
CORPORATE COMPLIANCE MANUAL

Code of Conduct

and

Compliance Guidelines

CATSKILL REGIONAL MEDICAL CENTER

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

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Part I. Overview

A. This Manual. This Corporate Compliance Manual sets forth standards of conduct that all personnel employed by or associated with Catskill Regional Medical Center (the “Hospital”) are expected to follow. The Hospital’s Code of Conduct applies to all Hospital employees, physicians, Board members, volunteers and contractors when performing work in support of the Hospital. The Manual is designed to be a guide and resource to help all personnel ensure that their behavior is in compliance with all laws and regulations that affect all of their business dealings. The Manual also describes the procedures that will be followed in enforcing these standards and ensuring that the Hospital stays in compliance with all applicable laws.

All personnel will be expected to read and understand the Manual and to review it as necessary in order to be alert to situations which could be contrary to the established policies of the Hospital. All personnel must, upon receiving a copy of this Manual or the Brief Summary of the Compliance Program’s Code of Conduct and Compliance Procedure, sign and date an Acknowledgment of Receipt and return that Acknowledgment to the Compliance Officer.

B. The Importance of the Compliance Program. The implementation of an effective Compliance Program is important for several reasons.

First and foremost, it is essential that we ensure that we are operating pursuant to the highest ethical standards and conformity with all applicable legal rules. This is not only the right thing to do, but is also important for our continuing reputation for honesty and integrity in all of our business and medical dealings with others. That reputation has been achieved and maintained through the integrity of our officers and employees, and it is one of our greatest assets: our success depends in large measure on the trust patients, government regulators, and the public place in us. A Compliance Program will help ensure that we are living up to this reputation and continue to deserve that trust.

Moreover, compliance with state and federal rules and regulations is essential because of our potential civil or even criminal liability if we were found to have violated the applicable legal standards.

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A governmental inquiry can result in very high financial exposure and damage to our reputation for honesty and integrity. Prevention is certainly the wiser business plan, and that is what our Compliance Program is designed to accomplish.

To be effective, however, a Compliance Program must be a real part of an institution's culture, mission, and values. As a result, an institution must demonstrate that it is both committed to, and actually exercises, due diligence in seeking to prevent and detect violations of law.

The Hospital believes that an effective compliance program must have seven basic elements as first described by the U.S. Sentencing Commission Guidelines, and as consistent with the requirements for Provider Compliance Programs from the New York State Office of Medicaid Inspector General, all of which are incorporated into the Hospital's program and documented in this Manual: (i) written policies and procedures that describe compliance expectations, (ii) the program must be administered by a designated Compliance Officer, who is responsible for its day-to-day operations; (iii) training and education of all affected employees and persons associated with the Hospital, including executive and governing body members on compliance issues, expectations and the compliance program operations; (iv) communication lines to the Compliance Officer that are accessible to all Hospital employees, executives and governing body members; (v) disciplinary policies to encourage good faith participation in the compliance program, (vi) a system for routine identification of compliance risk areas and (vii) a system for responding to compliance issues as they are raised, including investigation, and corrections of problems. In addition, the Hospital includes in its compliance program a policy of non-intimidation and non-retaliation for good faith participation in the compliance program. Our Compliance Program is designed to satisfy all these elements.

C. Questions and Concerns: Even the most carefully constructed Compliance Program, however, cannot cover every situation that our personnel might face. As a result, if you are unsure of what a proper course of conduct might be in a specific situation, or believe that the standards of

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conduct set forth in this Manual may have been violated, then you are urged to contact the Hospital's Compliance Officer or the dedicated voice mail Compliance Helpline at Ext 3045.

Part II. Code of Conduct

As a central part of the Compliance Program, this Code of Conduct sets forth the standards of conduct that all personnel are expected to follow. Everyone should adhere both to the spirit and the language of the Code, maintain a high level of integrity in their business conduct and avoid any conduct that could reasonably be expected to reflect adversely upon the integrity or reputation of the Hospital.

A. Mission and Values.

The Hospital is committed not only to providing patients with high quality and caring medical services, but also to providing those services pursuant to the applicable ethical, business, and legal standards. These standards must apply to our interactions with everyone with whom we deal. This includes our patients, other health care providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety.

In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Hospital. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the compliance program has become an integral part of our corporate mission and business operations.

B. General Standards.

1. **Compliance with Standards – Honesty and Lawful Conduct.** All personnel and physicians associated with the Hospital are expected to comply and be familiar with all applicable federal and state laws, rules, and regulations that are relevant to their job or work with the Hospital. All physicians are also expected to comply specifically with all of the requirements for documenting and

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coding appropriate levels of service and with all federal and state medical necessity rules. All personnel and physicians must also avoid any illegal conduct, both in business and personal matters, and should take no action that they believe may be in violation of any statute, rule, or regulation. If personnel are unsure whether an action is lawful, then they should not do it until they check with their supervisor or the Hospital's Compliance Officer.

In addition, all personnel must comply with the standards of conduct set forth in this Manual and in applicable Hospital and departmental compliance policies and procedures. Strict compliance with these legal and compliance standards is a condition of employment, and violation of any of these standards of conduct will result in discipline being imposed, up to and including termination.

2. Cooperation with the Compliance Program. Because of the importance of the Compliance Program, we require that each of you cooperate fully with this effort. The compliance program will work effectively only if everyone works together to ensure its success, understands what is required under the law and our own Code of Conduct, and works to ensure that those standards are being followed. In particular, all personnel and physicians must cooperate with all inquiries concerning possible improper business, documentation, coding or billing practices, respond to any reviews or inquiries, and actively work to correct any improper practices that are identified.

3. Avoiding Conflicts of Interest. The relationship between the Hospital and its staff and Board of Directors is one which carries with it a duty of honesty, loyalty and fidelity. All personnel 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 impropriety or a conflict or duality of interest can be detrimental to the Hospital, and therefore must be avoided.

The Hospital has prepared a Conflicts of Interest Policy Statement (the "Conflict of Interest Policy") that is designed to be a guide for the Board of Directors and Management who might find themselves in a position where their personal interest could conflict with the interests of the Hospital. The Conflict of Interest Policy sets forth general principles with respect to ethics, integrity and conflicts

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of interest. It also establishes procedures whereby any potential conflict of interest or improper conduct is to be disclosed, so that corrective action may be taken promptly, if necessary. All personnel are expected to read and understand the Conflict of Interest Policy and to review it periodically to be alert to situations which could create a conflict. Any conflict of interest or *possible* conflict of interest should be disclosed as set forth in the Conflict of Interest Policy, and the personnel involved must refrain from participating in the consideration of the matter.

C. Standards Relating to Coding, Billing, and Providing Services.

1. Medical Necessity for Services and Tests/ Quality of Care. The Hospital will submit claims to Medicare or Medicaid (or any other health care program) only for services that were medically necessary, that constituted a covered service or as otherwise allowed by law. Medical necessity will be determined individually for each service or test provided or ordered by the responsible physician. A medically necessary service or test is defined as one that is reasonable and necessary for the diagnosis or treatment of an illness, injury, or to improve the functioning of a malformed body member. 42 U.S.C. 1395y(a). The government will generally only pay for services and tests that are medically necessary and will deny payments for those that are not necessary, such as many screening tests, or tests conducted for research purposes.

Further, the Hospital will not submit claims to Medicare and Medicaid for so called “never events” or hospital acquired conditions that the federal and/or state governments have deemed to be non-reimbursable.

2. Correct Coding. All federal and state regulations governing billing procedures will be meticulously followed, and all personnel responsible for billing will be trained in the appropriate rules governing billing, coding, and documentation.

If the documentation in the medical record is unclear, then coding or billing personnel must request clarification or additional information from the physician or provider of services. This includes when the appropriate code or diagnosis is unclear. Personnel shall not create coding or diagnostic

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information based on their own interaction with the patient, from information provided from an earlier date of service, or based on what they might conclude is the probable or most likely diagnosis. In addition, DRG, APC, CPT-4, HCPCS, and ICD-9-CM codes should never be selected only on the basis of whether the given code guarantees payment. Billing may never be based on a “default” to a particular code. Rather, only those codes that correspond to the service rendered and documented should be selected.

It is also strict policy that no personnel associated with the Hospital knowingly engage in any form of upcoding of any services in violation of any law, rule, or regulation. All federal and state regulations governing billing procedures will be meticulously followed. The Hospital does not provide financial incentives to physicians, providers, employers, or outsiders to upcode claims.

3. Billing-Generally. Only those medical services to patients that are consistent with acceptable standards of medical care may be billed. The Hospital only bills for the actual services rendered, and only when those services were consistent with accepted standards of medical care. The billing for such services must comply with all applicable rules and regulations governing correct documentation, coding and billing.

a. Adequate Documentation. Billing must always be based on adequate documentation of the medical justification for the service provided and for the bill submitted, and this medical documentation must comport with the applicable regulations. A bill may not be submitted to a payor if the documentation of the nature or scope of the service is unclear or if it is otherwise unclear what the appropriate code is.

b. Accurate and Truthful Billing. All billing must be accurate and truthful; and no personnel should ever misrepresent charges to, or on behalf of, a patient or third-party payor. The Hospital bills only for those services that were actually and appropriately rendered. False statements or intentional omissions of material information by any personnel to a government agency or other payor

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will not be tolerated. Deliberate misstatements to government agencies or other payors will expose the personnel involved to termination and criminal penalties.

All personnel, moreover, must avoid not only intentional misstatements, but reckless ones as well. It is, of course, illegal to intentionally falsify billing documents submitted to the government or private insurance companies. It is also illegal, however, to supply false information with either a deliberate ignorance or a reckless disregard of its falsity or truth. Thus, if personnel have any question as to the truth or accuracy of a bill for services, or if there is material information that is missing, the bill for the services in question must be held until the uncertainties are resolved by supervisory personnel. Anything less can result in over billing and is strictly prohibited.

4. Billing for Hospital Inpatient, Outpatient and Ambulatory Surgery Services. It is the Hospital's policy that medical records for inpatient services, Ambulatory Surgery, and outpatient services will be coded as accurately and correctly as possible. All coding will be based upon the appropriate documentation in the medical records and upon the appropriate and most current coding guidelines, as set forth in the Medical Records Department's internal coding procedures and guidelines, the Coding Clinic, the CPT-4, ICD-9 and APC guidelines, and any relevant coding bulletins and updates received by the Hospital.

5. Training and Coding Updates. All coders will be fully trained in how to read, review and appropriately code medical records. All new coders will be placed on a probationary period during which all of the cases they code will be reviewed by a supervisor; and they will then be given continual feedback as to their performance and the accuracy of their coding.

On a regular basis, all coders will also be sent to attend training sessions, seminars, and workshops outside the Hospital on proper coding practices, on the governing rules and regulations, on recent developments in the coding guidelines, and on other appropriate subject matters.

All coders will also be informed of all updates and modifications to the Coding Clinic, all other relevant coding guidelines, and will be kept abreast of all bulletins and other relevant communications

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from the state and federal government on documentation, coding, and billing requirements. The Medical Records Department will be responsible for reviewing both the yearly revisions to the Coding Clinic and the CPT-4 guidelines, as well as all incoming bulletins and communications. The Director of Medical Records will ensure that the Department's internal coding guidelines and coding policies and procedures are revised or updated accordingly, and will distribute all updates to all relevant staff and conduct training sessions at staff meetings, or on a more formal basis, to improve coding accuracy and to ensure that all personnel understand any changes in the documentation, coding and billing requirements.

6. Billing Rules for Hospital Lab and Other Hospital Out-Patient Diagnostic Testing. As part of the compliance program, the clinical laboratory and those departments of the Hospital that bill for out-patient testing must follow various rules and regulations. A few of the key standards of conduct are as follows:

a. Bill Only Tests that Were Actually Ordered and Conducted. The Hospital will bill only for outpatient tests that were ordered by a physician and actually conducted. If a test is ordered, but is not performed for any reason, then no bill for the test may be submitted to any third-party payor. Tests should be performed only when there is a clear order from the patient's physician and there is no reason to believe that the test is not medically necessary.

b. Medical Necessity for Tests. Although it is ultimately the ordering physician's responsibility to determine whether a test is medically necessary or not, we should not submit claims to Medicare or Medicaid (or any other health care program) that we have reason to believe are not, in fact, medically necessary. All of our ordering procedures – from requisition design to our interactions with the ordering physicians – must be designed to encourage ordering physicians to order only medically necessary tests for which reimbursement will be sought from the government.

7. Billing for Physician Extenders. Federal and state regulations allow, in certain limited circumstances, for the billing of services rendered by physician extenders ("PEs"), such as physical therapists, physician assistants and nurse practitioners. The rules governing how and when a

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provider can bill for services by PEs can be complex, and can vary based on who employs the PE (e.g. a physician group or a hospital), where the service is rendered (e.g. in the physician's office or in the hospital), and what kind of supervision is provided by the physician. Billing for PE services, whether "incident to" or direct, will be done in compliance with the applicable rules and regulations, and should occur only after an appropriate review has determined how those rules and regulations apply to the specific services being rendered.

8. Correct Use of Provider Identification Numbers. Every insurer to whom claims for payment are submitted requires the use of identifying numbers on the claims form (e.g., National Provider Identifiers or NPIs). The rules for obtaining and using identifying numbers vary from insurer to insurer. Inclusion of the appropriate identifying numbers on any claims form, however, is essential to allow for timely processing of the claims.

Moreover, the physician or provider who actually provided the service must be accurately and correctly reflected on the claims form. In this regard, use of another's name or identification number, in lieu of one's own when the other provider was not involved in the delivery of the service, may be considered to be fraudulent billing. The correct use of identifying numbers on claims forms has recently been the subject of increased government scrutiny, focusing on, in particular, whether the actual provider of services is identified on the claims form.

If personnel have any questions regarding the correct use of identifying numbers in connection with claims for payment, they should contact the Compliance Officer.

9. Teaching Physicians. Teaching physicians must adhere to federal and state regulations governing when they may bill Medicare and/ or Medicaid while supervising interns, residents or fellows. The federal government is particularly sensitive to billing practices in teaching settings, and the potential financial exposure for improper billing is enormous.

All teaching physicians associated with the Hospital – and all personnel who are involved in the billing process in any way, regardless of job title – are required to be aware of, understand and adhere to

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the federal regulations. Particular care must be taken to ensure that bills are submitted only when the physical presence and documentation requirements of the federal and state regulations have been met.

D. Other Billing Practices.

In addition to complying with federal and state documentation and coding practices, the Hospital will also provide and bill for services in compliance with federal and state rules concerning such matters as waiver of coinsurance, billing Medicare patients for non-covered services, providing professional courtesy to other physicians or providers, and collecting appropriate information concerning primary and secondary insurance.

1. Waiver of Coinsurance. It is illegal to offer remuneration – defined to include a waiver of coinsurance and deductible amounts – to a patient to induce that patient to order an item or service for which payment may be made under Medicare or Medicaid. A waiver is appropriate only if the patient has a documented financial need. As a result, the Hospital will not waive any patient’s coinsurance unless the patient has an actual financial need and that need is documented in an appropriate record. Otherwise, all patients will be billed pursuant to normal procedures for the coinsurance; the coinsurance will then be written off to bad debt only if the normal procedures have failed to result in collection of the coinsurance. Exceptions may be made for risk management purposes.

2. Professional Courtesy. Under the federal Stark regulations, professional courtesy may be offered to referring, non-employed physicians only if there is a written policy approved by the Board of Directors and certain other requirements are met. The Hospital does not provide professional courtesy discounts.

3. Waivers from Patients. If, in an outpatient setting, a Hospital physician deems it clinically appropriate to order a test or perform a service that Medicare may find to be medically unnecessary and thus not reimbursable, the patient should complete and sign a Medicare “Advance Beneficiary Notice.” This notice informs that patient that the test may not be covered by Medicare and that he or she thus may be liable for paying for the test. In cases in which medically unnecessary tests are

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performed for a Medicare patient, the patient generally may not be billed for the service without such a Notice having been completed.

4. Collecting Insurance Information. Medicare requires that all providers must bill other primary payors before billing Medicare and must maintain a system that is reasonably designed to identify payors other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. As a result, the Hospital has instituted such procedures, for both inpatients and outpatients, in compliance with applicable Medicare rules, and will make appropriate efforts as to all patients to determine who the primary or secondary payors are and to bill accordingly.

5. Retention of Records. All billing that demonstrates the Hospital's right to receive payment from third-party payors, and all medical and other records that disclose the nature and extent of services furnished and the medical necessity for those services, will be retained for a period of at least six years from the date of the services or test provided or as otherwise required by law.

6. Compliance with Licensure and Competency Requirements. All physicians and other providers employed by the Hospital will be properly licensed pursuant to applicable state requirements, and the Hospital will take steps on a regular basis to ensure each complies with state requirements and basic competency. The Hospital will not submit any bill to a third party payor for services provided by a physician or other provider who is not properly licensed.

E. Standards Relating to Emergency Treatment.

1. Medical Screening. To ensure compliance with federal and state laws, rules and regulations, including but not limited to the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Hospital will provide an appropriate medical screening examination to determine whether or not an individual requesting such an examination has an emergency medical condition. The screening process will be conducted in a non-discriminatory manner, and will not provide a different level of care based on the patient's payment status, race, sex, national origin, or other suspect classification. Nor will the screening examination or stabilizing treatment be delayed by inquiring about the patient's

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ability to pay for care. Rather, based on the patient's presenting symptoms, the screening examination will be reasonably calculated to determine in a timely manner whether an emergency medical condition actually exists.

2. Admission, Transfer or Discharge. If the examination reveals that an emergency medical condition does exist, the patient will be given treatment to stabilize that condition or will be transferred to another hospital. Such a transfer will occur only if the patient requests the transfer or the medical benefits to be expected from the transfer outweigh the risks associated with the transfer, and if the transfer is otherwise made in an appropriate manner as required by federal law. If admission to the Hospital is necessary, the patient will be admitted unless the treatment required by the patient is outside the scope of services offered by the Hospital, the patient refuses admission, or the patient requests transfer to another facility. In such instances, the patient will either be discharged or transferred, as appropriate, but only after the patient's emergency medical condition has been stabilized or as allowed by law.

F. Standards Relating to Business Practices.

1. Business Practices. The Hospital will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of our services.

a. Business Transactions. Business transactions and joint ventures with other health care providers will be aimed at enhancing the quality or continuity of care provided to patients. Financial investments in such transactions and ventures, and any return on investments, will be based on the bona fide financial value of the investment and its positive impact on the Hospital's ability to deliver medical services. Such investments will not be based on an intent to induce or reward referrals to or from another provider.

In the course of the Hospital's business practices, personnel must deal with a variety of individuals, companies, organizations, and governmental agencies. In those dealings, all personnel must

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never make any misrepresentations, dishonest statements, or statements intended to mislead or misinform. If it appears that anything you have said has been misunderstood, correct it promptly.

b. Business Records. In addition, management must ensure that all business records are accurate and truthful, with no material omissions; that the assets and liabilities of the Hospital are accounted for properly in compliance with all tax and financial reporting requirements, and that no false records are made. Similarly, all reports submitted to governmental agencies, insurance carriers, or other entities will be accurately and honestly made.

c. Cost Report. Finally, the institutional cost report will be prepared in compliance with all applicable state and federal regulations. Costs will be claimed when based on appropriate and accurate documentation, unallowable costs will not be claimed for reimbursement; and all costs will be properly allocated to the appropriate cost centers based on verifiable information and data.

2. Purchasing and Competitive Bidding Policy. All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for the Hospital or its patients at the most reasonable price. No purchasing decision may be made based on any consideration that any employee, officer or director – or any family member or friend of any of them – will benefit by the transaction. Rather, the sole criteria behind all purchasing decisions must be only the best interest of the Hospital. Nor can any service or item be purchased in return for a referral of patients from another or with a view towards inducing another to refer patients.

In purchasing items or contracting for services, the Hospital's competitive bidding and pricing rules must be followed.

3. Payments and Gifts. No personnel may engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to influence or reward favorable decisions of any patient, physician, government representative, contractor, vendor, or any other person in a position to benefit the Hospital or its workforce members.

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a. Giving Payments or Gifts. Personnel may not accept any gift, gratuities or other favors under circumstances from which it could be inferred that the personnel's action was for their own benefit, and not solely for the benefit of the Hospital. Gifts of cash or cash equivalents are strictly prohibited.

b. Accepting Payments or Gifts. This policy does not prohibit the receipt of gifts of "nominal value" that are clearly tokens of friendship or business hospitality. Personnel may also occasionally accept gifts that consist of educational practice-related items that are solely for the healthcare benefit of Hospital patients.

Any questions regarding whether or not an item or situation falls within the scope of this section must be raised immediately with the Compliance Officer, who will assess the propriety of the particular situation and may involve legal counsel.

4. Grants. From time to time, Hospital personnel and departments receive grants from government agencies, private industry, and various philanthropies to conduct research or other projects in association with the Hospital. While the receipt of such money is to be encouraged in appropriate cases, the receipt and use of grants must be subject to adequate safeguards to ensure that an appearance of impropriety, or actual impropriety, is not created.

The receipt and use of all grant money at the Hospital must be pre-approved by management. As part of this pre-approval process, the appropriateness of the proposed research or project will be reviewed, and a system of tracking the use and allocation of the grant money will be put into place. This system will ensure that the money is being used in conformity with the requirements of the grant and in a manner consistent with the policies of the Hospital, the needs of its patients, and the scope of the personnel's employment with the Hospital.

The receipt, or continued receipt, of the grant money should not create an appearance that the judgment of Hospital personnel will be adversely affected, so as to place their own interest, or that of an outside concern, above that of the Hospital and its patients. Grant money should not be accepted in return

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for the promise or expectation that the Hospital or any of its personnel will purchase specific services or supplies from a particular company. The Hospital does not accept remuneration as an inducement to purchase any services or items and even the appearance that remuneration is being accepted for that purpose must be assiduously avoided.

If a grant is provided in order to test, develop, or use equipment or supplies from a particular manufacture or supplier, then the terms and conditions of that grant will be subjected to close scrutiny during the pre-approval process. In addition, any subsequent purchase of such equipment or supplies must also be subjected to close review to ensure that the judgment of the Hospital personnel involved with the grant has not been compromised and that the purchase is otherwise in the best interest of the Hospital and its patients.

5. Credit Balances. On a periodic, regular basis, the Hospital will generate reports of the status of any credit balances of refunds owing to Medicare, Medicaid and other third-party payors. Such refunds will then be made to the appropriate payor in a timely and reasonable manner.

G. Standards Relating to Referrals.

1. Compliance with Federal and State Anti-Referral Laws. The federal and state Anti-Kickback statutes make it a crime to give or receive any remuneration (which is broadly defined to include money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid for by Medicare or Medicaid. The physician self-referral laws (the “Stark” laws) forbid referrals between physicians and health care entities which have certain prohibited financial relationships. Under the Stark laws, a physician cannot refer patients to entities furnishing a “designated health service,” which are payable under Medicare or Medicaid, if the physician or his or her immediate family members have a financial interest in that entity. A prohibited financial relationship includes both an ownership or investment interest and any compensation arrangement.

The Hospital does not pay incentives to any personnel based upon the number of persons treated by the Hospital or the value of services provided. Nor does the Hospital pay physicians, or anyone else,

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either directly or indirectly, for patient referrals. The decision to refer patients is a separate and independent clinical decision made by the referring physician or healthcare provider.

The Hospital also does not accept any form of remuneration in return for referring our patients to other health care providers. Rather, in discharging patients and referring them to other providers, it is the Hospital's policy: (i) that such referrals will be based on the patient's documented medical need for the referred service and the ability of the referred providers to meet that need; and (ii) that the patient's freedom to choose the provider is at all times respected and honored.

The Hospital is committed to ensuring its compliance with all state and federal anti-referral laws, including the federal and state Stark and Anti-Kickback laws. Compliance with these laws is required whenever the Hospital has both a financial and a referral relationship of any kind with another entity or person.

It is thus our strict policy not to pay or offer payment or remuneration of any kind to any physician, group, facility, company or entity, either directly or indirectly, for the referral to the Hospital of services or items that are reimbursed by any federally funded health care program, including Medicare and Medicaid. Similarly, the Hospital will not accept any form of remuneration in return for referrals from the Hospital to other health care providers.

Rather, all services provided by or to the Hospital, and all financial transactions with other entities or persons, will be based on the fair market value of the service or transaction at issue and a reasonable commercial evaluation that does not take into account the volume or value of any referrals between the parties. Moreover, the Hospital will enter into such fair market value arrangements only for necessary services or items that are to be actually provided as agreed to between the parties.

2. Relationships with Other Healthcare Providers. In compliance with these laws, all contracts, leases, and other financial relationships with other healthcare medical providers who have a referral relationship with the Hospital will be based on the fair market value of the services or items being

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provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

The Hospital will not engage in any practice that violates the anti-referral laws or tend to create an appearance of illegality or impropriety, including but not limited to:

- Free Services. Providing free services or items to, or accepting such services or items from, another provider with whom there is a referral relationship, except as appropriate for short-term urgent circumstances, or to provide community benefit, e.g., to a school, or for the indigent or medically underserved;
- Above Fair Market Value. Paying or charging excessive amounts above fair market value to another provider for the provision of equipment, space or personnel services;
- Below Fair Market Value. Paying or charging amounts below fair market value to another provider for the provision of equipment, space or personnel services in return for referral of business paid for by Medicare or Medicaid;
- Joint Ventures. Entering into joint ventures with other providers or facilities for which an exception under the Stark law does not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer; all joint ventures will be structured to meet or come as close as possible to a safe harbor under the anti-kickback laws.

Thus, for instance, the Hospital will not provide: excessive payments for medical directorships; free services to physicians who otherwise have a financial relationship with the Hospital; free or below market rents or fees for administrative services; interest-free loans; or excessive payment for intangible assets in a physician practice acquisition. Similarly, all recruiting arrangements with physicians will not require the physician to refer patients to the Hospital or compensate the physician, directly or indirectly, for the volume or value of referrals generated by the physician.

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3. Contract Compliance Review. All arrangements with other parties, including any person, physician, health care provider, agency, facility, company or other entity, pursuant to which the Hospital has both a financial relationship and a referral relationship, will be subject to the Hospital's internal review process as described in the Hospital's Contract Compliance Review Policy and Procedure. All contracts, leases, and other financial relationships with providers with whom the Hospital has a referral relationship will thus be reviewed to ensure compliance with the federal and state Anti-Kickback and Stark Laws, and compliance with any applicable Safe Harbor or Exception under those laws.

4. Marketing Activities. All marketing activities and advertising by personnel must be based on the merits of the services provided and not on any promise, express or implied, of remuneration for referrals.

In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. In this regard, the Hospital's best advertisements are the quality of the medical services we provide, including clinical diagnostic testing. No personnel should disparage the services or business of a competitor through the use of false or misleading representations.

H. Standards Relating to Confidentiality.

1. Confidential Patient Information. The Hospital and its personnel are bound by and must observe all confidentiality provisions of the Health Insurance Portability and Accountability Act ("HIPAA") and other applicable state and federal regulations and laws governing the confidentiality of patient records and information.

All personnel must comply with the policies and procedures developed by the Hospital in connection with its HIPAA Compliance Program. All personnel will keep patient protected health information ("PHI") in the strictest of confidence. Such information will not be disclosed to anyone

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unless authorized by the patient or otherwise permitted by law. Authorized disclosures of PHI are strictly limited to the minimum necessary to accomplish your job responsibilities.

In addition, the Hospital recognizes the increased prevalence of identity theft, and is committed to protecting its patients from identity theft. In compliance with the rules promulgated under the Identity Theft Red Flags and Address Discrepancies Under the Fair and Accurate Credit Transactions Act of 2003, (the “Red Flag Rules”) set forth at 16 CFR Part 681, the Hospital has developed an Identity Theft Prevention Program which does the following:

- i. Identifies the kinds of red flags that are relevant to the Hospital;
- ii. Explains the Hospital’s process for detecting them;
- iii. Describes how the Hospital intends respond to red flags to prevent and mitigate identity theft; and
- iv. Sets forth a process to ensure that the policy is current.

2. Confidential Business Information. Confidential information acquired by personnel about the business of the Hospital must also be held in confidence and may not be used as a basis for personal gain by the personnel, their families, or others. Such information includes, but is not limited to patient lists, development plans, marketing strategy, financial data, proprietary research, and information about pending or contemplated business deals.

Information relating to transactions pending with the Hospital is not to be released to any person unless this information 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, Hospital employees and affiliates must not attempt to buy, lease, or sell for their own benefit or that of their family the item under consideration, until the Hospital’s decision on the matter has been executed. Finally, other than in connection with the personnel’s discharge of their official responsibilities with the Hospital, all personnel must also refrain from disclosing information about any consideration or decision, or any other information which might be prejudicial to the interest of the Hospital.

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The governing principle is that if any material confidential information pertaining to the Hospital is received by personnel, they must not use such information for their own or their family's benefit, nor should they disclose it to others for their personal use.

I. Government Inquiries.

1. Speaking with Government Agents. Personnel may speak voluntarily with government agents, and the Hospital will not attempt to obstruct any government inquiry or prevent any Hospital personnel from speaking with government agents, should the personnel desire to do so. It is recommended to all personnel, however, that before speaking with government agents, they contact their supervisor and the Compliance Officer. No person may respond to any request for information in a manner that represents that s/he is acting on behalf of the Hospital without first contacting their supervisor.

2. Responding to Subpoenas and Requests for Documents. In no event, however, may any personnel respond to a government request to disclose documents that are the property of the Hospital without first speaking with their supervisor. Except in the normal course of business, no personnel who receive a governmental request for documents or a subpoena may release Hospital documents without permission of their supervisor. No person may respond to any request for information in a manner that represents that s/he is acting on behalf of the Hospital without first contacting their supervisor. A supervisor who receives such information should contact the Compliance Officer, as well as Performance Improvement/Risk Management, who will notify legal counsel.

3. Accurate and Complete Responses. If a response is given to a request for information from government agencies, the response must be accurate and complete. It is the Hospital's policy to comply with the law and to cooperate with reasonable demands made during the course of a legitimate governmental investigation or inquiry.

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4. No Destruction or Alteration of Records or Evidence. No Hospital personnel are to destroy, alter or change any written or electronic Hospital records in response to a request for such records. Such action will subject the personnel to immediate discharge and possible criminal prosecution.

J. Scope and Application of Standards to Personnel and Others.

1. Personnel Covered. The Hospital Compliance Program, including the standards set forth in this Code of Conduct and the Compliance Procedures set forth in the next section of this Manual, apply to all personnel employed by or associated with the Hospital.

2. Other Compliance Protocols. In addition to the Code of Conduct and Compliance Procedures set forth in this Manual, many of the Hospital's departments have department-specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to compliment the procedures and standards set forth in this Manual.

3. Responsibility of All Employees. All employees are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job within the Hospital. All employees are also expected to comply with the standards set forth in this Code of Conduct and with any applicable departmental compliance protocols. Strict compliance with these legal and compliance standards is a condition of employment, and violation of any of these standards of conduct will result in discipline being imposed, including termination.

4. Responsibilities of Department Heads, Supervisors and Managers. All department heads, supervisors and managers have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the personnel they supervise understand the importance of this Code of Conduct and the Compliance Program, that these personnel are aware of its provisions and of the procedures for reporting suspected unlawful activity (set forth in the next Part of this Manual); and that all personnel are protected from retaliation if they come forward with information about suspected wrongdoing.

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5. Raise Compliance Issues. If any personnel believe that this Code of Conduct or any applicable legal rules were or may have been violated – or has a question about a compliance issue – they should raise their concern with their supervisor and/or with the Hospital’s Compliance Officer, as set forth below in Part III.

6. Review of These Compliance Policies and Procedures. All personnel will be expected to read and understand this Compliance Manual, or a summary of it, and to review it periodically. The Compliance Officer will ensure that it is distributed to all personnel and that new personnel receive a copy along with a training session as to them.

7. Contractors and Other Providers. To the extent practicable, all persons and entities with which the Hospital contracts will be asked to cooperate with the Hospital’s Compliance Program. This includes individual physicians, physician groups, vendors, contractors, and other healthcare providers.

Part III. Compliance Procedures

This section of the Manual explains the rules under which the compliance program will operate. To be effective, a compliance program must provide for the following: continued reporting of issues or possible violations of the Code of Conduct to the Compliance Officer; enforcement of the Code through the promulgation of disciplinary procedures; continued, periodic reviews and self-audits of our business practices; and implementation of modifications in the compliance program, as necessary, to prevent future violations. Rules and procedures as to each of these topics are set forth below.

A. Compliance Personnel

1. Compliance Officer. A Compliance Officer has been appointed to run the day to day operations of the Compliance Program and will be assisted, as necessary, by outside compliance counsel. The Compliance Officer is responsible for ensuring that compliance issues are properly

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addressed as they arise and that appropriate compliance assurance reviews, audits, and inquiries are conducted. The Compliance Officer is also responsible for receiving and responding to all reports, complaints, and questions about compliance issues. In this regard, the Compliance Officer is the Compliance Program's "point person," to whom all officers and employees can turn to express concerns about such matters.

The Compliance Officer will have the authority to review all documents and other information that are relevant to compliance activities including, but not limited to: patient records, billing records, records concerning marketing efforts, and records of arrangements with other parties. The Compliance Officer will also be informed of, and have access to, all information concerning any overpayments made to the institution and all pertinent audits, reviews, or investigations by any state or federal governmental agency.

The Compliance Officer will report directly on compliance matters to the President/CEO and to the Governance Committee of the Board of Directors.

2. Hospital-Level Compliance Committee. A Compliance Committee composed of management officers has also been formed. This Committee works with the Compliance Officer and is responsible for monitoring the implementation and operation of the Compliance Programs, and assists the Compliance Officer in reviewing compliance issues and implementing appropriate corrective action.

3. Reporting to the Board of Directors. On at least a quarterly basis, the Compliance Officer will report to the Governance Committee of the Board of Directors concerning: the compliance efforts that have taken place; specific compliance issues; and any changes to the compliance program that can be made to improve compliance.

4. Modification and Revision of Compliance Procedures and this Manual. On a periodic basis, the Compliance Officer will review and evaluate the effectiveness of the operation of the Compliance Program, as set forth in this Manual. Based on such reviews, the Compliance Officer will then recommend to the Board of Directors appropriate modifications of, or revisions to, the compliance procedures or this Manual.

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B. Reporting, Review, and Corrective Action.

1. Reporting and Complaint Procedures. All personnel should raise any question they might have about potentially unethical or illegal conduct with the Compliance Officer. Moreover, even if personnel merely have a general question about the propriety of conduct, they should still reach out to the Compliance Officer for guidance. Obviously, it is preferable that questions about a potentially troublesome issue be raised before the issue becomes a legal problem. Communications may be verbal or written, including by email, memorandum, letter or incident report. If an employee reports an incident of suspected non-compliance to a supervisor, the supervisor must promptly forward the report to the Compliance Officer.

The failure to report compliance issues and assist in their resolution may result in disciplinary action, up to and including termination.

2. Confidentiality and the Compliance Helpline. A “Compliance Helpline” has also been set up. This Helpline is composed of a dedicated voice mail telephone line monitored by the Compliance Officer. In addition to raising questions directly with the Compliance Officer, all personnel may call into the Helpline to report possible violations, ask questions, or raise compliance concerns.

A report or question may be raised anonymously, if personnel choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. To the extent possible, the Compliance Officer will not disclose the identity of anyone who reports a suspected violation of law or who participates in an investigation, although there may be a point where an individual’s identity may become known or have to be revealed. All personnel should be aware, however, that the Compliance Officer, and compliance counsel are obligated to act in the best interests of the Hospital and do not act as the personal representative or lawyer for employees.

3. Retaliation is Prohibited. Retaliation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is itself a serious violation

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of the Code of Conduct. Acts of retaliation should be reported to the Compliance Officer immediately and will be disciplined appropriately.

4. Investigation. Upon receiving a report of possible unethical or illegal conduct, substantial routine errors, systematic errors or of a pattern of possible improper billing, the Compliance Officer will contact senior management. Compliance counsel will be contacted as appropriate.

The Compliance Officer will then work under the supervision and direction of outside compliance counsel, as necessary, to conduct an investigation and take all necessary and appropriate actions. All personnel are expected to cooperate in such investigations.

The objective of such an inquiry will be to determine whether, first, a compliance issue exists or there has been a violation of the Code of Conduct or applicable legal rules. If an issue or violation does exist, then the inquiry will attempt to determine its cause, so that appropriate and effective corrective action can be instituted.

In addition, for reports that include possible improper billing or related issues, the investigation may also include, if necessary, selecting for review a small, random sampling of bills, along with the supporting medical documentation.

During these reviews, any bills that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding them have been resolved. If it is determined at the conclusion of the inquiry that any bills were submitted in error to the government or any other payor, any payments received will be refunded.

5. Corrective Action and Responses to Suspected Violations. Whenever a compliance problem or billing error by the Hospital is uncovered, the Compliance Officer will ensure that appropriate and effective corrective action is implemented. This may include, for instance, evidence that the Hospital is billing for services or procedures that were not performed or ordered, instances of double billing, use of improper codes, or suspect financial relationships with physicians or providers who refer patients to the

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Hospital. In discharging this responsibility, the Compliance Officer will work in consultation with senior management, the Department Chairperson, and compliance counsel, among others, as appropriate.

Any corrective action and response implemented must be designed to ensure that the violation or problem does not reoccur (or reduce the likelihood that it will reoccur) and be based on an analysis of the root cause of the problem. In addition, the corrective action plan should include, whenever applicable, a review to determine if the corrective action plan has been effective. Corrective actions may include, but are not limited to, the following:

- Informing and discussing with the offending physician, billing personnel, or other staff members both the violation and how it should be avoided in the future;
- Providing remedial education (formal or informal) to ensure that involved personnel understand the applicable rules and regulations;
- Conducting a follow-up review to ensure that the problem is not recurring;
- A focused audit after remedial education;
- Refunding any payments that resulted from improper bills;
- Imposing discipline, as set forth below;
- Suspending all billing of the services provided by a physician or provider, as set forth below;
and
- Voluntarily disclosing to an appropriate governmental agency.

If it appears that a larger, systemic problem may exist, then possible modification or improvement of the Hospital's compliance or billing practices will be considered. Such action might include, for instance, creating new procedures, or modifying existing procedures, so as to ensure that similar errors will not reoccur in the future. Possible changes or additions to procedures will be reviewed with senior management and, if appropriate, with the Board of Directors.

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Other corrective actions that may be considered might also include working with a specific department to formulate new or revised policies or procedures for that department, and conducting formal or informal training on specific issues for an entire department.

6. Discipline. All personnel are expected to adhere to this Code of Conduct and applicable departmental compliance protocols. If the Compliance Officer concludes, after an appropriate investigation, that the Code has been violated, appropriate discipline, up to and including discharge or termination of privileges, may be imposed. The imposition of discipline can be based on the personnel's unlawful or unethical actions, condoning or failing to report unlawful actions by others, retaliation against those who report wrongdoing, or other violation of the Code of Conduct.

The Compliance Officer may also recommend termination of a physician's contractual and employment rights with the Hospital, pursuant to the terms and conditions of the physician's contract. The CEO may also refer the matter to the Medical Board for corrective action and discipline pursuant to the Hospital Bylaws of the Medical Staff.

In recommending discipline of a non-physician employee, the Compliance Officer will refer the matter to the appropriate senior management, human resources as appropriate, and the employee's supervisor for disciplinary action.

C. Compliance Assurance Monitoring and Training

In addition to the responsibilities set forth above, the Compliance Officer and the Hospital-level Compliance Committee will also be responsible for continued monitoring of compliance with this Manual and all applicable federal and state rules, laws, and regulations.

1. Compliance Assurance Reviews. On a periodic basis, the Compliance Officer and Committee will ensure that reviews of coding, billing, and business practices are conducted. These reviews may include, but are not limited to, the following:

a. Chart and Billing Reviews. The Compliance Officer or designee will conduct chart reviews of a small sample of medical records, and corresponding billing documents, to test

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the adequacy of documentation and coding of services being billed by the Hospital, including the documentation and coding of physician services, out-patient testing or procedures, clinic services, inpatient services or other Hospital services. The reviewer will examine the medical record and the relevant billing documents, and check both the adequacy of the documentation and the appropriateness of the billing code(s) selected. If the review uncovers billing, coding, or documentation errors, the Compliance Officer (working with the Compliance Committee) will determine the scope of the problem, expand the scope of the review as necessary and appropriate, and ensure that appropriate corrective action is undertaken.

b. Review of Billing Denials and Patient Complaints. Periodic reviews will also be performed of denials from Medicare, Medicaid, and other third-party payors in order to determine whether any patterns of improper billing exist that need correction. In addition, billing complaints from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues.

c. Response to Third Party Audits. Following resolution of audits by third-party payors, the results of the audit will be reviewed to determine if those results reflect any systemic deficiency or problem in the Hospital's compliance with state or federal rules, regulations, or laws. If such a problem is identified, appropriate corrective action will be taken.

d. Review of Compliance Issues. Periodically, the Compliance Officer will review reports received of suspected violations of the Code of Conduct to determine if there are any patterns of violations that might indicate broader compliance issues.

e. Review of Exclusion Lists. The Compliance Officer or designee will conduct annual checks of the OIG's List of Excluded Individuals/Entities, the New York State Office of Medicaid Inspector General's list of excluded providers, and the General Service Administration's list of Parties Excluded from Federal Programs for all owners, directors, employees, contractors, agents and physicians with staff privileges. In addition, all potential employees will be screened to ensure they are

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not ineligible to participate in federal health care programs. A person who becomes excluded while employed at the Hospital is subject to termination. Personnel who are excluded shall disclose their exclusion to the Corporate Compliance Officer as soon as feasible.

f. Business Reviews. Periodically, the Compliance Officer will spot check the Hospital's business practices to insure compliance with applicable laws, rules and regulations. Such checks might include a review of the Hospital's credit balance, its practice of waiving co-payments or providing professional courtesy, and the fair market value of leases, equipment rental agreements, or personal service contracts with other providers.

g. Purchasing Reviews. Periodically, the Compliance Officer will review the Hospital's competitive bidding practices and, for vendors not subject to the competitive bidding procedures, a review of the quoted prices of other, similarly situated vendors for the same or similar goods or services.

h. Departmental Reviews. The Compliance Officer, with the assistance of the Hospital-level compliance committee, will also ensure that the compliance reviews specified in the various departmental compliance policies and procedures are conducted on an annual or periodic basis.

i. Response to Reviews. If any of these reviews indicate that possible compliance issues might exist, the Compliance Officer will inform counsel, the appropriate department head, and senior management, as appropriate. A determination will then be made whether further investigation is required and whether the Hospital's practices need to be modified or improved in any way to ensure continuing compliance with applicable federal and state laws and regulations.

2. Compliance Review of Contracts. All arrangements with other parties, including any person, physician, health care provider, agency, facility, company or other entity, pursuant to which the Hospital has both a financial relationship and a referral relationship ("Covered Arrangements") will be subject to the Hospital's internal review process as described in the Hospital's Contract Compliance

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Review and Procedure. The requirements of the Contract Compliance Review Policy include, but are not limited to, the following:

a. Written Agreement Required. All Covered Arrangements will be memorialized in a written agreement, and the Compliance Officer will maintain contracting and leasing oversight.

b. Review As To Stark Exceptions And Anti Kickback Safe Harbors. The proposed terms of a Covered Arrangement will be reviewed by the Hospital's Compliance Officer to ensure that those terms satisfy an Exception under the federal and state Stark laws (if the agreement is to be with a physician) and/or as close as possible to a Safe Harbor to the federal Anti-Kickback Statute if determined appropriate by the Hospital in consultation with counsel. The Compliance Officer will consult with counsel as necessary and appropriate in order to make these determinations.

If the Stark law is applicable, and the Arrangement does not fit within an applicable Exception, the Arrangement will either be restructured to fall within an Exception or it will not be pursued.

c. Review As To Business Terms. The Compliance Officer will also review the terms of any proposed Covered Arrangement to ensure that the services, items, personnel or space, etc. agreed upon:

- Will actually be provided and used, as described, over the term of the agreement;
- Are actually needed by one of the parties to meet a legitimate medical, operational or business interest not related to the volume or value of referrals; and
- Reflect, overall a negotiated, arms length, and commercially reasonable transaction.

A proposed Covered Arrangement will not be finalized until the Compliance Officer has completed this review of business terms and has signed off that the above concerns have been satisfied. If the terms of the proposed agreement do not satisfy these concerns, then the Arrangement will be modified, renegotiated or not pursued.

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d. Review As To Fair Market Value. The proposed terms of a Covered Arrangement will also be reviewed by the Department of Finance and/or the Corporate Compliance Officer to ensure that all remuneration, payments, fees and other financial terms are consistent with Fair Market Value, according to an appropriate valuation methodology.

A proposed Covered Arrangement will not be finalized until Finance and/or the Corporate Compliance Officer has completed its Fair Market Value review and has signed off that the financial terms are, in fact, consistent with Fair Market Value. If the terms are not consistent with Fair Market Value, then the Arrangement will be modified, renegotiated or not pursued.

e. Final Sign-Off. Once the above reviews have been completed, the proposed agreement will be forwarded to the Hospital's President and CEO for final review and approval.

3. Hospital Lab and Diagnostic Testing.

a. Ensuring Coding Accuracy. The Hospital-level Compliance Committee will work with the Compliance Officer to ensure that all relevant changes in how tests and procedures are coded (the "CPT-4" and "HCPCS" codes), and all relevant changes in the rules of how such tests are billed, are properly incorporated into the Hospital's daily practice. This includes timely updates of the Hospital's charge-master and will require, as necessary, coordination with Hospital's MIS, Patient Accounts, and Medical Records departments.

Each clinical department is responsible for tracking changes in the coding and billing rules relevant to its clinical practice, as these changes are announced in updates to the CPT-4 codes, in Medicare or Medicaid bulletins, in updates to the Medicare and Medicaid manuals, or in another source. The Compliance Committee, however, will meet periodically to ensure both that each department has, in fact, tracked the appropriate updates and that those updates have been properly entered into the Hospital's charge-master.

As necessary, the Committee will cause a follow-up review of the charge-master to be conducted, to confirm that it has been properly updated with the new codes. Also as appropriate, the Committee will

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ensure that staff in the appropriate departments receive the necessary training as to any changes or updates in the coding and billing rules.

b. Billing Audits. On a periodic basis, the Committee, in conjunction with the Compliance Officer, will ensure that an audit is performed as to how out-patient tests are ordered, performed, and billed. Such an audit will include the selection of a small number of randomly selected cases for review. If the audit establishes a possible pattern of non-compliance, then appropriate corrective action will be taken.

c. Review of Requisition Forms. On a periodic basis, the Committee will ensure that a review is done of all requisition forms being used by all departments for out-patient testing. These reviews will ensure that the design of the forms encourages provider choice in the selection of tests and the ordering of only medically appropriate tests.

d. Annual Test Utilization Monitoring. Biannually, the Committee will ensure that a review of test utilization is conducted. Specifically, the top 30 tests performed for, or billed to, Medicare and Medicaid will be tracked. The percentage growth in claims for each of the top 30 tests will be calculated from one period to the next. If a test's utilization grows more than 10 percent, the Committee will undertake a reasonable inquiry to ascertain the cause of such growth. If it appears that the growth occurred for a benign reason, no further action will be taken.

If it appears that the increase in utilization may have been due to anything improper on the part of the Hospital, then an expanded inquiry will be conducted, which may be at the direction and under the supervision of compliance counsel. At the conclusion of this inquiry, an appropriate response or corrective action, as described above, will be implemented.

e. Standing Orders. In situations in which a patient is receiving an extended course of treatment, it may be necessary to create a standing order with the clinical laboratory to have the same test conducted on a periodic basis. Once it is no longer necessary to conduct a test specified as a standing order as to a particular patient, however, the order must be terminated. As a result, for all

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standing orders with patients who are receiving extended treatment, the clinical laboratory will periodically contact providers with standing orders to verify the continuing necessity of the order.

f. Annual Notice to Providers. On an annual basis, the Compliance Committee will ensure that a Notice is sent out to all providers who order tests for out-patients, reminding the providers of some of the rules and regulations governing the ordering of tests reimbursed by governmental payors.

4. Hospital Inpatient Services, Ambulatory Surgery, and Outpatient Services. On a regular basis, the Medical Records Department will conduct Compliance Assurance reviews aimed at ensuring compliance with the applicable coding rules and guidelines and the Hospital's policy of accuracy in coding. These reviews will include the following:

- The Director of the Medical Records Department will review and track all denials of submitted bills, the DRG appeal process, and the results of all coding validation reviews in order to determine whether any endemic problems exist in the Department's coding practices.
- On a continuing basis, the coding supervisors will review a sample of records already reviewed and coded by the staff. These reviews will check accuracy of the coding, as well as other relevant compliance or quality assurance issues, ranging from the accuracy of the sequencing of diagnostic and operative information in the medical records to accuracy and completeness of filing of records.
- As these reviews proceed, staff coders will be given regular feedback as to the accuracy and appropriateness of their medical record reviews and coding.
- On an occasional basis, the Hospital may also retain an outside consulting firm to conduct an independent review of the accuracy of the department's coding.

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- If any of these reviews or audits uncovers a potential pattern of coding errors, or any other compliance issue, then immediate corrective action, as detailed above, will be implemented.
- These internal audits will be periodically reported to the Hospital's Compliance Officer.

5. Tracking New Developments. On a continuing basis, the Compliance Officer and the Compliance Committee will ensure that all new regulatory or legal requirements issued by the federal or state government are reviewed by appropriate personnel. This includes the following:

- reviewing all new rules governing the documentation, coding and billing of services provided by the Hospital;
- receiving and reviewing all Medicare bulletins, Medicaid updates, annual updates to the Current Procedural Terminology (CPT), or other announcements;
- communicating with the appropriate professional society as to recent initiatives or developments that might affect the Hospital, or new practices that might assist the Hospital in complying with rules and regulations that specifically apply to its areas of practice;
- reviewing all new Special Fraud Alerts issued by the Office of the Inspector General and the New York Office of Medicaid Inspector General, and each of their Annual Work Plans;
- reviewing and analyzing areas of risk or concern identified by the Hospital or the New York State Office of the Medicaid Inspector General (OMIG); and
- reviewing and analyzing potential "Red Flags," as set forth in Part II, Section H(1), above.

Based on any relevant new development, the Compliance Officer, in conjunction with the Compliance Committee, will review existing policies and procedures to ensure that the Hospital is in compliance with the requirements of federal and state law. If necessary, the Compliance Officer and Committee will then work to ensure that appropriate corrective action is taken.

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6. Coordination with quality issues. On a continuing basis, the Compliance Officer will review quality issues raised by the Hospital's Performance Improvement Department to determine whether any such issue may be systemic in nature to the extent that such may raise compliance concerns.

7. Coordination with credentialing. On a continuing basis, the Compliance Officer will be informed of any action that may be taken against a medical staff member's privileges that may raise compliance issues, or quality issues of such an extent that a compliance issue may exist.

8. Training. The Compliance Officer is responsible for ensuring that this Compliance Manual or summary of it is distributed to all personnel and providers and for maintaining a file containing each person's signed acknowledgment form. All new personnel should also receive a copy of this Manual or a summary of it and sign the acknowledgment form.

In addition, to ensure compliance with applicable federal and state statutes and rules, including but not limited to the Deficit Reduction Act of 2005, the Compliance Officer will develop an annual schedule of training on compliance issues, as necessary, for new and existing personnel and providers. The training for different groups of personnel should focus on the legal requirements most relevant to their particular jobs, including a periodic review of department compliance procedures. The Compliance Officer will maintain a record of all personnel who have attended such training.

Finally, the Compliance Officer will be responsible for any remedial training that is required as part of the Compliance Program.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received the “Corporate Compliance Manual” for Catskill Regional Medical Center. (the “Hospital”).

I agree to read the Manual, to conduct myself in conformity with all its requirements, to adhere to the spirit and letter of the Code of Conduct, and to cooperate with management in carrying out the objectives of the compliance program.

Acknowledged and agreed:

Signature

Print name

Job Title or Description

_____, 2010
Today’s Date

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

Catskill Regional Medical Center

Summary of Compliance Program Code of Conduct and Compliance Procedure with

A Summary of Federal and New York State False Claims and Related Statutes

I. Mission and Values. Catskill Regional Medical Center (the “Hospital”) is committed to the following:

- Providing patients with high quality and caring medical services pursuant to the highest ethical, business, and legal standards.
- Having all personnel adhere to the highest ethical and legal standards in all of their dealing with patients, other health providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received.
- Avoiding even the appearance of dishonesty or wrongdoing.
- Maintaining the Compliance Program as an integral part of our corporate mission and business operations and using the program to ensure our continuing compliance with all legal and ethical rules.

II. Code of Conduct. All personnel are required to adhere to the following Code of Conduct and to avoid any conduct that might reflect adversely upon the integrity or reputation of the Hospital.

- Honesty. All personnel must be honest and truthful in all of their dealings, both within and without the Hospital.
- Lawful Conduct. All personnel must avoid doing anything that is, or might be, against the law. If any personnel are unsure whether an action is lawful, then they should not do it until they have checked with their supervisor or the Compliance Officer.
- Cooperation with the Compliance Program. All personnel must cooperate fully with all inquiries concerning possible compliance issues and actively work to correct any improper practices that are identified.
- Billing. All federal and state regulations governing billing procedures will be meticulously followed for all physician, hospital, or other medical services billed by the Hospital. Federal and state laws addressing false claims (described in Appendix A) impose penalties and fines on individuals and entities that are found guilty of filing false or fraudulent claims for payment from Medicare, Medicaid or other federal health programs.

All billing must be accurate and truthful.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

No personnel should ever misrepresent charges to, or on behalf of, a patient or third-party payor. Deliberate or reckless misstatements to government agencies or other payors will expose the personnel involved to termination and criminal penalties. For example, under the federal Program Fraud Civil Remedies Act, if a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim.

- Only those medical services to patients that are consistent with acceptable standards of medical care may be billed.
- Billing procedures must always be based on adequate documentation of the medical justification for the service provided and for the bill submitted, and this medical documentation must comply with all applicable regulations.
- No “defaults” to a particular billing code may ever be used. CPT and diagnostic codes should never be selected on the basis of whether that given code guarantees payment. Only those codes that correspond to the service rendered and documented should be selected.
- Whenever the Hospital has learned or knows that it has received payments for which it was not entitled from a governmental or private payor, the payments will be refunded to the appropriate payor as soon as possible.
- Adequate Documentation and Correct Coding. Billing must always be based on adequate documentation of the medical justification for the service provided and for the bill submitted. All codes – including DRG, CPT and ICD-9 diagnostic codes – should never be selected on the basis of whether the given code guarantees or enhances payment; rather, only those codes that correspond to the service rendered and documented should be selected. A bill should not be submitted to a payor if the documentation of the nature or scope of service is unclear or it is otherwise unclear what the appropriate code is. For example, under the Federal False Claims Act, an individual or entity found guilty of “knowingly” presenting a false or fraudulent claim to the Federal Government is obligated to repay all of the falsely obtained reimbursement, and will be liable for a substantial civil penalty, plus three times the amount of actual damages sustained by the government. “Knowingly” has been defined to include, among other things, acting in reckless disregard of the truth or falsity of the information.

If the documentation is unclear, then coding personnel must request clarification or additional information from the physician or provider of service. This includes when the appropriate code or diagnosis is unclear. Coding personnel can not create coding or diagnostic information based on their own interaction with the patient, from information provided from an earlier date of service, or based on what they might conclude is the probable or most likely diagnosis.

- General Business Practices. The Hospital will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of our services.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

- All business records must be accurate and truthful, with no material omissions.
 - The assets and liabilities of the Hospital must be accounted for properly in compliance with all tax and financial reporting requirements.
 - All information submitted to governmental agencies, insurance carriers or other entities will be accurate and honest.
 - The institutional cost report will be prepared in compliance with all applicable state and federal regulations.
-
- Payments, Gifts, and Bribes. Personnel may not accept any gifts, or other favors from anyone outside the Hospital that are intended, or could be seen as intended to influence your actions and decisions as a Hospital employee. Nor may they give anything of value, including bribes, kickbacks, or payoffs, to any government representative, contractor, vendor, or any other person in a position to benefit the Hospital in any way. Personnel may provide or receive, however, ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior of the recipient.
 - Purchasing and Competitive Bidding. All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for the Hospital at the most reasonable price. No purchasing decision may be made based on considerations that any personnel, or family member or friend of personnel, will benefit.
 - Marketing and Patient Referrals. In marketing the Hospital's services, personnel must be truthful and honest in all representations they make about the Hospital and never agree to offer anything in value in return for referrals. The Hospital does not pay anyone, either directly or indirectly, for referrals; nor does the Hospital accept any form of remuneration in return for referring to other health care providers individuals who have been under our care.
 - Financial Interests and Conflicts of Interest. All personnel owe a duty of loyalty to the Hospital and any potential conflict of interest must be disclosed to ensure that an appearance of impropriety is not created and that the integrity of the Hospital operations is not compromised. All personnel must thus disclose to the Compliance Officer any financial interest they or a member of their family have in any enterprise that does business or competes with the Hospital in any manner.
 - Confidential Information. All personnel will keep patient information in the strictest of confidence. Such information will not be disclosed to anyone unless authorized by the patient or otherwise permitted by law.
 - In addition, personnel may not disclose or release without the prior authorization of the appropriate supervisor any confidential information relating to the following: Hospital operations, pending or contemplated business transactions, trade secrets, and confidential personnel information. All confidential information pertaining to the Hospital is to be used for the benefit of the Hospital and its patients, and is not to be used for the personal benefit of Hospital personnel, their families, or friends.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

- Requests for Information. While personnel may speak voluntarily with government agents, it is recommended that, before doing so, they contact their supervisors and the Compliance Officer first. In no event, however, may any personnel respond to a request to disclose Hospital documents without first speaking with their supervisors.
- Relationships with Physicians and Other Providers. All contracts, leases, and other financial relationships with physicians (and with any other medical provider who has a referral relationship with the Hospital) will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties. Nor will free services or items be accepted or provided in return for referrals.
- Contractors. To the extent practicable and to the extent of their involvement with the Hospital, all persons and entities with which the Hospital or any of its facilities contracts will be expected to cooperate with the Hospital's Compliance Program.
- Grants. The receipt and use of all grant money at the Hospital must be pre-approved by appropriate senior management. The receipt, or continued receipt, of grant money must occur under conditions which do not create an appearance that the judgment of Hospital personnel will be adversely affected, so as to place their interest, or that of an outside concern above that of the Hospital and its patients. Grant money should not be accepted in return for the promise or expectation that the Hospital or any of its personnel will purchase specific services or supplies from a particular company. The Hospital does not accept remuneration as an inducement to purchase any services or items and even the appearance that remuneration is being accepted for that purpose must be assiduously avoided.
- Department Heads, Supervisors and Managers. All department heads, supervisors and managers have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the personnel they supervise understand the import of this Code of Conduct and compliance program.
- Departmental Compliance Protocols. In addition to the Code of Conduct and Compliance Procedures set forth in this Summary and the Compliance Manual, many of the Hospital's departments have department-specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to compliment the procedures and standards set forth in the Manual.
- Responsibility of All Employees. All employees are expected to comply and be familiar with all federal and state laws, rules and regulations that govern their job within the Hospital. All employees are also expected to comply with the standards set forth in this Code of Conduct and with any applicable departmental compliance protocols. Strict compliance with these legal and compliance standards is a condition of employment, and violation of any of these standards of conduct will result in discipline being imposed.

III. Compliance Procedures. As set out more fully in the Compliance Manual and the attached detail of the Federal and New York State Statutes, the following are some of the compliance procedures available to Hospital personnel:

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

- Compliance Officer. A Compliance Officer has been appointed to run the day-to-day operations of the Compliance Program and is responsible for receiving and responding to all reports, complaints, and questions about compliance issues. In this regard, the Compliance Officer is the compliance program's "point person," to whom all officers and employees can turn to express concerns about such matters.
- Compliance Help Line. A "Compliance Help Line" has also been set up. This Help Line is composed of a dedicated voice mail telephone line monitored by the Compliance Officer. In addition to raising questions directly with the Compliance Officer, all personnel may call into the Help Line to report possible violations, ask questions, or raise compliance concerns.
- Reporting and Complaint Procedures. All personnel can and should raise any question they might have about potentially unethical or illegal conduct with the Hospital's Compliance Officer.
- Confidentiality. Your report or question may be raised anonymously, if you choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing.
- No Retaliation Allowed. Retaliation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is itself a serious violation of the Code of Conduct. Both federal and state laws offer protection to individuals who disclose certain unethical and illegal conduct. In New York, an employee who has made a disclosure to a public body is only afforded the protections in New York Labor Law 740, if such employee has first brought up the matter with a supervisor and given the employer a reasonable opportunity to correct the alleged violation.
- Responses, Remedial or Corrective Action, and Discipline. Violations of the Code of Conduct can result in remedial action, including: additional training; discipline up to and including discharge; modification or improvement of the business practices of the Hospital; and modification or improvement of the compliance program itself to better ensure continuing compliance with applicable federal and state laws and regulations.
- Ongoing Compliance Reviews. On a regular, periodic basis, the Compliance Officer, or a designee acting under his supervision, will conduct reviews of business and billing practices of the Hospital. In addition, department heads of some of the Hospital's departments will also conduct relevant compliance assurance reviews for their departments, as required in departmental compliance protocols and elsewhere.

IV. Compliance Contacts and Numbers. Any Hospital personnel may contact the Compliance Officer with any compliance question or issue. The telephone numbers are as follows:

- The Hospital Compliance Officer. The Compliance Officer is Marc Mendelsohn and he can be reached at (845) 794-3300 ext. 2376.
- The Hospital Compliance Help Line. The dedicated voice mail Compliance Help Line number is (845) 794-3300 ext. 3045.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

CATSKILL REGIONAL MEDICAL CENTER
HARRIS, NY * * CALLICOON, NY

Source: Administration

Policy No.: PC1046
HR 0019

Approval: CFO/Corporate Compliance Officer

Page: 1 of 4

Category: Compliance

Date of Origin: 1/07

Subject: Compliance with Applicable Federal and State
False Claims Acts and Related Laws

Date Reviewed:

Reference:

Date Revised:

PURPOSE: To ensure compliance with all applicable federal and New York State False Claims Act laws and regulations, and to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005.

POLICY: It is the policy of the Catskill Regional Medical Center (CRMC) and its subsidiaries, affiliated entities and managed companies that all personnel (including employees, management, physicians, consultants, contractors and other agents) (referred to collectively herein as "CRMC") shall comply with all applicable federal and New York State False Claims Act laws and regulations. CRMC has instituted various procedures, which are set forth in CRMC's Compliance Manual, to ensure compliance with these laws and to assist CRMC in preventing fraud, waste and abuse in federal health care programs. As part of CRMC's Compliance Program, personnel shall receive training on these laws, which are summarized below, and should consult with the Compliance Officer (who may confer with legal counsel, as needed) if they have questions about the application of these laws to their job.

PROCEDURE: As a part of CRMC's commitment to ethical and legal conduct, employees are required to immediately bring to the attention of their supervisor and/or the Corporate Compliance Officer, information regarding suspected improper conduct. Employees may also call the Compliance Helpline at (845) 794-3300 extension 3045 to discuss concerns about possible violations of the law or institutional policy. CRMC will investigate allegations of fraud, waste or abuse swiftly and thoroughly and will do so through its internal compliance programs and processes.

A summary of federal and state laws regarding fraud and abuse follows. Further information and materials relating to the Hospital's policies for detecting and preventing fraud are available in the Hospital policy manual and Code of Conduct. The Hospital policies and procedures which address these issues are as follows:

- Code of Conduct
- Conflict of Interest
- Corporate Compliance Manual and Procedures

I. FEDERAL LAWS

A. The Federal False Claims Act

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

The Federal False Claims Act is a law that prohibits a person or entity, such as CRMC from “knowingly” presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from “knowingly” making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

The Federal False Claims Act broadly defines the terms “knowing” and “knowingly” Specifically, knowledge will have been proven for purpose of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

A person or entity found guilty of violating this law is obligated to repay all of the falsely obtained reimbursement and will be liable for a civil penalty of up to \$11,000, plus three times the amount of actual damages sustained by the government as a result of the prohibited conduct for each violation of the Act. In addition to being liable for damages and civil penalties, violating the Federal False Claims Act can subject a person or entity to exclusion from participation in Federal health care programs, such as Medicare and Medicaid.

B. Whistleblower Protections

Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as “qui tam” actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims (also known as “relators” or “whistleblowers”) are granted protection under the law. Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys’ fees and costs.

C. The Program Fraud Civil Remedies Act (“PFCRA”)

This Federal law makes it illegal for a person or entity to make, present or submit (or cause to be made, presented or submitted) a “claim” (i.e., a request, demand or submission) for property, services, or money to an “authority” (i.e., an executive department of the Federal Government, e.g., the U.S. Department of Health and Human Services, which oversees Medicare and Medicaid programs) when the person or entity “knows or has reason to know” that the claim: (i) is false, fictitious or fraudulent; or (ii) includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent; or (iii) includes or is supported by any written statement which omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact; or (iv) is for the provision of items or services which the person or entity has not provided as claimed.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

In addition, it is illegal to make, present or submit (or cause to be made, presented, or submitted) a written “statement” (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity “knows or has reason to know” such statement: (i) asserts a material fact which is false, fictitious or fraudulent or (ii) omits a material fact making the statement false, fictitious or fraudulent because of the omission.

Similar to the Federal Claims Act, the PFCRA broadly defines the terms “knows or has reason to know” as (1) having actual knowledge that the claim or statement is false, fictitious, or fraudulent; (2) acting in deliberate ignorance of the truth or falsity of the claim or statement; or (3) acting in reckless disregard of the truth or falsity of the claim or statement. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

The PFCRA provides for civil penalties of up to \$5,000 for each false claim paid by the government, and, in certain circumstances, an assessment of twice the amount of each claim.

In addition, if a written statement omits a material fact and is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, the law provides for a penalty of up to \$5,000 to be imposed for each such statement.

D. The Fraud Enforcement and Recovery Act of 2009 (FERA)

On May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act (“FERA”) of 2009. FERA expands the False Claims Act’s liability on those who make false statements or claims for reimbursement to the government by, among other things, creating liability for anyone who knowingly retains a government overpayment without regard to whether or not that entity or person used a false statement or claim to do so. FERA also eliminates the requirement that a claim be presented to a government official before liability may attach. FERA expands the False Claims Act’s anti-retaliation provisions from only employees to include contractors and agents as well. Finally, FERA effectively allows the government more time to intervene in whistleblower actions.

II. NEW YORK STATE LAWS

A. Civil and Administrative Penalties

The New York State False Claims Act (Articles 187 through 194 of the Finance Law) closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is \$6,000 to \$12,000 per claim, and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government’s legal fees. The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties.

Article 145-b of the Social Services Law makes it a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or other agency

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

may recover three times the amount incorrectly paid along with civil penalties of up to \$2,000 per violation. If repeat violations occur, more severe penalties may be imposed.

Article 145-c of the Social Services Law - if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's (and their family's) needs are not taken into account for six months if the false statement is a first offense, 12 months if the false statement is a second offense, and five years for four or more offenses.

B. Criminal Penalties

Social Services Law Section 145

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor

Social Services Law Section 366-b, Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment, a false or fraudulent claim for furnishing services, knowingly submit false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services, is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretence, false promise, including a scheme to defraud, or other similar behavior. This law has been applied to Medicaid fraud cases. Depending upon the value of the property, the larceny can be from a Class E to a Class B felony.

Penal Law Article 175, False Written Statements makes it a misdemeanor to knowingly file a false instrument (document) with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.

Penal Law Article 176, Insurance Fraud makes it a misdemeanor to commit a "fraudulent insurance act," which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds \$1,000, the crime is punishable as a felony.

Penal Law Article 177 makes it a misdemeanor to engage in "healthcare fraud," which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year exceeds \$3,000, the crime is punishable as a felony.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

C. Whistleblower Protections

Federal False Claims Act (31 USC 3730(h))

The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claims Act (State Finance Law Section 191)

The False Claims Act also provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law Sections 740 and 741

Under New York's Labor Law, employers are prevented from taking any retaliatory actions (i.e., discharge, suspension, demotion or other adverse action in terms of condition of employment) against an employee who discloses (or threatens to disclose) to a supervisor or to public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or which constitutes the crime of health care fraud. The law allows employees so treated to bring a civil court action for injunctive relief to restrain continued retaliation; reinstatement to the same or equivalent position held before the retaliatory action; reinstatement of benefits and seniority; compensation for lost wages, benefits and other remuneration; and the payment of reasonable costs and attorneys' fees. The protections provided by this law in regard to disclosures to public bodies are only available if the employee has brought the activity, policy, or practice in violation of law, rule or regulation to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy practice. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

Catskill Regional Medical Center Code of Conduct and Compliance Procedures

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the “Code of Conduct and Compliance Procedures – A Brief Summary” for Catskill Regional Medical Center (“Hospital”) along with the detailed information about federal and state laws regarding false claims and whistleblower protections.

I agree to read the Summary, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the Code of Conduct, and to cooperate with management in carrying out the objectives of the compliance program.

I further certify that I know of no conduct by any Hospital personnel that may constitute a violation of any law, rule, or regulation applicable to the Hospital and its business or medical practices.

Acknowledged and agreed:
Signature:

Print Name:

Job Title or Description:

Department:

Date:

_____, 2010