payors, be appropriate, accurate and in compliance with applicable laws and regulations. Standards relating to billing will be found in a later section of this document.

ADMINISTRATION AND APPLICATION OF STANDARDS

These Standards of Conduct apply to ***all*** employees, including supervisors, managers, directors and administrators. They also apply to temporary and contract employees, as well as independent contractors doing business with The Hospital and to the physicians on the Medical Staff.

These Standards are not intended to cover every situation, which may be encountered, and employees should comply with all applicable laws and regulations whether or not specifically addressed in the Standards.

Questions about the existence, interpretation or application of any law, regulation, policy or standard should be directed, without hesitation, to an employee's supervisor, manager/director or to the Compliance Officer. Because laws, regulations and policies are constantly evolving, this

Compliance Program will be revised and updated as needed. Revisions will be communicated timely to Hospital employees through administrative notification and changes will be posted to the Compliance Web page.

Failure to comply with the Standards of Conduct or to conduct business in an honest, ethical, reliable manner can result in civil fines or criminal penalties against the Hospital and its employees or disciplinary action by the Hospital, including termination. Supervisors are responsible for ensuring that their new employees receive education on the Compliance Program and then participate in mandatory training related to the Program. Compliance with and promotion of the Standards of Conduct will be a factor in evaluating the performance of Hospital employees.

Following the Standards of Conduct is not hard to do. Employees should not be apprehensive or frightened. Remember, it is simply:

MANY CARING HANDS
DOING WHAT THEY OUGHT TO DO --
DOING WHAT THEY ARE SUPPOSED TO DO.

The prevention, detection and correction of fraud, abuse and waste in The Hospital is important.

It is everyone's job.

II.

BILLING AND AREAS OF CONCERN

A. **Prohibited Billing Practices.** Generally, federal laws and regulations provide civil and criminal penalties for individuals and hospitals that submit claims for services which were: (i) not provided; (ii) billed in a manner other than as actually provided; (iii) not medically necessary; or (iv) billed in a manner that did not comply with applicable government requirements. Examples of prohibited practices include:

1. Submitting a claim that represents the Hospital performed a service all or part of which was simply not performed;

2. Upcoding, that is, using a billing code that provides a higher payment rate than the billing code that actually reflects the services furnished to a patient;

3. DRG creep. Like upcoding, DRG creep is the practice of billing using a DRG code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient;

4. Duplicate billing, that is, submitting more than one claim for the same service or submitting a bill to more than one primary payor at the same time;

5. Misrepresenting the qualifications of the person rendering the service or representing that supervision requirements were met when they were not;

6. Billing separately for diagnostic services provided to a patient in the three calendar days preceding hospital admission rather than rolling such claims into the diagnosis related group;

7. Billing for discharge in lieu of transfer;

8. Billing for services which are not covered; and

9. Unbundling, that is, submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

B. **Non-Covered Services.** Some services are not covered under Medicare. Examples include:

1. Services which are medically unnecessary. That is, items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or which are not medically necessary for the health of the patient;

2. Routine screening services;

3. Services considered by Medicare to be experimental in nature or not medically effective; and

4. Services that are considered not reasonable and appropriate or necessary for the diagnoses.

When a Medicare patient requests that a known non-covered service be billed, an Advanced Beneficiary Notice should be obtained from the patient explaining that the service is non-covered and will be the patient's responsibility.

C. **Kickbacks.** Federal law prohibits the Hospital from paying a physician or anyone else for the referral of a patient for services which might be covered by Medicare or Medicaid. Illegal payments may be subtle. Examples include (i) payment to a heavy admitter of "Medical Director" fees in excess of the value of the work the physician actually performs as a medical director; (ii) providing reduced rate rent; (iii) paying excessive travel fees. All payments from the Hospital to a physician and all leasing arrangements with physicians should be carefully examined to ensure that such payments or arrangements comply with applicable statutes and regulations and are not inducements to refer patients.

D. **Accurate Bills and Records.** Bills to Medicare and other federally funded health care programs, as well as to other payors, must be true, accurate and complete and for services believed to be medically necessary, and that were ordered by a physician or other appropriately licensed person. All physician and other professional services should be documented timely, correctly and properly. Patient records and other documentation which support the bills should also be true,

accurate and complete in accordance with professional standards and available for audit and review. The diagnoses and procedures reported on the reimbursement claim must be based on the patient record and other relevant documentation.

E. **Training and Incentives.** Training, education and documents necessary for accurate code assignment is and will continue to be made available to employees involved in coding. Billing department coders and billing consultants will not be provided any financial incentive to improperly upcode claims or otherwise improperly increase Hospital revenue.

F. **Cost Reports.** The CFO shall prepare or cause to be prepared policies and procedures ensuring against submission of false or inaccurate cost reports and ensuring that:

1. Costs are not claimed unless based on appropriate and accurate documentation;

2. Allocation of costs to various cost centers are accurately made and supportable by verifiable and auditable data;

3. Unallowable costs are not claimed for reimbursement;

4. Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;

5. Costs are properly classified;

6. Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;

7. All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;

8. Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;

9. The Hospital's procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines and policies;

10. Procedures are in place and documented for notifying promptly the Medicare fiscal

intermediary (or any other applicable payor, e.g. TRICARE and Medicaid) of errors discovered after the submission of the hospital's cost report.

G. **Bad Debts.** The CFO shall develop or cause to be developed a mechanism to review, at least annually: (i) whether Hospital is properly reporting bad debts to Medicare and (ii) all Medicare bad debt expenses claimed, to ensure that Hospital's procedures are in accordance with applicable federal and state statutes, regulations, guidelines and policies. In addition, such a review should ensure that the Hospital has appropriate and reasonable mechanisms in place regarding beneficiary deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. The CFO or his or her designee may consult with the appropriate fiscal intermediary if there are questions relating to bad debt reporting requirements.

H. **Credit Balances.** The CFO shall develop or cause to be developed policies and procedures providing for the timely reporting of Medicare and other federal health care program credit balances. The CFO shall designate appropriate employees to (i) review reports of credit balances and reimbursements or adjustments on a monthly basis and (ii) be responsible for tracking, recording and reporting credit balances.

I. **Retention of Records.** The Director of Health Information Management shall prepare or cause to be prepared policies and procedures regarding the creation, distribution, retention, storage, retrieval, disclosure and destruction of records and documents. Such records and documents shall include: (i) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs; and (ii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of the Hospital's auditing and monitoring efforts.

III.

COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

A. **Officer.** The CEO shall appoint a high level employee as Compliance Officer. The CFO of Finance shall not be appointed. The individual appointed as Compliance Officer shall serve for a term of one year and may be reappointed for additional terms.

B. **Duties.** The Compliance Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Compliance Officer. The Compliance Officer's primary responsibilities set out in the job description shall include:

1. Overseeing and monitoring the implementation of the Compliance Program;

2. Reporting on a regular basis to the Board of Directors, the CEO and the Compliance Committee on the progress of implementation, and assisting the Board, the CEO and the committee in establishing methods to improve the Hospital's efficiency and quality of services, and to reduce the Hospital's vulnerability to fraud, abuse and waste;

3. Periodically revising the Compliance Program as required by changes in the law and policies and procedures of government and private payor health plans;

4. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate employees are knowledgeable of, and comply with, pertinent federal and state standards;

5. Ensuring that independent contractors and agents who furnish medical services to the Hospital are aware of the requirements of the Hospital's Compliance Program with respect to coding, billing and marketing, among other things;

6. Coordinating personnel issues with the Director of Human Resources and the Medical Staff Office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, medical staff and independent contractors;

7. Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits;

8. Independently investigating and acting on matters related to compliance, including

the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all hospital departments, providers and sub-providers, agents and, if appropriate, independent contractors; and

9. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

C. **Authority.** The Compliance Officer shall have direct access to the CEO and, as required, to the Board of Directors. The Compliance Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records, and contracts and written arrangements or agreements with others. The Compliance Officer may seek advice of legal counsel and with consent of the Compliance Committee, may retain necessary consultants or experts.

D. **Reports.** The Compliance Officer shall report to the Board at least annually on the status of compliance in the Hospital. Such reports may be written or oral.

E. **Compliance Committee.** The Compliance Committee shall consist of 8 to 12 members and shall include representatives from Finance, Human Resources, Health Information Management, the Business Office and Nursing. The members of the committee and the Chairperson of the Compliance Committee shall be appointed annually by the CEO and shall each serve for one year or until his or her successor shall be appointed. Any vacancy on the committee, whether by resignation, illness, death or otherwise, shall be promptly filled by appointment by the CEO and each such appointee shall serve for the remainder of the unexpired term of his or her predecessor. Members may be reappointed from year to year. The CEO shall also appoint such ex officio members of the Compliance Committee as he or she deems necessary or advisable to assist the committee in the performance of its duties. Ex officio members of the committee may not vote on

matters before the committee. The Board of Directors may designate one of its members to attend meetings of the committee.

F. **Duties.** The duties of the Compliance Committee shall include:

1. Advising the Compliance Officer and assisting in the implementation and maintenance of the Compliance Program;

2. Working with appropriate departments of the Hospital to develop standards of conduct and policies and procedures to promote adherence to the Compliance Program;

3. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Hospital's standards, policies and procedures;

4. Determining the appropriate strategy and/or approach to promote adherence to the Compliance Program and the detection of potential violations;

5. Developing a system to solicit, evaluate and respond to complaints and problems;

6. Overseeing the education and training of employees and systems for communication with and by employees;

7. Analyzing the legal requirements with which the Hospital must comply and locating and analyzing specific risk areas within the Hospital; and

8. Establishing confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.

G. **Guidelines.** The Compliance Committee may adopt written guidelines for holding meetings and conducting the activities and operations of the committee.

IV.
TRAINING AND EDUCATION

A. **Necessity.** It is imperative that coding and billing of federal health care claims be truthful and accurate and within appropriate guidelines. Not only are severe penalties available to the

government but honesty and integrity in hospital operations are right and proper. However, sometimes conduct undertaken without wrongful intent but with inadequate knowledge may violate applicable laws and regulations. Proper and continuing training and education of employees at all levels is, therefore, a significant element of an effective compliance program.

B. **Initial Education.** Mandatory new employee orientation and the employee handbook will provide an overview of fraud and abuse laws, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process and highlight the Hospital's commitment to integrity in its business operations and compliance with applicable laws and regulations.

C. **General Rules**. Periodically, as necessary, appropriate employees will be retrained (i) in the Hospital's Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and the Hospital business relationships; (iii) relevant Medicare and other federal and state requirements; and (iv) the consequences both to the Hospital and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the Hospital's commitment to honesty and integrity in its business dealings.

D. **Substantive Rules**. Involved employees will be trained and retrained in the specific federal health care program rules (e.g. Medicare) that relate to their particular job function. By way of example:

1. Admitting personnel will receive training to ensure they are asking the necessary questions and obtaining the necessary information to comply with Medicare and Medicaid requirements.

2. Coding personnel will be taught current reimbursement principles, proper coding, the impact of coding on the DRG, and how to avoid the areas of concern applicable to the coding process described in Section II.

3. Patient care personnel will be instructed in charge entry and coding, and the importance of documenting services and supplies which will later be billed to Medicare or Medicaid.

4. Billing personnel will be instructed in Medicare requirements applicable to the preparation of claims for services, the distinction between covered and non-covered services and the importance of listing those services in the proper section of the UB92 and how to avoid the areas of concern applicable to the billing process described in Section II.

Such employees may be trained individually or as a group.

E. **Department Training and Education.** Each department director or manager shall periodically identify and advise the Compliance Officer of training and education necessary or advisable for all or any employees of his or her department. The Compliance Officer and the director or manager shall promptly arrange for such training and education.

F. **Types.** Training and education may occur in sessions with individual employees, in mandatory in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external work shops and seminars.

G. **Amount of Training.** All employees need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all employees. Targeted training and education will be provided to employees whose actions may affect the accuracy of claims submitted to the government. The actual amount of training should reflect necessity, an analysis of risk areas or areas of concern identified by the Hospital or the Office of the Inspector General, the Hospital's compliance experience and the results of periodic audits or monitoring.

H. **Documentation.** The training provided to each employee shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program. Documentation is important.

I. **Failure to Attend.** Failure to comply with training requirements or to attend scheduled training sessions of the Hospital or of each department may result in job transfer and/or disciplinary action.

J. **Physicians.** Hospital shall make available to physicians on its medical staff and to such physicians' office personnel, training and education in the claim development and submission process, including ordering Hospital services, medical necessity, coding, DRG's documentation, and such other information as might be reasonable or useful to enable Hospital to comply with applicable laws and regulations and to assist physicians in complying with such laws and regulations.

K. **Evaluation.** There should be periodic evaluations of training and education programs to determine, and if necessary improve, the value, effectiveness and appropriateness of any such program.

V.
COMMUNICATION

A. **Reason.** Open communications between employees and the Compliance Officer or Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse and waste. Without help from employees it may be difficult to learn of possible compliance problems and make necessary corrections.

B. **Questions.** At any time any employee or physician may seek clarification or advice from the Compliance Officer or members of the Compliance Committee in the event of any confusion or question with regard to this Program or any element of this Program or any Hospital policy or procedure related to this Program. Questions and responses should be documented and, if

appropriate, shared with other employees for informational and educational purposes. Employees should be encouraged to contact the Compliance Officer and any member of the committee and for this purpose the Compliance Officer will develop or cause to be developed publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

C. **Reporting.** Employees or physicians who are aware of or suspect acts of fraud, abuse or waste or violations of the Standards of Conduct should report such acts or violations. Several independent reporting paths are available:

1. Employees may but are not required to report to their supervisor or department director or manager. Supervisors and managers will thereafter promptly pass on the report to the Compliance Officer or member of the committee.
2. An employee or physician may report directly to the Compliance Officer or to a member of the committee.
3. The Hospital has contracted with the _____ to operate a 24 hour, 365 day hotline known as the "Complianceline". Employees and physicians may use this line anonymously at any time, day or night. The phone number of the ethics line has been posted at various places throughout the Hospital and employees will be reminded of the number and of their duty to report actual or suspected wrongdoing through pay check envelope "stuffers", the newsletter and other methods. Employees should be encouraged to use this line. Past experience indicates it works very well.
4. Next to each time clock in the Hospital is a locked "mail box", envelopes and blank forms. The forms may be completed anonymously, sealed in the envelopes and dropped in the box. The boxes will be checked at intervals each week by the Compliance Officer.
5. Employees and physicians may also call the hotline or the Office of the Inspector General of the Health and Human Services Department, 1-800-HHS-TIPS (447-8477). The Compliance Officer will post this number in one or more prominent locations in the Hospital.

D. **Confidentiality.** Reports received will be treated confidentially to the extent possible under applicable law. However, there may be a time when an individual's identity may become known or have to be revealed if governmental authorities become involved or in response to subpoena or other legal proceeding.

E. **Non-Retaliation.** There will be no reprisals or retaliation against any employee who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Standards of Conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action.

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of the Standards of Conduct or violation of relevant law or regulation should be documented by the Compliance Officer. Information about such reports should be furnished periodically to the Board and the Administrator - CEO and to the Compliance Committee at its regular meetings.

VI.
INVESTIGATION

A. **Requirement and Purpose.** Reports or reasonable indications of fraud, abuse or waste, violations of this Compliance Program, violations of the Standards of Conduct, violations of Hospital policy or procedure or violations of applicable law or regulation will be promptly investigated. The purpose of the investigation shall be to identify those situations involving fraud, abuse or waste or relevant violations or unacceptable conduct; to identify individuals who may have knowingly or inadvertently caused or participated in such situations or may need further training and education; to facilitate corrective action; and to implement procedures necessary to ensure future compliance.

B. **Control of Investigation.** The Compliance Office shall be responsible for directing the investigation of the alleged situation or problem. In undertaking investigations, the Compliance Officer may utilize other Hospital employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

C. **Process.** Because of the many situations or problems which are possible, the process and

method of investigation is left to the sound judgment and discretion of the Compliance Officer. However, the Compliance Officer or his or her designee, may conduct interviews with any Hospital employee and with other persons and may review any Hospital document including but not limited to those related to the claim development and submission process, patient records, e-mail and the contents of computers and word processors.

D. **Documentation.** The Compliance Officer shall prepare a report which (i) defines the nature of the situation or problem (ii) summarizes the investigation process (iii) identifies any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicare/Medicaid laws, regulations and policies, and (iv) if possible, estimate the nature and extent of the resulting overpayment by the government.

E. **Response.**

1. **Possible Criminal Activity.** In the event the investigation reveals or uncovers what appears to be criminal activity on the part of any employee, the following action will be taken:

    1. All billing involved in the situation or problem will be discontinued until such time as appropriate corrections are made.

    2. A summary of the results of the investigation shall be sent for appropriate disciplinary action to the department director or manager (or the appropriate assistant or associate administrator if the director or manager is implicated) of any employee whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for Medicare/Medicaid or other applicable laws and regulations. Pending disciplinary action, any such employee may be removed from any position with oversight of or impact upon the claims development and submission process.

    3. State and federal agencies will be notified as deemed appropriate by legal counsel, the Administrator and the Board. Hospital may attempt to negotiate a voluntary disclosure agreement prior to the disclosure.

2. **Other Non-Compliance.** In the event the investigation reveals claims development and

submission problem, which do not appear to be the result of criminal activity on the part of any employee, the following action will be taken:

1. If duplicate payments have been made by Medicare/Medicaid or other health care program or excessive payments made because of coding or other Hospital errors or mistakes (i) the defective practice or procedure will be corrected as quickly as possible; (ii) the duplicate or improper payments will be calculated and repaid to the appropriate payor or fiscal intermediary; and (iii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

2. If no duplicate or excessive payments have been made because of Hospital errors or mistakes (i) the defective practice or procedure will be corrected as quickly as possible; (ii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

3. A summary of the results of the investigation shall be sent for appropriate disciplinary action, if any, to the department director or manager (or the appropriate assistant or associate administrator if the director or manager is implicated) of any employee whose conduct may be wrongful or inappropriate under the circumstances.

3. **Voluntary Disclosures.** All voluntary self-disclosures will be guided by the OIG's Provider Self-Disclosure Protocol 63 Fed. Reg. 58399 (October 21, 1998).

F. **Reports by Compliance Officer.** The Compliance Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the Board and the Administrator - CEO and to the Compliance Committee at its regular meetings.

VII.

AUDITS

A. **Process.** Periodic audits will be undertaken in order to identify deficiencies in the Claim

development and submission process. Hospital will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by persons with appropriate knowledge and experience.

B. **Time.** The Compliance Committee shall designate the time for audits and the departments and functions to be audited.

C. **New Employees.** It is the responsibility of each department manager to ensure that employees who are new to a position, which has a direct impact on the claim development and submission process, are provided adequate and appropriate training and education. To verify that each new employee understands the essential elements of his or her job function, the work of such new employees should be audited or reviewed until the director or manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of the audit or review. Directors or managers may rely on other competent and experienced employees to assist in such reviews. New employees whose work does not meet the necessary quality or standard within a reasonable time after employment may be transferred to another job in or out of the department and such transfer shall not be considered disciplinary action for any purpose or reason.

D. **Periodic Tests and Audits.** The Hospital, under the direction of the Compliance Officer, will conduct periodic tests of claims submitted to Medicare, Medicaid and other federal health care plan and audits of the claims development and submission process. The audits shall include reviewing the work of coders, billers, admitting and registration clerks, patient care providers (including physicians where reasonably possible) ancillary departments such as laboratory and diagnostic imaging and risk areas identified by the OIG or fiscal intermediaries. Audits shall also cover the Hospital's relationship with third party contractors, including physicians on its medical staff, and

compliance with laws governing kickback arrangements. The Compliance Office may request that the director or manager of each affected department prepare and submit testing, audit and monitoring plans for his or her department.

E. **Access.** Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers and word processors. Auditors and reviews shall at all times bear in mind confidentiality requirements.

F. **Action.** The Compliance Officer will be notified of the results of all audits. Further action, if any, by the Compliance Officer with respect to any deviation or discrepancy revealed by an audit will be taken under the provisions of Section VI.

G. **Documents.** All audits shall be thoroughly documented. Such documents shall be maintained in the permanent files of the Compliance Officer and adequately secured.

VIII.
SCREENING

A. **New Employees.** Hospital will conduct a reasonable background investigation of all new employees, or applicants for employment, who have or will have discretionary authority to make decisions that or whose job function may materially impact the Medicare/Medicaid claim development and submission process or the Hospital's relationship with physicians on its medical staff. The purpose of the background investigation is to determine whether any such employee or applicant has been (i) convicted of a criminal offense related to health care or (ii) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

B. **Providers.** A similar reasonable background investigation will be undertaken for providers who do or will possess an individual Medicare or Medicaid provider number. Such providers also

should be periodically screened.

C. **Vendors and Contractors.** Reasonable background investigations will be conducted for vendors and contractors to determine if any such vendor or contractor has a criminal conviction related to health care or has been disbarred or excluded by a federal agency.

D. **Process.** The Compliance Officer, in consultation as necessary with the Director of Human Resources, the Medical Staff Coordinator and other employees, will implement and maintain policies and procedures for developing relevant applications for employment and for conducting such background investigations. The application for employment should require the applicant to disclose any criminal conviction related to health care programs or exclusion action. The background investigations should utilize the OIG Cumulative Sanction Report, the General Services Administration list of debarred contractors and the National Practitioner Data Bank.

E. **Prohibition.** The Hospital will not hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicare/Medicaid claim development and submission process or the Hospital's relations with its staff physicians if such prospect or employee has been convicted of a crime related to health care or has been excluded or debarred. The Hospital will not contract with any person or entity which has been so convicted or excluded or debarred and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. The Hospital will make reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity, including physicians, excluded from participation.

IX.
EVALUATIONS

Adherence to and promotion of this Program will be a factor in evaluating the performance of employees, including supervisory, managerial and administrative personnel.

X.
REPORTS

The Compliance Officer shall make written evaluation reports on compliance activities including reports or complaints received from employees, investigations, audits and monitoring, to the Board, CEO, and members of the Compliance Committee on a regular basis. Reports to the Board shall be at least annually or more often as necessary or advisable.

XI.
DEPARTMENTS

A. **General.** Each director or manager of an affected department is responsible for implementing and maintaining compliance standards and policies and procedures and manuals specific to their departments and reasonably necessary to ensure compliance with this Program and applicable laws and regulations.

B. **Contents.** The compliance standards for each affected department shall contain a statement of compliance policy for that department and shall define and assign responsibility for updating the compliance standards, the department compliance manual, training and education, record keeping and the completion of audit work plans requested by the Compliance Officer. The department compliance manuals may contain such other matters as the director or manager deems necessary or appropriate so long as it does not conflict with this Program.

C. **Resource.** The department compliance manuals shall be a resource for the employees of each affected department to enhance the ability of employees to perform their jobs in compliance with this

Program and applicable laws and regulations. Employees should be encouraged to periodically review their departmental compliance manuals and to discuss any compliance issue with their supervisor or director or manager. Directors and managers are encouraged to involve their employees in the preparation of such department manuals.

D. **Approval.** Department compliance manuals must be approved by the Compliance Officer. The Compliance Officer may assist in the preparation and maintenance of any such manual upon request.

XII.
RESPONSE TO GOVERNMENTAL INQUIRIES

A. **Cooperation.** Federal agencies have available a number of investigation tools including search warrants, subpoenas and civil investigation demands. Actions also may be brought against the Hospital to exclude it from participating in Medicare/Medicaid if the Hospital fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of The Hospital to cooperate with and properly respond to all governmental inquiries and investigations.

B. **Process.** Employees who receive a search warrant, subpoena or other demand or request for investigation, or if approached by a federal agency, should attempt to identify the investigator, if any, and immediately notify the Compliance Officer or, in that Officer's absence, a member of the Compliance Committee or the employee's supervisor. Employees should request the government representative to wait until the Compliance Officer or his or her designee arrives before conducting any interview or reviewing documents. The Compliance Officer in consultation with outside legal counsel is responsible for coordinating the Hospital's response to warrants, subpoenas, inquiries and investigations by federal agencies. If appropriate, the Hospital also may provide legal counsel to employees.

C. **Documents.** The Hospital's response to any warrant, subpoena, investigation or inquiry must

be complete and accurate. No employee shall alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk or tape. Documents and records must be preserved in their original form.

XIII.
DISCIPLINE AND DISCLAIMER

A. **Other Reasons:** In addition to possible disciplinary action mentioned elsewhere in this Program employees may be subject to disciplinary action for:

14. Failure to perform any obligation or duty required of employees relating to compliance with this Program or applicable laws or regulations.

15. Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

B. **Procedure**. Possible disciplinary action will follow Hospital's existing disciplinary policies and procedures. Progressive discipline is not required.

C. **Disclaimer.** Nothing in this Program shall (i) constitute a contract of or agreement for employment; or (ii) modify or alter in any manner any employee's at-will employment status. Any part of this Program may be changed or amended at any time without notice to any employee.