Greater Hudson Valley Health System

Corporate Compliance Plan

Do the right thing!

Updated April, 2011

ORANGE REGIONAL MEDICAL CENTER
CATSKILL REGIONAL MEDICAL CENTER

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Letter from the Audit & Compliance Department:

To: All Hospital Employees, Physicians, and Contractors

We are responsible for maintaining the various components of the Hospital's Compliance Plan in concert with the Hospital's President, Board of Directors, Compliance Committees, and Audit and Compliance staff.

The Compliance Plan provides for a method of reporting suspected violations of the Plan or other improper behavior. You, as Employees, Physicians, or Contractors, have a duty to report a known or suspected violation of the Plan using any one of the methods of reporting herein described. There will be no retaliation or retribution against anyone who reports in good faith.

GHVHS's comprehensive Compliance Program helps to ensure that business practices are conducted at all times in compliance with all applicable federal, state and local laws and regulations, and the ethical standards and practices of the Hospital. A "culture of compliance" between all employees, physicians, and contractors is what makes our Program a success

Stephen J. Sugrue
VP, Audit & Compliance

Karen Siverding
Compliance Officer &
Internal Audit

Mission and Value Statement

The Greater Hudson Valley Health System (Orange Regional Medical Center, and Catskill Regional Medical Center) hereinafter "Hospital" believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. Our Code of Conduct provides guidance to all Hospital Employees, Physicians, and Contractors and assists us in carrying out our daily activities in accordance with ethical and legal standards. These obligations apply to our relationships with patients, physicians, third-party payors, regulatory agencies, subcontractors, independent contractors, vendors, consultants, and one another.

The Code of Conduct is a critical component of our overall Compliance Program. We have developed the Code as part of an ongoing process to ensure that we meet our ethical standards and comply with all applicable laws and regulations.

Quality of Patient Care and Bill of Rights

The Hospital has standards of patient care that reflect federal, state and local laws and regulations, respective medical, professional and clinical practice guidelines, and professional and accrediting body standards. These standards of patient care are approved by the Hospital's Board of Directors.

The Office of the Inspector General of the United States Department of Health and Human Services ("OIG") has authority to exclude an entity from participating in the federal health care programs if it provides substandard care to its patients. In order to ensure the care that the Hospital renders meets professionally recognized standards, the Hospital will comply with all relevant Medicare Conditions of Participation. In addition, the Hospital maintains and seeks to enhance protocols that it utilizes to monitor the quality of care provided in its various departments.

The Hospital's patients deserve care with concern for personal dignity and independence, and the Hospital views these as important factors in the healing process. It is the responsibility of the staff at the Hospital to respect and preserve these rights for those who come to the Hospital for medical care.

Designating a Compliance Officer

All Medicare and Medicaid participating providers are required to designate an employee with the responsibility to maintain the day to day operation of the Plan. This responsibility is vested in the Compliance Officer. The Chief Compliance Officer reports directly to and is responsible to the CEO and to the Board of Directors.

The Chief Compliance Officer's duties include:

1. Overseeing and monitoring the Hospital's compliance activities;

2. Reporting to the Board of Directors and the Hospital on the progress of implementation;

3. Assisting the CEO and the Board 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;

4. Ensuring that the Compliance Plan is being implemented and evaluating its progress;

5. Periodically reviewing the Compliance Plan and recommending revisions as necessary to meet changes in the business and regulatory environment;

6. Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the Compliance Program, and ensures that all appropriate Employees and Contractors are knowledgeable of, and comply with, pertinent federal and state law;

7. Ensuring that independent contractors and other third parties dealing with the Hospital are aware of the Hospital's Compliance Plan with respect to coding, billing and marketing;

8. Ensuring that state licensure records, National Practitioner Data Bank and OIG List of Excluded Individuals and Entities, and the General Services Administration's (GSA's) List of Parties Debarred from Federal Programs have been checked with respect to all Employees and Contractors;

9. Working closely with legal counsel to review and update the education, training, and the Hospital's Code of Conduct to reflect the current federal, state and local laws;

10. Coordinating internal auditing and monitoring of activities within the Hospital;

11. Accessing and reviewing business contracts involving the Hospital's clinical staff and Contractors where appropriate;

12. Ensuring that the Compliance Plan has been effectively communicated to all Employees and Contractors of the Hospital;

13. Establishing and administering a communication system that is available to all Employees or Contractors to report any suspected illegal conduct or other conduct that violates the Code of Conduct or applicable law;

14. Receiving and investigating reports of possible illegal conduct or other conduct that violates the Code of Conduct;

15. Developing policies and programs that encourage managers, Employees, Contractors and clinical staff to report suspected fraud and other improprieties without fear of retaliation; and

Establishing Compliance Committees

To help ensure the success of the Compliance Plan, the Hospital established Compliance Committees to identify and build upon existing Hospital policies and procedures and to develop and implement a work plan for the creation and establishment of the Plan.

In coordination with the Chief Compliance Officer, the Compliance Committees meet periodically to discuss, review and resolve compliance issues. In coordination with the Compliance Officer, the Compliance Committees' functions include, but are not limited to:

- Developing and executing an annual Hospital Compliance Work Plan
- Analyzing the business, industry, environmental and legal requirements with which the Hospital must comply, including specific risk areas;
- Assessing existing policies and procedures that address these areas for possible incorporation into the Compliance Plan;
- Developing a code of conduct, standards of conduct, policies, and procedures to promote compliance with the Hospital's policies;
- Recommending and monitoring the development of internal systems and controls to carry out the Hospital's standards, policies and procedures as part of its daily operations;
- Developing a system to solicit, evaluate and respond to complaints; and
- Determining the appropriate approach or strategy to promote compliance with the Plan and detect potential violations.

Acting through the Compliance Officer, the Committees are empowered to investigate, evaluate and report facts, and make recommendations to Management and/or Board of Directors of possible responses or initiatives, including disciplinary or other adverse action for misconduct by Hospital Employees or Contractors.

Audit & Compliance Staff

To help ensure the success of the Compliance Program, CRMC has a site specific Audit & Compliance officer who is responsible for the oversight of the Harris and Callicoon Campuses, as well as outpatient sites and physician practices.

The GHVHS Director of Internal Audit is responsible for system-wide coordination of Audit activities to ensure both Compliance and the best use of resources.

The Hospital is subject to numerous federal and state laws regulating practices and relationships within the health care industry. These laws are designed to prevent fraud in federal and state healthcare programs, including Medicare and Medicaid, and abuse of the public funds supporting the programs, regulate patient referrals, and prohibit false statements to the government. The Hospital is committed to compliance with all applicable federal and state rules. All Employees, Physicians, and Contractors should be aware of these laws and notify the Compliance Officer of any potential violations involving the Hospital.

Patient Freedom of Choice

A patient (assuming capacity) has the right to make all decisions regarding his or her health care, including involvement in the plan of treatment, requests for treatment within the boundaries of what is considered to be medically necessary and appropriate, refusal of treatment, formulating advance directives, and selecting his or her health care providers.

The government has indicated that patient choice may be compromised when hospital discharge planners refer patients for post-hospital home health services, long-term care services, rehabilitation services, and DME supplies. The Hospital shall ensure that it adheres to the Medicare Conditions of Participation for hospitals which require special disclosures for patients requiring post-hospital home health services or skilled nursing facility services.

Advanced Directives and Do Not Resuscitate Orders-DNR

The Hospital will comply with all federal and state laws governing advance directives and DNRs. At a minimum, the Hospital will comply with the letter and the intent of the provisions of the Federal Patient Self-Determination Act.

Physicians may, for personal reasons, refuse to carry out Advance Directives. Physicians who refuse to carry out such order must immediately notify hospital administration which shall arrange for the appropriate and timely transfer of care of that patient to another provider.

Finally, any conflicts that arise between a patient, his or her surrogate and a member of the Hospital's medical staff or other staff shall be referred to the appropriate committee within the Hospital. The committee will review the circumstances associated with the conflict and issue a recommendation regarding how to proceed.

Health Insurance Portability and Accountability Act- HIPAA

As of April 14, 2003, all hospitals were required to comply with the privacy rules of the Health Insurance Portability and Accountability Act ("HIPAA"). Generally, the HIPAA privacy rule ("Privacy Rule") addresses the use and disclosure of individuals' health information (protected health information or PHI) by hospitals and other covered entities, as well as standards for individuals' privacy rights to understand and control how their health information is used. The Hospital shall ensure that it is compliant with all applicable provisions of the Privacy Rule, including provisions pertaining to required disclosures and that its privacy procedures are tailored to fit the particular size and needs of the Hospital.

In addition, the HIPAA security rule ("Security Rule") specifies a series of administrative, technical, and physical security procedures for hospitals that are covered entities and other covered entities to use to assure the confidentiality of electronic PHI. The Hospital updates as necessary appropriate safeguards to ensure continued compliance with the Security Rule.

Emergency Medical Treatment and Labor Act- EMTALA

The Hospital provides for appropriate emergency medical screening and examination. Except for in limited circumstances, no patient may be transferred to another facility until after that individual has been stabilized and all other applicable requirements under the Emergency Medical Treatment and Labor Act have been satisfied. The Hospital will provide appropriate screening and treatment services to emergency patients utilizing the full capabilities of the Hospital's staff, including specialists who are on call.

Safety and Quality Improvement Act of 2005 PSQIA

The Patient Safety and Quality Improvement Act creates Patient Safety Organizations (PSOs) to collect, aggregate, and analyze confidential information reported by health care providers. Many providers fear that patient safety event reports could be used against them in medical malpractice cases or in disciplinary proceedings. The Act addresses these fears by providing Federal legal privilege and confidentiality protections to information that is assembled and reported by providers to a PSO or developed by a PSO ("patient safety work product") for the conduct of patient safety activities. The Act also significantly limits the use of this information in criminal, civil, and administrative proceedings. The Act includes provisions for monetary penalties for violations of confidentiality or privilege protections.

The Federal Anti-Kickback Statute, 2 U.S.C. § 1320a-7b (b)

Generally, the Federal Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration, directly or indirectly, in return for referrals or to induce referrals, or to arrange for or recommend goods, facilities, services or items for which payment may be made under a federal health care program.

The Federal Anti-Kickback Statute has been expanded from Medicare, Medicaid and certain state programs to include all federal health care programs. "Federal health care programs" is broadly defined to include any plan or program that provides health benefits funded in whole or in part by the federal government. The Federal Anti-Kickback Statute has been interpreted to cover arrangements where one purpose of the remuneration is to induce referrals, even though other legitimate business purposes may exist. Compliance counsel should be consulted whenever a kickback issue exists, and prior to entering into relationships with physicians and other healthcare professionals. The federal government has identified certain business arrangements, some of which are discussed below, which could potentially violate the Federal Anti-Kickback Statute.

Joint Ventures

From time to time, a hospital may enter into relationships with physicians or other providers in a position to refer patients to such hospital. These relationships may take the form of joint ownership in a corporate entity. Where the hospital and a potential referral source invest money jointly in an entity, payments received from the entity, and/or any other financial transaction surrounding the formation of the entity, may be scrutinized to determine whether the joint venture runs afoul of the Anti-Kickback Statute. The Hospital ensures that it structures any relationship with a potential referral source in a manner that is consistent with the provisions of the Anti-Kickback Statute. When possible, the Hospital attempts to structure transactions so that such transactions fit within the statutory and regulatory safeharbors set forth in the Anti-Kickback Statute and its regulations. In addition, the Hospital ensures that any sum of money that it receives from or provides to any venture with a potential referral source is not a payment for referrals.

Gifts to Referral Sources

The Hospital will not routinely give anything of value to physicians or other providers that are in a position to refer patients to the Hospital. While there may be some instances where specific items may be given, Employees should always consult with the Compliance Officer prior to providing any gift to a referral source or to an entity that has the potential to refer patients to the Hospital.

Relationship with Physicians

The Hospital may enter into contracts and other arrangements with physicians and other health care entities to provide or receive services reimbursed under the federal health care programs and by commercial payors. These agreements may include, but are not limited to, medical director agreements, management agreements, space and equipment leases, billing and staffing services agreements and agreements with laboratories, pharmaceutical manufacturers, nursing homes, durable medical equipment suppliers and home health agencies. The Hospital will review all such agreements to ensure that payments under any such agreements do not violate state or federal anti-kickback statutes. The Hospital will ensure, at a minimum, that any payments made under such arrangements are at fair market value, based on an arm's-length transaction, and that they do not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties to the contract. In order to ensure that all such agreements are compliant with state and federal anti-kickback statutes, the Compliance Officer and legal counsel (as appropriate) will review all agreements with the aforementioned providers, manufacturers and suppliers before such agreements are executed.

Gainsharing Arrangements

The Hospital may enter into agreements with physicians in an effort to encourage physicians to reduce costs to the Hospital by implementing cost saving strategies. Under these arrangements, called "gainsharing arrangements", the Hospital may pay to its physicians a portion of the cost savings that the Hospital saves under the cost-saving strategy that the physicians implemented.

Gainsharing arrangements may implicate the Federal Anti-Kickback Statute because the payments to the physicians under the arrangement may be viewed as an inducement for referrals. As a result, any proposed gainsharing arrangement with a physician or group of physicians will be reviewed by the Compliance Officer or legal counsel.

Malpractice Subsidies

In an effort to avoid sudden disruptions in provider services because of a provider's loss of malpractice coverage, some hospitals have adopted the practice of subsidizing physicians' malpractice insurance. Such subsidy payments may implicate the Federal Anti-Kickback Statute and similar state statutes in that the subsidy payment could be viewed as an improper inducement for referrals. In addition, these payments may implicate the Stark Law (discussed below). Accordingly, the Compliance Officer and legal counsel must review and approve all contracts that provide for malpractice subsidies to any physician.

Discounts

The Hospital may enter into agreements with commercial payors that set forth the price at which certain hospital services are provided. Any discounts included within those agreements may implicate federal and state fraud and abuse laws. For this reason, the Compliance Officer must approve all agreements which provide discounts to commercial payors before any agreement containing such discounts is executed.

Professional Courtesies

The Hospital may offer services to its staff and employees at no cost or at a discount. This practice is often referred to as a "professional courtesy." Under certain circumstances, professional courtesies may violate the Federal Anti-Kickback Statute if they are offered to persons in return for referrals. In addition, professional courtesies may implicate the Stark Law, in which case they will be required to fit within the exception set forth in 42 C.F.R. § 411.357(s).

Finally, certain professional courtesies offered to federal health care program beneficiaries may implicate the Civil Monetary Penalties provision (the "CMP Law"), which prohibits inducements to beneficiaries of Medicare, Medicaid and any other federal healthcare program. Professional courtesies that implicate the CMP Law may take the form of waivers of co-payments and/or deductibles.

The Compliance Officer will review all policies relating to professional courtesies before such courtesies are provided on a routine basis.

Medical Staff Credentialing

Certain medical staff credentialing practices may implicate the Federal Anti-Kickback Statute. For example, conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the law. On the other hand, a credentialing policy that outright refuses privileges to physicians with significant conflicts of interest would not appear to implicate the Statute. The Compliance Officer shall periodically review the Hospital's credentialing practices to ensure that such practices do not run afoul of the Federal Anti-Kickback Statute.

Ethics in Patient Referrals Act ("Stark Statute"), 42 U.S.C. § 1395nn

The Stark Statute provides that if a physician (or a family member) has a "financial relationship" with a hospital, then the physician is prohibited from referring patients to that hospital for the provision of "designated health services" ("DHS") that are paid for by Medicare or Medicaid, unless an exception applies. A "financial relationship" includes direct or indirect ownership or investment interests and direct or indirect compensation arrangements between a physician (or the physician's family member) and any entity that provides DHS.

"Designated Health Services" include:

a. clinical laboratory services;
b. physical therapy services;
c. occupational therapy services;
d. radiology or other diagnostic services;
e. radiation therapy services;
f. durable medical equipment and supplies;
g. parenteral and enteral nutrients, equipment, and supplies;
h. prosthetics, orthotics and prosthetic devices and supplies;
i. home health services;
j. outpatient prescription drugs; and
k. inpatient and outpatient hospital services.

There are various penalties for violating the Stark Statute. First, an entity to which a prohibited referral was made may not bill for services rendered. Therefore, if an entity provides DHS to a client referred by a physician who has a financial relationship which does not meet one of the exceptions below, the entity will not be paid for providing those services. In addition, an entity which received payment pursuant to an illegal referral must refund the payment. In addition to having to return the money, both the physician and the entity who accepted the prohibited referral may be subject to civil money penalties and exclusion from the Medicare and Medicaid program for making such illegal referrals. A violation of the Stark Statute may result in penalties of $15,000 per claim, plus triple the amount claimed, and $100,000 for participation in a circumvention scheme. Further, a violation of the Stark Statute could also form the basis for a False Claims Action.

Financial relationships covered by the Stark Statute include investment interests, loans, and compensation relationships (including the payment of cash or in-kind benefits). The prohibited financial relationships can be either direct or indirect, such as through an intermediate party. To be prohibited, the financial relationship need not relate to the provision of DHS (for instance, the joint venture between a hospital and a physician to operate a hospice would create an indirect compensation relationship between the hospital and the physician for purposes of the Stark Statute).

Unlike the Federal Anti-Kickback Statute, whether a particular arrangement violates the Stark Statute does **not** depend on the **intent** of the parties. Therefore, an arrangement which implicates the Stark Statute **must** qualify for an exception. There are a number of exceptions to the Stark Statute which, if met, have the effect of permitting a physician with an ownership interest or compensation arrangement with an entity to refer Medicare or Medicaid clients to such entity for the provision of DHS. Legal counsel should be consulted regarding the availability of these exceptions.

Physician Recruitment

A physician recruitment arrangement between a hospital and a physician has the potential to violate the Stark Statute. If a hospital pays a physician to relocate in order to practice in the geographic area of the hospital so as to become a member of the hospital staff, the following conditions must be met to satisfy the Stark exception for physician recruitment.

1. The agreement between the hospital and physician must be set out in writing and signed by both parties;
2. The arrangement may not be conditioned on the physician's referral of patients to the hospital;
3. The hospital's payment to the physician shall not depend on the volume or value of referrals or business generated between the parties; and
4. The physician may establish relationships with other hospitals and may refer patients to other entities.

The physician will have met the "relocation" requirement if the physician moves his or her medical practice at least 25 miles from its existing location, or at least 75% of the physician's revenues come from services rendered to patients who were not patients at the physician's medical practice within the prior three years.

There are additional requirements regarding compensation and record-keeping for payments made in connection with a recruiting arrangement.

Joint Ventures

A joint venture arrangement whereby a hospital, or any of its subsidiaries or related organizations share control with a physician, may implicate the Stark Statute. The myriad of potential possibilities with, among other things, investments into the joint venture, control, revenue sharing, and other factors that are unique to each joint venture arrangement require a detailed analysis of both Stark and Anti-Kickback laws.

Other Financial Arrangements Between Physicians and Hospitals

A comprehensive Stark analysis must be undertaken when a hospital and physician enter into any financial arrangement. While exceptions may exist for certain types of arrangements, such as equipment and office leases, bona fide employment arrangements, personal services arrangements and one time isolated transactions, any such arrangements must be reviewed by the Compliance Officer and legal counsel (as appropriate) to determine whether the arrangement meets one of the enumerated exceptions.

New York Fraud and Abuse Provisions

The New York State Office of the Medicaid Inspector General, as well as the New York State attorney General's Office and the Medicaid Fraud Control Unit, investigates claims of fraudulent activities in billing or other services. The following are specific New York State laws affecting the hospitals practice:

New York Self Referral Law

The New York State Health Care Practitioner Referrals Act, which is modeled loosely on the federal Stark Statute, prohibits referrals from practitioners to health care providers for clinical laboratory services, x-ray or imaging services or pharmacy services if the practitioner has a financial relationship with the health care provider through an ownership or investment interest, or compensation arrangement. There are certain exceptions to the prohibition on referrals, including: (i) the provision of in-office ancillary services; (ii) services furnished to HMO subscribers and other managed care enrollees; (iii) referrals for inpatient hospital services; (iv) financial relationships with a general hospital unrelated to the provision of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services, or x-ray or imaging services; (v) ownership of investment securities in publicly-traded companies with total assets exceeding $100 million; and (vi) the rental or lease of office space.

Additional exceptions exist that apply to certain compensation arrangements with physicians, including: (i) isolated financial transactions; (ii) employment arrangements; (iii) physician recruitment; and (iv) compensation arrangements with group practices. The Compliance Officer and legal counsel shall be consulted with respect to the availability of any of these exceptions.

Anti-Kickback Laws

New York has laws prohibiting the payment of kickbacks or other remuneration as an inducement for patient referrals. Under New York law, it is a crime for a Medicaid provider to solicit, receive, offer or give consideration in any form which is intended to induce the referral of a patient for an item or service that is reimbursed by Medicaid. The New York law incorporates by reference the federal statutory exemptions and safe harbor regulations of the Federal Anti-Kickback Statute. Violations of the New York law are punishable by imprisonment and fines of up to $10,000 or double the gain from the violation.

In addition, it is considered professional misconduct for a physician to offer, give, solicit or receive any fee or other consideration "to or from a third party for the referral of a patient or in connection with the performance of professional services." A physician found to violate this rule could be subject to disciplinary action, including suspension or revocation of the physician's license to practice medicine.

Fee-Splitting Provisions

New York has several laws that prohibit fee-splitting. Physicians and other licensed professionals are not permitted, directly or indirectly, to request, receive, or participate in the "division, transference, assignment, rebate, splitting or refunding of a fee," or to request, receive, or profit "by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of professional care or service."

False Claims Provisions

New York has several laws aimed at curbing the submission of false claims and statements to state and federal health care programs, including Medicare and Medicaid. Under these laws, no person or entity may knowingly and willfully (with intent to defraud) prepare or present any claim for payment or other benefit to Medicaid, any other payor or any public office which is known to contain materially false information. It is also unlawful to conceal any material facts in an attempt to obtain payment of public funds. The penalties for a false claims violation include potential civil and criminal liability.

Claims Development And Submission

The Hospital has an obligation to its patients, third party payors, and the federal and state governments to exercise diligence, care and integrity when submitting claims for payment for services rendered. To uphold this obligation, the Hospital shall maintain honest, fair, and accurate billing practices. All individuals involved in the billing functions of the Hospital, including its physicians, shall have experience and knowledge, and billing personnel shall be appropriately trained to perform all billing functions in accordance with federal, state and local law.

The Hospital has and shall maintain detailed written billing policy and procedure manuals to provide guidance to billing and coding staff, including job descriptions and the duties and minimum experience and educational requirements for each position in the billing department. With respect to reimbursement claims, the Hospital's written policies and procedures reflect and reinforce current federal and state statutes and regulations regarding the submission of claims. These policies create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical staff.

To avoid potential criminal and civil liability for violations of the Civil False Claims Act, 31 U.S.C. §§3729a-3733; the False Statements Act, 18 U.S.C. § 1001; and the corresponding administrative prohibitions for false claims and statements, 42 U.S.C. § 1320a-7b(a); and all applicable New York State laws and regulations, the Hospital's billing policies and procedures should particularly emphasize the following:

1. Bill third-party payors for those services provided, as supported by medical record documentation;
2. Avoid any duplicate billing;
3. Provide for proper and timely documentation of the services of health care providers;
4. Avoid improper unbundling (billing for each component of the service instead of billing an all inclusive code); [1]
5. Submit claims only when appropriate documentation supports the claims and only when such documentation is maintained and available for review;
6. Assure that the compensation for any Employee or Contractor, including the billing coders and billing consultants, not provide any financial incentive to upcode claims;
7. Avoid billing for non-covered services as if covered;
8. Avoid billing for services not rendered (the practice of submitting a claim that represents that the provider performed a service all or part of which was simply not performed);
9. Avoid improperly billing for discharge in lieu of a transfer;[2]

[1] A common billing error that may lead to liability under state and federal law is a practice referred to as "unbundling" or "fragmentation." Medicare, Medicaid and commercial payors often require that certain procedures be billed and paid together. For example, certain clinical laboratory services, such as blood test panels, must be billed together. Providers who separate these tests and bill them separately so as to increase their reimbursement from such tests may be liable under federal and state laws relating to false claims or insurance fraud. All Employees who have billing responsibilities must ensure that all tests and services that are required to be billed together are not submitted separately. If you have any questions regarding proper claims submission, you should contact your immediate supervisor or the Compliance Officer.

10. Avoid submitting multiple claims for OPPS services delivered to the same patient on the same day;[3]

11. Adhere to and continuously monitor The Centers for Medicare and Medicaid Services' ("CMS") post-acute care transfer policy[4] and maintain an accurate list of all designated Diagnosis Related Groups ("DRGs") subject to the policy;

12. Ensure that Hospital coding software includes up-to-date edit files;

13. Assure that written policies and procedures regarding billing are designed to ensure that the procedure codes selected represent the actual services provided, irrespective of the discounting status.[5] In addition, the Hospital shall ensure that any Employee responsible for billing reviews the annual OPPS rule update to understand more fully CMS' multiple procedure discounting rule;

14. Ensure that the appropriate level evaluation and management ("E/M") code is used and that such code accurately reflects the services provided to a patient;[6]

15. Assure that written policies and procedures regarding submission of claims for services address current CMS guidance relating to those items and services that are entitled to pass-through treatment;[7]

16. Ensure that the Hospital, and all Employees responsible for billing, review and become familiar with CMS' outlier rules and requirements that are intended to curb abuse of outlier payments by hospitals;

17. Ensure that the Hospital facilities and affiliated organizations are only designated as provider-based if they satisfy the criteria set forth in the applicable provider-based status regulations;[8]

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[2] The practice of billing for discharges when a patient is transferred has received significant scrutiny from federal enforcement agencies. When a patient is transferred from a hospital that is paid under the Inpatient Prospective Payment System ("IPPS") to another hospital that is paid under the IPPS, the transferor hospital is entitled to a per diem rate. The hospital that receives the patient, presuming the patient is ultimately discharged from that hospital, is entitled to a DRG payment based on the final discharge code. The discharge payment is higher than the transferor hospital's per diem payment. Because of this payment discrepancy, some transferring hospitals, in an effort to increase their reimbursement, improperly bill the services rendered to the transferred patient as a discharge rather than a transfer. This practice is prohibited under the Medicare billing guidelines. All Employees in charge of billing under the IPPS must ensure that they bill Medicare appropriately for patients that are transferred to other hospitals paid under the IPPS.

[3] Under the Hospital Outpatient Prospective Payment System ("OPPS"), all services provided to the same patient on the same day within a specific hospital are required to be submitted on the same claim. Employees assigned to billing tasks must ensure that the claims that the hospital submits comply with this billing guideline.

[4] Medicare's post-acute care transfer policy provides that, for certain designated DRGs, a hospital will receive a per diem transfer payment, rather than a full DRG payment, if the patient is discharged to certain post-acute care settings. CMS may periodically revise the list of designated DRGs that are subject to its post-acute care transfer policy, so it is essential that the Hospital and Employees review and monitor the list of DRGs periodically.

[5] There are different "E/M Codes" that apply to each evaluation and management services depending on the service rendered to a patient. To the extent that a higher level code is used inappropriately, an enforcement agency could allege that the hospital engaged in upcoding.

[6] Certain items are paid separately when provided in a hospital and are not grouped with other procedures. These items include current orphan drugs, certain cancer therapy drugs and biologicals and brachytherapy devices used to treat cancer, certain radiopharmaceutical drugs and biological products and certain new medical devices. When a hospital provides these items, it is entitled to "pass-through" payments for a period of two to three years. CMS frequently updates items and services that are entitled to pass-through treatment under the OPPS. Accordingly, Employees who are charged with the task of submitting claims for services that may be entitled to pass-through treatment should be mindful of guidance relating to which items and services are entitled to pass-through treatment.

18. Ensure that persons with billing responsibilities carefully review coverage guidance that CMS, Medicaid state agencies and commercial payors have issued pertaining to billing for services provided to enrollees in clinical trials to ensure that the claims that the hospital submits for services rendered to clinical trial enrollees is compliant with such guidance;[9]

19. Avoid charging Medicare or Medicaid substantially more than the charge to others for the same item or service;[10]

20. Assure that written policies and procedures address the importance of disclosure when a Medicare beneficiary has alternative coverage;[11]

21. Assure that written policies and procedures concerning proper coding reflect the current reimbursement principles set forth in the applicable regulations and are developed in tandem with private payor and organizational standards. Particular attention should be paid to issues of medical necessity and appropriate diagnosis;

22. Ensure that claims for dialysis services are consistent with the level of care stated in the physicians' orders;[12]

23. Ensure that claims for arterial stent implantation are supported by adequate documentation with respect to the medical necessity of such procedure; and

24. Ensure that the Hospital satisfies the eligibility criteria set forth in Section 1923 of the Social Security Act prior to accepting disproportionate share hospital (DSH) payments from the State of New York, and that no DSH payments are accepted in excess of the Hospital's uncompensated care costs.

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[7] CMS' policy regarding provider-based designations sets forth standards by which multiple provider facilities will be designated as one facility for Medicare accounting and cost allocation purposes. Certain hospital-affiliated entities and clinics can be designated as "provider-based" which allows for a higher level of reimbursement for certain services. The government is concerned that the provider-based designation could result in higher payments to facilities that may not be entitled to them.

[9] Hospitals frequently treat patients that are enrolled in clinical trials. In certain clinical trials, the trial sponsor may pay for certain costs. Other services may be paid under the Medicare program or under the Medicaid program.

[10] Federal law provides that providers may not submit a claim based on costs or charges to the Medicare or Medicaid programs that is "substantially in excess" of its usual cost or charge.

[11] Medicare will not pay for a service where a beneficiary has worker's compensation, automobile or liability insurance; or coverage under an employer group health plan. Where a service is covered under one of these forms of insurance, Medicare will not have primary responsibility for paying for the service. A provider may be required to inform Medicare of instances where it has knowledge that the beneficiary has coverage from one of the payors discussed above. A provider that knowingly fails to disclose, when required, whether a beneficiary has alternative coverage may be subject to fines.

[12] Observation services are outpatient services that are paid on an hourly basis and can last up to 48 hours. Inpatient services are paid under a DRG at a much higher rate. Any claims for inpatient admissions for dialysis services must be consistent with the physicians' orders stated level of care as "admission to inpatient status." The Hospital may not bill for dialysis services as an "admission to inpatient status" if the physicians' orders clearly state "admission to observation status".

Documentation

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

1. The medical record is complete and legible;

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

3. If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party with appropriate medical training;

4. CPT and ICD codes used for claims submission are supported by documentation in the medical record; and

5. Appropriate health risk factors are identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis is documented.

Inadequate documentation can be the root of investigations of inappropriate or erroneous conduct, and have been identified by CMS and the OIG as a leading cause of improper payments.

Medical Necessity: Reasonable and Necessary Services

While physicians and other appropriately licensed health care professionals are able to order any services that are appropriate for the treatment of their patients, Medicare and other government and private health care plans will only pay for those services that meet appropriate medical necessity standards (as in the case of Medicare, "reasonable and necessary services"). The Hospital may not bill the payor for services that do not meet the applicable standards.

Therefore, the Hospital should ensure that claims are submitted to the payor only for services that the Hospital believes are medically necessary and that were ordered by a physician or other appropriately licensed individual. Upon request, the Hospital should be able to provide documentation to support the medical necessity of a service (or recertification) that the Hospital has provided. If the patient requests or consents to a service that is not covered by insurance, the patient should be informed the service is not covered prior to the furnishing of such service. The Hospital may then bill the patient directly.

Record Retention

All records of the Hospital shall be maintained in accordance with Medicare, Medicaid, and all federal, state and local regulatory guidelines, and the Hospitals' records retention policy. Medical records shall be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage.

Financial Accounting Records: Integrity and Accuracy

All financial reports, accounting records, research reports, expense accounts, time sheets, and other financial documents shall accurately represent the performance of operations. The Hospital's employees shall be trained and their work shall be monitored to assure proper maintenance of information to comply with the Hospital's policy, accreditation standards, and any other such laws, statutes or regulations.

The Hospital shall establish procedures to assure a system of internal controls which provides reasonable assurance that financial records are executed and retained consistent with federal, state and local regulatory requirements and accounting industry guidelines, and the Hospital shall ensure that all records are prepared in a timely manner and are properly supported.

Cost Reports

The Hospital strives to ensure full compliance with applicable statutes, regulations and program requirements and private payor plans. With respect to cost reports, the following principles shall be adhered to:

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

2. Allocations of costs to various cost centers shall be accurately made and supported by verifiable and auditable data;

3. Unallowable costs shall not be claimed for reimbursement;

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

5. Costs shall be properly classified;

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

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

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

9. Purchase credits shall be properly identified as a separate line item on the Medicare cost report to ensure accurate reporting of rebates;

10. The Hospital shall properly account for net revenue distributions and shall properly distribute any administrative fees received from group purchasing organizations (GPOs);

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

12. Procedures shall be in place and documented for promptly notifying the Medicare contractor/fiscal intermediary (or any applicable payor, including, but not limited to, TRICARE and Medicaid) of errors discovered after the submission of the hospital cost report.

In addition, the Hospital shall ensure that any organ acquisition costs claimed on the Medicare cost report are accurate and appropriate and exclude costs that should be allocated to post transplant activities or other benefiting cost centers.

Credit Balances

All providers who receive excess amounts of reimbursement from Medicare, Medicaid or other federal health care programs are required to periodically report such overpayments. Providers are required to describe any credit balances that exist and provide their justification for retaining any overpayment. Providers may not retain overpayments on the basis that a federal payor owes them money for other services rendered to federal health care program beneficiaries. In fact, providers may be liable under the federal False Claims Act for failing to report and repay any overpayment to which the provider is not entitled. In addition, many commercial payor contracts contain provisions that relate to recoupment of overpayments and the appropriate treatment of amounts paid in excess of that to which a provider is entitled.

Bad Debt

At least once annually the Hospital shall review (i) whether it is properly reporting bad debts to Medicare, and (ii) all Medicare bad debt expenses claimed, to ensure that the Hospital's procedures are in accordance with applicable federal and state statutes, regulations, guidelines and policies. Such review shall also 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 debt any routinely waived Medicare co-payments or deductibles, which waiver shall also constitute a violation of the Federal Anti-Kickback Statute (discussed above). The Hospital shall consult with its Medicare contractor/fiscal intermediary and legal counsel as to bad debt reporting requirements if questions arise.

Limiting Services to Beneficiaries and Beneficiary Inducements

Hospitals may be penalized for any arrangement that encourages the reduction or limitation of direct patient care services provided to a federal health care program beneficiary. As a result, gainsharing arrangements with physicians (discussed above) must be particularly scrutinized to ensure that the arrangements do not serve to limit or reduce care provided to patients.

In addition, the Hospital will ensure that it does not engage in practices designed to limit the care provided to its patients that are enrolled in managed care organizations. The Hospital will not engage in any practices that result in a lower quality of care to any patients.

With limited exceptions (discussed below), Medicare providers are not permitted to provide remuneration, which is defined as anything of value, to Medicare beneficiaries when the provider knows or should know that the remuneration being offered is likely to steer a beneficiary to a certain provider to receive goods or services. Moreover, it is also not permissible for a provider to provide goods or services at a price below fair market value. However, it may be permissible to provide a gift or service with a value of up to $10 per item and $50 annually per beneficiary.

Limited exceptions to the "Beneficiary Inducements" Rule

1. Non-routine, unadvertised waiver of co-payments or deductible amounts (with additional provisions as discussed below);
2. Properly disclosed differentials in a health insurance plan's co-payments or deductibles;
3. Incentives on items or services covered by Medicare or Medicaid that promote the delivery of pre-natal, post-natal or well baby care;
4. A practice that is covered under a Federal Anti-Kickback safe harbor; and
5. Waivers of co-payment amounts that exceed the minimum co-payment amounts under the Medicare hospital outpatient fee schedule.

The Compliance Officer and legal counsel should be consulted regarding the availability of an exception.

Free Transportation

Free transportation services for beneficiaries are subject to the limits of $10 per item and $50 annually per beneficiary. The OIG has indicated that sanctions will not be imposed for free transportation services provided in excess of these limits if the following conditions are met with respect to those services:

1. The program was in existence prior to August 30, 2002;
2. The transportation is available to all patients and their families;
3. The transportation is provided to the patients and their families only to and from the hospital for the purpose of receiving hospital services (or for families to visit patients in the hospital);
4. The transportation is only within the hospital's primary service area;
5. The costs for the transportation are not in any way claimed or paid for by the federal government; and
6. The transportation does not include ambulance transportation.

Waivers of Co-Payments

Routine waivers of co-payments are prohibited, as are advertisements that co-payments or deductibles may be waived. However, waivers based on a financial needs assessment of the beneficiary or when there has been an exhaustion of reasonable collection efforts are permissible. Additionally, a hospital may waive a co-payment amount that is in excess of the minimum co-payment amount of the Medicare hospital outpatient fee schedule or for a Risk Management exception.

Conflicts of Interest

The Hospital has instituted a corporate compliance program to ensure that all of its business practices are in compliance with applicable civil and criminal laws, rules and regulations. As part of this program, this Conflicts Policy is designed to be a guide for Board Directors and Covered Employees who might find themselves in a position where their personal interests could conflict with the interests of the Hospital. It is vitally important that both the fact and the appearance of conflicting interests and improper conduct be avoided.

The relationship between the Hospital, its Board and Covered Employees is one which carries with it a duty of honesty, loyalty and fidelity. All Board Directors and Covered Employees must exercise the utmost good faith in all transactions which touch upon their duties and responsibilities for, or on behalf, of the Hospital. Even the *appearance* of illegality, of impropriety, or of a conflict of interest or duality of interest can be detrimental to the Hospital, and therefore must be avoided.

This Conflicts Policy sets forth general principles with respect to ethics, integrity and conflict of interest. All Board Directors and Covered Employees will be expected to read and understand this Conflicts Policy and to review it at least annually in order to be alert to situations which could create a conflict of interest or otherwise be contrary to the established policies of the Hospital. The Conflicts Policy also includes a disclosure form, pursuant to which Board Directors and Covered Employees should disclose at least annually any potential conflict of interest or improper conduct so that corrective action may be taken promptly, if necessary. Failure to comply with this Conflicts Policy is grounds for removal of a Board Director or Committee member or discipline of a Covered Employee.

In addition, whenever Covered Employees apply for, are offered or receive grants or other money, whether from a public or private source, to conduct any kind of research or special projects, the receipt and use of that money must be consistent with the needs and best interests of the Hospital and its patients. All such grants must be pre-approved by senior management, as detailed in the accompanying Procedures; and, especially when the money is supplied by private industry, there cannot be even the appearance that the grant is being given as an inducement for the physician, a department, or the Hospital to purchase services or supplies from that company.

Covered Personnel

This Conflicts of Interest Policy Statement ("Conflicts Policy") applies to all Board Directors, all non-Board Directors serving on Board Committees, and all employees of the Hospital who are in a position to influence any substantive business decision by the Hospital or any entity controlled by the Hospital (collectively, the "Hospital"), including but not limited to the following personnel (collectively, "Covered Employees"): all officers, directors, managers and administrators of the Hospital, regardless of title, and all other Hospital employees with substantial business decision making authority. Such business decisions include, but are not limited to, the decision to purchase goods or services for the Hospital and any other decision affecting the course of a business transaction entered into by the Hospital.

Disclosure of Interests

Board Directors and Covered Employees and anyone who was in a position to exercise substantial influence over the Hospital's affairs during the prior five years (the "Coverage Period") must examine their own and their immediate family's activities, and promptly report the existence of any enterprises in which they or their immediate family has an "interest," as defined below, and which the person knows is engaged, or is reasonably likely to engage, in transactions with the Hospital.

A person will be considered to be in position to exercise substantial influence over the Hospital's affairs if, at any time during the Coverage Period, that person was either entitled to vote on any matter over which the Board has authority, regardless of whether or not a Board Director, or, regardless of title, that person had ultimate responsibility for implementing Board decisions or for supervising the management, administration or operation of the Hospital, or, regardless of title, that person had ultimate responsibility for managing the finances of the Hospital. All such persons are referred to herein as "Interested Persons".

Personal Interests Defined

A person is deemed to have an "interest" in an enterprise when he or she, or a member of his or her immediate family, has some relationship with the enterprise that could be viewed as possibly compromising the person's loyalty to the Hospital and obligation to make decisions that are only in the Hospital's best interest. A person's immediate family includes his or her spouse, siblings, children and their respective in-laws, parents, or parents-in-law. Relationships of concern include being employed by, having a contractual relationship with, being a member, owner, director, or officer of, or having a financial interest in an enterprise:

from which the Hospital purchases or leases equipment, services, or supplies, or that provides services that compete with the Hospital;

with which the Hospital negotiates real estate transactions (such as the leasing of space), and which either benefits from the real estate transaction or competes with the Hospital in the leasing, use or purchase of real estate; or

which renders directive, managerial, or consulting services to any organization that does business with, or competes with, the Hospital in providing services.

If the financial interest is the ownership of securities which are publicly traded, such interest must be disclosed *only if* the combined holdings of the securities of both the person and his or her immediate family constitute 5% or more of the outstanding securities of the entity concerned.

In addition to the foregoing, an "interest" also includes any service by any person covered by this Conflicts Policy as a member of the governing board or as an officer of any healthcare organization licensed, registered, or approved under Article 28 or 28A of the New York Public Health Law.

Purchasing Department Covered Employees

In addition to the other requirements in this Conflicts Policy, Covered Employees of the Purchasing Department who have any financial or other interests in a supplier, either directly or indirectly through immediate family members must report such interests in writing to the Purchasing Manager. The Purchasing Manager, in consultation with the Compliance Officer, will then decide whether the interest in question is of sufficient magnitude to warrant the disqualification of the Covered Employee concerned from negotiating any proposed purchases with the supplier.

Grant Recipients

If a grant is provided in order to test, develop, or use equipment or supplies from a particular manufacturer or supplier, then any subsequent purchase of such equipment or supplies must also be subjected to close review to ensure that the judgment of any Board Directors and Covered Employees involved with the grant has not been compromised and that the purchase is otherwise in the best interest of the Hospital and its patients. In such instances, any Board Directors and those Covered Employees directly involved in the receipt and use of the grant money shall disclose that fact as a possible conflict of interest on the attached disclosure form and shall take no part in the final determination as to the proposed purchase.

Compensation Decisions

In making decisions about the compensation of senior management or physicians, the Board will observe the following safeguards:

A voting member of any Board Committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Hospital for services is precluded from voting on matters pertaining to that member's compensation.

Physicians who receive compensation, directly or indirectly, from the Hospital, whether as Covered Employees or independent contractors, are precluded from serving on any committee whose jurisdiction includes compensation matters. However, no physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.

Gifts, Bribes, and Gratuities

Acceptance of gifts, gratuities, favors or other benefits from persons or entities who do business with the Hospital or to whom the Hospital or its physicians make referrals shall not be permitted. Solicitation of such gifts, favors, or other benefits, regardless of value, shall likewise be prohibited. Notwithstanding the foregoing, the acceptance of common business hospitality such as occasional meals, entertainment, or nominal gifts with an annual aggregate value of $50.00 or less shall not be considered a violation of this section.

Kickbacks and Rebates

Improper payments such as kickbacks or rebates are unethical and in many cases illegal. Hospital physicians and other Hospital health care providers and their families are prohibited from receiving anything of value from any person or entity who might receive a patient referral from or make a patient referral to the Hospital. Kickbacks can take many forms and are not limited to direct cash payment or credit. They may include pre-bates, rebates and in-kind services. Notwithstanding the foregoing, the acceptance of common business hospitality such as occasional meals, entertainment, or nominal gifts with an annual aggregate value of $50.00 or less shall not be considered a violation of this section.

Other Items to Disclose to the Compliance Officer

Receipt of discounts and free services, travel, meals, lodging and entertainment, must be reported to the Compliance Officer unless the value of such benefits has an annual aggregate value of $50.00 or less.

Disclosure Procedure

The following specific disclosure procedures shall be followed:

Disclosure Requirements

All Board Directors, Covered Employees and anyone who during the Coverage Period was an Interested Person who have any of the interests outlined above **must disclose their interest** and all material facts in the Conflict of Interest Disclosure Statement filed with the Compliance Officer, who shall keep a confidential file of these Statements and address any potential problems or possible conflicts of interest as provided in the accompanying Procedures. In addition, any person who was an Interested Person during the Coverage Period having a reportable interest, as outlined above, **shall disclose such interest and all relevant material facts to the Board** (or in such Interested Person's absence, such disclosure shall be made by another Board Director or officer of the Hospital ("Officer") having knowledge of the facts), and **it shall be made a matter of record**.

Continuing Disclosure

In addition to completing the annual disclosure statement, all Board Directors and Covered Employees must also immediately disclose to the Compliance Officer any possible conflicts of interest as they arise. Interested Persons have the additional obligation of disclosing any interest, as defined herein, to the Board (or, in the Interested Person's absence, having such disclosure made to the Board by another Board Director or Officer with knowledge of the facts) as they arise, and of making such interest a matter of record.

Such continuing disclosure must occur in the following situations:

- upon finding that the Board Director, Covered Employee, Interested Person or his or her immediate family (as defined above) has an interest or possible interest in an enterprise that might create a possible conflict of interest;
- upon a Board Director or Covered Employee entering into an any outside relationship which might involve a conflict of interest with, or cause embarrassment to, the Hospital;
- upon a Board Director or Covered Employee considering assuming such interests or outside relationships;
- upon a Board Director or Covered Employee receiving or being offered any gift or gratuity which exceeds the annual aggregate threshold amount of $50 or under circumstances from which it *might* be inferred that the gift or gratuity was being given to influence such Board Director's or Covered Employee's actions or decisions on behalf of the Hospital; and
- upon a Board Director or Covered Employee receiving or being offered grant money from any public or private benefactor.

If a Board Director, Covered Employee or Interested Person is in doubt as to the proper application of this Conflicts Policy and whether disclosure is required in a specific instance, s/he should err on the side of disclosure and immediately make all the facts known to the Compliance Officer and the Board, as appropriate.

The willful, knowing, or reckless failure to disclose a conflict of interest will be considered to be a violation of this Conflicts Policy and will subject the offending party to discipline, including termination or, for Board Directors, removal from the Board.

Confidential Information

Confidential information acquired by Board Directors, Covered Employees and Interested Persons about the business of the Hospital must be held in confidence and may not be used as a basis for personal gain by the Board Directors, Covered Employees, Interested Persons, their immediate families, or others. Information relating to transactions pending with the Hospital is not to be released to any person unless it has been published or otherwise made generally available to the public. Similarly, if the Hospital is considering buying, leasing, or selling any property, item, or interest, no Board Director, Covered Employee or Interested Person may attempt to buy, lease, or sell for their own benefit (or for the benefit of their immediate family) the item under consideration, until the Hospital's decision on the matter has been executed. Finally, other than in connection with the discharge of their official responsibilities with the Hospital, all Board Directors, Interested Persons and Covered Employees must also refrain from disclosing information about any Hospital consideration or decision, or any other information which might be prejudicial to the interest of the Hospital.

The governing principle is that if any confidential information pertaining to the Hospital is received by Board Directors, Interested Persons or Covered Employees, such information cannot be used for their own benefit, their immediate family's benefit, or to benefit others; nor should they disclose such information to others for their personal use.

Anti-Trust and Trade Regulations

It is the policy of the Hospital to avoid any activities that unfairly or illegally reduce or eliminate competition, control prices, allocate markets, or exclude competitors.

1. Employees, Physicians, or Contractors shall comply with the letter and spirit of all antitrust laws of the United States and of the State of New York. No Employee or Contractor of the Hospital shall have any authority to engage in conduct that does not comply with this policy or to authorize, direct, approve or condone such conduct by any other person.

2. No Employees, Physicians, or Contractors shall enter into understandings or agreements (whether written or oral) that could unfairly or illegally reduce or eliminate competition, control prices, allocate markets, or exclude competitors. This includes agreements or information sharing with other practices or carriers that affect prices, charges, profits and service or supplier selection.

3. Employees, Physicians, or Contractors who negotiate or enter into contracts with competitors, potential competitors, contractors or suppliers shall do so on a competitive basis considering such factors as price, quality and service. This policy is especially important for Employees or Contractors having purchasing, planning or marketing responsibilities.

4. Employees, Physicians, or Contractors who attend association or professional association meetings or who otherwise come in contact with competitors should avoid discussions at those meetings regarding pricing or other topics, which could be interpreted as collusion or cooperation between competitors.

5. Any Employee, Physician, or Contractor who suspects that a violation of the antitrust and trade regulation laws has occurred shall disclose that information to the Compliance Officer.

Greater Hudson Valley Health System

Corporate Compliance Plan

Do the right thing!

Part II- Administration of the Plan

Education and Training

In accordance with the New York State Office of the Medicaid Inspector General, the effective implementation of the Compliance Plan requires training and education for all Employees and Contractors so that each has a clear understanding of his or her responsibilities and rights under the Plan. Education and training emphasizes the Hospital's commitment to full compliance with all laws, regulations and guidelines of federal and state programs.

It is not essential, however, that every Employee be educated concerning every aspect of the Plan. Accordingly, each Employee and Contractor shall receive a compliance handout or manual that contains materials appropriate, as determined by the Compliance Officer, to his or her position and training. Various Employees and Contractors shall be directed toward relevant topic areas, as follows:

1. Compliance Materials
2. Other Training and Education
3. Mandatory Attendance and Recordkeeping
4. New Employees
5. Fraud and Abuse Education Policy

The Hospital requires annual education and training of its physicians, other health care providers, administrative Employees and, if appropriate, Contractors providing a similar service or function.

Individuals directly involved with billing, coding or other aspects of the federal health care program shall receive appropriate education specific to each individual's responsibilities. Some examples of items which shall be covered in coding and billing training include:

- Coding requirements;
- Claim development and submission processes;
- Signing a form for a physician without the physician's authorization;
- Proper billing standards and procedures and submission of accurate bills for services or items rendered to federal health care program beneficiaries; and
- The legal sanctions for submitting deliberately false or reckless billings.

The Hospital shall maintain updated ICD, HCPCS and CPT manuals (in addition to the Medicare contractor/fiscal intermediary bulletins constraining those sources,) and make them available to all Employees and Contractors involved in the billing process. The Hospital shall also make available updates on current billing standards and procedures.

Mandatory Reporting

Each employee, vendor, and Board member has a responsibility to report any activity by any colleague, clinician, independent contractor or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, and standards of medical practice or the Compliance Program. We encourage a culture in which all feel free to report behaviors or actions which they believe should be reported. The Hospital is committed to making every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports a concern in good faith.

As per the Non-retaliation policy, any and all employees who, in good faith, participate in the compliance program, including, but not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials, will be protected against any retaliation or intimidation. Any employee who intentionally makes a false accusation with the purpose of harming or retaliating against any individual will be subject to appropriate disciplinary action as indicated. Additionally, if an employee or professional staff member knows of an apparent violation, actual or threatened, and fails to report the situation; such person may be subject to disciplinary action.

Developing Effective Lines of Communication

An open line of communication between the Compliance Officer and all Employees or Contractors subject to this Plan is critical to the successful implementation and operation of the Plan.

Reporting Methods

An Employee or Contractor shall report his or her good faith belief of violations of the Compliance Program or applicable laws as follows:

1. Either orally or in writing to his or her supervisor, a director or officer of the Hospital, or the Compliance Officer;

2. By calling the Compliance hotline (advertised throughout the hospital).

3. By contacting:

   Stephen Sugrue, RN, CEN, Esq.
   Chief Compliance Officer
   Orange Regional Medical Center
   60 Prospect Avenue
   Middletown, NY 10940
   ssugrue@ormc.org
   Phone: (845) 342-7346

   Karen Sieverding
   Corporate Compliance Officer &
   Internal Audit
   Catskill Regional Medical Center
   68 Harris Bushville Rd
   Harris, NY 12742
   sieverk@crmcny.org

   (845) 794-3300 x 2105

Receiving a Question/Concern

Upon receipt of a question or concern, any supervisor, officer or director shall immediately deliver a report of the question or concern to the Compliance Officer, with the proviso that, if the question or concern is an allegation of a violation of the Compliance Plan or law by the Compliance Officer, the report of the question or concern shall instead be immediately delivered to the CEO.

The Compliance Officer, or his or her designee, shall document the information necessary to conduct an appropriate investigation of all complaints. If the Employee or Contractor was seeking information concerning the Compliance Plan or its application, the Compliance Officer or his or her designee shall record the fact of the call and the nature of the information sought and responds as appropriate.

Any threat of reprisal against a person who acts pursuant to his or her responsibilities under the Plan is not only contrary to the Hospital's policy, it may in some instances be a violation of the law. Threat of reprisal shall be subject to appropriate discipline.

Any attempt to harm or slander another through false accusations, malicious rumors or other irresponsible actions is a violation of the Hospital's policy. Such action shall be subject to discipline.

The Hospital, at the request of a reporting Employee or Contractor, shall provide anonymity to the Employee or Contractor who makes the report to the extent possible under the circumstances in the judgment of the Compliance Officer, consistent with the Hospital's obligation to investigate concerns and take necessary corrective action.

Auditing and Monitoring

An ongoing evaluation process is critical in detecting noncompliance and improving the quality of work, and will help ensure the success of the Hospital's Plan, as well as the adherence to New York State Office of the Medicaid Inspector General guidelines. This ongoing evaluation will include audits of compliance with the procedures and Code of Conduct set forth in the Plan, to be conducted or directed by the Compliance Officer; and claims development and submission.

The audits and reviews should target the Hospital's compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare carriers, Medicaid, appropriate state entities, and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations, OIG annual work plan and law enforcement initiatives.

Audits or reviews should be conducted in an objective and supportable fashion. Audit decisions based on discretion or the exercise of subjective judgment should be carefully documented. In certain circumstances, involving legal counsel in the audit process may be appropriate. Audit techniques may include, but are not limited to:

- Personnel interviews;
- General questionnaires submitted to Employees and Contractors;
- Reviews of medical records that support claims for reimbursement;
- Review of written materials and documentation prepared by the Hospital; and
- For multi-site practices, onsite visits.

The Hospital will conduct annual education and training programs to address identified deficiencies and conduct focused issue audits in areas the Compliance Officer or Compliance Committee has determined present compliance issues or challenges for the Hospital.

Procedures shall be established by the Compliance Officer to ensure that appropriate personnel area notified of changes in laws, regulations or policies, and additional training is provided as necessary to assure continued compliance

Responding to Detected Offenses and Developing Corrective Action Initiatives

Investigation

Upon receipt of audit results or a report or other information suggesting a possible compliance issue other than one involving the Medicare and Medicaid programs, the Compliance Officer shall conduct an investigation.

Corrective Action

If, following the conclusion of an investigation involving a compliance issue, it appears that there are genuine compliance concerns, the Compliance Officer shall immediately formulate and implement a corrective action plan. The corrective action plan shall be designed to ensure that the specific issue is addressed and, to the extent possible, that similar problems do not occur in other departments or areas.

Possible Criminal Activity

If the investigation reveals possible criminal activity (conduct which is intentional, knowing and willful), the Hospital shall:

1. Immediately stop the activity related to the problem until the offending practice is corrected;
2. Initiate appropriate disciplinary action against the person or persons whose

conduct appears to have been intentional, willfully indifferent, or with reckless disregard for the law;
3. Make such disclosure to any regulatory or prosecutorial authorities as legal counsel advises;
4. Promptly undertake an appropriate program of education to prevent future similar problems; and
5. Document corrective actions taken upon notice.

Other Noncompliance

If the investigation reveals noncompliant conduct which does not appear to be criminal, the Hospital shall:

1. Immediately stop the activity related to the problem until the offending practice is corrected;
2. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances;
3. Make such disclosure to any regulatory or prosecutorial authorities as legal counsel advises;
4. Promptly undertake an appropriate program of education to prevent future similar problems; and
5. Document corrective actions taken upon notice.

Any issue for which a corrective action plan is implemented shall be specifically targeted for monitoring and review in audits of that department or area.

Enforcing Standards through Well Publicized Disciplinary Guidelines

Disciplinary action for Employees or Contractors who have failed to comply with the Hospital's policies and procedures, including federal and state laws, or for those who have otherwise engaged in conduct that has the potential of impairing the Hospital's reputation as a reliable, honest and trustworthy health care provider, is an important part of this Plan. Therefore, violations shall subject the offender to some manner of discipline or corporate action.

Management's Responsibility for Discipline

Under the direction of the CEO, and Audit and Compliance Committee of the Board of Directors, the Compliance Officer shall assure that the Hospital establishes procedures for the discipline of Employees or Contractors for violation of the Compliance Plan and the Code of Conduct contained in the Plan.

Compliance as an Element of Performance Reviews

The Hospital's Compliance Plan requires that the promotion of, and adherence to, the elements of the Compliance Plan be a factor in evaluating the performance of Hospital Employees and Contractors. Employees and Contractors will be periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims development and submission process will:

1. Discuss with all supervised Employees and Contractors the compliance policies and legal requirements applicable to their function.

2. Inform all personnel that strict compliance with these policies and

requirements is a condition of employment.

3. Disclose to all supervised personnel that the Hospital will take disciplinary action up to and including termination or revocation of privileges for violation of these policies and requirements.

Managers and supervisors will be sanctioned for failure to adequately instruct their subordinates, or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the earlier discovery of any problems or violations and would have provided the Hospital the opportunity to correct them.

Persons Involved in Improper Activities

Any Employee who violates the Plan or the Code of Conduct contained in the Plan shall be appropriately disciplined in accordance with the Hospital's policies and procedures and contractual terms, if applicable. Violations include the failure to report suspected improper activity. Any discipline shall be appropriately documented in the Employee's or Contractor's personnel file, along with a statement of reasons for imposing such discipline.

Employee, Contractor, and Vendor Screening

It is the policy of the Hospital to make reasonable inquiry into the background of current and prospective Employees, Contractors and vendors who are engaged in business or activity which by its nature might place the Hospital at risk for violation of the law or this Compliance Plan.

In conjunction with policies and procedures developed and administered by the Hospital, all Employees, Physicians, Contractors, and vendors shall be screened to determine whether they have been (a) convicted of a criminal offense related to health care; or (b) listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation.

Where appropriate, contractual arrangements with vendors or Hospital purchase orders shall contain a statement that the vendor agrees to abide by any applicable provisions of the Hospital's Corporate Compliance Plan.

New Employee Policy

All new Employees, Physicians, and Contractors, including but not limited to professional and billing personnel, who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, shall undergo a reasonable and prudent background investigation, including a reference check. This investigation shall be conducted by the Hospital as part of every such employment application. The application should specifically require the applicant to disclose any criminal conviction for Medicare/Medicaid fraud and abuse, as defined by 42 U.S.C. § 1320a-7(i), or program exclusion.

The Hospital will not knowingly employ or contract with any individual who has been convicted of any criminal offense or who is listed as debarred, excluded or otherwise ineligible for participation in federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)). Any current Employees or Contractors will be removed from direct responsibility for or involvement with any federal health care program, pending the resolution of any criminal charges or proposed debarment or exclusion. If resolution of the matter results in conviction, debarment or exclusion, the Hospital will terminate its employment or other contract arrangement with the Employee or Contractor.

The Hospital shall ensure that all new employees are trained with respect to the applicable components of this Compliance Plan.

Additional Policies

CRMC maintains the following Compliance Policies that are an integral part of the Compliance Plan. These policies are available on Medworxx or from any manager:

Advance Beneficiary Notice Policy
Chief Compliance Officer
Compliance Business Courtesies
Compliance Auditing and Monitoring
Compliance Investigations Policy
Conflict of Interest Policy
Conflict of Interest Disclosure Form
Credit and Collections Diagnosis Change Policy
Ethical Code of Behavior
Exit Interview Policy
Federal Subpoena Policy
Gifts Policy
Hotline Operations
Joint Venture Policy
Medicaid Credit Balances
Non Retaliation Policy
OMIG Audit Process
Physician Contract Management Policy
Records Retention and Destruction
Medical Staff Conflict of Interest Policy
Employee Discount Policy
Compliance with Federal and State False Claims Acts and Whistleblower Protections
Sanction Screening
Advanced Beneficiary Notice