COMMUNITY PROVIDERS, INC.
CORPORATE COMPLIANCE PLAN

Prepared for:
CVPH MEDICAL CENTER AND
ELIZABETHTOWN COMMUNITY HOSPITAL

By the Corporate Compliance Committee

Approved by the CVPH Board of Directors – 4/27/10
Approved by the CPI Board of Directors – 4/29/10

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Overview

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) and other federal agencies charged with responsibility for enforcement of federal law have emphasized the importance of voluntarily developed and implemented Compliance Plans. This Plan has been developed based on the OIG's Compliance Plan Guidance for Hospitals, the Centers for Medicare and Medicaid Services (CMS) regulations and guidelines, requirements imposed on other health care facilities in corporate integrity agreements negotiated by the OIG, and input from the health care industry, particularly the American Hospital Association, the Healthcare Association of New York State, as well as corporate counsel and corporate auditors.

The government, especially the OIG, has a zero tolerance policy toward fraud and abuse and will use its extensive statutory authorities to reduce fraud in Medicare and other federally-funded health care programs. Champlain Valley Physicians Hospital Medical Center (CVPH) and Elizabethtown Community Hospital (ECH), which are affiliated entities, share that intolerance for fraud and abuse. This Compliance Plan offers a vehicle to ensure that both Hospitals maintain an organizational culture that ensures compliance with all federal and state laws; federal, state, and private payor health care program requirements; as well as ethical and business policies and practices. The respective Boards of Directors of CVPH and ECH have adopted this Compliance Plan and appointed Corporate Compliance Officers for both Hospitals.

This Compliance Plan is a dynamic document; and therefore, one that will be modified and/or expanded over time. Through this document, we have attempted to provide guidance and structure to assist ourselves as we comply with civil, criminal, and health care laws. This Plan was initially implemented in 1998 and has been reviewed and/or revised annually.

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Community Providers, Inc. Corporate Compliance Philosophy

Community Providers, Inc. (CPI) is a not-for-profit 501(c)(3) corporation that acts as a holding company for several health care related entities. Below is a brief outline of each company within CPI. As a whole, CPI endorses a strong Corporate Compliance Program for each of its entities. The vast majority of CPI's revenue is derived from the two Hospitals outlined below. As such, they have been the major focus of the following Corporate Compliance Plan. While the Foundation of CVPH, Mediquest, EMT of CVPH, Champlain Valley Health Network and Valcour Imaging have much less activity that is relative to a Corporate Compliance Program, the philosophies and policies outlined below apply to those entities also. It is CPI's intent to operate within all federal and state guidelines for all of its subsidiaries and for its own limited operations as well.

Company	**Tax Status**	**Business**
CVPH Medical Center	Not-for-profit	Acute Care Hospital / Skilled Nursing Facility
Elizabethtown Community Hospital	Not-for-profit	Critical Access Hospital
Mediquest Corporation	For-profit	Real Estate
EMT of CVPH, Inc.	Not-For-profit	Ambulance service
The Foundation of CVPH, Inc.	Not-for-profit	Fund Raising
Champlain Valley Health Network, Inc.	For-profit	Physician Office Support and Billing
Valcour Imaging, LLC(Joint Venture Between CVPH Medical Center & Associates in Radiology of Plattsburgh, PC)	Limited Liability Corporation For Profit	Imaging Services

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Compliance Program – CVPH Medical Center (CVPH) and Elizabethtown Community Hospital (ECH)

Problem Statement

There is a major effort by the federal and state governments to significantly reduce fraud in the health care industry. Instances of variation from federal and state regulations are being treated as fraud and abuse. Hospitals throughout the country have been assessed fines and penalties and have been required to pay interest and damages for failure to adhere to the regulations. As a result, Hospitals have developed internal compliance programs.

It is believed CVPH and ECH are in essential compliance. However, considering the broadness of the government's review and the complexity of the business, a Compliance Plan has been established after reviewing overall operations.

Goals of This Program

1. To ensure an organizational culture within both CVPH and ECH that promotes the prevention, detection, and resolution of instances of conduct that do not conform with federal and state laws; federal, state, and private payor health care program requirements; as well as the Hospitals' ethical and business policies and Hospitals' practices.

2. To ensure that effective internal controls are in place within CVPH and ECH that promote adherence to the appropriate federal, state and local laws and the program requirements of federal, state, and private health plans.

Objectives to be Accomplished by This Plan

1. To help us fulfill our fundamental care-giving mission to patients and the community, and to assist us in identifying weaknesses in internal systems and management.

2. To tangibly demonstrate to employees and the community at large our strong commitment to honest and responsible provider and corporate conduct.

3. To identify and prevent criminal and unethical conduct.

4. To ensure false or inaccurate claims are not submitted to the federal and state governments and/or private payors.

5. To minimize inaccurate patient billing claims and, thereby, reduce the Hospitals' exposure to civil damages and penalties, criminal sanctions, and administrative remedies through a system of early detection and reporting.

6. To create a centralized source for distributing information on health care statutes, regulations, and other program directives related to fraud and abuse and associated issues.

7. To develop a program that encourages employees to report potential problems.

8. To assure quality of care and maintain each patient's/resident's rights through development of procedures that allow the prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other health care professionals, and consultants.

9. To initiate immediate and appropriate corrective action.

10. To prevent discriminatory admission or improper denial of access to care.

11. To ensure involvement/participation in care and treatment decisions.

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Guiding Principles – CVPH Medical Center

It is the policy of the Board of Directors of CVPH Medical Center to require compliance with the laws and regulations of the United States and the State of New York. The Board also ensures that CVPH functions are pursued in a manner consistent with the letter and the spirit of the law.

CVPH is committed to compliance with such laws and regulations, and intends to ensure that its operations, as carried out by its employees, members of the medical staffand agents of CVPH, are conducted in accordance with these laws and regulations. As a result of its commitment and intentions toward compliance, CVPH has developed a Corporate Compliance Plan.

This Compliance Plan is focused on the areas of federally funded insurance programs for patient services. CVPH has routinely performed audits of the billing operations to ensure compliance with rules and regulations. All activities related to the program will be conducted as advised by legal counsel so the activities are conducted within the context of the attorney/client privilege.

CVPH has established the qualifications and responsibilities for an individual to serve as its Compliance Officer and has appointed a Compliance Officer.

The Finance and Audit Committee of the Board of CVPH meets annually with the representatives of the accounting firm that audits the financial statements. A portion of this meeting is conducted without the presence of CVPH administration.

CVPH has established a Compliance Committee to assist with its compliance efforts. Regular reporting of activities related to the implementation and operation of the Compliance Plan to the Board of Directors will occur.

All employees, members of the medical staff and agents of CVPH will become familiar with the Compliance Plan. They will be educated to act in compliance with federal and state rules/regulations, as well as program guidelines. They will also be informed of the process to follow if they feel someone in the organization is not adhering to those rules, regulations, and program guidelines.

Employees,members of the medical staff and agents of CVPH will be advised of the following:

A. No employee, member of the medical staff or agent of CVPH has the authority to act contrary to the provisions of this Plan, or to authorize, direct, or condone violations offered by any other employee, medical staff member or agent.

B. Any employee, member of the medical staff or agent who has knowledge of facts or incidents that he or she believes may violate rules, regulations, and guidelines has an obligation to report the matter to the Compliance Officer in a timely manner.

C. If an employee, member of the medical staff or agent acting in good faith and upon the advice of the President/Chief Executive Officer of the Medical Center nevertheless becomes involved in a proceeding, the Medical Center will assist the employee, medical staff member or agent to the fullest extent permissible and appropriate.

D. Any employee, member of the medical staff or agent who violates this Plan, or who orders or who knowingly permits a subordinate to violate this Plan, will be subject to appropriate disciplinary action that may include discharge or termination of his or her relationship with the Hospital.

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Guiding Principles – Elizabethtown Community Hospital

It is the policy of the Board of Directors of Elizabethtown Community Hospital to require compliance with the laws and regulations of the United States and the State of New York. The Board also ensures that ECH functions are pursued in a manner consistent with the letter and the spirit of the law.

ECH is committed to compliance with such laws and regulations, and intends to ensure that its operations, as carried out by its employees, members of the medical staff and other agents of ECH, are conducted in accordance with the laws and regulations. As a result of its commitment and intentions toward compliance, ECH has developed a Corporate Compliance Plan.

This Compliance Plan is focused on the areas of federally funded insurance programs for patient services. ECH routinely performs audits of the billing operations to ensure compliance with rules and regulations. All activities related to the program will be conducted as advised by legal counsel so the activities are conducted within the context of the attorney/client privilege.

ECH has established the qualifications and responsibilities for an individual to serve as its Compliance Officer and has appointed a Compliance Officer.

ECH has established a Compliance Committee to assist with its compliance efforts. Regular reporting of activities related to the implementation and operation of the Compliance Plan will be submitted to the Performance Improvement Steering Committee and the Board of Directors.

All employees, members of the medical staff and agents of ECH will become familiar with the Compliance Plan. They will be educated to act in compliance with federal and state rules/regulations, as well as program guidelines.

Employees, members of the medical staff and agents of ECH will be advised of the following:

A. No employee, member of the medical staff or agent of ECH has the authority to act contrary to the provisions of this Plan, or to authorize, direct, or condone violations offered by any other employee, medical staff member or agent.

B. Any employee, member of the medical staff or agent who has knowledge of facts or incidents that he or she believes may violate rules, regulations, and guidelines has an obligation to report the matter to the Compliance Officer in a timely manner.

C. If an employee, member of the medical staff or agent acting in good faith and upon the advice of the Administrator of the Elizabethtown Community Hospital nevertheless becomes involved in a proceeding, the Hospital will assist the employee, medical staff member or agent to the fullest extent permissible and appropriate.

D. Any employee, member of the medical staff or agent who violates this Plan, or who orders or who knowingly permits a subordinate to violate this Plan, will be subject to appropriate disciplinary action that may include discharge or termination of his or her relationship with the Hospital.

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Compliance Program Elements

As part of the development of this Compliance Plan, the Hospitals' are following the Seven-Step Plan as developed by the Department of Health and Human Services' Office of the Inspector General.

The Seven-Step Plan Includes:

1. Establishment of compliance standards, written policies, and procedures.

2. Assignment of oversight responsibilities to someone high in the corporate structure.

3. Provision of education and training to managers, supervisors, employees, Medical Staff, and Board members utilizing various meeting formats, as appropriate.

4. Monitoring and auditing the existing systems to detect noncompliance and improve quality using self-assessment tools.

5. Establishment of effective lines of communication for reporting violations and clarifying policies.

6. Maintenance of consistent enforcement and discipline through well-publicized standards of conduct, discipline, guidelines, and procedures.

7. When warranted, utilization of corrective action by taking appropriate and immediate response to offenses and preventing further offenses through systematic changes.

With each step, we will need to take a variety of actions in order to implement. Further discussion of each step follows:

Establishment of Compliance Standards, Written Policies, and Procedures:

This Plan requires the development and distribution of written compliance standards, policies, and procedures. The policies will be developed under the supervision and direction of the Compliance Officers at CVPH and ECH, and will be provided to all individuals who are affected by the specific policy at issue. At CVPH, all employees and members of the medical staff have access to the CVPH Compliance Plan, as well as other related policies, through Policy Manager, an on-line policy tool.

Standards of Conduct:

The CVPH Medical Center Board of Directors, Medical Staff, Administrative Staff, and employees, as well as the ECH Board of Directors, Medical Staff, Administrative Staff, and employees, will comply with all legislation, rules, and regulations governing federal and state health care programs. These standards of conduct are driven by each organization's Mission Statement, Organizational Ethics Statement, Code of Conduct, and Guiding Principles. Standards of conduct that relate to complying with fraud and abuse laws and other ethical areas will be incorporated into affected employees' annual training. Specific attention to education of staff about prevention and detection of fraud will be provided. The Hospitals' will incorporate, as appropriate, additional education programs for employees based on job functions and areas of responsibility.

Risk Areas:

On an on-going basis, the Hospital will conduct risk assessments of the organization in order to prioritize the areas of the highest risk. The assessment will serve as a basis for the compliance work plan during the year.

The Hospitals' assure that their written policies and procedures take into consideration the regulatory exposure for each function, or department in each Hospital, and that education associated with compliance with fraud and abuse laws and other ethical areas are mandated for affected employees. Both CVPH and ECH intend to comply with **all** applicable rules, regulations, statutes, federal legislation, and program guidelines. In the event issues arise which are not covered in existing policies, policies will be revised or developed as appropriate.

The Office of the Inspector General periodically issues special fraud alerts setting forth activities believed to raise legal and enforcement issues. This Plan requires that the Compliance Officers, and other appropriate personnel, consider any and all Special Fraud Alerts issued by the OIG. This Plan addresses the implications of failing to evaluate and, if appropriate, cease and correct conduct criticized in such a Special Fraud Alert. If appropriate, the steps described in Section 6, *Responding to Detected Offenses and Developing Corrective Action Initiatives,* regarding investigations, reporting, and correction of identified problems will be followed. Initially, focus will be on the following areas of potential risk:

a. Global Regulatory Risks:

- Compliance with Medicare Regulations, including conditions of participation
- Compliance with Medical Assistance Regulations
- Compliance with Tax Rules and Regulations
- Compliance with Labor Laws and Regulations
- Compliance with Federal and State Health, Safety, and Environmental Regulations
- Compliance with Licensing and Credentialing Requirements
- Compliance with Patient Rights Laws*/Patient Abuse Laws*
- Compliance with the Americans with Disabilities Act
- Compliance with the Federal Family Medical Leave Act

- Compliance with ERISA and Department of Labor Regulations
- Compliance with Nuclear Regulatory Commission Standards
- Compliance with OSHA Standards
- Compliance with Environmental Protection Agency Standards
- Compliance with The Joint Commission Standards
- Compliance with Patient Confidentiality Laws and Regulations
- Conflicts of Interest
- Compliance with Record Retention Requirements
- Compliance with Food and Drug Administration Standards
- Compliance with Antitrust Laws
- Compliance with HIPAA
- Compliance with EMTALA
- Compliance with Federal & State Antikick Statutes as well as Stark Laws
- Compliance with the Deficit Reduction Act of 2005
- Compliance with False Claims Act
- Compliance with NYS Hold-Harmless Provisions Associated with Participating Provider Contracts
- Compliance with Charity Care Legislation

b. Functional Risks:

- Billing for services or supplies that were not provided
- Billing two insurers or one insurer, such as Medicare and a beneficiary, in an attempt to ensure payment
- Unbundling of charges to receive individual payments versus aggregated payments
- Billing for non-covered services
- Waiving of copayments or deductible amounts without documentation of financial hardship
- Misrepresenting the diagnosis for a patient to justify the services or equipment furnished or upcoding the service performed to receive increased payment
- Billing for over utilization of services by Hospital personnel (i.e., relates to unbundling as opposed to bundling versus a physician over utilizing services, which is also addressed through quality assurance programs and policies and procedures).
- Misrepresentation of dates of service or patients served to receive reimbursement.
- Improper use of modifiers to receive increased reimbursement.
- Other areas identified annually in the OIG Work Plan.

Claims Development and Submission Process:

With respect to reimbursement claims, our Hospitals' written policies and procedures reflect and reinforce current federal and state statutes and regulations regarding the submission of claims and Medicare cost reports. The policies create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical staff.

It is the Hospitals' policy to ensure that proper and timely documentation of all physician and other professional services is provided prior to billing to ensure that

only accurate and properly documented services are billed. Claims will only be submitted when appropriate documentation supports the claim. This documentation will be organized in a legible form for audit and review purposes. All diagnoses and procedures reported on the reimbursement form will be based on the medical record or other such documentation. Coding staff will have access to the necessary documentation for determining the accurate coding assignment and will not receive any financial incentive to improperly upcode claims.

The written policies and procedures concerning proper coding reflect the current reimbursement principles set forth in applicable regulations and will be updated as necessary. The official coding guidelines are promulgated by CMS, the National Center for Health Statistics, the American Medical Association, American Hospital Association, and the American Health Information Management Association. (See International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM]; CMS Common Procedure Coding System (HCPCS); and Physicians' Current Procedural Terminology [CPT]). Our policies explicitly refer to issues of medical necessity, appropriate diagnosis codes, DRG coding, individual Medicare Part B claims (including evaluation and management coding), and the use of patient discharge codes.

a. Outpatient services rendered in connection with an inpatient stay: CVPH and ECH have developed policies to address the billing of these services and to comply with the Medicare billing rules for outpatient services rendered in connection with an inpatient stay.

   These policies describe the systems in place to identify each inpatient stay and scrutinize the propriety of any potential bills for outpatient services rendered to that patient at each Hospital within the applicable time frame prior to admission.

   In addition to the pre-submission undertakings described above, the Hospitals also perform a post-submission testing process via periodic post-submission random internal audits that examine or reexamine previously submitted claims for accuracy; and advise the fiscal intermediary and any other appropriate government fiscal agents in accordance with current regulations or program instructions with respect to return of overpayments of any incorrectly submitted or paid claims. If the claim has already been paid, the Hospitals' promptly reimburse the fiscal intermediary and the beneficiary for the amount of the claim paid by the government payor and any applicable deductibles or copayments, as appropriate.

b. Submission of claims for services: The Hospitals' policies provide that all claims for clinical and diagnostic testing services are accurate and correctly identify the services ordered by the physician (or other authorized requester) and performed. More specific and detailed information is contained in the hospitals' Laboratory Compliance Plan.

1) Long Term Care Claims and Billing:
PRI and MDS assessment instruments will be completed using accurate and relevant documentation indicative of the intensity of care of LTC residents. This will result in appropriate billing based on care mix and level of care in the RUGS II and RUGS III reimbursements systems.

2) Testing Services:
The Hospitals' will ensure that all claims for testing services submitted to Medicare or other federally-funded health care programs are accurate and correctly identify the services ordered by the physician (or other individual authorized by law to order tests) and performed.

3) Selection of CPT or HCPCS Codes:
The Hospitals' will ensure the CPT or HCPCS codes used to bill Medicare or Medicaid accurately describes the services ordered and performed. All codes will be obtained, follow current year guidelines, and be verified by the CVPH or ECH prior to implementation. The Hospitals' will choose only the code that most accurately describes the ordered and performed test. To ensure code accuracy, the Hospitals' require that the codes be reviewed by individuals with technical expertise in the testing area (Supervisor(s), Director(s), Business Office Staff, and if needed, the Medical Director) before such codes are approved for claims submissions. The OIG views intentionally upcoding (i.e., the selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service) as raising false claims issues. If there is a question regarding coding, even after review by technical experts, the Internal Auditor for CVPH and the Director of HIS in collaboration with the CFO of ECH, will direct questions to the Medicare carrier or intermediary.

4) Selection of ICD-9-CM Codes:
At the direction of the CMS, Medicare carriers and intermediaries have established lists of tests that must be accompanied by diagnostic information to establish medical necessity before Medicare coverage will be assumed ("limited coverage policy"). Such diagnostic information may be submitted either through the use of ICD-9-CM codes or a narrative description. The Hospitals' will only submit diagnostic information obtained from the physician who ordered the test.

The Hospitals' will not:

(a) use diagnostic information provided by the physician from earlier dates of service (other than series orders)
(b) use "cheat sheets" that provide diagnostic information that has triggered reimbursement in the past
(c) use computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician
(d) make up diagnostic information for claims submission purposes.

The Hospitals' will:

(a) contact the ordering physician to obtain diagnostic information in the event that the physician has failed to provide such information
(b) provide services and diagnostic information supplied pursuant to a standing order executed in connection with an extended course of treatment
(c) accurately translate narrative diagnoses obtained from the physician to ICD-9-CM codes. Where diagnostic information is obtained from a physician or the physician's staff after receipt of the specimen and/or the requisition form, documentation of the receipt of such information will be created and maintained.
(d) For ECH, the ICR, supporting schedules and any prior adjustments are reviewed for accuracy and signed off by the Hospital's auditing firm prior to submission.

6) Proper Use of Modifiers:
The Hospital will ensure that modifiers used to bill federally funded programs accurately describe the services which have been performed and documented. Modifiers will only be added following a review of documentation located in the medical record or in the rendering department.

7) Tests Covered by Claims for Reimbursement:
The Hospitals' will only submit claims for tests that were both ordered and performed. If the Hospitals' receive a test request without a test order or with an ambiguous test order that is subject to multiple interpretations, the Hospitals' will check with the doctor to determine what tests he or she wanted performed before submitting a claim for reimbursement to Medicare. For example, if the Laboratory performed a test that the doctor did not order, the Laboratory will not erroneously bill for that test. Similarly, if the Laboratory cannot perform an ordered test due to, for example, a Laboratory accident or insufficient quantities of specimen, the Laboratory will not submit a claim to Medicare. The OIG considers the submission of a claim for tests that were either not ordered or not performed to be a potential false claim.

c. Physicians at Teaching Hospitals: Although CVPH is not designated as a teaching Hospital, we sometimes have residents who are supervised by a "teaching physician". As such, CVPH will ensure the following with respect to claims submitted on behalf of the "teaching physician":

- only services actually provided may be billed;
- every physician who provides or supervises the provision of services to a patient should be responsible for the correct documentation of the services that were rendered;

- the appropriate documentation must be placed in the patient record and signed by the physician who provided or supervised the provision of services to the patient;
- every physician is responsible for assuring that in cases where that physician provides evaluation and management (E&M) services, a patient's medical record includes appropriate documentation of the applicable key components of the E&M service provided or supervised by the physician (e.g., patient history, physician examination, and medical decision making), as well as documentation to adequately reflect the procedure or portion of the service performed by the physician; and
- every physician will document his or her presence during the key portion of any service or procedure for which payment is sought.

d. Cost Reports: With regard to cost report issues, it is our policy to ensure full compliance with applicable statutes, regulations, program requirements, and private payor plans. Among other things, this includes:

- costs are not claimed unless based on appropriate and accurate documentation;
- allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data;
- unallowable costs are not claimed for reimbursement;
- accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;
- costs are properly classified;
- fiscal intermediary prior year audit adjustments are implemented and either are or are not claimed for reimbursement and clearly identified as protested amounts on the cost report;
- all related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;
- requests for exceptions to the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) Limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;
- the Hospital's procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines, and policies;
- procedures are in place and documented for notifying promptly the Medicare fiscal intermediary (or any other applicable payor, e.g., TRICARE [formerly CHAMPUS] and Medicaid) of errors discovered after the submission of the Hospitals' cost reports.
- For ECH, the ICR, supporting schedules and any prior adjustments are reviewed for accuracy and signed off by the Hospital's auditing firm prior to submission.

Medical Necessity: Reasonable and Necessary Service:

Patient billing claims will only be submitted to third party payors for services that the Hospitals' have reason to believe are medically necessary. Physicians will be able to order any tests, including screening tests, they believe to be appropriate to the treatment of their patients. Physicians and patients will be made aware, however, that

a third party payor may not pay for a service it does not consider medically necessary.

There will be proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed. Patient billing claims will be submitted only when appropriate documentation is maintained and available for audit and review. Records will include documentation of services, the person providing the service, and authentication by the ordering physician that meets current state and federal regulations. The medical record will support all diagnoses and procedures submitted on the reimbursement claim.

Documentation necessary for accurate code assignment will be available to the coding staff. Compensation to the coding staff and the Financial Counselors will not provide any financial incentive to improperly upcode claims.

Antikickback and Self-Referral Concerns:

The Hospitals' have policies and procedures in place with respect to compliance with federal and state antikickback statutes, as well as the Stark self-referral law. Toward this end, the Hospitals' counsel or Compliance Officer will, among other things, obtain copies of all OIG regulations, special fraud alerts, and advisory opinions concerning the antikickback statute, Civil Monetary Penalties Law (CMPL), and Stark self-referral law[1], and ensure that the Hospitals' policies reflect the guidance provided by the OIG. Such policies provide that:

- all of the Hospitals' contracts and arrangements with referral sources comply with all applicable statutes and regulations;
- the Hospitals' do not submit, or cause to be submitted to the federal health care programs, claims for patients who were referred to the Hospitals' pursuant to contracts and financial arrangements designed to induce such referrals violating the antikickback statute, Stark self-referral law, or similar federal or state statute or regulation; and
- the Hospitals' do not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the Hospitals' in return for a physician's ability to provide services to federal health care program beneficiaries at the Hospitals'.

Further, the policies and procedures will reference the OIG's safe harbor regulations, clarifying those payment practices that would be immune from prosecution under the antikickback statute (see 42 C.F.R. 1001.952).

Bad Debts:

Medicare bad debts are currently audited annually by the Medicare Fiscal Intermediary. In addition, the Hospitals' will conduct an internal review, at least

[1] The fraud alerts and antikickback or CMPL advisory opinions are published on HHS-OIG's home page on the Internet.

annually to assess: 1) whether bad debts are being properly reported to Medicare; and 2) whether all Medicare bad debt expenses claimed are in accordance with applicable federal and state statutes, regulations, guidelines, and policies. In addition, such reviews will ensure that the Hospitals' have appropriate and reasonable mechanisms in place regarding beneficiary deductible or co-payment collection efforts and have not claimed as bad debts any routinely waived Medicare copayments and deductibles, which waiver also constitutes a violation of the antikickback statute.

Credit Balances:

The Hospitals' have procedures to provide for the timely and accurate reporting of Medicare and other federal health care program credit balances. The Hospitals' information systems have the ability to print out the individual patient accounts that reflect a credit balance to permit simplified tracking of credit balances.

The Directors of Patient Accounting at CVPH and ECH have the responsibility for the tracking, recording, and reporting of credit balances. Further, the Controllers at both Hospitals are responsible for reviewing reports of credit balances and reimbursements or adjustments on a periodic basis as an additional safeguard.

Retention of Records:

Records, including clinical medical records and financial records, will be maintained on all patient services. These records and all quality assurance reviews will be retained minimally in accordance with state and federal guidelines and CVPH and ECH record retention policies.

Compliance as an Element of a Performance Plan:

To ensure that corporate integrity rises to the level of importance required of all health care organizations and to ensure adherence at all levels to federal and state laws, rules, and regulations, the evaluation of all management staff includes a factor relating to the promotion of, and adherence to, the elements of the Compliance Plan. Managers and supervisors, along with other employees, are periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims, and cost report development and submission processes and those who oversee staff whose job functions include the above will:

(a) discuss with all employees the compliance policies and legal requirements applicable to their function;
(b) inform all employees that strict compliance with these policies and requirements is a condition of employment; and
(c) disclose to all employees that the organization will take disciplinary action up to and including termination for violation of these policies or requirements.

In addition to making performance of these duties an element in evaluations, the Hospitals' managers and supervisors will be disciplined for failure to adequately instruct their subordinates or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence, availability, and access

to information on the part of the manager or supervisor would have led to the discovery of any problems or violations and given the opportunity to correct them earlier.

Designation of a Compliance Officer and a Compliance Committee

Both CVPH and ECH have designated Compliance Officers and have established Compliance Committees. The Compliance Officers of both organizations, who each report directly to their Chief Executive Officers, report to their respective Boards on an annual basis. The Chief Executive Officers of both organizations are ex-officio members of the Compliance Committee.

Compliance Officer:

The Compliance Officers' primary responsibilities include:

- reporting on a regular basis to the Hospitals' governing body, Chief Executive Officer, and Compliance Committee on the progress of implementation, and assisting these components in establishing methods to improve the Hospitals' efficiency and quality of services, and to reduce the Hospitals' vulnerability to fraud, abuse and waste;
- periodically revising the Plan in light of changes in the needs of the organization, in the law, policies and procedures of government, and private payor health plans;
- developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the Compliance Plan, and ensuring that all appropriate employees, Medical Staff members, as well as the Board of Directors are knowledgeable of, and comply with, pertinent federal and state standards;
- ensuring that independent contractors and agents who furnish medical services to the Hospitals' are aware of the requirements of the Hospitals' Compliance Plan with respect to coding, billing, and marketing, among other things;
- coordinating personnel issues with the Hospitals' Human Resources Departments as appropriate;
- assisting the Hospitals' financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;
- independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations responding to reports of problems or suspected violations, and any resulting corrective action with all Hospital departments, providers, and sub-providers' agents and, if appropriate, independent contractors;
- developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation; and
- developing auditing programs and conducting periodic audits to ensure compliance at the request of counsel.

The Compliance Officer of each Hospital has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient medical records, billing records, and records concerning the marketing efforts of the Hospitals' and the Hospitals' arrangements with other parties, including

employees, professionals on staff, independent contractors, suppliers, agents, and Hospital-based physicians, etc. The Compliance Officers also review contracts and obligations (seeking the advice of legal counsel, where appropriate) that may contain referral and payment issues that could violate the antikickback statute, as well as the Stark self-referral prohibition and other legal or regulatory requirements.

In the event of a conflict involving corporate compliance between the Compliance Officer, the CEO and Hospital counsel, the issue will be brought to the Chair of the Board of Directors for discussion of the set of facts with the Board of Directors.

Compliance Committee:

CVPH and ECH have each established a Compliance Committee to advise and assist the Compliance Officers in the implementation of the Compliance Plan. The Committee's functions include:

- analyzing the Hospitals' environments, the legal requirements with which they must comply, and specific risk areas;
- assessing existing policies and procedures that address these areas for possible incorporation into the Compliance Plan;
- working with appropriate Hospital departments to develop standards of conduct and policies and procedures to promote compliance with the Hospitals' Plan;
- recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Hospitals' standards, policies, and procedures as part of its daily operations;
- determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and
- developing a system to solicit, evaluate, and respond to complaints and problems.

It is our intent that in the future the Committee will also address other functions as the compliance concept becomes part of the overall operating structure and daily routine of the Hospitals'. The organizational charts for Corporate Compliance for the Hospitals' are included in Appendix B.

Conducting Effective Training and Education

Our Compliance Plan requires compliance and ethics training during orientation and periodically thereafter for all members of the board of directors, corporate officers, managers, supervisors, employees, and physicians, as well as the continued retraining of current staff at all levels of the organization. It is especially crucial that personnel involved in coding, billing, sales, marketing, etc., receive training appropriate to their job function and the rules and regulations affecting their areas. Staff is required to attend specific training on a regular basis, including appropriate training in the federal and state rules, regulations, and program guidelines, and the policies of private payors, as well as training in corporate ethics. Training will be conducted upon hire, annually and repeated at regularly scheduled times, using a variety of teaching methods to ensure that all employees fully comprehend the implications of failing to comply with our Compliance Plan and all applicable rules, regulations, and program requirements. The training and education programs will cover our compliance policies and will reinforce the fact that strict compliance with

the law and our policies is a condition of employment. Employees will be informed that failure to comply will result in disciplinary action, up to and including termination. Training of staff will highlight the prohibition against offering remuneration, or other inducement, in return for referrals, and the fact that we will take appropriate disciplinary action up to and including termination for violations of the laws or failure to report a potential violation by another employee, supervisor, or outside contractor or provider. All actions will follow our established policies and procedures.

Training for specific departments may include information on a variety of topics:

- Billing for items or services not actually rendered
- Medical necessity
- Upcoding
- DRG creep
- Outpatient services rendered in connection with inpatient stays
- Teaching physician and resident requirements for teaching Hospitals, as appropriate
- Duplicate billing
- False cost reports
- Unbundling
- Billing for discharge in lieu of transfer
- Patients' freedom of choice
- Credit balances - failure to refund
- Incentives that violate the antikickback statute or other similar federal or state statute or regulation
- Joint ventures
- Financial arrangements between Hospitals' and Hospital-based physicians
- Stark self-referral law
- Knowingly failing to provide covered services or necessary care to members of a health maintenance organization
- Patient dumping
- Government and private payor reimbursement principles
- General prohibitions on paying or receiving remuneration to induce referrals
- Proper confirmation of diagnoses
- Submitting a claim for physician services when rendered by a non-physician (i.e., "incident to" rule and the "physician physical presence" requirement)
- Signing a form for a physician without the physician's authorization
- Alterations to medical records
- Prescribing medications and procedures without proper authorization
- Proper documentation of services rendered
- Duty to report misconduct
- False Claims Act

Attendance and participation in training programs are conditions of continued employment. Failure to comply with training requirements may result in disciplinary action. Adherence to the provisions of the Compliance Plan, including training requirements, is a factor in the employee's annual evaluation process.

Education on Corporate Compliance occurs at the following as appropriate: General Orientation, Mandated Programs, HealthStream, Departmental Meetings,

Manager/Supervisor Meetings, General and Departmental Medical Staff Meetings, and the Board of Directors Meetings.

Developing Effective Lines of Communication

Access to the Compliance Officers:

Employees will have an open line of communication to the CVPH and ECH Compliance Officers. The employees can discuss issues of concern **directly** with the Compliance Officer of each Hospital and be assured of having anonymity and a guarantee that there will be no retribution against fraud and abuse information provided. Employees are encouraged to communicate any issues or areas of concern. Working with or through legal counsel, the gray areas of interpretation of Medicare and Medicaid guidelines and regulations can be identified. Yet in all cases, the Compliance Officers encourage employees not to guess, but to ask whether there is confusion or a question.

Help Line and Other Forms of Communication:

CVPH Medical Center:

CVPH has established a Help Line for employees to contact the Compliance Officer directly. This number is 562-7067 (or if placing the call internally, extension 7067). The Help Line can be accessed by all CVPH employees, as well as independent contractors, as one avenue for reporting actual or potential compliance violations. The phone number is listed in CVPH's internal telephone directory.

All matters reported through the Help Line will be documented and investigated promptly. A log will be maintained by the Compliance Officer that records all calls, including the nature of any investigation and its results. This information will be included in reports to the Board of Directors, Compliance Committee, and others as required. Each reported incident will be examined on a case-by-case basis, with the Compliance Officer working closely with legal counsel. Individuals will not be subject to retaliation on the part of any person affiliated with the Hospital based on reports that are submitted in good faith. Any such retaliation is a violation of this Compliance Plan and should be reported immediately to the Compliance Officer. A copy of the policy for use of the Help Line is included in the Appendix.

Other avenues that can be utilized to report potential or actual compliance violations include e-mails and/or any form of handwritten memoranda to the Compliance Officer. If an individual does not want to use the Help Line or any other reporting structure because of the individuals or circumstances involved in the report, the Chief Executive Officer, any member of the Executive Staff, the Patient Care Coordinators, or any member of the Compliance Committee should be contacted.

Elizabethtown Community Hospital:

ECH has established a Help Line for employees to contact the Compliance Officer directly. This number is 873-3001, or internally at ext. 3001. The Help Line can be accessed by all ECH employees, as well as independent contractors, as one avenue

for reporting actual or potential compliance violations. The phone number is listed in ECH's internal telephone directory. Persons wishing to report a violation and wish to remain anonymous can do so by using the ECH Compliance Drop Box (located in the copier room in Administration) or by leaving a detailed message on the ECH Compliance Help/Hot Line at 873-3026 or internally at ext. 3026.

All matters reported through the Help Line will be documented and investigated promptly. A log will be maintained by the Compliance Officer that records all calls, including the nature of any investigation and its results. This information will be included in reports to the Board of Directors, Compliance Committee, and others as required. Each reported incident will be examined on a case-by-case basis, with the Compliance Officer working closely with legal counsel. Individuals will not be subject to retaliation on the part of any person affiliated with the Hospital based on reports that are submitted in good faith. Any such retaliation is a violation of this Compliance Plan and should be reported immediately to the Compliance Officer. A copy of the policy for use of the Help Line is included in the Appendix.

Other avenues that can be utilized to report potential or actual compliance violations include e-mails and/or any form of handwritten memoranda to the Compliance Officer. If an individual does not want to use the Help Line or any other reporting structure because of the individuals or circumstances involved in the report, the Chief Executive Officer or any member of the Compliance Task Force should be contacted.

Enforcing Standards Through Well-Publicized Disciplinary Guidelines

Discipline Policy and Action:

This Compliance Plan includes the initiation of corrective and/or disciplinary action against individuals who have failed to comply with the Hospitals' compliance policies and/or federal or state laws or who have otherwise engaged in wrongdoing that has the potential of impairing the Hospitals' status as reliable, honest and trustworthy providers. This Compliance Plan will follow the Hospitals' respective policies on progressive discipline.

Non-Employment or Retention of Sanctioned Individuals:

With the employment process for CVPH and ECH, a background check is completed on all final candidates which includes for ALL: Nurse Aide registry and GSA/OIG check and criminal background check. For those final candidates for positions covered under the DOH regulations for long-term care, background and criminal history record checks are completed. The background check includes a review of professional license (including all states and disciplines), references from current/previous employers, education record, motor vehicle check (if required for position), internal security check (CVPH only), drug screen (CVPH only), and an employee health assessment (post-offer). For final candidates for positions in the Skilled Nursing Facility, the background check includes finger printing. A drug and alcohol screening are completed on all final candidates for ECH.

The employment application specifically requires the applicant to disclose any criminal conviction, and HR will query the OIG website to ascertain that no new

employees (CVPH only) and ECH queries all employees, Board of Directors, contractors, vendors and Medical Staff members through the OIG website annually are listed on the site, as defined by 42 U.S.C. 1320a-7(1), or exclusion action. Hospitals' policies prohibit the employment of individuals recently convicted of a criminal offense related to health care or listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs (as defined in 42 U.S.C. 1320a-7b(f)). In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, these individuals are removed from direct responsibility for or involvement in any federal health care program. With regard to current employees or independent contractors, if resolution of the matter results in conviction, debarment, or exclusion, the Hospitals' will terminate its employment or other contract arrangement with the individual or contractor.

Sanctioned or Excluded Practioners:

The Hospitals' will adhere to Medicaid and Medicare laws regarding rendering services based upon the direction of Sanctioned or Excluded Practioners.

Auditing and Monitoring:

The Hospitals' believe that to be effective, the Plan should incorporate thorough monitoring of its implementation and regular reporting to senior management. The Compliance Officers will maintain reports created by the ongoing monitoring, including reports of suspected noncompliance. Auditing and monitoring reports will be shared with the Hospitals' senior management, and the Compliance Committee. The Hospitals' will do periodic audits by internal or external auditors who have expertise in federal and state health care statutes, regulations, and federal health care program requirements. The audits will focus on each Hospital's programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions. The audits will review the Hospitals' compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations, and law enforcement's initiatives. In addition, they will focus on any area of concern identified by any entity, i.e., federal, state, or internally, specific to the individual Hospital.

Monitoring techniques may include sampling protocols that permit the Compliance Officers to identify and review variations from an established baseline. Significant variations from the baseline should trigger a reasonable inquiry to determine the cause of the deviation. If the inquiry determines that the deviation occurred for legitimate, explainable reasons, the Compliance Officers, Hospital administrators, or managers may want to limit any corrective action or take no action. If it is determined that the deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, the Hospitals' will take prompt steps to correct the problem. Any overpayments discovered as a result of such deviations should be returned promptly to the affected payor, with appropriate documentation and a thorough explanation of the reason for the refund.

Monitoring techniques at CVPH and ECH also include a periodic review of reserves the Hospitals' have established based on estimates they have made for the purpose of determining an approximate value of funds that may be due to or from Medicare, Medicaid, TRICARE administrators, or any other federal health care program. When it is finally determined that funds are due to a government payor, the Hospitals' will settle in the appropriate manner according to government policies and processes. This information is reviewed by internal personnel, external auditors, and governmental auditors on an annual basis.

The Hospitals' have had an internal auditing program in place for a number of years prior to the adoption of this Plan. Copies of audits performed over the past several years have been incorporated into the Corporate Compliance binder to be used as a reference point for future audits in the areas reviewed.

The Hospitals' Plan will also incorporate periodic (at least annual) reviews of whether each Plan's compliance elements have been satisfied, (e.g., whether there has been appropriate dissemination of the Plan's standards, training, ongoing educational programs, and disciplinary actions, among others). This process will verify actual conformance by all departments with the Compliance Plan. Such reviews could support a determination that appropriate records have been created and maintained to document the implementation of an effective program. However, when monitoring discloses that deviations were not detected in a timely manner due to program deficiencies, appropriate modifications must be implemented. Such evaluations, when developed with the support of management, can help ensure compliance with the Hospitals' policies and procedures.

With these reports, Hospital management can take whatever steps are necessary to correct past problems and prevent them from recurring. In certain cases, subsequent reviews or studies will occur to ensure that the recommended corrective actions have been implemented successfully.

The Hospitals' will document their efforts to comply with applicable statutes, regulations, and federal health care program requirements. For example, if CVPH or ECH, in its efforts to comply with a particular statute, regulation, or program requirement, requests advice from a government agency (including a Medicare fiscal intermediary or carrier) charged with administering a federal health care program, the Hospital will document and retain a record of the request and any written or oral response. Maintaining a log of oral inquiries between the Hospitals' and third parties represents an additional basis for establishing documentation on which the Hospitals' may rely to demonstrate attempts at compliance. Records will be maintained demonstrating reasonable reliance and due diligence in developing procedures that implement such advice.

Responding to Detected Offenses and Developing Corrective Action Initiatives

Violations and Investigations:

Upon reports or reasonable indications of suspected noncompliance, the Compliance Officers will contact counsel to determine what investigation is to be conducted. An

investigation will promptly be conducted to determine whether a material violation of applicable law or the requirements of the Compliance Plan has occurred, and if so, to determine the steps to take to correct the problem. Instances of noncompliance are determined on a case-by-case basis.

The existence, or amount, of a monetary loss to a health care program is not solely determinative of whether or not the conduct should be investigated and reported to governmental authorities. In fact, there may be instances where there is no monetary loss at all, but corrective action and reporting are still necessary to protect the integrity of the applicable program and its beneficiaries. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the government, and the submission of any overpayments, if applicable. Advice from the Hospitals' counsel or an outside law firm may be sought to determine the extent of the Hospitals' liability and to plan the appropriate course of action.

Where potential fraud or False Claims Act liability is not involved, the Hospitals' will follow CMS regulations and contractor guidelines for returning overpayments to the government as they are discovered. The Compliance Officers will be made aware of these overpayments, violations, or deviations and look for trends or patterns that may demonstrate a systemic problem.

Depending upon the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents. Records of the investigation will contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, and the results of the investigation (e.g., any disciplinary action taken and the corrective action implemented). While any action taken as the result of an investigation will necessarily vary depending upon the situation, the Hospitals' will strive for some consistency by utilizing sound practices and disciplinary protocols. Further, after a reasonable period, the Compliance Officers will review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

If an investigation of an alleged violation is undertaken and the Compliance Officers believe the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be placed on administrative leave until the investigation is completed. In addition, the Compliance Officers will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation. If the Hospitals' determine that disciplinary action is warranted, the discipline will be prompt and imposed in accordance with written standards of disciplinary action.

Reporting:

If the Compliance Officers, Compliance Committee, or management officials discover credible evidence of misconduct from any source and, after a reasonable inquiry, have reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Hospitals' will promptly report the existence of misconduct to the appropriate governmental authority within a reasonable period, but not more than sixty (60) days after determining there is credible evidence of a

violation. To qualify for the not-less-than-double-damages provision of the False Claims Act, the report must be provided to the government within thirty (30) days after the date when the Hospitals' first obtained the information (31 U.S.C. 3 729[a]). Prompt reporting will demonstrate the Hospitals' good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions (e.g., penalties, assessments, and exclusions) if the Hospitals' become the target of an OIG investigation.

When reporting misconduct to the government, the Hospitals' should provide all evidence relevant to the alleged violation of applicable federal or state law(s) and potential cost impact. The Compliance Officers, under advice of counsel and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. Once the investigation is completed, the Compliance Officers will be required to notify the appropriate governmental authority of the outcome of the investigation, including a description of the impact of the alleged violation on the operation of the applicable health care programs or their beneficiaries. If the investigation ultimately reveals that criminal or civil violations have occurred, the appropriate federal and state officials will be notified immediately.

As previously stated, the Hospitals' will take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payor and the imposition of proper disciplinary action. Failure to repay overpayments within a reasonable period could be interpreted as an intentional attempt to conceal the overpayment from the government.

7

Conclusion

These basic recommended elements, coupled with other published regulations and guidelines, are the foundation for a comprehensive Compliance Plan for CVPH Medical Center and Elizabethtown Community Hospital. On advice from counsel and senior management, the Hospitals' may add to or modify these elements to better reflect the corporate structure of the Hospitals', their mission, and their employee composition. CVPH and ECH believe that by implementing an effective Compliance Plan, we will achieve better quality control of claims submission and reduce the risk of future criminal and civil liabilities.

APPENDIX

A. Compliance Plan Addendums

- **CVPH Physician Billing Services**
- **EMT of CVPH**
- **Champlain Valley Health Network, Inc. (CVHN)**
- **Valcour Imaging, LLC**

B. Organizational Charts – Corporate Compliance Committees

- **CVPH Medical Center**
- **Elizabethtown Community Hospital**

C. Policy: Use of Help Line for Compliance Reporting

- **CVPH Medical Center**
- **Elizabethtown Community Hospital**

D. Policies

Appendix A:

Compliance Plan Addendums

- **CVPH Physician Billing Services**
- **EMT of CVPH**
- **Champlain Valley Health Network, Inc. (CVHN)**
- **Valcour Imaging, Inc.**

CVPH PHYSICIAN BILLING SERVICES

COMPLIANCE PLAN ADDENDUM

CVPH Physician Billing Services will comply with the Community Providers, Inc. corporate compliance plan with the following additions:

Written Policies and Procedures

1. **Standards of Conduct:**

   CVPH has developed a Code of Conduct that details the fundamental principles, values, and framework for action within the organization. The Code articulates CVPH Physician Billing Services' commitment to comply with all federal and state standards, with an emphasis on preventing fraud and abuse. They state the ethical principles relating to compliance and clearly define the commitment to compliance and the expectations for all billing company managers and employees.. CVPH Physician Billing Services standards of conduct reflect a commitment to the highest quality health data submission, as evidenced by accuracy, reliability, timeliness, and validity.

2. **Written Policies for Risk Areas:**

   CVPH has policies in place that address the education and training requirements for billing and coding personnel; the risk areas for fraud, waste, and abuse; the integrity of the information system; the methodology for resolving ambiguities in the provider's paperwork; the procedure for identifying and reporting credit balances; and the procedure to ensure duplicate bills are not submitted in an attempt to gain duplicate payment.

   The policies and procedures describe the necessary steps to take in reviewing a billing document. These policies outline the specific steps the coder should take if unable to locate a code for a documented diagnosis or procedure or if the medical record documentation is not sufficient to determine a diagnosis or procedure.

   CVPH will conduct a comprehensive risk analysis. This risk analysis will identify and rank the various compliance and business risks the company may experience in its daily operations.

   Once completed, the risk analysis will serve as the basis for the written policies to be developed. The OIG has provided the following specific list of particular risk areas that should be addressed by billing companies. It should be noted that this list is not all encompassing and the risk analysis completed as a result of the company's audit may provide a more individualized roadmap.

Among the risk areas the OIG has identified as particularly problematic are:

a. Billing for items or services not actually documented
b. Unbundling
c. Up coding
d. Inappropriate balance billing
e. Inadequate resolution of overpayments
f. Lack of integrity in computer systems
g. Computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented
h. Failure to maintain the confidentiality of information/records
i. Knowing misuse of provider identification numbers, which results in improper billing
j. Duplicate billing in an attempt to gain duplicate payment
k. Failure to properly use modifiers
l. Billing company incentives that violate the anti-kickback statute or other similar federal or state statute or regulation
m. Joint ventures
n. Routine waiver of co-payments and billing third-party insurance only
o. Discounts and professional courtesy

Additional risk areas should be assessed by billing companies as well as incorporated into the written policies and procedures and training elements developed as part of their compliance programs.

CVPH will implement policies that require notification to providers who are coding to implement and follow compliance safeguards with respect to documentation of services rendered. CVPH will incorporate in its contractual agreements the provider's acknowledgement and agreement to address coding compliance safeguards, as these contracts renew.

3. Risk Assessment Coding Services:

The written policies and procedures concerning proper coding will reflect the current reimbursement principles set forth in applicable statutes, regulations and federal, state, or private payor health care program requirements and should be developed in tandem with organizational standards. Furthermore, written policies and procedures should ensure that coding and billing are based on medical record documentation. Particular attention should be paid to issues of appropriate diagnosis codes and individual Medicare Part B claims. All rejected claims pertaining to diagnosis and procedure codes should be reviewed by the coder. This should facilitate a reduction in similar errors. Among the risk areas to be addressed are:

a) Internal coding practices
b) "Assumption" coding
c) Alteration of the documentation
d) Coding without proper documentation of all physician and other professional services
e) Billing for services provided by unqualified or unlicensed clinical personnel
f) Availability of all necessary documentation at the time of coding
g) Employment of sanctioned individuals

CVPH will assure that essential coding materials are readily accessible to all coding staff and emphasize the importance of safeguarding the confidentiality of medical, financial, and other personal information used for billing purposes.

4. Claim Submission Process:

These policies create a mechanism for the billing staff to communicate effectively and accurately with the health care provider:

a. All the providers that CVPH bills for assign their own billing codes to the services they provide. It is the responsibility of these providers to ensure that proper and timely documentation of all physician and other professional services is obtained prior to CVPH billing which in turn will ensure that only accurate and properly documented services are billed.

b. Claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained, appropriately organized in legible form, and available for audit and review. The documentation, which may include patient records, should record the time spent in conducting the activity leading to the record entry and the identity of the individual providing the service.

c. The diagnosis and procedures reported on the reimbursement claim should be based on the medical record and other documentation and that the documentation necessary for accurate code assignment should be available to coding staff at the time of coding. The CMS Common Procedure Coding System (HCPCS), International Classification of Disease (ICD), Current Procedural Terminology (CPT), and ANY other applicable code or revenue code (or successor code[s]) used by the coding staff should accurately describe the service that was ordered by the physician.

d. The compensation for billing department coders and billing consultants should not provide any financial incentive to improperly up code claims.

e. A process should be in place for pre- and post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement.

f. Clarification from the provider will be obtained when documentation is confusing or lacking adequate justification.

5. Coding and Billing Training:

In addition to specific training in the risk areas identified in Section 2 above, primary training to appropriate corporate officers, managers, and other billing company staff will include such topics as:

a. Specific government and private payor reimbursement principles;
b. General prohibitions on paying or receiving remuneration to induce referrals;

c. Proper selection and sequencing of diagnoses;
d. Improper alterations to documentation;
e. Submitting a claim for physician services when rendered by a non-physician (i.e., the "incident to" rule and the physician physical presence requirement);
f. Proper documentation of services rendered, including the correct application of official coding rules and guidelines;
g. Signing a form for a physician without the physician's authorization; and
h. Duty to report misconduct.

6. Format of the Training Program:

Attendance and participation at training programs will be a condition of continued employment and failure to comply with training requirements will result in disciplinary action, including possible termination, when such failure is serious. Adherence to the provisions of the compliance program, such as training requirements, will be a factor in the annual evaluation of each employee. Records of the training sessions, including a list of topics covered, material distributed, and attendance lists will be maintained by the Corporate Compliance Officer.

7. Annual Reviews:

Annual Reviews will be conducted of whether the program's compliance elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs, and disciplinary actions, among others. This process will verify actual conformance with the compliance program. However, when monitoring discloses deviations were not detected in a timely manner due to program deficiencies, appropriate modifications must be implemented. Such evaluations, when developed with the support of management, can help ensure compliance with the CVPH policies and procedures.

As part of the review process, the Compliance Officer or reviewers may consider techniques such as:

a) On-site visits
b) Testing billing and coding staff on their knowledge of reimbursement and coverage criteria (e.g., presenting hypothetical scenarios of situations experienced in daily practice and assess responses)
c) Unannounced mock surveys, audits, and investigations
d) Checking personnel records to determine whether any individuals who have been reprimanded for compliance issues in the past are among those currently engaged in improper conduct
e) Interviews with personnel involved in management, operations, coding, claim development and submission, and other related activities
f) Trend analyses, or longitudinal studies, that seek deviations, positive or negative, in specific areas over a given period

The reviewers should:

1. Possess the qualifications and experience necessary to adequately identify potential issues with the subject matter to be reviewed.
2. Be objective and independent of line management.
3. Have access to existing audit and health care resources, relevant personnel, and all relevant areas of operation
4. Present written evaluation reports on compliance activities to the President, and members of the compliance committee at least annually
5. Specifically identify areas where corrective actions are needed.

With these reports, management can take whatever steps are necessary to correct past problems and prevent them from recurring. In certain cases, subsequent reviews or studies would be advisable to ensure that the recommended corrective actions have been implemented successfully.

CVPH employees will document their efforts to comply with applicable statutes, regulations, and federal health care program requirements. For example, in an effort to comply with a particular statute, regulation, or program requirements, requested advice from a government agency (including a Medicare fiscal intermediary or carrier) charged with administering a federal health care program, the employee will document and retain a record of the request and any written or oral response. This step is extremely important, as CVPH will rely on that response to guide it in future decisions, actions, or claim reimbursement requests or appeals. A log of oral inquiries between employees and third parties will help the organization document its attempts at compliance.

EMT OF CVPH

COMPLIANCE PLAN ADDENDUM

I. BASIC ELEMENTS OF A COMPLIANCE PROGRAM

- **Development of Compliance Policies and Procedures**
  EMT of CVPH has developed and distributed written standards of conduct, as well as written policies and procedures, which promote commitment to compliance and address specific areas of potential fraud or abuse. These written policies and procedures will be reviewed periodically (e.g., annually) and revised as appropriate to ensure they are current and relevant.

- **Designation of a Compliance Officer**
  EMT of CVPH has designated a compliance officer and will attend the Corporate Compliance Committee meetings of CVPH and will be charged with the responsibility for operating and monitoring the organizations' compliance program.

- **Education and Training Programs**
  Compliance programs must include as a key element the regular training and education of employees and other appropriate individuals. Training content should be tailored appropriately and should be delivered in a way that will maximize the chances that the information will be understood by the target audience.

- **Internal Monitoring and Reviews**
  EMT of CVPH has developed and will use appropriate monitoring methods to detect and identify problems, and to help reduce the future likelihood of problems. Claims and system reviews are common internal monitoring methods.

- **Responding Appropriately to Detected Misconduct**
  EMT of CVPH has developed policies and procedures directed at ensuring that it responds appropriately to detected offenses, including the initiation of appropriate corrective action. Its' response to detected misconduct will vary based on the facts and circumstances of the offense. However, the response will be appropriate to resolve and correct the situation in a timely manner. The EMT of CVPH's compliance officer, and legal counsel in some circumstances, will be involved in situations when serious misconduct is identified.

- **Developing Open Lines of Communication**
  EMT of CVPH will use the procedures currently in place at CVPH for access and communication with the Compliance Officer.

- **Enforcing Disciplinary Standards Through Well-Publicized Guidelines**
  This compliance plan includes the initiation of corrective and/or disciplinary action against individuals who have failed to comply with EMT of CVPH's/CVPH's

compliance policies and/or federal or state laws or who have otherwise engaged in wrong doing that has the potential of impairing CVPH Medical Center's or EMT of CVPH's status as reliable, honest, trustworthy providers. The compliance plan will follow CVPH's policies on discipline.

II. ELEMENTS OF A COMPLIANCE PROGRAM FOR AMBULANCE SUPPLIERS

EMT of CVPH assures that its written policies and procedures will take into consideration the following areas of functional risk:

Situations when individuals had other acceptable means of transportation;

- Medically unnecessary trips;
- Submission of excessive claims;
- Trips claimed but not rendered;
- Misrepresentation of the transport destination to make it appear as if the transport was covered;
- False documentation;
- Billing for each patient transported in a group as if he/she was transported separately; and
- Upcoding from basic life support to advanced life support services.

A. Evaluation and Risk Analysis

EMT of CVPH will conduct an evaluation of internal operations as well as factors that affect such operations (e.g., Federal health care program requirements).

The evaluation process should evaluate a variety of practices and factors, including policies and procedures, employee training and education, employee knowledge and understanding, claims submission process, coding and billing, accounts receivable management, documentation practices, management structure, employee turnover, contractual arrangements, changes in reimbursement policies, and payor expectations.

1. Policies and Procedures

This Plan requires the development and distribution of written compliance standards, policies and procedures.

2. Training and Education

Compliance program education will be available to all employees, even those whose job functions are not directly related to billing or patient care.

3. Assessment of Claims Submission Process

EMT of CVPH will conduct periodic claims reviews to verify that a claim ready for submission, or one that has been submitted and paid, contains the required, accurate, and truthful information required by the payor. The review should focus, at a minimum, on the documentation present in the ACR, the medical necessity of the transport as determined by payor requirements, the coding of the claim, the co-payment collection process, and the subsequent payor reimbursement. The claims review should be conducted by individuals with experience in coding and billing and they should be familiar

with the different payors' coverage and reimbursement requirements for ambulance services. The reviewers should be independent and objective in their approach.

EMT of CVPH will not only monitor identified errors, but will also evaluate the source or cause of the errors. A detailed and logical process of analysis will make claims reviews useful tools for identifying risks, correcting weaknesses, and preventing future occurrences of errors.

EMT of CVPH will conduct a baseline audit to develop a benchmark from which to measure performance. This audit will establish a consistent methodology for selecting and examining records in future audits. The results of each of the audits will be tracked to document progress. The results of each subsequent audit will indicate whether further actions are appropriate.

As part of its compliance efforts, EMT of CVPH will document (i) how often audits or reviews are conducted and (ii) the information reviewed for each audit. In addition, the results of such reviews will be compared to previous findings to determine if a problem persists or if the supplier's corrective actions are working.

- Pre-Billing Review of Claims
  As a general matter, EMT of CVPH will review claims on a pre-billing basis to identify errors before claims are submitted. If there is insufficient documentation to support the claim, the claim will not be submitted for payment until it is determined by a responsible person within the organization that the appropriate, adequate documentation exists to support the claim. Pre-billing reviews also allow suppliers to review the medical necessity of their claims before they are submitted for reimbursement. If, as a result of the pre-billing claims review process, a pattern of claim submission or coding errors is identified, a responsive action plan will be developed which would include a plan to ensure that overpayments are identified and repaid.

- Paid Claims
  In addition to a pre-billing review, a review of paid claims may be necessary to determine error rates and quantify overpayments and/or underpayments.

- Claims Denials
  EMT of CVPH will periodically review their claims denials from payors to determine if denial patterns exist. If a pattern of claims denials is detected, the patterns should be evaluated to determine the cause and appropriate course of action. Employee education regarding proper documentation, coding, or medical necessity may be appropriate.

4. System Reviews and Safeguards

Periodic review and testing of a supplier's coding and billing systems are also essential to detect system weaknesses. One reliable systems review method is to analyze in detail the entire process by which a claim is generated,

including how a transport is documented and by whom, how that information is entered into the supplier's automated system (if any), coding and medical necessity determination protocols, billing system processes and controls, including any edits or data entry limitations, and finally the claims generation, submission, and subsequent payment tracking processes.

5. Sanctioned Suppliers

Federal law prohibits Medicare payment for services furnished by an excluded individual, such as an excluded ambulance crewmember. Accordingly, with respect to its existing employees and contractors, CVPH through the CVPH Human Resources Department will check the OIG's and General Services Administration's (GSA) web sites to ensure that it does not employ or contract with individuals or entities that have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs. The OIG and GSA websites are listed at www.oig.hhs.gov and www.arnet.gov/epls respectively, and contain specific instructions for searching the exclusion and debarment databases.

- Identification of Risks
  EMT of CVPH will follow the same procedures as CVPH Medical Center with regard to staying current with all applicable rules, regulations, statutes, federal legislation and program guidelines.

- Response to Identified Risks
  EMT of CVPH will adapt to CVPH's protocols and reasonable timeframes for responding to identified problems.

III. SPECIFIC FRAUD AND ABUSE RISKS ASSOCIATED WITH MEDICARE AMBULANCE COVERAGE AND REIMBURSEMENT REQUIREMENTS

The following section is from the Federal Register Compliance Program Guide, which provides the basis for the EMT of CVPHs policies and procedures.

Ambulance suppliers should, at a minimum, review and understand applicable ambulance coverage requirements. Ambulance suppliers that are not complying with applicable requirements should take appropriate prompt corrective action to follow the standards set forth. The new Medicare ambulance fee schedule covers seven levels of service including Basic Life Support (BLS), Advanced Life Support, Level 1 (ALS1), Advanced Life Support, Level 2 (ALS2), Specialty Care Transport, Paramedic ALS Intercept, Fixed Wing Air Ambulance, and Rotary Wing Air Ambulance. Generally, Medicare Part B covers ambulance transports, if applicable vehicle and staff requirements, medical necessity requirements, billing and reporting requirements, and origin and destination requirements are met. Medicare Part B will not pay for ambulance services if Part A has paid directly or indirectly for the same services (e.g., a transport from a skilled nursing facility to a Hospital).

A. Medical Necessity

There have been a number of transportation fraud cases against the Medicare and Medicaid programs involving medically unnecessary transport.

Consequently, medical necessity is a risk area that should be addressed in an ambulance supplier's compliance program. Medicare Part B covers ambulance services only if the beneficiary's medical condition contraindicates another means of transportation. The medical necessity requirements vary depending on the status of the ambulance transport (i.e., emergency transport vs. non-emergency transport). If the medical necessity requirement is met, Medicare Part B covers ambulance services when a beneficiary is transported:

- To a Hospital, a critical access Hospital (CAH), or a skilled nursing facility (SNF) from anywhere, including another acute care facility or SNF;
- To his or her home from a Hospital, CAH, or SNF; or
- Round trip from a Hospital, CAH, or SNF to an outside supplier to receive medically necessary therapeutic or diagnostic services.

B. Upcoding

Notwithstanding local or state ordinance requirements regarding ambulance staffing and all-ALS mandated services, ambulance suppliers should use caution to bill, at the appropriate level, for services actually provided. The Federal Government has prosecuted a number of ambulance cases involving upcoding from BLS to ALS related to both emergency and non-emergency transports.

C. Non-Emergency Transports

There have also been a number of Medicare fraud cases involving (i) non-emergency transports to non-covered destinations and (ii) transports that were not medically necessary.

Under no circumstances should ambulance suppliers intentionally mischaracterize the condition of the patient at the time of transport in an effort to claim inappropriately that the transport was medically necessary under Medicare coverage requirements. In instances where it is not clear whether the service will be covered by Medicare, the ambulance provider should nonetheless appropriately document the condition of the patient and maintain records of the transport.

- Scheduled and Unscheduled Transports

  Because of the potential for abuse in the area of non-emergency transports, Medicare has criteria for the coverage of non-emergency scheduled and unscheduled ambulance transports.

  Medicare does not cover transports for routine doctor and dialysis appointments when beneficiaries do not meet the Medicare medical necessity requirements.

D. Documentation, Billing, and Reporting Risks

Currently, the CMS 1500 forms are the approved forms for requesting Medicare payment for ambulance services. Inadequate or faulty documentation is a key risk area for ambulance suppliers. The compilation of correct and accurate documentation (whether electronic or hard copy) is

generally the responsibility of all the ambulance personnel, including the dispatcher who receives a request for transportation, the personnel transporting the patient, and the coders and billers submitting claims for reimbursement. When documenting a service, ambulance personnel should not make assumptions or inferences to compensate for a lack of information or contradictory information on a trip sheet, PCR, or other medical source documents.

To ensure that adequate and appropriate information is documented, an ambulance supplier should gather and record, at a minimum, the following:

- Dispatch instructions, if any;
- Reasons why transportation by other means was contraindicated;
- Reasons for selecting the level of service;
- Information on the bed-confined status of the individual;
- Who ordered the trip;
- Time spent on the trip;
- Dispatch, arrival at scene, and destination times;
- Mileage traveled;
- Pick up and destination codes;
- Appropriate zip codes; and
- Services provided, including drugs or supplies.

EMT of CVPH shall use the appropriate Ambulance Billing Authorization and Privacy Acknowledgment Form-Suppliers document and obtain the transported patient's signature whenever reasonably practical to do so. In those instances when a patient's condition prevents them from signing, other appropriate documentation and authorized signatures shall be obtained to validate actual transport on the specified date. The original signed documents will remain on file with EMT of CVPH and be available for review and audit as necessary. A copy of the current authorization form currently in use is attached to this addendum.

E. HCPCS and Diagnosis Code Selection

The appropriate diagnosis and procedure codes (e.g., ICD–9, HCPCS/ CPT) should be used when submitting claims for reimbursement. The codes reported on the ambulance trip sheets or claim forms should be selected to describe most accurately the illness, injury, signs or symptoms associated with the patient and transport. Although ICD–9 codes are universally known as diagnosis codes, coders use them to describe signs and symptoms. Coders are taught that the patient's condition should be coded to the highest level of certainty and specificity. Diagnostic code information should not be based on past medical history or prior conditions, unless such information also specifically relates to the patient's condition at the time of transport.

False or uncertain diagnoses should never be added to the trip sheets or claims to justify reimbursement. If there is a question on the proper code to use when coding from the trip sheet or preparing a bill that cannot be appropriately resolved within the organization's proper chain of command, the ambulance supplier should seek guidance, in writing, from its local carrier. In addition to obtaining written guidance, ambulance suppliers should

maintain documentation of communication with its carrier. If the ambulance supplier experiences difficulty in obtaining clarification, it should submit with the claim a narrative explaining the issue and the basis for the selected choice. Copies of any carrier correspondence should be appropriately maintained by the ambulance supplier.

F. Origin/Destination Requirements– Loaded Miles

Medicare only covers transports for the time that the patient is physically in the ambulance. Effective January 1, 2001, ambulance suppliers must furnish the ''point of pick-up'' zip code on each ambulance claim form. Under the new Medicare ambulance fee schedule, the point of pick-up will determine the mileage payment rate as well as whether a rural adjustment factor will be applied to the base rate. The ambulance supplier should document the address of the point of pick-up to verify that the zip code is accurate.

The ambulance crew should accurately report the mileage traveled from the point of pick-up to the destination. Medicare covers ambulance transports to the nearest available treatment facility. If the nearest facility is not appropriate (e.g., because of traffic patterns or lack of equipment), the beneficiary should be taken to the next closest and appropriate facility. If a beneficiary requests a transport to a facility other than the nearest appropriate facility, the ambulance supplier should inform the patient that he or she may be responsible for payment of the additional mileage incurred.

G. Multiple Payors–Coordination of Benefits

Ambulance suppliers should make every attempt to determine whether Medicare, Medicaid, or other Federal health care programs should be billed as the primary or as the secondary insurance. Claims for payment should not be submitted to more than one payor, except for purposes of coordinating benefits (e.g., Medicare as secondary payer). Section 1862(b)(6) of the Social Security Act (42 U.S.C. 1395y(b)(6)) states that an entity that knowingly, willfully, and repeatedly fails to provide accurate information relating to the availability of other health benefit plans shall be subject to a civil monetary penalty (CMP).

The OIG recognizes, particularly for ambulance suppliers that may have incomplete insurance information from a transported patient, that there are instances when the secondary payor is not known or cannot be determined before the ambulance transportation claim is submitted. In such situations, if it is determined that an inappropriate or duplicate payment is received, the payment should be refunded to the appropriate payor in a timely manner. Accordingly, ambulance suppliers should develop a system to track and quantify credit balances to return overpayments when they occur.

H. Medicare Part A Payment for ''Under Arrangements'' Services

In certain instances, including transports for patients of a SNF or a Hospital, Medicare Part A covers ambulance transports. Ambulance suppliers that provide such inpatient transports ''under arrangements'' should not bill Medicare for these transports. Medicare reimburses the facility under the Part A payment for the patient's entire Part A stay, including any pre-discharge ambulance transports. Thus, ambulance suppliers should not submit a claim to

Medicare Part A or B for a service that was provided under arrangement with a Part A provider. In addition, all such arrangements should be carefully reviewed to ensure that there is no violation of the anti-kickback statute, as more fully described in section V of this document.

IV. MEDICAID AMBULANCE COVERAGE

The Medicaid program, a joint Federal and State health insurance program, provides funds for health care providers and suppliers that perform or deliver medically necessary services for eligible Medicaid recipients. Medicaid regulations, to which ambulance suppliers must adhere, vary depending on the applicable State regulations. However, two Federal regulations form the basis for all Medicaid reimbursement for transportation services and ensure a minimum level of coverage for transportation services. All States that receive Federal Medicaid funds are required to assure transportation for Medicaid recipients to and from medical appointments (42 CFR 431.53). Federal regulations further define medical transportation and describe costs that can be reimbursed with Medicaid funds (42 CFR 440.170(a)).

In short, Medicaid often covers ambulance transports that are not typically covered by Medicare, such as coverage of transports in wheelchair vans, cabs and ambulettes. The State Medicaid Fraud Control Units and Federal law enforcement have pursued many fraud cases related to transportation services billed to Medicaid programs. Ambulance suppliers should review the Medicaid regulations governing their State or service territories to ensure that any billed services meet applicable Medicaid requirements.

V. KICKBACKS AND INDUCEMENTS

- **The Anti-Kickback Statute**
  The anti-kickback statute prohibits the purposeful payment of anything of value (i.e., remuneration) in order to induce or reward the generation of Federal health care program business, including Medicare and Medicaid business. (See section 1128B(b) of the Social Security Act (42 U.S.C. 1320a– 7b).) It is a criminal prohibition that subjects violators to possible imprisonment and criminal fines. In addition, violations of the anti-kickback statute may give rise to CMPs and exclusion from the Federal health care programs. Both parties to an impermissible kickback transaction may be liable: the party offering or paying the kickback and the party soliciting or receiving it. The key inquiry under the statute is whether the parties intend to pay, or be paid, for referrals. An ambulance supplier should neither make nor accept payments intended to generate Federal health care program business.

- **''Safe Harbors"**
  ''Safe Harbor'' regulations describe payment practices that do not violate the anti-kickback statute, provided the payment practice fits squarely within a safe harbor. The safe harbor regulations are voluntary regulations. Thus, failure to comply with a safe harbor does not mean that an arrangement is illegal. Rather, arrangements that do not fit must be analyzed under the anti-kickback statute on a case-by-case basis to determine if there is a violation. To minimize the risk of a violation, ambulance suppliers should structure arrangements to take

advantage of the protection offered by the safe harbors. Among the safe harbors potentially relevant to ambulance suppliers are the safe harbors for space and equipment rentals, personal services and management contracts, discounts, employees, price reductions offered to health plans, shared risk arrangements, and ambulance restocking arrangements.

- **''Remuneration'' for Purposes of the Statute**
  Under the anti-kickback statute, ''remuneration'' means virtually anything of value. A prohibited kickback payment may be in paid cash or in-kind, directly or indirectly, covertly or overtly. Almost anything of value can be a kickback, including, but not limited to, money, goods, services, free rent, meals, travel, gifts, and investment interests. Paying for referrals need not be the only or primary purpose of a payment; as courts have found, if any one purpose of the payment is to induce or reward referrals, the statute is violated.

- **A Referral Source for Ambulance Suppliers**
  Any person or entity in a position to generate Federal health care program business for an ambulance supplier is a potential referral source. Typically, these sources include, but are not limited to, governmental ''9–1–1'' or comparable emergency medical dispatch systems, private dispatch systems, first responders, Hospitals, nursing facilities, assisted living facilities, home health agencies, physician offices and patients.

- **Ambulance Suppliers - Sources of Referrals**
  In some circumstances, ambulance suppliers furnishing ambulance services may be sources of referrals (i.e., patients) for Hospitals, other receiving facilities, and second responders. Ambulance suppliers that furnish other types of transportation, such as ambulette or van transportation, may also be sources of referrals for other providers of Federal health care program services, such as physician offices, diagnostic facilities, and certain senior centers. In general, ambulance suppliers, particularly those furnishing emergency services, have relatively limited abilities to generate business for other providers or inappropriately steer patients to certain emergency providers.

- **Ambulance Suppliers - Avoiding Risk Under the Anti-Kickback Statute**
  Because of the gravity of the penalties under the anti-kickback statute, ambulance suppliers are strongly encouraged to consult with experienced legal counsel about any financial relationships with potential referral sources. In addition, ambulance suppliers should review OIG guidance related to the anti-kickback statute, including advisory opinions, fraud alerts and Special Advisory Bulletins. Ambulance suppliers concerned about particular existing or proposed arrangements may obtain binding advisory opinions from the OIG.

  Ambulance suppliers should exercise common sense when evaluating existing or prospective arrangements under the anti-kickback statute. One good rule of thumb is that all arrangements for items or services between potential referral sources should be fair market value in an arm's-length transaction not taking into account the volume or value of existing or potential referrals. For each arrangement, ambulance suppliers should carefully and accurately document how fair market value is determined (e.g., by market comparables, open

competitive bidding, cost basis, etc.). Discounts should be accurately reflected and appropriately disclosed on all claims and cost reports filed with the Federal health care programs, and accurate and complete records should be kept of all discount arrangements. Ambulance suppliers should consult the safe harbor for discounts (42 CFR 1001.952(h)) when entering into discount arrangements.

Another good rule of thumb is that ambulance suppliers should exercise caution when selling services to purchasers who are also in a position to generate Federal health care program business for the ambulance supplier (e.g., skilled nursing facilities that purchase ambulance services for private pay and Part A patients, but refer Part B and Medicaid patients to the ambulance supplier). Any link or connection between the price offered to the seller and referrals of Federal program business will implicate the anti-kickback statute. In other words, ambulance suppliers should not offer purchasers with Federal health care program business a price that is lower than the price they would charge a purchaser with a comparable volume of business and no Federal health care program referrals.

A third good rule of thumb is that an ambulance supplier should not offer or provide gifts, free items or services, or other incentives of greater than nominal value to referral sources and should not accept such gifts and benefits from parties soliciting referrals from the ambulance supplier. In general, token gifts used on an occasional basis to demonstrate good will or appreciation (e.g., logo key chains, mugs or pens) will be considered to be nominal in value.

Ambulance suppliers should review the following arrangements with particular care:

- **Arrangements for Emergency Medical Services (EMS)**
  Contracts with cities or other EMS sponsors for the provision of emergency medical services may raise anti-kickback concerns. Ambulance suppliers should not offer anything of value to cities or other EMS sponsors in order to secure an EMS contract, nor should they condition an EMS contract on obtaining non-EMS ambulance business. While cities and other EMS sponsors may charge ambulance suppliers amounts to cover the costs of services provided to the suppliers, they should not solicit inflated payments in exchange for access to EMS patients, including access to dispatch services under ''9–1–1'' or comparable systems.

- **Arrangements With Other Responders**
  It many situations, it is common practice for a paramedic intercept or other first responder to treat a patient in the field, with a second responder transporting the patient to the Hospital. In some cases, the first responder is in a position to influence the selection of the transporting entity. While fair market value payments for services actually provided by the first responder are appropriate, inflated payments by ambulance suppliers to generate business are prohibited, and the Government will scrutinize such payments to ensure that they are not disguised payments to generate calls to the transporting entity.

- **Arrangements With Hospitals and Nursing Facilities**

Because Hospitals and nursing facilities are key sources of non-emergency ambulance business, ambulance suppliers need to take particular care when entering into arrangements with such institutions.

- **Arrangements With Patients**
  Arrangements that offer patients incentives to select particular ambulance suppliers may violate the anti-kickback statute, as well as the CMP law prohibition against giving inducements to Medicare and Medicaid beneficiaries. Areas include, but are not limited to, routine waivers of copayments, ''insurance programs'' offering patients purported coverage for the ambulance supplier's services only, and free goods and services. Ambulance suppliers may waive copayments based on good faith individualized assessments of financial need, so long as the availability of financial hardship waivers is not advertised.

Ambulance Billing Authorization and Privacy Acknowledgment Form - SUPPLIERS

Patient Name: _____ **Transport Date:** _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to EMT OF CVPH for any services provided to me by EMT OF CVPH now or in the future. I understand that I am financially responsible for the services provided to me by EMT OF CVPH, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to EMT OF CVPH any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to EMT OF CVPH. I authorize EMT OF CVPH to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to EMT OF CVPH and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by EMT OF CVPH, now or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received EMT OF CVPH's Notice of Privacy Practices.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness.

X _____
Witness Signature

_____
Witness Printed Name

If patient is physically or mentally incapable of signing, Section II must be completed.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____
Representative Signature Printed Name of Representative

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** for emergency ambulance transports, if patient was physically or mentally incapable of signing, **and** no authorized representative (as listed in Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____
Signature of Crewmember Printed Name of Crewmember

B. Receiving Facility Representative Signature

The above-named patient was received by this facility at the date and time indicated above.

X _____ _____
Signature of Receiving Facility Representative Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the Hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility) ☐ Facility Face Sheet/Admissions Record
☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record

CVHN PHYSICIAN BILLING SERVICES

COMPLIANCE PLAN ADDENDUM

CVHN Physician Billing Services will comply with the Community Providers, Inc. Corporate Compliance Plan with the following additions:

Written Policies and Procedures

1. **Standards of Conduct:**

   CVHN has developed Standards of Conduct that details the fundamental principles, values, and framework for action within the organization. The standards articulate CVHN Physician Billing Services' commitment to comply with all federal and state standards, with an emphasis on preventing fraud and abuse. They state the ethical principles relating to compliance and clearly define the commitment to compliance and the expectations for all billing managers and employees. CVHN Physician Billing Services standards of conduct reflect a commitment to the highest quality health data submission, as evidenced by accuracy, reliability, timeliness, and validity.

2. **Written Policies for Risk Areas:**

   CVHN has policies in place that address the education and training requirements for billing and coding personnel; the risk areas for fraud, waste, and abuse; the integrity of the information system; the methodology for resolving ambiguities in the provider's paperwork; the procedure for identifying and reporting credit balances; and the procedure to ensure duplicate bills are not submitted in an attempt to gain duplicate payment.

   The policies and procedures describe the necessary steps to take in reviewing a billing document. These policies outline the specific steps the coder should take if unable to locate a code for a documented diagnosis or procedure or if the medical record documentation is not sufficient to determine a diagnosis or procedure.

   Risk Assessment – CVHN will conduct a comprehensive risk analysis. This risk analysis will identify and rank the various compliance and business risks the company may experience in its daily operations. A self-assessment will be performed annually of the risk areas and a work plan to mitigate these risks will be developed based on the self-assessment.

   Once completed, the risk analysis will serve as the basis for written policies to be developed. The OIG has provided the following specific list of particular risk areas that should be addressed by billing companies. It should be noted that this list is not all encompassing and the risk analysis completed as a result of the CVHN's audit may provide a more individualized roadmap.

Among the risk areas the OIG has identified as particularly problematic are:

a. Billing for items or services not actually documented
b. Unbundling
c. Up coding
d. Inappropriate balance billing
e. Inadequate resolution of overpayments
f. Lack of integrity in computer systems
g. Computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented
h. Failure to maintain the confidentiality of information/records
i. Knowing misuse of provider identification numbers, which results in improper billing
j. Duplicate billing in an attempt to gain duplicate payment
k. Failure to properly use modifiers
l. Billing company incentives that violate the anti-kickback statute or other similar federal or state statute or regulation
m. Joint ventures
n. Routine waiver of co-payments and billing third-party insurance only
o. Discounts and professional courtesy

Additional risk areas should be assessed and incorporated into written policies and procedures and training elements as part of the compliance program.

CVHN will implement policies that require notification to providers who are coding to implement and follow compliance safeguards with respect to documentation of services rendered. CVHN will incorporate in its contractual agreements the provider's acknowledgement and agreement to address coding compliance safeguards, as these contracts renew.

3. Risk Assessment Coding Services:

The written policies and procedures concerning proper coding will reflect the current reimbursement principles set forth in applicable statutes, regulations and federal, state, or private payor health care program requirements and should be developed in tandem with organizational standards. Furthermore, written policies and procedures should ensure that coding and billing are based on medical record documentation. Particular attention should be paid to issues of appropriate diagnosis codes and individual Medicare Part B claims. All rejected claims pertaining to diagnosis and procedure codes should be reviewed by the coder. This should facilitate a reduction in similar errors. Among the risk areas to be addressed are:

A. Internal coding practices
B. "Assumption" coding
C. Alteration of the documentation
D. Coding without proper documentation of all physician and other professional services
E. Billing for services provided by unqualified or unlicensed clinical personnel
F. Availability of all necessary documentation at the time of coding
G. Employment of sanctioned individuals

CVHN will assure that essential coding materials are readily accessible to all coding staff and emphasize the importance of safeguarding the confidentiality of medical, financial, and other personal information used for billing purposes.

4. Claim Submission Process:

These policies create a mechanism for the billing staff to communicate effectively and accurately with the health care provider:

1. All the providers that CVHN bills for assign their own billing codes to the services they provide. It is the responsibility of these providers to ensure that proper and timely documentation of all physician and other professional services is obtained prior to CVHN billing which in turn will ensure that only accurate and properly documented services are billed.

2. Claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained, appropriately organized in legible form, and available for audit and review. The documentation, which may include patient records, should record the identity of the individual providing the service.

3. The diagnosis and procedures reported on the reimbursement claim should be based on the medical record and other documentation and that the documentation necessary for accurate code assignment should be available to coding staff at the time of coding. The CMS Common Procedure Coding System (HCPCS), International Classification of Disease (ICD), Current Procedural Terminology (CPT), and ANY other applicable code or revenue code (or successor code[s]) used by the coding staff should accurately describe the service that was ordered by the physician.

4. The compensation for billing department coders and billing consultants should not provide any financial incentive to improperly up code claims.

5. A process should be in place for pre- and post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement.

6. Clarification from the provider will be obtained when documentation is confusing or lacking adequate justification.

5. Coding and Billing Training:

In addition to specific training in the risk areas identified in Section 2 above, primary training to appropriate corporate officers, managers, and other billing staff will include such topics as:

1. Specific government and private payor reimbursement principles;
2. General prohibitions on paying or receiving remuneration to induce referrals;

3. Proper selection and sequencing of diagnoses;
4. Improper alterations to documentation;
5. Submitting a claim for physician services when rendered by a non-physician (i.e., the "incident to" rule and the physician physical presence requirement);
6. Proper documentation of services rendered, including the correct application of official coding rules and guidelines;
7. Signing a form for a physician without the physician's authorization; and
8. Duty to report misconduct.

6. Format of the Training Program:

Attendance and participation at training programs will be a condition of continued employment and failure to comply with training requirements will result in disciplinary action, including possible termination, when such failure is serious. Adherence to the provisions of the compliance program, such as training requirements, will be a factor in the annual evaluation of each employee. Records of the training sessions, including a list of topics covered, material distributed, and attendance lists will be maintained by the Corporate Compliance Officer.

7. Annual Reviews:

Annual Reviews will be conducted of whether the program's compliance elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs, and disciplinary actions, among others. This process will verify actual conformance with the compliance program. However, when monitoring discloses deviations were not detected in a timely manner due to program deficiencies, appropriate modifications must be implemented. Such evaluations, when developed with the support of management, can help ensure compliance with CVHN policies and procedures.

As part of the review process, the Compliance Officer or reviewers may consider techniques such as:

A. On-site visits
B. Testing billing and coding staff on their knowledge of reimbursement and coverage criteria (e.g., presenting hypothetical scenarios of situations experienced in daily practice and assess responses)
C. Unannounced mock surveys, audits, and investigations
D. Checking personnel records to determine whether any individuals who have been reprimanded for compliance issues in the past are among those currently engaged in improper conduct
E. Interviews with personnel involved in management, operations, coding, claim development and submission, and other related activities
F. Trend analyses, or longitudinal studies, that seek deviations, positive or negative, in specific areas over a given period

The reviewers should:

1. Possess the qualifications and experience necessary to adequately identify potential issues with the subject matter to be reviewed.
2. Be objective and independent of line management.
3. Have access to existing audit and health care resources, relevant personnel, and all relevant areas of operation
4. Present written evaluation reports on compliance activities to the Board at least annually
5. Specifically identify areas where corrective actions are needed.

With these reports, management can take whatever steps are necessary to correct past problems and prevent them from recurring. In certain cases, subsequent reviews or studies would be advisable to ensure that the recommended corrective actions have been implemented successfully.

CVHN employees will document their efforts to comply with applicable statutes, regulations, and federal health care program requirements. For example, in an effort to comply with a particular statute, regulation, or program requirement, requested advice from a government agency (including a Medicare fiscal intermediary or carrier) charged with administering a federal health care program, the employee will document and retain a record of the request and any written or oral response. This step is extremely important, as CVHN will rely on that response to guide it in future decisions, actions, or claim reimbursement requests or appeals. A log of oral inquiries between employees and third parties will help the organization document its attempts at compliance.

VALCOUR IMAGING, LLC
CORPORATE COMPLIANCE PROGRAM

This Compliance Plan ("the Plan") is intended to facilitate Valcour Imaging, LLC ("VALCOUR") endeavoring to follow all applicable federal, state, and local laws, rules and policies relating to payment for health care services, including but not limited to billing, coding, claims submission, and health care fraud and abuse. The Plan, having been approved by Valcour Imaging, LLC's Members constitutes official company policy. VALCOUR'S physicians and employees who fail to comply with the elements of this Plan may face disciplinary actions including reprimand, suspension without pay, termination, or civil and/or criminal charges.

VALCOUR has engaged in most of the compliance plan procedures described in this program previously. The adoption of this program is intended to organize and memorialize in a formal manner the procedures to be followed by VALCOUR in its effort to always remain in compliance with applicable rules and laws. This program shall be reviewed and modified from time to time to remain current with changes in the laws and changes with the practice.

VALCOUR'S Director of Compliance the OFFICE MANAGER (currently KATHLEEN FREEMAN) should be contacted when questions on compliance arise or to report potential violations. At any time, communication to the Director of Compliance may occur either by telephone (518) 563-1900), memorandum, or in person. To the extent reasonably possible, all communication to the Director of Compliance will be treated confidentially. As a result of the unique and integrated business relationships involved, and to the fullest extent possible, the Compliance Committee of VALCOUR, LLC shall confer with and cooperate with the Compliance Committees of AROP LLC, AROP PC and Adirondack Medical Billing Services, LLC.

STANDARDS OF CONDUCT

VALCOUR is committed to conducting its business in a lawful and ethical manner. VALCOUR's physicians and employees are required to comply with all applicable laws, regulations, and policies affecting the operations of VALCOUR's practice, including but not limited to rules relating to:

- billing for items or services not actually provided;
- improper coding practices;
- providing medically unnecessary services;
- failure to provide sufficient documentation;
- improper reassignment of Medicare payment;
- supervision of diagnostic services;
- special rules for teaching physicians (e.g., physical presence);
- failure to provide medically necessary services to managed care patients;
- improper referral arrangements;
- waivers of co-payments and deductibles;
- improper patient inducements;
- require payments to Hospitals that violate the anti-kickback statute;
- improper marketing activities;

- contracts with suppliers, independent contractors, other medical practices, physicians practice management companies, billing agents, etc.;
- joint ventures with other physicians, vendors, Hospitals, and managed care organizations; and
- other physician and practice investments.

A summary of many of the relevant fraud and abuse laws and billing rules may be set forth in Appendix A of this Plan. The Director of Compliance should be consulted if questions arise or to report a potential violation.

COMPLIANCE AS AN ELEMENT OF PERFORMANCE EVALUATION

Physicians and/or staff who fail to comply with the rules and procedures set forth in this plan or the laws and regulations governing VALCOUR's practice will be subject to disciplinary action. Compliance will also be a factor in performance evaluations and compensation decisions, both positive and negative. Physicians and supervisors will be subject to sanctions for failing to adequately instruct staff about, or for failing to detect noncompliance with, applicable policies and legal requirements.

ILLEGAL REMUNERATION AND PROHIBITED REFERRALS

No physician or employee shall make, or offer to make, or solicit or receive any payment or provide any other thing of value to another person with the understanding or intention that such payment is to be used for an unlawful or improper purpose. This includes bribes, kickbacks, or payoffs, in cash or in kind, to garner favorable decisions, obtain patient referrals, discounts from vendors, etc. VALCOUR's physicians and employees will also abide by federal and state prohibitions on referrals to entities with which they have financial relationships. A summary of the relevant federal anti-kickback and self-referral laws is set forth in Appendix A of this Plan.

MEDICAL NECESSITY AND PATIENT RIGHTS

As a health care provider, VALCOUR is committed to providing high quality radiology services to its patients. Such services will be provided on the basis of medical necessity and will not discriminate on the basis of economic factors or patient characteristics such as race, ethnicity, gender, or age. Informed consent will be obtained from patients prior to providing radiology services. The confidentiality of patient records will be maintained as required by law.

BILLING AND CLAIMS SUBMISSION

VALCOUR requires its physicians, employees, and contractors to comply with all billing and claims submission requirements promulgated by federal, state, and other payors. For instance, VALCOUR's physicians, employees, and contractors must adhere to the following principles:

- Proper and timely documentation of all physician and other professional services must be maintained to ensure that only accurate and properly documented services are billed;

- Under no circumstances may claims be submitted for services not performed or for a level of service that exceeds the level of services actually provided;

- Physician and technical records and medical notes used as a basis for a claim submission should be appropriately organized to a legible form so they can be audited and reviewed;

- Diagnosis and procedures reported on reimbursement claims should be based on the medical record and other documentation;

- Physicians will provide the appropriate level of supervision necessary to properly bill for diagnostic services, teaching physician services, and services performed incident to physician services;

- The documentation necessary for accurate code assignment should be available to coding staff; and

- The compensation for billing department coders and billing consultants should not provide any financial incentive or improperly upcode claims.

Among other things, VALCOUR shall endeavor to follow the billing and coding rules issued by Medicare guidelines, Medicaid guidelines, American Medical Association guidelines and American College of Radiology. In order to ensure compliance with billing requirements, VALCOUR regularly monitors and audits its billing practices and takes corrective actions as necessary.

RECORD RETENTION

VALCOUR maintains a uniform system for record creation, distribution, retention, storage, retrieval, and destruction of documents as more fully described in Appendix B of this Plan. The types of documents developed under this system include (a) billing, claims documentation, and other financial records and (b) all records necessary to protect the integrity of the practice's compliance process and confirm the effectiveness of the program, e.g., documentation that employees were adequately trained, modifications to the compliance program, results of any investigations conducted, self-disclosure, and results of the practice's auditing and monitoring efforts. Under no circumstances may documents relating to a pending investigation or inquiry regarding a report of a possible billing error or an incident of fraud and abuse be destroyed without permission of the Director of Compliance and approval of legal counsel.

COMMUNICATION

VALCOUR's physicians and employees should be open and honest in their business relationships with other physicians and employees, VALCOUR's officers and directors, and

VALCOUR's lawyers, accountants, and consultants. VALCOUR encourages a free flow of information among these individuals. The failure to deliver information that is known or thought to be necessary, or the provision that is known or thought to be inaccurate, misleading, or complete, in unacceptable. All information, opinions, or advice obtained by any VALCOUR's employee from an outside source shall be reduced to a written memo and retained if obtained verbally and retained and filed if received in writing.

The Director of Compliance and Compliance Committee are responsible for prompting communication between VALCOUR's physicians and staff. Physicians and employees are encouraged to solicit the opinion of the Director of Compliance if they are uncertain about a compliance-related matter. They are expected to report billing errors or suspected incidents of health care-related fraud and abuse. Communication and reporting may take place by telephone, memoranda, electronic mail, or through the Compliance Box. The Director of Compliance shall use best efforts to keep all communication confidential.

COMPLIANCE OFFICER

The VALCOUR's Members appoint the OFFICE MANAGER (currently Kathleen Freeman) as its Director of Compliance. The Director of Compliance is responsible for overseeing implementation of this Plan, making recommendations to the Membership regarding changes in VALCOUR practice to enhance compliance, and updating the Compliance Plan. The Director of Compliance is accountable and reports directly to the Members of VALCOUR IMAGING, LLC. The Members of VALCOUR IMAGING, LLC also appoint the following individuals to the VALCOUR Compliance Committee: A physician appointed by the LLC Membership Directors, currently Wolodymyr Bula, M.D., the Office Manager, (currently Kathleen Freeman), Corporate Attorney, currently Gary L. Favro, Esq., one staff employee, (currently Jessika Perras), one representative from CVPH Medical Center, (currently Gary King), and the Manager of any billing service used by VALCOUR (currently AMBS, LLC, Dianne Ahrent). The Director of Compliance has the following specific responsibilities:

- Develop compliance policies and standards in coordination with the Compliance Committee and senior management and in consultation with the VALCOUR' legal advisors;

- Oversee/monitor implementation of compliance activities;

- Report on a regular basis to the Members of the LLC on implementation progress;

- Assist leadership in developing methods for reducing the practice's vulnerability to fraud, abuse, and waste;

- Periodically revise the Plan to reflect changes in practice, or in the law and policies of government and private payor health plans;

- Ensure that all relevant employees and management have read the compliance plan and sign a statement acknowledging their understanding of its requirements;

- Work with individual(s) responsible for personnel decisions to ensure that appropriate credentials and references are checked for all employees and independent contractors;

- Develop policies and programs that encourage reporting of suspected fraud and other improprieties without fear of retaliation;

- Independently investigate compliance problems and bring them to the attention of the Compliance Committee or the Membership of the LLC for appropriate response; and

- Carry out corrective actions with approval of the Membership of the LLC.

The Director of Compliance has the authority to review all documents and other information relevant to compliance activities, including, but not limited to patient records, billing records, contracts, and records relating to marketing of the practice, as well as the practice's arrangements with other parties, including Hospitals, other practices, independent contractors, vendors, agents, etc.

RESPONSIBILITIES OF THE COMPLIANCE COMMITTEE

The Compliance Committee should work with the Director of Compliance and other personnel associated with the practice to develop appropriate standards, policies, and procedures to promote compliance within the practice.

The Compliance Committee shall meet quarterly to review compliance issues and to provide a brief report to the Director of Compliance. The Compliance Committee shall also meet quarterly with the Director of Compliance to review compliance issues.

In addition to the above, the Compliance Committee shall be responsible for the following:

- Develop, coordinate and/or conduct educational activities and other methods of communication that focus on the elements of the Plan and the specific risk areas identified in the Plan (e.g. training seminars, disseminate educational materials);
- Seek to ensure that all relevant VALCOUR's employees and management are knowledgeable about and comply with relevant federal and state standards;
- Ensure that independent contractors and other VALCOUR's agents are aware of and comply with the components of the Plan, particularly billing coding and marketing;
- Conduct or assist in the conducting of appropriate internal compliance reviews and audits.

SCREENING EMPLOYEES AND CONTRACTORS

VALCOUR's physicians and employees are expected to be honest and lawful in their business dealings. VALCOUR will not employ or do business with individuals who have been convicted of health care fraud or listed by a federal agency as excluded, debarred or otherwise ineligible to participate in federally funded health care programs. Consequently, VALCOUR may perform background investigations for prospective employees, consultants, suppliers, and business partners. Applicants for employment with VALCOUR will be required to disclose any criminal conviction of civil monetary penalties assessed against or paid by, or exclusion action imposed against, the individual. A copy of a questionnaire to be completed by all employees is attached as Appendix D.

TRAINING AND EDUCATION

VALCOUR believes that continuing education for both its physicians and employees promotes professional excellence and regulatory compliance. Medical licensure, accreditation, and clinical proficiency require that VALCOUR's physicians enroll in continuing medical education. Similarly, to keep current with changes in their own fields, VALCOUR encourages, and in some cases may require, its non-physician personnel (especially those in coding/billing, marketing, management, and finance) to take advantage of appropriate educational opportunities.

In addition to professional training, the Director of Compliance will develop programs to advise employees about regulatory compliance issues. Likewise, VALCOUR's physicians and employees are required to participate in such programs and to educate themselves regarding compliance issues as a condition of employment and failure to do so may result in disciplinary action, including termination. Compliance training may be face-to-face, and include lectures, videos and interactive sessions. It may be conducted by the VALCOUR's personnel, outside trainers and lecturers, or a combination of both.

Compliance-related education programs should, at a minimum, include:

- an overview of federal and state fraud and abuse laws and regulations, coding requirements, claims development and submission processes, and market practices that reflect current legal and program standards (see Appendix A of this Plan for a list of primary federal fraud and abuse laws;
- understanding the significance of this Plan; and
- the role of each VALCOUR employee in adhering to the Plan.

Training will be geared to level of responsibility and job function. Physicians, managers, billers/coders, and sales staff should receive more extensive compliance training than other personnel. In addition, training for VALCOUR physicians should focus on medical record documentation and improper referral and investment arrangements. Training for billing personnel, by contrast, should focus on inappropriate coding and billing practices (e.g., unbundling and upcoding). Specific appropriate training topics include but are not limited to:

- Government and private payoff reimbursement principles;
- General prohibitions on false claims, self-referrals, and the payment or receipt of remuneration to induce referrals;
- Proper confirmation of diagnoses or interpretations;
- Submitting a claim for physical services when rendered by a non-physician (under "incident to," supervision, and physical presence requirements);
- Signing a form for a physician without a physician's authorization;
- Altering medical records after the fact;
- Proper documentation of services rendered;
- Duty to report misconduct.

The Compliance Committee shall be responsible for coordinating these training activities.

The Compliance Committee also is responsible for maintaining a library of regulatory compliance-related information and training manuals. This information includes coding references, carrier newsletters, Medicare manuals, federal regulations, HCFA interpretations, and materials published by the American College of Radiology, the American Medical Association, the Radiology Business Management Association and other relevant professional societies. The Compliance Committee is also responsible for regularly disseminating new compliance information to VALCOUR's physicians and employees.

The Compliance Committee is encouraged to document all educational activities. Appropriate documentation includes a record of dates, times, attendance, and agenda for all professional and compliance training sessions in which VALCOUR personnel participate. Copies of materials disseminated at training sessions should also be maintained to the extent feasible. Periodic reports on training and education shall be provided to the Director of Compliance by the Compliance Committee.

Compliance issues shall be discussed at all regular office meetings. Those employees who attend educational programs shall be required to share this experience and information with all staff members at the next regular office meeting.

DISCIPLINARY PROCEDURES

VALCOUR will not tolerate illegal or unethical conduct of any sort (business or personal) by its physicians or its employees. VALCOUR is prepared to take disciplinary action against individuals who violate the requirements of this Plan or otherwise engage in unethical or unlawful activities. VALCOUR will publish and distribute to all physicians and employees its disciplinary policies and procedures, a copy of which is attached as Appendix C of this Plan. The sanctions available under this Plan range from reprimand, to suspension

without pay, to termination. VALCOUR's physicians and employees shall be entitled to a fair hearing and other due process protections normally available under VALCOUR's disciplinary policies and procedures.

All aspects of disciplinary actions taken against VALCOUR's physicians and employees will be documented.

AUDITING AND MONITORING

VALCOUR is committed to ensuring that this Plan is properly implemented through a system of periodic monitoring and auditing of the business activities of the practice. The principal activities of concern include billing, coding, claims submission, documentation, marketing, referral arrangements, contracts, joint ventures, other investments, and the like. While the Director of Compliance will be ultimately responsible for coordinating formal audits, the audits themselves may be performed by internal or external auditors with expertise in federal and state health care statutes, regulations, and policies. The auditors must be independent of VALCOUR physicians and management and have broad access to records and personnel. The purpose of these audits is to detect failure to follow the plan and any signs of billing errors or fraud. The Director of Compliance shall be responsible for investigating incidents or systematic errors or reports of suspected noncompliance. The results of the audit process must be communicated to and discussed with legal counsel to determine whether any corrective action is required.

BASELINE AUDIT

The Compliance Committee will authorize and arrange for a comprehensive "baseline" audit of its claims submission process every 3 to 4 years. The purpose of this audit is to identify and subsequently correct any existing problems in VALCOUR's billing, coding, and claims submission process. The baseline audit involves the selection of a representative sample of claims and all supporting documentation (e.g., reports, claims and remittance documents corresponding to the time period covered by the audit). It is suggested that the following procedures be followed as part of the baseline audit:

Sample charts/files shall be pulled randomly for review. Once the claims in the sample have been pulled, the auditor(s) will compare the codes billed (e.g. CPT, ICD-9) to the documentation to ensure accuracy. Also, the auditor(s) should review the remittance forms (e.g. EOMBs) for payment discrepancies. The auditor(s) should report all findings, including potential problems, to the Director of Compliance. The Director of Compliance in turn should notify VALCOUR's Membership of the auditor's findings and also notify the Compliance Committee.

The audit methodology should include:

- On-site visits;
- Interviews with administrative personnel and physicians;
- Review of written materials, medical and financial records and other documentation;
- Trend analysis that spot deviations in specific areas over a given period; and
- Analysis and report of results.

While the audit process should cover the entire practice, the following functions will be emphasized because of heightened government scrutiny under fraud and abuse laws and regulations:

- Billing
- Coding
- Marketing
- Referrals
- Supplier, Hospital and other contracts
- Recordkeeping
- Compliance education
- Joint ventures
- Other physician and practice investments
- Assignment of benefits

Special attention will be focused on new employees and existing employees in new positions.

PERIODIC AUDITS

VALCOUR will conduct "spot-check" internal audits at regular intervals by examining approximately 40 files to ensure ongoing claims processing accuracy and compliance with any new rule or regulation implemented since the previous audit. Furthermore, the period audit should focus on problems discovered in the baseline audit and previous audits. The manner in which the periodic audits will be conducted is comparable to that described for the baseline audit. Significant variations should be investigated to determine the cause. If there is a legitimate explanation and no systemic error, the Director of Compliance may not need to take any corrective action. If the deviation is due to improper procedures, misunderstandings of rules, fraud or systemic problems, then prompt corrective action should be taken.

The auditors should also review whether the requirements of the compliance program are being followed. For instance, the review should determine whether the program standards have been adequately disseminated, whether appropriate training and education programs have been conducted, and whether the disciplinary process is working properly. The reviewers should also determine whether appropriate records are being kept and that other documentation requirements are being satisfied. Where it is determined that the Plan is not being followed, corrective action should be taken.

DISCLOSURE OF AUDIT RESULTS

The Director of Compliance will ensure that the finding of the audit are reported to the leadership of the practice. If violations are discovered, thus necessitating corrective action, the advice of legal counsel must be sought. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether VALCOUR has any affirmative duties to report the violation and/or make restitution to health care payors.

DOCUMENTATION

All efforts to comply with applicable statutes and regulations must be documented, including the fact that an audit has taken place and a description of the nature and results of the review. Any inquiries of third party payors or Medicare carriers should also be documented if the practice intends to rely on the response.

HOTLINE AND OTHER MECHANISMS FOR REPORTING VIOLATIONS

All VALCOUR personnel are required to report incidents of systemic billing errors, violations of this Plan, unethical conduct, or incidents of potential fraud and abuse to the Director of Compliance. Such report may be made in person, or by written communication. Reports will be treated as confidential to the extent reasonably possible. There shall be no retaliation against employees or others who submit good faith reports of misconduct. Reports may be made on an anonymous basis. Any reported matters that suggest substantial violations of compliance policies, regulations, or statutes should be documented and investigated promptly. These matters should be reported to the compliance committee and the practice leadership.

VALCOUR personnel may report to the Director of Compliance in any manner, including but not limited to the following:

(a) in person; or
(b) in writing; or
(c) by telephone; or
(d) by contacting the Chairman of the Compliance Committee, OFFICE MANAGER (currently Kathleen Freeman), or the Corporate Attorney, Gary L. Favro, Esq., (561-1100), 46 Court Street, Plattsburgh, New York 12901.

INVESTIGATIONS AND CORRECTIVE ACTION

If potential systemic problems, violations of this Plan, or potential incidents of fraud and abuse are reported or identified during the audit process, the Director of Compliance will consult with legal counsel as well as the compliance committee and VALCOUR leadership to determine an appropriate response. The Compliance Officer may decide to conduct further investigation. If such investigation reveals a significant problem or a material violation, VALCOUR is obligated to take corrective action.

INTERNAL INVESTIGATION

As with a periodic audit, an investigation of a particular practice or suspected violation typically involves review of relevant documentation and records, interviews with staff and physicians, and analysis of applicable laws and regulations. The results of such investigations must be thoroughly documented and shared with the Compliance Committee and the Members of the LLC on a confidential basis. Precautions should be taken to ensure that critical documents are not destroyed. Records of the investigation should include a description of the investigative process, copies of interview notes and key documents, a log

of witnesses interviewed and documents reviewed, the results of the investigation (e.g., any disciplinary actions taken or reports made), and any corrective action taken. The investigation can be conducted by the Director of Compliance, legal counsel, or an outside expert. Regardless of who actually conducts the investigation, the process must be conducted under the auspices of legal counsel. Any outside investigators should ordinarily be hired through legal counsel.

CORRECTIVE ACTION

If an audit or investigation reveals a systemic billing, coding, or claims submission problem, the Director of Compliance and legal counsel are responsible for drafting a corrective action plan ("CAP") if needed. The CAP should list each billing practice that may not meet all applicable requirements and specify what will be done to correct the practice. For each item listed in the CAP, deadlines are established by which the action must take place. The scope of possible corrective actions is quite broad, ranging from refunds of any overpayments received, to disciplinary actions, to reporting incidents of fraud and abuse to federal or state authorities. (The compliance officer should be informed of any routine returns of overpayments, even if they are not made as part of a formal investigation or audit.) The CAP, along with a copy of the billing practice review, must be sent to legal counsel for advice and assistance. All corrective actions must be thoroughly documented. Progress reports are prepared on a periodic basis that list each corrective action items and identify what activities have taken place on each item. Decisions whether to disclose the result of investigations or audits to federal or state authorities are made by the VALCOUR Membership of the LLC based upon recommendations of the Director of Compliance and legal counsel.

GOVERNMENT INVESTIGATIONS

If any VALCOUR physician or employee is contacted (e.g., inquiry, subpoena, personal visit) by a governmental agency regarding VALCOUR's business, VALCOUR physicians and employees are required to notify the Director of Compliance and VALCOUR' legal counsel immediately. While it is VALCOUR's policy to cooperate with governmental agencies, VALCOUR's legal rights and those of its physicians and employees must be protected. In the case where a governmental agent visits a VALCOUR physician or employee, the agent should be asked to contact the Director of Compliance to arrange an interview. The Director of Compliance, in turn, will notify legal counsel to discuss the matter.

MODIFICATIONS OF COMPLIANCE PROGRAM

This corporate compliance program shall be modified from time to time to remain current with any relevant charges in the rules and laws which affect the practice of radiology and compliance issues. All personnel, physicians and employees alike, are encouraged to communicate any suggestions for changes to this plan to the Director of Compliance and/or the Compliance Committee. These policies and procedures have been designed to enhance the functioning of the practice and decrease the chances of violating applicable

rules and regulations. We continue to seek ways to improve these procedures and we are always open to your suggestions.

USE OF BILLING SERVICE

VALCOUR may engage the services of a medical billing company from time to time. In the event a medical billing company is engaged by VALCOUR, the billing company shall follow and be bound by the provisions of this Compliance Program. The engagement of a billing company shall not limit the responsibility of VALCOUR as described in this Compliance Program to insure adherence to the procedures and terms described in the Compliance Program. VALCOUR may utilize the services of a billing company to assist in the collection of data for audits. VALCOUR shall also require the attendance of a management representative from the billing service at all Compliance Committee meetings.

ACKNOWLEDGEMENT

By signing below, the employee acknowledges and certifies that this Compliance Program has been read and is understood by the employee.

_____ Witness: _____
Employee Signature

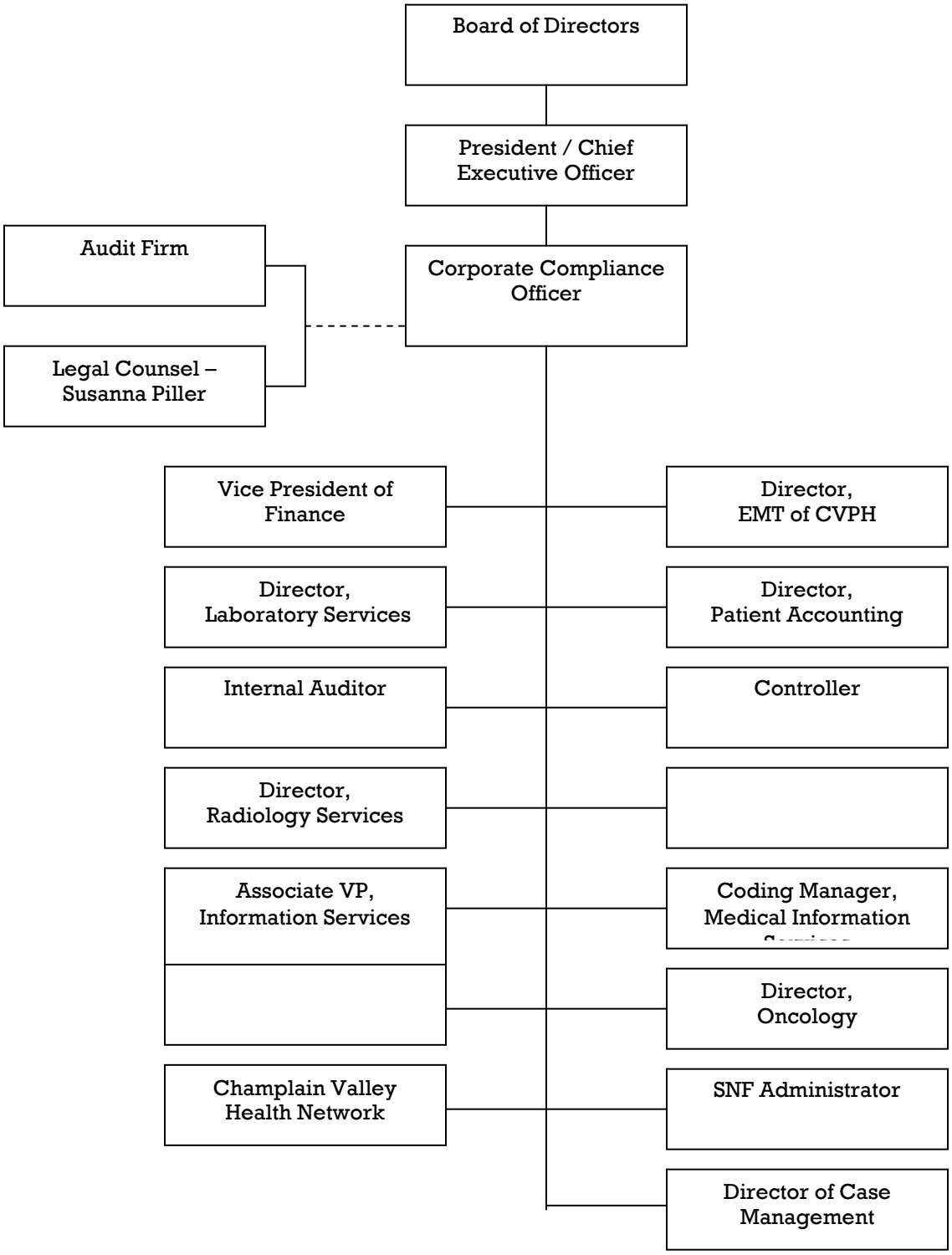
Date: _____

Appendix B:

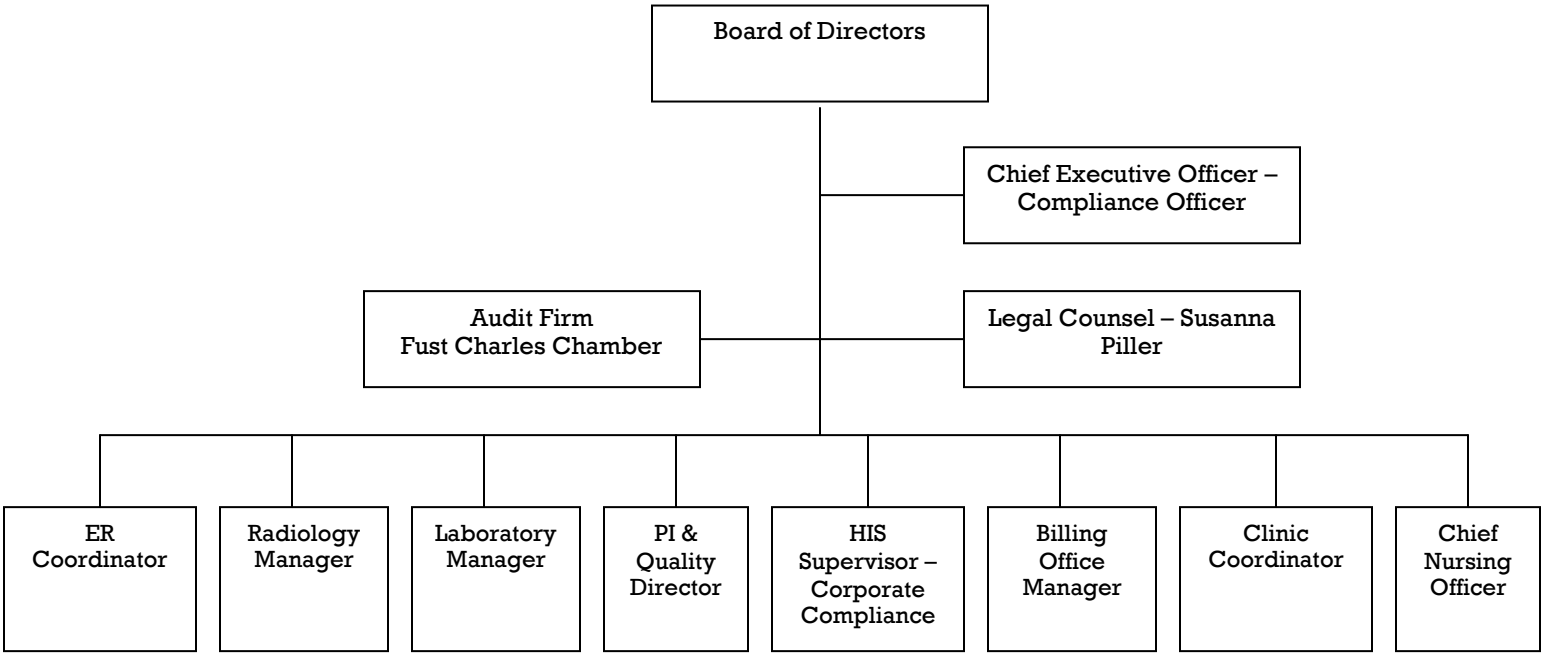
Organizational Charts – Compliance Committees

- **CVPH Medical Center**
- **Elizabethtown Community Hospital**

CVPH MEDICAL CENTER
CORPORATE COMPLIANCE
ORGANIZATIONAL STRUCTURE



ECH MEDICAL CENTER
CORPORATE COMPLIANCE
ORGANIZATIONAL STRUCTURE



Appendix C:

Policy: Corporate Compliance Reporting

- **CVPH Medical Center**
- **Elizabethtown Community Hospital**

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
ADMINISTRATIVE POLICY/PROCEDURE MANUAL

Number: 5.39
Section: Governance

SUBJECT: Use of Help Line for Compliance Reporting		
WRITTEN BY: Noreen Brady, VP Human Resources/ Corporate Compliance Officer		RESPONSIBLE DEPARTMENT: Administration
CONTRIBUTING DEPARTMENT(S):		
Administrative APPROVAL:		POLICY CREATION DATE: MAY 22, 2001
STANDARDS NUMBER(S):	SUPERSEDES POLICY: Same As Above DATED: APRIL 12, 2007	Revised DATE: APRIL 7, 2009
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

I. PURPOSE

CVPH Medical Center provides a Help Line for any individuals to report violations or alleged violations of rules and regulations at any time.

II. POLICY

CVPH Medical Center has established a Help Line (phone number: 562-3070) which is available for any individual to report actual or potential compliance violations, or violations or alleged violations of any rule and regulation. Help Line reports can only be accessed by the Compliance Officer. All reports made to the Help Line will be investigated in a prompt and reasonable manner by the Compliance Officer or, if appropriate, by a member of the Corporate Compliance Committee. Individuals will not be subject to retaliation on the part of any person affiliated with CVPH Medical Center based on reports that are submitted in good faith. Any such retaliation is a violation of the Compliance Plan and should be reported immediately to the Compliance Officer or the Chief Executive Officer of the Medical Center.

If an individual does not want to use the Help Line or any other reporting structure because of the individuals involved in the report, the Medical Center's President should be contacted.

III. DISTRIBUTION

This policy is available in Policy Manager to all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of this policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood. All questions regarding this policy or its implementation may be referred to the Compliance Officer.

CVPH MEDICAL CENTER
HELP LINE REPORT

IMPORTANT: This report is proprietary and contains information that is confidential. Photocopying this report or disclosing information it contains without authorization is strictly prohibited. If you find this report or receive it in error, please call ext. 3070 immediately.

ID#:_____ DATE:_____ TIME:_____

Caller Name (Optional):_____

Did person ask that identity be kept in confidence? Yes_____ No_____

Informational questions:

Detailed description of suspect conduct (including dates, duration, and location of incident)

_____

_____

_____

Names involved:_____
Department:_____
Others with knowledge of the problem:_____

Have you discussed this issue with your supervisor? Yes_____ No_____
If yes, when?_____
Specifics:_____

_____

Was anything ever put in writing or was all communication verbal?_____

_____

How did the caller find out about the problem?_____

_____

Can the caller provide any documentation? Yes_____ No_____

Was problem resolved? Yes____ No_____ If yes, explain:_____

_____

FOR COMPLIANCE USE ONLY:

To Whom was report referred?_____

Date and time assigned to caller for follow up: Date:_____ Time:_____

ELIZABETHTOWN COMMUNITY HOSPITAL
ADMINISTRATIVE POLICY/PROCEDURE

Subject: **Corporate Compliance Reporting**

Applies to: **All Departments** **Effective Date:** **10/98**

Responsible Department: **Corporate Compliance Committee**

Administrative Approval: Rodney C. Boula, Administrator/CEO **Date: 11/07**

New: **X** **Supersedes: 10/02**

Review Date, Reviewers Initials: 10/00 EMc; 10/02 EMc; 03/06 RCB; 11/15/07 RCB

Other Related Policies: **Corporate Compliance Plan; Standards of Conduct;**

I. POLICY

Elizabethtown Community Hospital has established a mechanism, which is available at any time for any individual to report actual or potential compliance violations including those involving billing and claims submission fraud and abuse laws and regulations. All reports made to the Compliance Officer will be investigated in a prompt and reasonable manner by the Compliance Officer, or if appropriate, by a member of the Compliance Team. Individuals shall not be subject to retaliation on the part of any person affiliated with Elizabethtown Community Hospital based on reports that are submitted in good faith. Any such retaliation is a violation of the Compliance Program and should be reported immediately to the Compliance Officer.

If an individual does not want to report to the Compliance Officer or any other reporting structure because of the individuals involved in the report, the Hospital's Administrator should be contacted.

II. PURPOSE

To provide individuals within ECH with a means for reporting violations at any time and without fear of repercussion or retaliation.

III. PROCEDURES

1) If an employee suspects or knows of a violation of fraud and abuse regulations or the Compliance Program the employee is encouraged to discuss the issue with his/her department manager.

2) If the employee does not wish to discuss the issue with the department manager he/she may report directly to the Compliance Officer either by phone (873-3001, or ext. 3001), in person or in writing; or

3) Persons wishing to report a violation and wish to remain anonymous can do so by using the ***ECH Compliance Drop Box*** (located in the copier room in Administration) or by leaving a detailed message on the ***ECH Compliance Help/Hot Line*** at: 873-3026 or internally at ext. 3026.

4) All reports of suspected fraud and abuse must be documented. Documentation shall include:

   a) Date and time call/report received.
   b) Who called/reported.
   c) Does person want to remain anonymous?
   d) Where does employee work?
   e) Why did he or she call/report?
   f) Was call/report informational, an allegation, or a "vent"?
   g) Assigned case number. Employee's name and the control number assigned will be kept separate and confidential.
   h) Names involved and department.
   i) Description of suspect conduct including dates, duration and locations of incidents.
   j) Names of others with knowledge of the problem.
   k) If situation was discussed with supervisor and specifics of discussion.
   l) If anything was put in writing or if all communication regarding the situation was verbal.
   m) How the person found out about the problem.
   n) If caller/reporter can provide any documentation.
   o) Date and time assigned to caller/reporter to follow up on status of his/her report.

All reports must be filed in the Corporate Compliance Officer's office and shall be retained for a minimum of seven years.

IV. DISTRIBUTION

This policy must be distributed to all management personnel. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation may be referred to the Administrator or Director of Operations.

ELIZABETHTOWN COMMUNITY HOSPITAL
Help Line Report

IMPORTANT: this report is proprietary and contains information that is confidential. Photocopy this report or disclosing information it contains without authorization is strictly prohibited. If you find this report or receive it in error, please call ext.3026.

ID#_____ **Date:**_____ **Time:**_____

Caller name (optional)_____
Did person ask that identity be kept in confidence? Yes____ No ____
Caller's department_____

Informational questions:

Detailed description of suspect conduct (including date, duration, and locations of incidents):
_____
_____
_____
_____

Names involved:_____
Department:_____

Others with knowledge of the problem:_____

Have you discussed this issue with your supervisor? Yes____ No ____

If yes, when?_____

Specifics of discussion:_____
_____

Was anything ever put in writing or was all communication regarding the situation verbal?
_____

How did caller find out about the problem?_____
_____

Can caller provide any documentation? Yes____ No ____
Was problem resolved? Yes___ No ___ If yes, explain how
_____

FOR COMPLIANCE OFFICE USE ONLY:
To who was report referred?_____
Date and time assigned to caller for follow up: Date_____ Time _____

Approved – October 1998, Corporate Compliance Committee
Reviewed – October 2007

Reviewed – March 2006
Reviewed – April 2008
Reviewed – April 2009
Reviewed – April 2010

Appendix D:

POLICIES

Conflict of Interest (CVPH)
Board of Directors Conflict of Interest (ECH)
Breach Notification Policy (ECH)
Code of Conduct (CVPH & ECH)
Organizational Ethics Statement (CVPH)
False Claims Act (CVPH & ECH)
Charity Care Guidelines (CVPH)
Helping Hand Program (ECH)
Record Retention & Destruction Policy (CVPH)
Document Retention & Destruction Policy (ECH)

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
HUMAN RESOURCES POLICY/PROCEDURE MANUAL

Number: 205.1
Section: Employment

<table>
<tr><td colspan="3">SUBJECT: Conflict of Interest</td></tr>
<tr><td colspan="2">WRITTEN BY: MICHELLE LEBEAU
Director of Labor Relations, Occupational Health & Education</td><td>RESPONSIBLE DEPARTMENT:
Human Resources</td></tr>
<tr><td colspan="2">ADMINISTRATIVE APPROVAL: NOREEN BRADY, VP OF HUMAN RESOURCES</td><td>POLICY CREATION DATE: 3/1/2009</td></tr>
<tr><td>NEW:
X</td><td>SUPERSEDES POLICY:

DATED:</td><td>REVISED DATE:</td></tr>
<tr><td colspan="3">OTHER RELATED POLICIES:</td></tr>
</table>

I. POLICY:

This policy outlines the standard of conduct expected of all management employees at CVPH (executive staff, directors, managers, supervisors and physician leaders) as well as others (employees, medical staff members) who are in a position to influence or make business decisions on behalf of CVPH Medical Center. It is expected that during the performance of duties at CVPH, conflicts of interest will be avoided. In the event that a person covered by this policy is involved in a conflict of interest, it is expected that the conflict will be disclosed so that resolution of the conflict may occur.

Patients, staff, and licensed independent practitioners who work in the Hospital who request information about the relationship between care, treatment, and services and financial incentives shall have such information made available to them.

II. PURPOSE:

The purpose of this policy is to ensure that CVPH Medical Center is operated consistent with applicable law and CVPH policies for the benefit of the community it serves.

It is the expectation of CVPH that all persons covered by this policy will avoid any actions that may involve, or may appear to involve, a conflict of interest with their obligations to CVPH.

III. DEFINITION:

A conflict of interest may be only a matter of degree, but exists when the person covered by this policy:

A. Is in a position to benefit directly or indirectly by using authority, influence or

inside information, or allows a friend, relative or associate to benefit from such authority, influence or information.

B. Uses authority, influence or information to make a decision which the person knew or should have known might adversely affect safety and quality of care, treatment, services or the organization.

IV. CONFLICTS OF INTEREST:

Some circumstances, which may involve a conflict of interest, include but are not limited to:

A. Receiving gifts, loans, or other special preferences from a person or organization that does or wants to do business with CVPH. See Administrative Policy 5.29, Vendor Policy;

B. Holding significant financial interest in or engaging in outside activities on a consulting basis or otherwise with a firm or organization which provides supplies, materials or equipment to CVPH;

C. Borrowing money from contractors or suppliers to CVPH;

D. Misuse of information gained through a person's position with CVPH, such as disclosure of confidential information to competitors, suppliers, third party payors or other entities that do business with CVPH, etc.;

E. Failure of new employees to notify Human Resources if they were employed by a Medicare intermediary/carrier or a New York State Medicaid office.

F. Any other violations of this policy.

V. EXPECTATIONS OF EMPLOYEES COVERED BY THIS POLICY:

Employees will:

A. Conduct personal and professional relationships in such a way that those affected are assured that decisions are made in the best interests of the organization and the individuals served by it.

B. Disclose to the appropriate authority, any direct or indirect financial or personal interests that might pose a potential conflict of interest.

C. Accept no gift or benefits that are of material value.

D. Inform the appropriate authority and other involved parties of potential conflicts of interest related to appointments or elections to boards or committees inside or outside the organization.

VI. PROCEDURES:

Disclosure Requirements:

A. CVPH Medical Center requires employees covered by this policy to file a Conflict of Interest Disclosure Statement on an annual basis. See Attachment A for

the Conflict of Interest Disclosure Statement

B. CVPH Medical Center also requires employees covered by this policy to file a Conflict of Interest Disclosure Statement at any time a conflict arises which has not been previously disclosed in an annual filing. The form to be utilized is the same as described in VI (A) above.

C. Employees covered by this policy should disclose possible conflicts of interest involving themselves or their immediate families to the Compliance Officer and their divisional vice president, who will evaluate the situation and provide any necessary guidance to avoid any appearance of impropriety.

D. If the employee has concerns about a possible conflict of interest involving other employees, the employee should contact the Compliance Officer or the Compliance Helpline at 562-3070.

E. Each newly hired employee covered by this policy must file a Conflict of Interest Disclosure Statement before the first scheduled day of work. A copy of this statement and the Conflict of Interest Policy will be provided to each newly hired employee covered by this policy after the formal offer of employment has been made and accepted and prior to the first day of work. The completed form will be referred to the Compliance Officer by Human Resources.

F. Current employees covered by this policy will receive annually, at the time of their performance evaluation, a Conflict of Interest Disclosure Statement for completion as well as a copy of this policy. The statement should be completed and sent to the Compliance Officer in a sealed envelope marked "Private and Confidential". Upon receipt, the Compliance Officer will review the statement. In any case where a potential conflict has been disclosed, the Compliance Officer will meet with the divisional vice president to discuss the disclosure and need for action, if any.

G. In the event potential conflicts are resolved, by agreements among the parties involved, such agreements will be documented, signed by all parties, and preserved.

H. A completed copy of the Conflict of Interest Disclosure Statement and related documents will be maintained by the Compliance Officer. The original will be sent to Human Resources for placement in the employee's file.

I. The employee upon discovery of a conflict of interest shall refrain from taking any action which will influence the outcome of any decision concerning which the employee has a conflict of interest.

J. Members of the Medical Staff and Allied Health Medical Staff who are not CVPH employees and have a conflict of interest as described in the Medical Staff Bylaws shall:

   a. Decline membership on committees that will consider matters related to that conflict if possible.

   b. Inform the chairperson of a committee or group considering a matter related to a conflict of interest, if a member of that committee or group. The chairperson of the meeting may, at the chairperson's discretion, allow the Medical Staff Member to participate in the discussion and remain in the

meeting while a vote is taken on the issue. However, at no time shall a medical staff member who has disclosed a conflict be allowed to vote on the issue.

VII. VIOLATIONS OF THIS POLICY:

In the event that this policy is violated, the employee will be subject to discipline up to and including termination.

V. DISTRIBUTION:

This policy is available in Policy Manager for all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

G:\Private\Administration\Exec Assist\Lisa\ADMINSEC\WORD\NB\POLICIES - HR\HR\205.1 - Conflict of Interest.doc

CVPH MEDICAL CENTER

(Attachment A)

CONFLICT OF INTEREST DISCLOSURE FORM

NAME: _____

DEPARTMENT: _____ **DATE:** _____

INSTRUCTIONS:

Employees who are in a position to influence or make business decisions on behalf of the Medical Center are required to file an annual disclosure form concerning situations that may create actual, potential, or apparent conflict of interest.

In this regard, you should read the Medical Center's Conflict of Interest Policy, which is enclosed, complete this form and forward it in a sealed envelope marked "PERSONAL AND CONFIDENTIAL" to the Compliance Officer. The Compliance Officer will review the disclosure form and discuss the content as needed with the divisional Vice President.

Upon completion of this review and resolution of potential conflicts the Compliance Officer will then certify either that:

- There are no conflicts or any conflict disclosed is not one that is prohibited under the Conflict of Interest Policy or other Hospital policies; **OR**
- The employee has taken appropriate steps to resolve the conflict.

DISCLOSURE:

1. Are you, your spouse, a dependent or significant other, an officer, director, trustee, partner (general or limited), employee, or regularly retained agent or owner of any organization that has or may have a business relationship with CVPH Medical Center?

   ☐ **YES** ☐ **NO**

   If yes, please provide the following information:

Organization	Position	Name (You or Name of Family Member)	Nature of Organization's Business

2. Have you, any members of your family or household, or a significant other had, or do any of you presently have, a financial interest in an outside business or firm which has a relationship with CVPH Medical Center – either as a supplier of goods or services, customer, or competitor?

   ☐ **YES** ☐ **NO**

(If yes, please provide the following information and complete question 3 and 4. If no, go to question 5).

Organization	Position	Name (You or Name of Family Member)	Nature of Organization's Business

3. Does this financial interest represent an ownership interest of 10% or more of the organization listed above?

☐ **YES** ☐ **NO**

4. Can you affect how much business this outside organization received from CVPH Medical Center?

☐ **YES** ☐ **NO**

5. Have you received, or do you presently receive salaries, fees, honoraria, royalties, gifts or other financial benefit from contributions to (or work on) books, articles, lectures, participation on committees, consulting work, or other activities in which you draw upon the reputation, experience or information of CVPH Medical Center?

☐ **YES** ☐ **NO**

6. Briefly describe any other interest, relationship, or transaction including any relationship which might result in payment to you, that could create a real, apparent, or potential conflict of interest contrary to the requirements, spirit, or general principles set forth in CVPH Medical Center's Conflict of Interest Policy.

_____

_____

_____

_____

7. Have you devoted or do you presently devote an average of eight hours or more per week to the activities of an outside firm or organization, the business or activities of which relate to your responsibilities or relationship as a CVPH employee?

☐ **YES** ☐ **NO**

If yes, please explain:

_____

_____

_____

8. Have you or any members of your family or household, or significant other accepted gifts or favors from an outside concern – including suppliers of goods or services, patients and/or competitors of CVPH Medical Center while you are or were in a position to influence CVPH decisions that may affect this outside concern?

☐ **YES** ☐ **NO**

Examples of Gifts/Favors:

- Accepting free concert tickets from a vendor that is bidding on a CVPH contract and one in which your recommendation is needed.
- Money of any amount.
- Stocks, bonds, notes, obligations of any value.
- Loans of any value.
- Gift certificates, free or discounted services and/or products (except as made available to the general public).
- Lodging, transportation, meals and entertainment, sporting events.
- Any other gift or favor of nominal value in violation of existing CVPH Policy.

Explain:_____

9. Are you or have you been, in a position to have direct authority or influence over the hiring, promotion, or salary decisions of a spouse, relative or significant other, or close personal friend?

☐ **YES** ☐ **NO**

If yes, please provide the names of those individuals involved?

EMPLOYEE'S CERTIFICATION:

The above is an accurate and current statement of all my reportable outside interests and activities.

Employee Signature: _____ Date:_____

Please return this form to the Compliance Officer in a sealed envelope.

COMPLIANCE OFFICER CERTIFICATION:

Describe any arrangements you worked out with the employee AND their divisional vice president to resolve any conflict of interest.

I certify, to the best of my knowledge, that the person named above does not have any conflicts of interest or has reported them and resolved them.

Compliance Officer: _____

Divisional Vice President: _____

Employee: _____

Date: _____

ELIZABETHTOWN COMMUNITY HOSPITAL
ADMINISTRATIVE POLICY AND PROCEDURE

Subject: Board of Directors Conflict of Interest

Written by: E. McCann **Effective Date: 8/97**

Contributing Department:

Approved by: **Date:**

New: **Supercedes: 8/97**

Review Date & Reviewer's Initials: LR 8/99 EMc 9/01

Other Related Policies:

POLICY

It is the policy of this Hospital to require each member of the Board of Directors, upon election or appointment, to sign a statement of acknowledgement, understanding and acquiescence to this Conflict of Interest Policy (See Attachment A).

GENERAL INFORMATION

On any matter being considered by the Board of Directors, if a member has any personal or other interest which could be construed as conflicting with the interests of the Hospital or any of its related corporate entities, he/she shall so advise the Chairperson prior to the discussion of the issue. At the discretion of the Chairperson, the member may participate in the discussion and remain in the meeting while a vote is taken on the issue. The member may also excuse himself/herself from the meeting during any part of the discussion. Should the matter be brought to a vote, the affected member shall not vote on it. In the event of a special meeting, the member having a conflict of interest shall not be counted to establish a quorum.

DISTRIBUTION

This policy must be distributed to all Administrative Staff members, Managers, and Nurse Managers by their immediate supervisor.

All receipts of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

Policy No.: 8-081809
Title: BREACH NOTIFICATION
Page 1 of 5 plus Attachments A & B
X New ☐ Revision ☐ Name Change

Responsible Department: Health Information Services; Quality
Administrative Approval:
Date:

PURPOSE

To outline the procedures to follow when there has been a breach in a patient's protected health information, including notification of the media when required, and Health and Human Services.

This policy document outlines ECH's policy regarding policy and procedure development needed to comply with the following:

- Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA)
  NOTIFICATION IN THE CASE OF BREACH

II. POLICY STATEMENT:

In the case of a breach of unsecured protected health information, notification of each individual whose protected health information has been, or is reasonably believed by ECH to have been, accessed, acquired, or disclosed as a result of the breach, notification must be made.

Business associates who maintain ECH patient information, upon discovery of a breach shall notify ECH of the breach. The notice shall include identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during the breach.

A. TIME FRAME FOR NOTIFICATION
ECH will notify the individual without delay and no later than 60 calendar days from when the breach was discovered by ECH or the business associate.

B. PROOF OF NOTIFICATION
There must be evidence that the required notification(s) were made, as well as any evidence to necessitate a delay in notification.

1. METHODS OF NOTICE
Individual Notice
Written notification by first-class mail to the individual (or the next of kin of the individual if the individual is deceased) at the last known address, or, if previously specified as a preference by the individual, by e-mail. The notification may be provided in one or more mailings as information is available.

- If the contact information is out-of-date and the patient can not be reached, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Secretary of HHS on the home page of the ECH website or notice in major print or broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside.
- In cases where ECH deems the situation urgent due to the possibility of misuse of the information, ECH may, **in addition** to the above requirements, provide information to affected individuals by phone or other means, as appropriate.

C. MEDIA NOTICE
If the unsecured protected health information of more than 500 residents is reasonably believed to have been accessed, acquired, or disclosed, notice will be provided to prominent media outlets serving the patient community.

D. NOTIFICATION TO SECRETARY OF HHS
Notice will be provided to the Secretary of Health and Human Services by ECH in the event that unsecured PHI has been acquired or disclosed in a breach.

- If the breach involves 500 or more individuals the notice must be provided immediately.
  - The Secretary will post on the Department of Health and Human Services website a list that identifies each covered entity involved in a breach in which more than 500 individuals unsecured PHI is acquired or disclosed.
- For breaches occurring to less than 500 individuals, breaches will be logged and submitted annually to the Secretary.

E. CONTENT OF NOTIFICATION TO INDIVIDUALS
Notice of a breach to individuals shall include, to the extent possible:

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
3. The steps individuals should take to protect themselves from potential harm resulting from the breach.
4. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.
5. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll free number, an e-mail address, Web site, or postal address.

F. DELAY OF NOTIFICATION FOR LAW ENFORCEMENT PURPOSES
If a law enforcement official determines that a notification, notice, or posting required under this section would impeded a criminal investigation or cause damage to national security, notification, notice, or posting shall be delayed.

III. DEFINITIONS:

Breach – (A) In General-The term ''breach'' means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

(B)Exceptions-The term breach does not include:

Any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if-

1. The acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and
2. That information is not further acquired, accessed, used, or disclosed by any person; or
3. Any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at the same facility; and
4. Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.

Unsecured Protected Health Information- protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute (ANSI).

IV. PROCEDURE:

A. BREACH OF PATIENT INFORMATION
In the event of a breach of patient information an Incident Report (Attachment A) will be filed and notification to the patient or patient family as appropriate shall be made.
1. The incident report will trigger filling out an Accounting of Disclosures form (Attachment B).
    a. This form must be brought to HIS
    b. HIS will scan the form into Liberty Net in the patient's chart and;
    c. Log the information into the Breach Log.
2. The event will be investigated by the Risk Manager.
3. The Risk Manager will notify the patient by mail as specified in this policy with the required content. A call will also be made if deemed appropriate and/or urgent.

B. SUSPECTED BREACH OF PATIENT INFORMATION
In the event there is reasonable suspicion of a breach of patient information employees shall fill out an Incident Report.
1. The incident will be investigated, if there has been a breach of information, or there is reasonable belief patient information has been accessed, acquired, or disclosed, notification must be made as outlined above.

C. In all of the above instances, document date discovered, date patient was notified with proof of notification.

D. In the unlikely event that a disclosure involves more than 500 patients the Compliance Officer will immediately notify HHS and the media.

E. Annual Reporting
The Health Information Supervisor will submit the Breach Log to the Risk Manager for submission to the Secretary of Health and Human Services if there have been breaches of patient information as defined in this policy.

Health and Human Services:1-877-696-6775
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

V. DISTRIBUTION

This policy must be distributed to all Administrative Staff members, Managers, and Nurse Managers by their immediate supervisor.

All receipts of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

DATE:	REVIEWED BY:	REVISION:	RELATED POLICY #:
8/14/09	M. Thompson	New	Uses and Disclosures of Protected Health Information Found at P:\HIPAA\ECH Completed Privacy Policies
			Accounting Disclosures Found at P:\HIPAA\ECH Completed Privacy Policies
			Privacy Terms and Definitions Found at P:\HIPAA\ECH Completed Privacy Policies

Policy and Procedure Manual on the Public Drive P:\Administrative Policy Manual

P:\HIPAA\ECH Completed Privacy Policies

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
HUMAN RESOURCES POLICY/PROCEDURE MANUAL

Number: 803.0
Section: Conduct

SUBJECT: CODE OF CONDUCT		
WRITTEN BY: Michelle LeBeau, Director of Labor Relations, Occupational Health and Education		**RESPONSIBLE DEPARTMENT:** Human Resources
ADMINISTRATIVE APPROVAL: NOREEN BRADY, VP OF HUMAN RESOURCES		**POLICY CREATION DATE:** 11/11/2006
NEW:	**SUPERSEDES POLICY:** 12/27/2006 **DATED:**	**REVISED DATE: 3/1/09**
OTHER RELATED POLICIES: All Policies		

I. POLICY:

CVPH Medical Center's Code of Conduct is based on the organization's core values of teamwork, quality, compassion, respect, communication, accountability, service, and trust. The Code of Conduct outlines behavioral expectations (acceptable behaviors) for the CVPH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff. It also outlines unacceptable behaviors, including disruptive behaviors, which are not in adherence with the Medical Center's Code of Conduct.

II. PURPOSE:

CVPH Medical Center believes that the CVPH Family represents the organization, their peers, and the community through their actions, attitude, and demeanor. This belief guides the actions of every member of the CVPH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff, and demonstrates CVPH's commitment to appropriate respectful behavior.

III. SCOPE:

This policy applies to all members of the CVPH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff.

IV. DEFINITIONS:

A. Disruptive Behavior - Includes behavior that appears to be illegal, unethical, unprofessional, abusive, demeaning, intimidating, harassing, insubordinate, sexually suggestive, unduly loud and/or occurring in an inappropriate setting.

B. Physical Abuse - Inappropriate physical contact with a patient, nursing home resident, employee, member of the medical staff or visitor on Medical Center premises, while conducting Medical Center business or when representing the Medical Center.

C. Verbal Abuse - Using profane or demeaning language including racial, ethnic or sexual slurs or comments to a patient, nursing home resident, employee, member of the medical staff or visitor while on Medical Center premises, while conducting Medical Center business or when representing the Medical Center.

D. Abandonment - Leaving the work station, the patient or the nursing home resident while on duty without receiving authorization from appropriate management.

E. Insubordination - The refusal to obey a directive of management, including the refusal to float.

F. Under the influence - When the actions or the appearance of an employee on duty indicates use of alcohol or drugs, to the extent patient/nursing home resident care is in jeopardy or ability to function in one's position is negatively affected.

G. Workplace Harassment – Any unwelcome, offensive and/ or inappropriate verbal or physical conduct, expressed or implied when:

1. Submission or exposure to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Acceptance or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
3. Such conduct is intended to, or does, adversely affect an individual's work performance, or creates an intimidating, hostile, or offensive working environment.

Harassment includes unwelcome conduct that is based on or related to race, color, religion, age, sex, pregnancy, sexual preference, national origin, or disability.

V. EXPECTATIONS RELATED TO THE CODE OF CONDUCT (ACCEPTABLE BEHAVIORS):

Each member of the CVPH Family, including all employees, members of the medical staff, volunteers, independent contractors, contracted staff, and agency staff, will adhere to the following expectations:

A. Teamwork

1. Strive to make people feel appreciated and valued.
2. Be open, responsive, approachable, and flexible.
3. Welcome new employees, physicians, and volunteers to CVPH.
4. Recognize and praise a job well done.

B. Quality

1. Perform one's job to the best of one's ability.
2. Demonstrate, through one's words and actions, that CVPH is a great place to receive care.
3. Contribute to a healing and caring environment.
4. Always strive to improve.
5. Commit to the highest level of personal and professional ethics and legal compliance.

C. Compassion

1. Treat others as they would like to be treated.
2. Remember that a Hospital environment can be frightening and provide reassurance.
3. Respect patient and family decisions for treatment options.

D. Respect

1. Respect the knowledge, dignity and perspective of the entire health care team.
2. Acknowledge others and treat them with courtesy.
3. Respect all, regardless of race, creed, health issues, financial situations, or other life circumstances.
4. Knock/announce before entering a room.
5. Address individuals by their name and avoid phrases such as "honey", "dear", and "sweetie".

E. Communication

1. Listen carefully and ask questions if uncertain.
2. Remember that the tone of one's voice and one's body language can say as much as one's words.
3. Share one's name with patients; explain what will be done and what they can expect.
4. Avoid using potentially offensive language.
5. Speak clearly when answering the phone, give one's name and department, and convey that you are here to help.
6. Avoid gossip.

F. Accountability

1. Wear the CVPH identification badge so that it is visible at all times and dress in a professional manner.
2. Be responsible to know the expectations of one's job.
3. Adhere to the policies and "best practice" standards of CVPH.
4. Acknowledge errors and/or issues and take necessary action to correct them.
5. Recognize and avoid conflicts of interest.

G. Service

1. Remember that patients and other customers are the reason for our work.
2. Be part of the solution when a workplace problem arises.
3. Maintain a healing environment that is clean, safe, professional, and quiet.
4. Use Hospital resources responsibly.

H. Trust

1. Maintain patient confidentiality within and outside of the workplace.
2. Be aware of one's surroundings when discussing confidential information.
3. Request and share information only on a professional "need to know" basis.
4. Protect confidentiality and security of all Hospital information to include patient and staff records, computer screens, passwords, and codes.
5. Question unauthorized people in the workplace and report any concerns to a supervisor.

VI. EXAMPLES OF VIOLATIONS OF THE CODE OF CONDUCT (UNACCEPTABLE BEHAVIORS):

Examples of violations of the Code of Conduct include but are not limited to the following unacceptable behaviors:

A. Using threatening, abusive, berating or condescending language;

B. Using profanity or similarly offensive language;

C. Throwing objects;

D. Workplace harassment (sexual or non sexual) including but not limited to

1. Sexual flirtations, touching, advances or propositions;
2. Verbal abuse;
3. Graphic or suggestive comments about an individual's dress or body;
4. Degrading words to describe an individual;
5. The display in the work place of sexually suggestive objects or pictures including nude photographs;
6. Sexually explicit jokes or lewd language.

E. Making unprofessional, negative comments about employees, members of the medical staff, patients and/or their families and/or visitors. Making unprofessional, negative comments about the quality of care rendered at the Medical Center;

F. Making threats, physical assaults or acts of overt intimidation against any employee, member of the medical staff, patients or their families or visitors;

G. Writing inappropriate comments in patients' medical records or other official documents;

H. Destroying Hospital property.

VII. PROCEDURES RELATED TO POTENTIAL CODE OF CONDUCT VIOLATIONS:

Employees may report potential breaches of the Code of Conduct to their manager or directly to Human Resources. The report (see Attachment A) must include the following information:

1. The date and time of the incident;
2. A factual description of the incident;
3. The name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
4. The circumstances which precipitated the incident;
5. The names of any other witnesses to the incident;
6. The consequences, if any, of the conduct as it relates to patient care, personnel, or Hospital operation;
7. Any action taken to intervene in, remedy, or resolve the incident. This should include the date, time, place, action and name(s) of those intervening.

Potential breaches of the Code of Conduct will be investigated and, if substantiated, may result in discipline up to and including termination of employment for employees as dictated by Human Resources policies and procedures. In the event the potential breach of the Code of Conduct involves a member of the medical staff or non-CVPH employed Allied Health staff, the CVPH Medical Staff Policy on Disruptive Behavior will be followed.

No employee shall be retaliated against for reporting a potential breach of the Code of Conduct.

VIII. CODE OF CONDUCT STATEMENT

The signed Code of Conduct Statement, Attachment B, will be kept in the employee's personnel file and will be reviewed and re-signed annually at the time of the performance evaluation.

IX. DISTRIBUTION:

This policy will be available in Policy Manager to all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation may be referred to your immediate Administrative supervisor.

(Attachment A)

REPORT OF POTENTIAL VIOLATIONS OF THE CODE OF CONDUCT

NAME: _____ DEPARTMENT: _____

JOB TITLE: _____ IMMEDIATE SUPERVISOR: _____

Please state the nature of your complaint:

DATE/TIME OF INCIDENT: _____

NAME(s) OF THE ACCUSED: _____

NAME(s) OF WITNESSES: _____

_____

_____

_____

DESCRIBE THE INCIDENT:

_____

_____

_____

_____

_____

_____

NAME OF ANY PATIENT OR PATIENT'S FAMILY MEMBER WHO MAY HAVE BEEN INVOLVED IN THE INCIDENT, INCLUDING ANY PATIENT OR FAMILY MEMBER WHO MAY HAVE WITNESSED THE INCIDENT:

_____

_____

_____

DESCRIBE THE CONSEQUENCES, IF ANY, OF THE CONDUCT AS IT RELATES TO PATIENT CARE, PERSONNEL OR MEDICAL CENTER OPERATION:

_____

_____

_____

DESCRIBE THE CIRCUMSTANCES THAT PRECEDED THE INCIDENT:

DESCRIBE ANY ACTION TAKEN TO INTERVENE IN, REMEDY, OR RESOLVE THE INCIDENT. THIS SHOULD INCLUDE THE DATE, TIME, PLACE, ACTION AND NAMES(S) OF THOSE INTERVENING, INCLUDING YOURSELF:

EMPLOYEE SIGNATURE:_____ DATE:_____

COMPLAINT SUBMITTED TO: _____

IMMEDIATE SUPERVISOR/HR/VPMA: _____

PERSON RECEIVING THE COMPLAINT: _____

DATE RECEIVED: _____

DATE HEARD: _____

(Attachment B)

CODE OF CONDUCT STATEMENT

I understand and acknowledge that CVPH Medical Center's policy on Code of Conduct outlines behavioral expectations of all Hospital employees. I recognize that I represent the organization, my peers, and the community through my actions, attitude, and demeanor.

A breach of the Code of Conduct will be considered to include, but not be limited to, those expectations outlined in the CVPH Medical Center's policy. Breaches of the code of conduct may result in discipline up to and including termination of employment.

I have read and understand the above statement and will abide by this policy.

Printed Name of Employee	Printed Name of Manager/HR Rep
Signature of Employee	Signature of Manager/HR Rep
Date	Date

ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

Policy No.: 1-060195
Title: CODE OF CONDUCT
Page 1 of 7 with attachments A & B
☐ **New X Revision** ☐ **Name Change**

Responsible Department: Human Resources
Administrative Approval:
Date:

I. Purpose

Elizabethtown Community Hospital believes that the ECH Family represents the organization, their peers, and the community through their actions, attitude, and demeanor. This belief guides the actions of every member of the ECH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff, and demonstrates ECH's commitment to appropriate respectful behavior. Furthermore, the code of conduct is an important part of an overall compliance plan, which has been approved by the Hospital's Board of Directors and the Board of Community Providers Inc.

II. Policy

Elizabethtown Community Hospital's Code of Conduct is based on the organization's core values of teamwork, quality, compassion, respect, communication, accountability, service, and trust. The Code of Conduct outlines behavioral expectations (acceptable behaviors) for the ECH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff. It also outlines unacceptable behaviors, including disruptive behaviors, which are not in adherence with ECH's Code of Conduct.

III Procedure

This policy applies to all members of ECH Family, including all employees, medical staff, volunteers, independent contractors, contracted staff, and agency staff.

IV Definitions

A. Disruptive Behavior - Includes behavior that appears to be illegal, unethical, unprofessional, abusive, demeaning, intimidating, harassing, insubordinate, sexually suggestive, unduly loud and/or occurring on Hospital property.

B. Physical Abuse - Inappropriate physical contact with a patient, employee, member of the medical staff or visitor on Hospital premises, while conducting Hospital business or when representing the Hospital.

C. Verbal Abuse - Using profane or demeaning language including racial, ethnic or sexual slurs or comments to a patient, employee, member of the medical staff or visitor while on Hospital premises, while conducting Hospital business or when representing the Hospital.

D. Abandonment - Leaving the work station or the patient while on duty without receiving authorization from appropriate management.

E. Insubordination - The refusal to obey a directive of management, including the refusal to float.

F. Under the influence - When the actions or the appearance of an employee on duty indicates use of alcohol or drugs, to the extent patient care is in jeopardy or ability to function in one's position is negatively affected.

G. Workplace Harassment – Any unwelcome, offensive and/ or inappropriate verbal or physical conduct, expressed or implied when:

1. Submission or exposure to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Acceptance or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
3. Such conduct is intended to, or does, adversely affect an individual's work performance, or creates an intimidating, hostile, or offensive working environment.

Harassment includes unwelcome conduct that is based on or related to race, color, religion, age, sex, pregnancy, sexual preference, national origin, or disability.

V. EXPECTATIONS RELATED TO THE CODE OF CONDUCT (ACCEPTABLE BEHAVIORS):

Each member of the ECH Family, including all employees, members of the medical staff, volunteers, independent contractors, contracted staff, and agency staff, must adhere to the following expectations:

A. Teamwork

1. Strive to make people feel appreciated and valued.
2. Be open, responsive, approachable, and flexible.
3. Welcome new employees, physicians, and volunteers to ECH.
4. Recognize and praise a job well done.

Maintain a Safe Environment:
We are committed to providing a safe environment for our patients, staff and visitors. This includes Occupational Safety and Health Administration (OSHA) requirements.

B. Quality

1. Perform one's job to the best of one's ability.
2. Demonstrate, through one's words and actions, that ECH is a great place to receive care.
3. Contribute to a healing and caring environment.
4. Always strive to improve.
5. Commit to the highest level of personal and professional ethics and legal compliance.

Provision of High-Quality Services:
ECH is committed to providing high-quality services to our patients, their families, visitors and the communities we serve, whether those services are provided through patient care or health and prevention. This includes but not limited to the rights of patients, medical screening and qualified individuals.

C. Compassion

1. Treat others as you would like to be treated.
2. Remember that a hospital environment can be frightening and provide reassurance.
3. Respect patient and family decisions for treatment options.

Respect and Protect Confidential Information:
We shall make all reasonable efforts to protect personal and confidential information concerning ECH patients, visitors, associates, business operations or other confidential information. This includes, but is not limited to HIPAA Privacy and Security regulations.

D. Respect

1. Respect the knowledge, dignity and perspective of the entire health care team.
2. Acknowledge others and treat them with courtesy.
3. Respect all, regardless of race, creed, health issues, financial situations, or other life circumstances.
4. Knock/announce before entering a room.

5. Address individuals by their name and avoid phrases such as "honey", "dear", and "sweetie".
6. If you have a difference of opinion, express yourself in a professional manner.
7. Show proper respect and consideration for each other.

Promote an Employment Philosophy of Respect:
We are committed to providing a working environment throughout the organization where everyone working for or providing services to ECH is regarded with respect and as a valuable contributor. This includes but is not limited to the ECH human resources policies and procedures, nondiscrimination and freedom from harassment.

E. Communication

1. Listen carefully and ask questions if uncertain.
2. Remember that the tone of one's voice and one's body language can say as much as one's words.
3. Share one's name with patients; explain what will be done and what they can expect.
4. Avoid using potentially offensive language.
5. Speak clearly when answering the phone, give one's name and department, and convey that you are here to help.
6. Avoid gossip.

Provide Accurate Information and Safeguard Assets, Property and Information:
We shall use our resources wisely and will be accountable for their proper use. This includes safeguarding ECH's proprietary information and creation and retention of accurate patient and business records.

F. Accountability

1. Wear the ECH identification badge so that it is visible at all times and dress in a professional manner.
2. Be responsible to know the expectations of one's job.
3. Adhere to the policies and "best practice" standards of ECH.
4. Acknowledge errors and/or issues and take necessary action to correct them.
5. Recognize and avoid conflicts of interest.
6. It is everyone's job to maintain ECH's integrity and reputation.
7. Be honest in doing your job.

Conflicts of Interest:
We will conduct ourselves with integrity, honesty and fairness to avoid any conflict between personal interests and the interests of ECH.
For example:

You shall not use your position or relationship with ECH to influence decisions in which you know, or have reason to know, that you have a financial interest.

ECH associates are required to file a conflict-of-interest disclosure statement and consult with the Administrator/CEO in circumstances that may lead to a conflict of interest, if engaged in any activity that could raise conflict.

Board members, management and others who occupy positions of trust must file annual conflict-of-interest disclosure forms.

G. Service

1. Remember that patients and other customers are the reason for our work.
2. Be part of the solution when a workplace problem arises.
3. Maintain a healing environment that is clean, safe, professional, and quiet.
4. Use Hospital resources responsibly.
5. Medical waste or other hazardous materials shall be disposed of properly.
6. Work and safety rules were created to protect us all. You are expected to comply with these rules.

Code, Bill and Collect in Accordance with Applicable Guidelines:

We are committed to integrity in our coding, billing and collection practices. All services must be accurately documented and coded. Individuals involved in documenting, coding, billing and collection for services are responsible for following federal and state regulations and ECH policies regarding these activities.

H. Trust

1. Maintain patient confidentiality within and outside of the workplace.
2. Be aware of one's surroundings when discussing confidential information.
3. Request and share information only on a professional "need to know" basis.
4. Protect confidentiality and security of all hospital information to include patient and staff records, computer screens, passwords, and codes.
5. Question unauthorized people in the workplace and report any concerns to a supervisor.

Compliance with Applicable Laws & Regulations:

ECH will conduct our business in compliance with laws, regulations and standards that apply to the services provided by ECH. This includes but is not limited to anti-kickback laws, Stark regulations and Deficit Reduction Act.

VI. EXAMPLES OF VIOLATIONS OF THE CODE OF CONDUCT (UNACCEPTABLE BEHAVIORS):

Examples of violations of the Code of Conduct include but are not limited to the following unacceptable behaviors:

A. Using threatening, abusive, berating or condescending language;

B. Using profanity or similarly offensive language;

C. Throwing objects;

D. Workplace harassment (sexual or non sexual) including but not limited to

1. Sexual flirtations, touching, advances or propositions;
2. Verbal abuse;
3. Graphic or suggestive comments about an individual's dress or body;
4. Degrading words to describe an individual;
5. The display in the work place of sexually suggestive objects or pictures including nude photographs;
6. Sexually explicit jokes or lewd language.

E. Making unprofessional, negative comments about employees, members of the medical staff, patients and/or their families and/or visitors. Making unprofessional, negative comments about the quality of care rendered at the Hospital;

F. Making threats, physical assaults or acts of overt intimidation against any employee, member of the medical staff, patients or their families or visitors;

G. Writing inappropriate comments in patients' medical records or other official documents;

H. Inappropriate use or destroying Hospital property.

I. When the actions or the appearance of an employee on duty gives reasonable suspicion of alcohol or drugs use.

J. Employees and agents may not use ECH or patient resources for personal or improper purposes, or permit others to do so.

VII. PROCEDURES RELATED TO POTENTIAL CODE OF CONDUCT VIOLATIONS:

Employees must report potential breaches of the Code of Conduct to their manager or directly to Human Resources. The report (see Attachment A) must include the following information:

1. The date and time of the incident;
2. A factual description of the incident;
3. The name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
4. The circumstances which precipitated the incident;

5. The names of any other witnesses to the incident;
6. The consequences, if any, of the conduct as it relates to patient care, personnel, or Hospital operation;
7. Any action taken to intervene in, remedy, or resolve the incident. This should include the date, time, place, action and name(s) of those intervening.

Potential breaches of the Code of Conduct will be investigated and, if substantiated, may result in discipline up to and including termination of employment for employees as dictated by Human Resources policies and procedures. In the event the potential breach of the Code of Conduct involves a member of the medical staff the ECH Medical Staff Policy on Disruptive Behavior must be followed.

ECH shall not permit any action or retaliation or reprisal to be taken against an employee who reports a violation of law, regulations, standard procedure or policy.

A complaint or report that this policy has been violated is a serious matter. Dishonest complaints or reports are also against our policy and ECH shall take appropriate disciplinary action if its investigation shows that deliberately dishonest and bad faith accusations have been made.

VIII. CODE OF CONDUCT STATEMENT (Form)

The signed Code of Conduct Statement, Attachment B, will be kept in the employee's personnel file and will be reviewed and re-signed annually at the time of the performance evaluation.

IX. DISTRIBUTION:

This policy must be distributed to all ECH personnel.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation may be referred to your immediate Administrative supervisor.

DATE:	REVIEWED BY:	REVISION:	RELATED POLICY #:
6/30/09	R. Boula		Corporate Compliance Plan (See below for link)
			10-071009 Corporate Compliance Policy

(Attachment A)

REPORT OF POTENTIAL VIOLATIONS OF THE CODE OF CONDUCT

NAME: _____ DEPARTMENT: _____

JOB TITLE: _____ IMMEDIATE SUPERVISOR: _____

Please state the nature of your complaint:

DATE/TIME OF INCIDENT: _____

NAME(s) OF THE ACCUSED: _____

NAME(s) OF WITNESSES: _____

_____

_____

_____

DESCRIBE THE INCIDENT:

_____

_____

_____

_____

_____

_____

NAME OF ANY PATIENT OR PATIENT'S FAMILY MEMBER WHO MAY HAVE BEEN INVOLVED IN THE INCIDENT, INCLUDING ANY PATIENT OR FAMILY MEMBER WHO MAY HAVE WITNESSED THE INCIDENT:

_____

_____

_____

DESCRIBE THE CONSEQUENCES, IF ANY, OF THE CONDUCT AS IT RELATES TO PATIENT CARE, PERSONNEL OR ECH OPERATIONS:

_____

_____

DESCRIBE THE CIRCUMSTANCES THAT PRECEDED THE INCIDENT:

DESCRIBE ANY ACTION TAKEN TO INTERVENE IN, REMEDY, OR RESOLVE THE INCIDENT. THIS SHOULD INCLUDE THE DATE, TIME, PLACE, ACTION AND NAMES(S) OF THOSE INTERVENING, INCLUDING YOURSELF:

EMPLOYEE SIGNATURE: _____ DATE: _____

COMPLAINT SUBMITTED TO: _____

IMMEDIATE SUPERVISOR/HR: _____

PERSON RECEIVING THE COMPLAINT: _____

DATE RECEIVED: _____

DATE HEARD: _____

(Attachment B)

CODE OF CONDUCT STATEMENT

I understand and acknowledge that Elizabethtown Community Hospital policy on Code of Conduct outlines behavioral expectations of all hospital employees. I recognize that I represent the organization, my peers, and the community through my actions, attitude, and demeanor.

A breach of the Code of Conduct will be considered to include, but not be limited to, those expectations outlined in the Elizabethtown Community Hospital' s policy. Breaches of the code of conduct may result in discipline up to and including termination of employment.

I have read and understand the above statement and will abide by this policy.

Printed Name of Employee	Printed Name of Manager/HR Rep
Signature of Employee	Signature of Manager/HR Rep
Date	Date

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
ADMINISTRATIVE POLICY/PROCEDURE MANUAL

Number: 9.8

SUBJECT: Organizational Ethics Statement		
WRITTEN BY: Deborah Stewart Risk Manager/Patient Representative		**RESPONSIBLE DEPARTMENT:** Administration & Ethics Committee
CONTRIBUTING DEPARTMENT(S):		
Administrative **APPROVAL:**		**POLICY CREATION DATE:** APRIL 1998
STANDARDS NUMBER(S):	**SUPERSEDES POLICY:** SAME AS ABOVE **DATED:** MAY 1, 2003	Revised **DATE:** JULY 20, 2009
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

I. PURPOSE

The Governing Board of CVPH Medical Center has established this statement of organizational ethics in recognition of this institution's responsibility to its patients, staff, physicians, and the community we serve. It is the responsibility of every member of the CVPH Medical Center community - governing board members, administration, medical staff members and employees to act in a manner that is consistent with the organizational statement and its supporting policies.

II. GENERAL STATEMENT

Our behavior is guided by our dedication to the principle that all patients, employees, physicians, and visitors deserve to be treated with dignity and respect. This is reflected in the CVPH Medical Center's Mission, Vision and Value Statement, as well as our adherence to the principles of Healing Promises and our Code of Conduct.

In all the various settings in which CVPH provides patient services, we will consistently follow well-designed standards of care and practice based up on the needs of the patient and without regard to his or her ability to pay. Even as we work to provide care in a more economical manner for patient and providers, we strive to provide care that meets healthcare industry standards.

III. PATIENTS' RIGHTS

We will treat all patients with dignity, respect and courtesy. Patients and/or their next of kin, families, or their significant others will be involved in the decisions regarding

the care that we provide, to the extent that such is practical and legally acceptable. We will also seek to inform all patients and others speaking for them about the therapeutic alternatives and the risks associated with the care they are seeking. In doing so, we will also seek an understanding of their objectives for care. We will adhere to the guidelines set by the New York State Patient Bill of Rights, and the Federal Patient Self Determination Act.

IV. RESOLUTION OF CONFLICT

CVPH Medical Center recognizes that conflict may arise among those who participate in Hospital and patient care decisions. Whether this conflict is between members of administration, medical staff, employees, the Board of Directors of this institution, or between patient caregivers and the patient, we will seek to resolve all conflicts fairly and objectively. In the cases where mutual satisfaction cannot be achieved, it is the policy of CVPH to involve the administrator on call, ethics committee, or other staff to obtain second opinions, as needed, to pursue a mutually satisfactory resolution.

V. FAIR BILLING PRACTICES

The following practices are in place to ensure that appropriate billing takes place for all Hospital patients and to provide financial assistance to under or uninsured patients who may not be able to afford necessary medical care.

1. Every effort is made to gather complete and accurate billing information at the time of registration.
2. An authorization to bill third party insurers and consent to release information to a third party insurer is obtained from all patients at the point of service.
3. Third party insurers are billed in compliance with all Federal, State and insurance regulations and requirements.
4. All initial patient billing is itemized for uninsured patients and will be provided upon request for patient balances after insurance has paid.
5. The Fair Debt Collection Practices Act is adhered to for collection procedures.
6. CVPH offers financial assistance to qualified under or uninsured patients through our C.A.R.E.S. [community assistance resource evaluation service] program.
7. Patient's complaints regarding billing or the cost of care are handled in an expeditious manner.
8. Efforts are made to educate the public regarding insurance requirements, coverages, and medical billing nuances.

VI. FAIR MARKETING PRACTICES

CVPH Medical Center strives to be clear, accurate, honest and forthright in all of its communications with the community. This applies to newsletters, brochures and other collateral material, statements to the news media, and advertising. The Medical Center is aware of and respects its role in the community as a resource for health-related information and as an advocate for health education.

CVPH Medical Center adheres to the guidelines for the practice of public relations, the release of information, and standards of advertising as adopted by the American Hospital Association Society for Marketing and Public Relations.

VII. CONFIDENTIALITY

CVPH recognizes the need to maintain patient and other health information (verbal, written, or electronic), in a confidential manner. Patient and health information will not be shared in an unauthorized manner and sensitive information concerning employee, physician, and management issues will be maintained in the strictest confidence and utilized only by those individuals authorized to review and act upon such information.

VIII. ETHICAL BUSINESS PRACTICE

CVPH protects the integrity of clinical decision making, regardless of how CVPH compensates its Administrative Staff, Directors, Clinical Staff, and Independent Practitioners. Clinical decisions, including tests, treatments, and other interventions, are based on identified patient health care needs. Policies and procedures addressing this issue are available, on request, to all patients, clinical staff, licensed independent practitioners, and Hospital personnel. CVPH has developed a voluntary Corporate Compliance Program in accordance with the Office of the Inspector General. This program is focused on strengthening the systems of patient care delivery and substantially reducing fraud, waste, abuse, and the cost of health care to federal, state, private insurers and our patients.

Related Policies

The following related policies, procedures, and other documents provide further and specific guidance for ethical conduct:

- Mission, Vision, and Value Statement
- Plan for Patient Care
- Admission Policy
- Policy on Patient Rights and Responsibilities
- Policy on Workplace Harassment
- Policy on Informed Consent
- Policy on DNR
- Policy on Advance Directives
- Policy on Health Care Proxy
- Policy on Honoring a Patient's/Resident's Wishes for Nutrition and Hydration
- Policy on Foregoing Life Sustaining Treatment
- Policy on Confidentiality
- Health Information Confidentiality and Security Program
- Policy on Code of Conduct
- Community Providers, Inc.
- Corporate Compliance Plan
- Patient Comments
- Transfer Policy
- Policy on Solicitation and Distribution

- Institutional Review Board Policy
- Policy on Exclusion from Patient Care
- Policy on Anatomical Gift Donation
- Policy on Determination of Death
- Policy on HIPPA Compliant Authorization

DISTRIBUTION

This policy is available in Policy Manager for all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

Elizabethtown Community Hospital

Code of Ethical Conduct for the Board of Directors

As a 501(c)3 not-for-profit corporation incorporated in the State of New York, the Board of Directors of the Elizabethtown Community Hospital is committed to maintaining the highest standard of conduct in carrying out its fiduciary duties of care and loyalty in pursuit of its mission. As such, each and every member of the Board shall adhere to the following code of conduct:

Bylaws & Policies

- Be aware of and fully abide by the certificate of incorporation, bylaws, policies, rules and regulations of ECH;
- Ensure the compliance with all laws, regulations and contractual requirements;
- Respect and fully support the duly made decisions of the Board in accordance with his/her fiduciary duties and loyalty to ECH;
- Respect the work and recommendations of Committees;
- Work diligently to ensure that the Board fully assumes its role as a policy-making governing body;
- View and act towards the Chief Executive Officer (CEO) with the sole responsibility for the day-to-day management of the organization, including personnel, and for implementation of Board policies and directives.

Informed Participation

- Attend all meetings of the Board and assigned Committees;
- Keep well-informed of all matters, including financial, that come before the Board and or assigned Committees;
- Respect and follow the decision making structure of the Board and Administration;
- Constructively and appropriately bring to the attention of the Board, Officers, Committee chairs and/or appropriate staff any questions, personal views, opinions and comments of significance on relevant matters of governance, policymaking and the community;
- Oppose, on the record, matters coming before the Board with which one disagrees or is in serious doubt;
- Appropriately challenge, within the structure and bylaws of ECH, those decisions that violate the legal, fiduciary or contractual obligations of the corporation;
- Do not commit to others or self to vote a particular way on an issue before participating in deliberation session in which the matter is to be discussed and action duly taken;
- Act in ways that do not interfere with the duties or authority of staff;

Conflict of Interest, Representation & Confidentiality

• Represent the best interests of ECH at all times and declare any and all quality of interests or conflicts of interests, material or otherwise, that may impede or be perceived as impeding the capacity to deliberate or act in good faith on behalf of the best interests of ECH;
• Conform to the procedures for conflicts of interest and disclosure as stated in the bylaws or otherwise established by the Board;
• Will not seek or accept, on behalf of self or any other person, any financial advantage or gain that may be offered because or as a result of the Board member's affiliation with ECH.
• Publicly support and represent the duly made decisions of the Board;
• Speak positively of the organization to Board members and all current and potential stakeholders of the Hospital and to the communities we serve;
• Do not take any public position representing ECH on any issue that is not in conformity with the official position of ECH;
• Do not use or otherwise relate one's affiliation with the Board to independently promote or endorse political candidates or parties for the purpose of election;
• Maintain full confidentiality of information obtained as a result of Board service in accordance with Board policy or direction;

Interpersonal

• Speak clearly, do not interrupt, listen carefully to and respect the opinions of fellow Board members and key staff;
• Promote collaboration and partnership among all members of the Board;
• Maintain open communication and an effective partnership with the Board's Officers and Committee leadership;
• Be "solution focused", offering criticism only in a constructive manner;
• Do not filibuster or engage in activities during meetings that are intended to impede or delay the progress and work of the board because of differences in opinion or other personal reasons;
• Always work to develop and improve one's knowledge and skills that enhance one's abilities as a Board member.

Certification

I, the undersigned, certify that I have read and understand the Code of Ethical Conduct of ECH. I agree that my actions will fully comply with the statements and intent of the Code of Ethical Conduct. I affirm that neither I, nor any member of my family or household, has had an interest or taken any action which counters the conflict of interest's policies of the organization or impedes my ability to act as a fiduciary and in the best interests of ECH, except potentially those interests or actions as stated and fully disclosed on the organization's Conflict of Interest form.

_____ _____

(Board Member Signature) Date

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
ADMINISTRATIVE POLICY/PROCEDURE MANUAL

Number: 5.44

 Section: Governance

SUBJECT: False Claims Act		
WRITTEN BY: Noreen Brady, VP of Human Resources Corporate Compliance Officer		**RESPONSIBLE DEPARTMENT:** Administration
CONTRIBUTING DEPARTMENT(S):		
Administrative **APPROVAL:**		**POLICY CREATION DATE:** JANUARY 1, 2007
NEW:	**SUPERSEDES POLICY:** Same As Above **DATED:** JANUARY 1, 2007	Revised **DATE:** JUNE 30, 2008
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.) - CPI, Inc. Corporate Compliance Plan; CVPH Medical Center Code of Conduct		

I. POLICY

CVPH Medical Center is committed to complying with all laws and regulations pertaining to the preparation, delivery and billing for services which apply to CVPH because of its participation in Medicare, Medicaid and other state and federal government programs. All billings for patient services and other transactions must be properly documented and authorized and all records must be accurately and completely supported. All management, employees, agents and contractors of CVPH will work to prevent any potential fraud, abuse and/or waste and will detect and correct any cases of fraud, abuse and/or waste in the event they occur.

II. PURPOSE

The Deficit Reduction Act of 2005, effective January 1, 2007 requires all providers that annually receive at least $5 million in Medicaid payments establish written policies, procedures and protocols for the training of all management, employees, agents and contractors on the federal False Claims Act. The purpose of this policy is to provide information regarding the False Claims Act, whistleblower protections, and the Medical Center's Corporate Compliance Plan as well as related policies and procedures for preventing, detecting and correcting fraud, abuse and/or waste.

III. FALSE CLAIMS ACT

The False Claims Act (FCA) is a Civil War era law intended to address profiteering which occurred during that war. The FCA imposes civil liability on organizations and individuals that make false claims for payment to the government. It is used today to authorize federal prosecutors to file a civil action against any person or entity that knowingly files a false claim with a federal health care program, including Medicare

or Medicaid programs. The FCA applies to Hospitals, providers, beneficiaries, and health plans doing business with the federal government as well as billing companies, contractors, and other persons or entities connected with the submission of claims to the government. The FCA is set forth in Title 31 of United States Code, beginning with section 3729.

The government can use the FCA against both organizations and individual employees who commit billing fraud. It applies to any person who does the following:

1. Knowingly presents or causes to be presented, a false or fraudulent claim for payment or approval to an officer or employee of the United States government;

2. Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government;

3. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid; or

4. Knowingly makes, uses or causes to be made or used, a false record or statement or conceals, avoids, or decreases an obligation to pay or transmit property to the government

Anyone who violates the FCA is liable for civil penalty of not less than $5,500 and not more than $11,000 per claim, plus three times the amount of the damages the government sustains. The government may also exclude violators from participating in Medicare, Medicaid and other government programs. Intentional submission of a false claim is subject to federal criminal enforcement and may also be liable to the United States government for the costs of civil action brought to recover any penalties or damages. The government relies heavily on the federal and state FCA to prosecute billing fraud. The FCA authorizes what is known as *qui tam* actions and awards to *qui tam* plaintiffs. The FCA's *qui tam* provisions permit private persons to: (1) sue, on behalf of the government, persons or entities who knowingly have presented the government with false or fraudulent claims; and (2) share in any proceeds ultimately recovered as a result of the suit.

The FCA includes provisions to discourage employers from retaliating against employees for initiating *qui tam* lawsuits. Any employee who is terminated, demoted, suspended or in any way discriminated against because of acts in support of an action under the FCA has a right to sue the employer for reinstatement, back pay and other damages.

In addition to the federal FCA and Social Security legislation (1902(a)(68)(A)), New York has its own False Claims Act, set forth in Section 145-b of the New York Social Services Law. The New York False Claims Act is triggered by claims for payment

submitted to the state and its agencies. The New York False Claims Act is very similar to the FCA in terms of the types of acts that give rise to liability.

The Office of Inspector General's self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

IV. EXPECTATIONS TO ENSURE CODING AND BILLING COMPLIANCE

As discussed previously, the punishment for filing a False Claim can be severe. CVPH Medical Center is successful with its healthcare billing compliance as long as all management, employees, agents and contractors perform their duties and responsibilities correctly and take initiative to ensure a culture of compliance.

- We will maintain honest and accurate records of all our activities.
- We are committed to both accurate billing and submission of claims only for services that are actually rendered and medically necessary.
- We will not file a claim for services that were not rendered or were not rendered as described on the claim form.
- We are committed to ensuring that bills submitted for payment are properly coded, documented and billed in accordance with all applicable laws, regulations, guidelines and policies.
- We will research all credit balances and refund any money received that is not due to us in a timely manner.
- We will promote and adhere to the goal of full and accurate compliance with all laws and regulations.
- We will not submit any claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, incomplete or fictitious.
- We will bill for services using only charge codes that accurately describe the services that were provided.
- If inaccuracies are discovered in bills that have already been sent, we will take immediate steps to alert the payer and correct the bill in accordance with the payer's guidelines and requirements.
- We will submit claims only for services and supplies ordered by a physician or other authorized person and provided to the patient.
- Insufficient documentation to support the services provided is perhaps the most common reason for Medicare to deny or delay reimbursement. Physicians, nurses, and other practitioners will complete medical records and other documentation to prove that they provided items or services to patients.
- We will take particular care to avoid improper or illegal billing and coding practices such as upcoding and unbundling.

V. PROCEDURE

All management, employees, agents and contractors of CVPH Medical Center are required and responsible for reporting healthcare billing compliance concerns, including actual or potential violations of law, regulation, policy and/or procedure.

Without help from management, employees, agents, and contractors, it may be difficult to learn of possible compliance problems and make necessary corrections through prevention, detection and resolution of instances that do not conform to healthcare billing compliance. CVPH Medical Center's Corporate Compliance Program adheres to a culture of open lines of communication, problem resolution and a strict non-retaliation policy to protect those that report in good faith a potential compliance issue from any kind of retaliation.

All CVPH Medical Center employees should be familiar with the Community Providers, Inc. Corporate Compliance Plan that incorporates the CVPH Medical Center Compliance Plan. (This can be found on line in Policy Manager in the Organizational Section under the Plan for Patient Care.) In the event a discovery of a potential compliance concern that might lead to a violation of CVPH Medical Center Policies and Procedures or any federal or state law or regulation, the following should be done:

A. In accordance with the Corporate Compliance Plan and the Code of Conduct, the manager, employee, agent or contractor should report problems if they see something that looks suspicious. The report should be brought first to the employee's immediate supervisor as the supervisor may be in the best position to understand and correct the problem. Problems can also be brought to the Compliance Officer directly or via the Compliance Help Line (ext. 3070). (The Compliance Help Line allows the person bringing forth the concern to remain anonymous.) Concerns may also be brought forth to the Patient Care Coordinator who will contact the Administrator on Call. It is expected that once reported, there will be prompt investigation, and if necessary, prompt remediation. The Corporate Compliance Plan and the Code of Conduct prohibit any retaliatory action against an employee for reporting concerns regarding potential violations of CVPH Medical Center polices and procedures or any federal or state law or regulation.

B. Be persistent. If the person who was first brought the concern is unresponsive, the issue should be brought to the Compliance Officer.

C. The Compliance Officer will investigate all matters referred to determine what, if any, corrective actions are necessary and make recommendations regarding these as set forth in the Community Providers, Inc. Corporate Compliance Plan.

D. It is recognized that detection and timely reporting of misconduct will help maintain the integrity of the organization and reserve its status as a reliable, honest and trustworthy healthcare provider. Furthermore, penalties and sanctions can be materially reduced by voluntary disclosures of violations of civil, criminal or administrative law in a timely manner.

VI. DISTRIBUTION

This policy will be available in Policy Manager to all employees on an as needed basis.

CVPH Medical Center is educating it's employees on an ongoing basis and expects to incorporate this Policy and educational programming in the Health Stream Corporate Compliance for review annually.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten (10) days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation may be referred to your immediate supervisor.

As Part of the requirements of the Deficit Reduction Act, CVPH has developed four additional policies to ensure consistent education and communication associated with the Deficit Reduction Act.

Subject: Compliance Education and Training

Purpose

The development and implementation of regular, effective education and training seminars for employees is an integral part of the compliance program. Compliance education is divided into two general components. First, all employees and contractors and agents as defined below, must receive an introduction to the compliance program conducted during New Employee General Orientation and annually thereafter. Second, employees whose work is linked to identified high risk areas should receive specialized compliance education pertaining to their function and responsibilities.

1. All employees, including new hires, will receive education related to the organization's overall compliance program.
2. Contractors and agents who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity including new hires, will receive education related to the organization's overall compliance program.
3. Employees in identified risk areas will receive more detailed education related to their function and responsibilities.

Procedures

1. The Compliance Officer (CO) is responsible for developing the compliance education curriculum and monitoring and ensuring that the compliance training and orientation meets the policy standards on this subject.
2. Compliance education seminars must include an explanation of the structure and operation of the compliance program. They will introduce the CO to the organization. Compliance education seminars, at a minimum, will include information on the following aspects of the compliance program
3. Compliance education seminars must include an explanation of the structure and operation of the compliance program. The availability of the Community Providers Inc. Corporate Compliance Plan manual on the on-line Policy Manager. They will introduce the CO to the organization. Compliance education seminars, at a minimum, will include information on the following aspects of the compliance program:
    - Code of Conduct and other related written guidance such as Conflicts of Interest;
    - Seven Key Elements to an effective Corporate Compliance Program;
    - Communication channels (Help Line);
    - Organizational expectations for reporting problems and concerns; and
    - Nonretaliation/nonretribution policy (Whistleblower protection);

- Federal and State Laws pertaining to civil or criminal penalties and Qui Tam provisions under the False Claim Acts (State and Federal)
- Elements of Fraud and Abuse; and
- Disciplinary Process in place for the Compliance Program

4. Comprehensive education materials will be developed to facilitate the compliance sessions and ensure that a consistent message is delivered to all employees. Education protocols and materials must be standardized, so as to evidence that everyone attending a seminar receives the same instruction.
5. Each training session will require that individuals present document their attendance by completing an attendance log or electronically sign-in should the facility have that ability.
6. Employees will be provided with the opportunity to seek clarification or more information on any aspect of the compliance program.
7. Only properly trained individuals will be used to provide compliance education and training seminars. Compliance program trainers must be knowledgeable of the (a) compliance program; (b) applicable federal laws and regulations; (c) requirements of the Sentencing Commission Guidelines; (d) relevant organization policies/procedures; (e) operations of the compliance program; and (f) content of the Code of Conduct and Ethics.
8. The CO is responsible for coordinating with management to ensure that specialized compliance education occurs in identified risk areas.
9. The CO is also responsible for submitting periodic reports to the Compliance Committee on all education seminars related to the compliance program.

Subject: Compliance Office and Legal Counsel Protocol and Procedures

Purpose

One of the primary purposes of the compliance program is to identify any activities that might constitute a violation of criminal, civil, or administrative law. Therefore, it is necessary to establish protocols and procedures to guide the activities of the compliance office and legal counsel.

Although the Compliance Officer will most often address the majority of allegations of misconduct, issues occasionally arise that should be addressed under direction of legal counsel. This policy provides guidance for the compliance office to determine when and how issues should be turned over to legal counsel. Furthermore, it provides guidance for both the compliance office and legal counsel to conduct compliance inquiries and investigations. For purposes of this policy, the term "legal counsel" refers to either inside or outside counsel.

Policy

1. Upon reasonable evidence of suspected noncompliance with any criminal, civil, or administrative law, legal counsel should conduct an investigation into the legal sufficiency of the allegations.

2. In light of timely reporting requirements, credible allegations of misconduct related to billing and reimbursement should be turned over to legal counsel as expeditiously as possible.
3. During any investigation, legal counsel and the compliance office must ensure that all relevant evidence is preserved.

Procedures

1. Upon report or notice of suspected noncompliance with any criminal, civil, or administrative law, the Compliance Officer (CO) will conduct an "initial inquiry" into the alleged misconduct. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible noncompliance to warrant further investigation.
2. If, during the initial inquiry, the CO determines that there is sufficient evidence of possible noncompliance to warrant further investigation, then the issue should be turned over to legal counsel and a memorandum to this effect should be executed. The memorandum should state whether inside or outside counsel will be leading the investigation, as well as, whether the investigation is being conducted in anticipation of litigation. If the organization wants documents produced during the investigation by legal counsel to be possibly protected from disclosure, all such documents should include the statement: "Privileged and Confidential Document; Subject to Attorney-Client Privileges; Attorney Directed Work Product." Note that the application of the attorney-client privilege and work product doctrine differs under federal law and the laws of various states, although in general these privileges are narrow in scope. Because the rules can vary, you should consult an attorney in your jurisdiction for specific legal advice regarding the scope of the attorney-client privilege and the work product doctrine.
3. At this point legal counsel will conduct an investigation to evaluate the facts to determine whether credible evidence exists to indicate that a violation of criminal, civil, or administrative law has occurred. It will also be the responsibility of legal counsel to:
    - Notify the senior management of the organization of the results of its legal investigation; and
    - Provide the compliance office with sufficient factual details from its legal investigation to allow the CO to properly address any compliance issue.
4. Both the initial inquiry and legal investigation will be conducted as expeditiously as possible.

Subject: Disciplinary Action Process for Compliance Violation

Purpose

Community Providers Inc. (CPI) recognizes that a critical aspect of its compliance program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal, state, and private payer healthcare program requirements, as well as the organization's ethical and business policies.

Policy

1. All employees, contractors and agents have an affirmative duty and responsibility for reporting perceived misconduct, including actual or potential violations of laws, regulations, policies, procedures, or this organization's standards/code of conduct.
2. Employees, contractors and agents who violate any Compliance Policy, Code of Conduct or Ethics, Compliance Program, law, rule, regulation whether it be intentionally or unintentionally are subject to the Human Resource Corrective Action Policy or other applicable disciplinary procedures in addition to prosecution by any local, state or federal authority.

Subject: Deficit Reduction Act (False Claims Act)

Reference(s): 31 U.S.C. 3729-3733

Purpose

Community Providers Inc. (CPI)) developed and implemented a compliance program in an effort to establish, in part, effective internal controls that promote adherence to applicable federal and state laws and the program requirements of federal, state, and private health plans. The Deficit Reduction Act of 2005 (DRA) mandated that any entity receiving or making annual payments exceeding $5 million must establish written policies for all employees of the entity and of any contractor or agent to the entity, that provide detailed information about the False Claims Act (FCA) under sections 3729 through 3733 or title 31 United States Code (USC). The DRA requires that the entity develop policies and procedures regarding education of employees, contractors and agents with regards to civil and criminal penalties under the FCA and whistleblower protections under such laws with regards to preventing and detecting fraud, waste and abuse. The entity must include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

CPI is committed to complying with all applicable laws and regulations. PHHS supports the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements. This policy sets forth the guidelines to be followed by all employees regarding the FCA and in detecting and preventing fraud, waste and abuse.

Definitions

1. Fraud: An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
2. Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in unnecessary cost to government programs, or in seeking

reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards of healthcare. It also includes member practices that result in unnecessary cost to government programs.

3. False Claims Act: The provisions under the FCA state that it is a violation to:
    a. Knowingly present or cause to be submitted a false claim to the government.
        1. For purposes of this section, the terms ''knowing'' and ''knowingly'' mean that a person, with respect to information-
            a. has actual knowledge of the information;
            b. acts in deliberate ignorance of the truth or falsity of the information; or
            c. acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
    b. Knowingly use of false record or statement to obtain payment on a false claim paid by the government.
    c. Engage in a conspiracy to defraud the government by the improper submission of a false claim for payment.
    d. Damages and penalties for violating the FCA may include:
    e. Civil penalties of not less than $5,500 and not more than $11,000 per violation, plus
    f. Three times the amount of damages which the government sustains because of the violation
4. Qui Tam Provisions (whistleblower rights): The provision of the FCA allows a person to bring an action under the Act on behalf of the federal government and share in the recovery.

Policy

1. All employees must conduct themselves in an ethical and legal manner as defined in CVPH's Code of Conduct. See Code of Conduct and Ethics.
2. All employees, contractors and agents are responsible for reporting potential or suspected incidents of fraud and abuse, and other wrong doing directly to their supervisor and/or executive management or report suspected incidents to CPI' Compliance Office directly or via the Help Line. All employees should be educated about fraud and abuse, including the detailed provisions of the FCA, administrative remedies, State laws pertaining to civil or criminal penalties and Qui Tam provisions through mandatory corporate compliance training. The Compliance Officer (CO) in consultation with legal counsel has responsibility for receiving and acting upon all information suggesting the existence of possible fraud, abuse or other wrongdoing; and for directing all investigations arising from this information.
3. Allegations determined by the CO and/or legal counsel to be potential violation of law shall be disclosed within
thirty (30) days to a duly authorized law enforcement agency.

Procedures

1. All employees will receive training related to the provisions of the FCA during the annual compliance program training as outlined in applicable Compliance Procedures.
2. Contractors and agents will have access to training material related to the provisions of the FCA and policies and procedures will be made readily available in either electronic or paper form upon request.
3. Training will be provided in accordance with current mandatory Compliance Training and Education procedures.
4. All employees, contractors and agents with knowledge of potential fraud and abuse situations or have a potential fraud and abuse situation reported to them must report the incident in accordance with policies and procedures defined in the Corporate Compliance Procedures Manual.
5. If during the initial analysis or inquiry, the CO determines that there is an allegation or evidence of a violation of law or regulation the CO is required to follow policies outlined in the Corporate Compliance Procedure Manual with regards to handling potential violations, reporting of suspected violations to third parties, protocols for interacting with legal counsel and any other applicable policy or procedure.
6. Senior management is responsible for ensuring that effective controls are in place for the detection of potential incidents of fraud and abuse. With oversight and support from the CO, operations managers will establish and maintain methods for detecting and preventing incidents of fraud and abuse, including but not limited to a claims quality assurance program that monitors the accuracy of adjudicated claims, a compliance hotline and a process that identifies employees, contractors, vendors and providers that are debarred or excluded from participating in federal programs.
7. When CPI detects a compliance problem, it is the CO's responsibility to ensure that the incident is appropriately handled by qualified personnel and in accordance with applicable compliance procedures.
8. To the extent practical or allowed by law, the CO must maintain the confidentiality or anonymity of an employee
   when requested.
9. CPI shall take appropriate and consistent disciplinary and enforcement action against employees, providers, subcontractors, consultants, and agents found to have committed fraud and abuse violations.
10. Retaliation or retribution for reporting issues "in good faith" is prohibited.

Subject: Problem Reporting and Nonretaliation

Purpose

Community Compliance Inc. (CPI) recognizes that a critical aspect of its compliance program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal, state, and private payer healthcare program requirements, as well as the organization's ethical and business

policies. To promote this culture, CPI established a problem resolution process and a strict non-retaliation policy to protect employees and others who report problems and concerns in good faith from retaliation. Any form of retaliation or retribution can undermine the problem resolution process and result in a failure of communication channels in the organization.

Policy

1. All employees, contractors and agents have an affirmative duty and responsibility for reporting perceived misconduct, including actual or potential violations of laws, regulations, policies, procedures, or this organization's standards/code of conduct.
2. An "open-door policy" will be maintained at all levels of management to encourage employees, contractors and agents to report problems and concerns.
3. Employees, contractors and agents are encouraged to utilize the Help Line. In furtherance of their protection against retaliation, callers may remain anonymous or may seek confidentiality.
4. Employees, contractors and agents may also proceed up the chain-of-command or communicate with the Human Resources Department if their problem or concern is not resolved.
5. Any form of retaliation against any employee, contractor or agent who reports a perceived problem or concern in good faith is strictly prohibited.
6. Any employee, contractor or agent who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.
7. Employees, contractors and agents cannot exempt themselves from the consequences of their own misconduct by reporting the issue, although self-reporting may be taken into account in determining the appropriate course of action.

Procedures

1. Procedures that apply to all employees, contractors and agents:
    - Knowledge of misconduct, including actual or potential violations of laws, regulations, policies, procedures, or the organization's Code of Conduct and Ethics must be immediately reported to management, the Compliance Officer (CO), or the Help Line.
    - Knowledge of a violation or potential violation of this policy must be reported directly to the CO or the Help Line.
    - Employees may also report problems or concerns to the Human Resources Department.
    - If an employee's concern or problem cannot be satisfactorily resolved or special circumstances exist, the employee should report such concern or problem to the CO or the Help Line.
2. Procedures that apply to management (which includes executives, vice presidents, directors, managers, and supervisors):
    - Management must take appropriate measures to ensure that all levels of management support this policy and encourage the reporting of problems

and concerns. At a minimum, the following actions should be taken and become an ongoing aspect of the management process:

- Meet with department staff and discuss the main points within this policy;
- Provide all department staff with a copy of this policy; and
- Post a copy of this policy on all employee bulletin boards.

3. Procedures that apply to the Compliance Officer (CO):
    - The CO will be responsible for the investigation and follow-up of any reported retaliation against an employee.
    - The CO will report the results of an investigation into suspected retaliation to the governing entity deemed appropriate, such as the Compliance Committee or the Board of Directors.

ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

Policy No.: 10-042210
Title: FALSE CLAIMS ACT
Page 1 of 5
X New ☐ Revision ☐ Name Change

Responsible Department: Administration
Administrative Approval:
Date:

I. Purpose

The Deficit Reduction Act of 2005, effective January 1, 2007 requires all providers with Medicaid payments establish written policies, procedures and protocols for the training of all management, employees, agents and contractors on the federal False Claims Act. The purpose of this policy is to provide information regarding the False Claims Act, whistleblower protections, and the Hospital's Corporate Compliance Plan as well as related policies and procedures for preventing, detecting and correcting fraud, abuse and/or waste.

II. Policy

Elizabethtown Community Hospital is committed to complying with all laws and regulations pertaining to the preparation, delivery and billing for services which apply to ECH because of its participation in Medicare, Medicaid and other state and federal government programs. All billings for patient services and other transactions must be properly documented and authorized and all records must be accurately and completely supported. All management, employees, agents and contractors of ECH will work to prevent any potential fraud, abuse and/or waste and will detect and correct any cases of fraud, abuse and/or waste in the event they occur.

III. Procedure

All management, employees, agents and contractors of Elizabethtown Community Hospital are required and responsible for reporting healthcare billing compliance concerns, including actual or potential violations of law, regulation, policy and/or

procedure. Without help from management, employees, agents, and contractors, it may be difficult to learn of possible compliance problems and make necessary corrections through prevention, detection and resolution of instances that do not conform to healthcare billing compliance. ECH's Corporate Compliance Program adheres to a culture of open lines of communication, problem resolution and a strict non-retaliation policy to protect those that report in good faith a potential compliance issue from any kind of retaliation.

All ECH employees should be familiar with the Community Providers, Inc. Corporate Compliance Plan that incorporates the ECH Compliance Plan. In the event a discovery of a potential compliance concern that might lead to a violation of Elizabethtown Community Hospital's Policies and Procedures or any federal or state law or regulation, the following should be done:

E. In accordance with the Corporate Compliance Plan and the Code of Conduct, the manager, employee, agent or contractor should report problems if they see something that looks suspicious. The report should be brought first to the employee's immediate supervisor as the supervisor may be in the best position to understand and correct the problem. Problems can also be brought to the Compliance Officer directly or via the Compliance Help Line (ext. 3026). (The Compliance Help Line allows the person bringing forth the concern to remain anonymous.) It is expected that once reported, there will be prompt investigation, and if necessary, prompt remediation. The Corporate Compliance Plan and the Code of Conduct prohibit any retaliatory action against an employee for reporting concerns regarding potential violations of Elizabethtown Community Hospital policies and procedures or any federal or state law or regulation.

F. Be persistent. If the person who was first brought the concern is unresponsive, the issue should be brought to the Compliance Officer.

G. The Compliance Officer will investigate all matters referred to determine what, if any, corrective actions are necessary and make recommendations regarding these as set forth in the Community Providers, Inc. Corporate Compliance Plan.

H. It is recognized that detection and timely reporting of misconduct will help maintain the integrity of the organization and reserve its status as a reliable, honest and trustworthy healthcare provider. Furthermore, penalties and sanctions can be materially reduced by voluntary disclosures of violations of civil, criminal or administrative law in a timely manner.

V. EXPECTATIONS TO ENSURE CODING AND BILLING COMPLIANCE

As discussed previously, the punishment for filing a False Claim can be severe. Elizabethtown Community Hospital is successful with its healthcare billing compliance as long as all management, employees, agents and contractors perform their duties and responsibilities correctly and take initiative to ensure a culture of compliance.

- We will maintain honest and accurate records of all our activities.
- We are committed to both accurate billing and submission of claims only for services that are actually rendered and medically necessary.
- We will not file a claim for services that were not rendered or were not rendered as described on the claim form.
- We are committed to ensuring that bills submitted for payment are properly coded, documented and billed in accordance with all applicable laws, regulations, guidelines and policies.
- We will research all credit balances and refund any money received that is not due to us in a timely manner.
- We will promote and adhere to the goal of full and accurate compliance with all laws and regulations.
- We will not submit any claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, incomplete or fictitious.
- We will bill for services using only charge codes that accurately describe the services that were provided.
- If inaccuracies are discovered in bills that have already been sent, we will take immediate steps to alert the payer and correct the bill in accordance with the payer's guidelines and requirements.
- We will submit claims only for services and supplies ordered by a physician or other authorized person and provided to the patient.
- Insufficient documentation to support the services provided is perhaps the most common reason for Medicare to deny or delay reimbursement. Physicians, nurses, and other practitioners will complete medical records and other documentation to prove that they provided items or services to patients.
- We will take particular care to avoid improper or illegal billing and coding practices such as upcoding and unbundling.

IV. Definitions

The False Claims Act (FCA) is a Civil War era law intended to address profiteering which occurred during that war. The FCA imposes civil liability on organizations and individuals that make false claims for payment to the government. It is used today to authorize federal prosecutors to file a civil action against any person or entity that knowingly files a false claim with a federal health care program, including Medicare or Medicaid programs. The FCA applies to hospitals, providers, beneficiaries, and health plans doing business with the federal government as well as billing companies, contractors, and other persons or entities connected with the submission of claims to the government. The FCA is set forth in Title 31 of United States Code, beginning with section 3729.

The government can use the FCA against both organizations and individual employees who commit billing fraud. It applies to any person who does the following:

5. Knowingly presents or causes to be presented, a false or fraudulent claim for payment or approval to an officer or employee of the United States government;

6. Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government;

7. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid; or

8. Knowingly makes, uses or causes to be made or used, a false record or statement or conceals, avoids, or decreases an obligation to pay or transmit property to the government

Anyone who violates the FCA is liable for civil penalty of not less than $5,500 and not more than $11,000 per claim, plus three times the amount of the damages the government sustains. The government may also exclude violators from participating in Medicare, Medicaid and other government programs. Intentional submission of a false claim is subject to federal criminal enforcement and may also be liable to the United States government for the costs of civil action brought to recover any penalties or damages. The government relies heavily on the federal and state FCA to prosecute billing fraud. The FCA authorizes what is known as *qui tam* actions and awards to *qui tam* plaintiffs. The FCA's *qui tam* provisions permit private persons to: (1) sue, on behalf of the government, persons or entities who knowingly have presented the government with false or fraudulent claims; and (2) share in any proceeds ultimately recovered as a result of the suit.

The FCA includes provisions to discourage employers from retaliating against employees for initiating *qui tam* lawsuits. Any employee who is terminated, demoted, suspended or in any way discriminated against because of acts in support of an action under the FCA has a right to sue the employer for reinstatement, back pay and other damages.

In addition to the federal FCA and Social Security Legislation (1902(a)(68)(A), New York has its own False Claims Act, set forth in Section 145-b of the New York Social Services Law. The New York False Claims Act is triggered by claims for payment submitted to the state and its agencies. The New York False Claims Act is very similar to the FCA in terms of the types of acts that give rise to liability.

The Office of Inspector General's self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

V. Distribution

This policy must be distributed to all Administrative Staff members, Managers, and Nurse Managers by their immediate supervisor.

All receipts of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

DATE:	REVIEWED BY:	REVISION:	RELATED POLICY #:
4/22/2010	K. Bigelow	New	CORPORATE COMPLIANCE PLAN

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
ADMINISTRATIVE POLICY/PROCEDURE MANUAL

Number: 4.18

 Section: Fiscal

SUBJECT: Charity Care Guidelines		
WRITTEN BY: Paula McDonald, Patient Accounting Manager		RESPONSIBLE DEPARTMENT: Finance
CONTRIBUTING DEPARTMENT(S):		
ADMINISTRATIVE APPROVAL:		POLICY CREATION DATE: SEPTEMBER 1, 2002
NEW:	SUPERSEDES POLICY: SAME AS ABOVE DATED: SEPTEMBER 22, 2009	REVISED DATE: MARCH 24, 2010
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

I. PURPOSE

In accordance with its Charity Care Program, CVPH Medical Center will provide uncompensated health care to all patients that are determined to be uninsured and unable to pay for services. This policy shall be applied in accordance with established procedures and no patient shall be denied health care based upon race, creed, color, sex, national origin, ability to pay, or any other prejudgment. CVPH strives to meet or exceed the minimum standards set by NYS in determining eligibility for financial assistance. A translator will be provided when necessary to communicate with the applicants. A summary of this policy will be placed on the CVPH website. A brochure will be developed and provided to each uninsured patient at the time of registration.

II. PROCEDURE

Eligibility

A. Patient eligibility will be based on the following information:
- Patient is a U.S. Citizen
- Patient must reside in CVPH's Services area, Counties of Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren and Washington in New York State.
- Must be Uninsured or only have Medicare / Medicare HMO Primary Insurance.

B. All inpatient and outpatient accounts are eligible for charity care for services provided by CVPH Medical Center. An application must be filled out by the

patient/guarantor. The patient/guarantor has up to 180 days after service date to apply for charity care.

C. Patients without insurance coverage will be encouraged to meet with a Financial Counselor or another representative that can assist in the application for coverage through Medicaid, Child Health Plus, Family Health Plus, or other similar programs in effect at the time.

D. Eligibility will be determined by comparing applicant's income to the Income Eligibility Guidelines, which are updated annually based on the federal poverty guidelines. Applicants must supply the following information:
   1. Income from all sources for individuals responsible for this obligation, listing gross income for the most recent three month period (income from seasonal employment will be based on 12 month average).
   2. Number of exemptions as determined by federal income tax laws.
   3. A copy of the most recent federal income tax return, or proof of income listed under II D 1.

E. All third party resources and non-Hospital financial aid programs, including public assistance available through state Medicaid programs, must be exhausted before charity can be requested. A denial from Social Services for "failure to comply" with State/County regulations would disqualify patient/guarantor from application for CARES. A Medicaid denial is required for all services and must be no more than 3 months old. The denial may be waived on a case-by-case basis upon authorization of the Director of Patient Accounting.

III. PROGRAM ADMINISTRATION

The Hospital's Charity Care Program will be administered according to the following guidelines. Accounts for which charity care has been applied for will not be billed until the application process is complete and a determination has been made. CVPH has the CARES information brochures available at all primary service sites (see brochure attached). All Self Pay Patients are notified on their statements to contact us to see if they are eligible for the CARES program.

A. The application information, along with a copy of the most recent federal income tax return, will be reviewed and verified by the Business Office personnel.
B. After reviewing income, Patient Accounting personnel will determine if the patient/guarantor qualified for charity benefits based on the Income Guidelines within thirty business days of receipt of complete application.
C. The Customer Service Representative reviews the request form and documents the decision regarding approval or disapproval.
D. The Customer Service Representative will then notify the patient in writing of the following:
   1. If the patient/guarantor qualified for 100 percent charity.
   2. If the patient/guarantor qualified for a reduction in liability, he/she will be notified and payment arrangements made for the amount of the remaining obligation.
   3. If not eligible for any reduction in liability.
E. Falsification of application or refusal to cooperate will result in denial of charity

benefits.

F. The Hospital reserves the right to change benefit determination if financial circumstances have changed. The Patient Accounting Customer Service Representative will not do so without the approval of the Director/Manager of Patient Accounting.

NOTE

CVPH Medical Center may add criteria to the above, which will allow additional persons to be eligible for uncompensated services. Excessive medical expenses or other expenses beyond the control of the patient/guarantor would represent acceptable criteria for exceptions to this policy. Such criteria is considered by the facility when in the view of Hospital management, payment and/or a deferred payment plan would create undue hardship.

IV. DISTRIBUTION

This policy is available in Policy Manager for all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

Attachments

CARES

Dear

Part of our mission at CVPH is to provide access to healthcare for people who do not have the opportunity to be insured.

The enclosed CVPH CARES application is needed to determine if you may be eligible for a governmental program or one of our financial assistance programs. Please contact Upper Hudson Enrollment Services at 562-3740 to see if you are eligible for government sponsored insurance. We will need this information in order to process your application.

Please fill out the application completely and return it with a copy of last year's income tax return, two current pay stubs and/or proof of other income. In the case of married applicants or domestic partners, both husband and wife or partners must sign the application and provide a copy (ies) of income tax returns. Please also include a copy of your denial from Medicaid. We will not process your application without all the information requested.

All applications will be reviewed and weighed against guidelines established for our financial assistance program. You will be notified as to your eligibility within 30 days of the receipt of your application. If you are eligible, you and your family will have access to healthcare at CVPH for a nominal fee or at discounted rates. We will issue the CVPH CARES charity cards for you to present when you access any of the CVPH departments. This card will not cover the cost of the physicians who interpret x-rays, cardiology tests, and pathology exams. Also, you will be responsible for paying physicians who are not employed by CVPH.

Again, take your time and fill the application out completely and return it as soon as possible. If you have any questions and would like to discuss our program, please call 562-7075 OPTION 2. Please return the completed application to: CVPH Medical Center, 21 Plattsburgh Plaza or mailed to PO Box 2868, Plattsburgh, NY 12901, Attn: Cares Program.

Customer Service Representative
Ext: _____

CVPH MEDICAL CENTER

CARES APPLICATION

Applicant Name .....

Mailing Address_____

_____

Phone Number_____

Number of Family Members residing in the household considered dependents per IRS regulations_____

Name of Dependents	Date of Birth	Social Security Number
Applicant	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Annual Gross Income: Employment, Disability, Social Security, Pension, Other

Applicant $_____Source_____

Spouse $_____Source_____

Other $_____Source_____

Tax Return/Other Income: $_____

Applicant: Employer Name_____

Address_____

Spouse/Other: Employer Name_____

Address_____

ASSETS:	Asset Amount	Bank Source
Savings	$_____	_____
Checking	$_____	_____
Stocks/Bonds/CD's	$_____	_____
Other	$_____	_____

YOU MUST ATTACH A COPY OF LAST YEAR'S INCOME TAX RETURN (S), 2 PAY STUBS, PROOF OF OTHER INCOME. PLEASE ALSO INCLUDE ANY OTHER QUALIFYING INFORMATION NEEDED TO PROCESS YOUR APPLICATION.

SELF-EMPLOYED APPLICANTS MUST INCLUDE DENIAL FROM MEDICAID OR UPPER HUDSON ENROLLMENT SERVICES.

I HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS AN ACCURATE AND COMPLETE DISCLOSURE OF MY FAMILY INCOME AND ASSETS. I AUTHORIZE THE HOLDER OF THIS REQUEST FOR UNCOMPENSATED SERVICES TO VERIFY THE ABOVE INFORMATION.

Signature_____Signature_____

Date_____

Thank you for the offer but I am not interested in the Cares Program.

Signature_____Signature_____

Date_____

OFFICE USE ONLY

MR#_____ # FAMILY MEMBER_____

MR#_____ INCOME $_____

CARES Application Review Form

Date received in Office _____

Date reviewed by Cares Committee_____

Information verified by: Vernice Finch

% Federal Poverty Guideline_____100____150____200____250____300____400

Financial Class _____Y01_____Y02_____Y03_____Y04_____Y05

Eligible for balance elimination: _____Yes _____No

Eligible for balance reduction: _____Yes _____No

Discount Percentage for Inpatient: ____ 100% ____80% _____40% ____20% ____ 0%

Discount Percentage for Outpatient: ____100% ____ 86% ____58% ____ 44%____30%

Balance reduced $_____ (See attached print of accounts)

Balance due by patient $_____

Payment Plan _____ for _____ months

Approved By: _____ Date_____

CVPH Cares Card Number_____ Expiration Date_____

Acceptance signed by patient_____Yes_____No

Date Patient Notified_____ Statement sent ____Letter_____

Denial Reason

Failure to provide information,
Failure to take action to obtain 3rd party coverage at qualifying income level
Excessive income or resources
Self-pay DRG offered (for non-eligible patients)_____Yes _____No

Denied By: _____ Date Denied:_____

CVPH CARES PROGRAM INCOME GUIDELINES

Updated 6/10/08 **01-Feb-09**

For families with more than 8 dependants increase base level by: $ 3,740

Selected Payer Rate: Excellus Blue Cross **70%**

# of Dep-endents	% OF Poverty Level	Household Income From:	Household Income To:	Guarantor Share-Inpatient Basis: DRG	Guarantor Share-Outpatient Basis: Charges	# of Dep-endents	Household Income From:	Household Income To:	Guarantor Share-Inpatient Basis: DRG	Guarantor Share-Outpatient Basis: Charges
1	100%	$ -	$ 10,830	$0	$0	5	$ -	$ 25,790	$0	$0
1	150%	$ 10,830	$ 16,245	$0	$0	5	$ 25,790	$ 38,685	$0	$0
1	200%	$ 16,245	$ 21,660	20%	14%	5	$ 38,685	$ 51,580	20%	14%
1	250%	$ 21,660	$ 27,075	60%	42%	5	$ 51,580	$ 64,475	60%	42%
1	300%	$ 27,075	$ 32,490	80%	56%	5	$ 64,475	$ 77,370	80%	56%
1	400%	$ 32,490	$ 43,320	100%	70%	5	$ 77,370	$ 103,160	100%	70%
2	100%	$ -	$ 14,570	$0	$0	6	$ -	$ 29,530	$0	$0
2	150%	$ 14,570	$ 21,855	$0	$0	6	$ 29,530	$ 44,295	$0	$0
2	200%	$ 21,855	$ 29,140	20%	14%	6	$ 44,295	$ 59,060	20%	14%
2	250%	$ 29,140	$ 36,425	60%	42%	6	$ 59,060	$ 73,825	60%	42%
2	300%	$ 36,425	$ 43,710	80%	56%	6	$ 73,825	$ 88,590	80%	56%
2	400%	$ 41,070	$ 58,280	100%	70%	6	$ 88,590	$ 118,120	100%	70%
3	100%	$ -	$ 18,310	$0	$0	7	$ -	$ 33,270	$0	$0
3	150%	$ 18,310	$ 27,465	$0	$0	7	$ 33,270	$ 49,905	$0	$0
3	200%	$ 27,465	$ 36,620	20%	14%	7	$ 49,905	$ 66,540	20%	14%
3	250%	$ 36,620	$ 45,775	60%	42%	7	$ 66,540	$ 83,175	60%	42%
3	300%	$ 45,775	$ 54,930	80%	56%	7	$ 83,175	$ 99,810	80%	56%
3	400%	$ 54,930	$ 73,240	100%	70%	7	$ 99,810	$ 133,080	100%	70%
4	100%	$ -	$ 22,050	$0	$0	8	$ -	$ 37,010	$0	$0
4	150%	$ 22,050	$ 33,075	$0	$0	8	$ 37,010	$ 55,515	$0	$0
4	200%	$ 33,075	$ 44,100	20%	14%	8	$ 55,515	$ 74,020	20%	14%
4	250%	$ 44,100	$ 55,125	60%	42%	8	$ 74,020	$ 92,525	60%	42%
4	300%	$ 55,125	$ 66,150	80%	56%	8	$ 92,525	$ 111,030	80%	56%
4	400%	$ 66,150	$ 88,200	100%	70%	8	$ 111,030	$ 148,040	100%	70%

All discounts above require a meeting with a CVPH representative to determine elibility for governmental programs, and are contingent upon certain payment terms.

This schedule is updated annually based on the federal poverty guideline at http://aspe.hhs.gov/poverty

ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

Policy
Title: HELPING HANDS PROGRAM
Page 1 of 3
☐ **New X Revision** ☐ **Name Change**

Responsible Department: Finance
Administrative Approval:
Date:

I. Purpose

To promulgate the policy/procedures for the administration of Charity Care

II. Policy

In accordance with its Charity Care Program, Elizabethtown Community Hospital will provide uncompensated health care to patients who meet the eligibility guidelines. This policy shall be applied in accordance with established procedures and no patient shall be denied uncompensated health care based upon race, creed, color, sex, national origin, and/or any other prejudgment.

III. Procedure

ELIGIBILITY

Patient's eligibility shall be based on the following information:

A. All patients are eligible to apply.

B. Household income shall determine the percentage of eligibility. Applicants must supply the following:

1. All household income, from all sources for individuals responsible for this obligation, listing gross income for the most recent three-month period (income from seasonal employment will be based on 12 month average.)

2. Number of exemptions as determined by federal income tax laws.
3. A copy of the most recent federal income tax return.
4. Names and dates of birth of all household members.
5. All third party resources and non-hospital financial aid programs, including public assistance available through state Medicaid programs, must be exhausted before Charity Care can be determined.
6. Listing of all possession of assets (such as home, vehicles, recreational vehicles, camp sites etc.).

C. Asset Exemption.

The residence where a patient and/or the patient's family reside, automobiles needed to transport all working parties to and from work.

PROGRAM PROCESS

The Hospital's Charity Care Program shall be administered according to the following guidelines:

A. The completed application (Attachment 1) with copies of all other required information shall be reviewed and verified by the Business Office personnel.
B. After reviewing application the hospital shall determine if the patient/guarantor qualifies for charity benefits based on the income and or asset listings (Attachment 2).
C. Finance personnel shall then do the following:
   1. If the patient qualifies for Charity Care, patient/guarantor will be notified.
   2. If the patient/guarantor qualifies for a reduction on liability, he/she will be notified and payment arrangements can be made in the Business Office to meet individual needs.
   3 If not eligible for any reduction in liability, the patient/guarantor shall be notified and payment arrangements must be made in the Business Office to meet individual needs.
   4 Falsification of application or refusal to cooperate will result in denial of Charity Benefits.
   5 The Hospital reserves the right to change benefit determination should financial circumstances and or assets change.
   6 Charity Care provided shall be budgeted for an annual basis. For 2010 the budget allows for $150,000 in charge base allowances. The budget will be reevaluated in the 4th quarter of each year for possible revision based upon the overall financial performance of the facility.
   7 For patients granted financial assistance, the remaining balance is required to be satisfied within a one year period unless other arrangements are made at the time of application.

D. A patient notice of Financial Aid will be posted throughout the hospital and health centers (Attachment 3)

IV. Definitions (if applicable)

V. Distribution

This policy must be distributed to all Finance personnel.

All receipts of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

DATE:	REVIEWED BY:	REVISION:	RELATED POLICY #:
4/22/2010	A. Chardavoyne		

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
ADMINISTRATIVE POLICY/PROCEDURE MANUAL

Number: 6.23

SUBJECT: Record Retention and Destruction Policy		
WRITTEN BY: Debra Mussen, MIS Director		**RESPONSIBLE DEPARTMENT:** Medical Information Services
CONTRIBUTING DEPARTMENT(S):		
Administrative APPROVAL:		**POLICY CREATION DATE:** JANUARY 1, 1999
NEW:	**SUPERSEDES POLICY:** (SAME AS ABOVE) **DATED:** APRIL 1, 2005	**Revised DATE:** AUGUST 18, 2006
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

I. POLICY

All records and documents will be retained according to an established Record Retention Schedule. The schedule will comply with all regulatory and accrediting agency requirements. Records will be destroyed after the retention requirements are met. Confidential records will be destroyed by burning, shredding, pulping or burying under observation of a CVPH employee.

II. PURPOSE

The purpose of this policy is to ensure that CVPH records and documents are available as needed, and comply with regulatory and accrediting agencies' standards.

III. PROCEDURE

A. Retention Procedures:

1. Records/Documents will be retained as hard copy or a combination of hard copy and/or microfilm, optical disc, magnetic tape, or a computerized form as best meets CVPH needs, in accordance with the Record Retention Schedule (See Attachment A).

2. The retention schedule will comply with the most stringent requirements of the following regulatory/accrediting agencies:

- New York State Code
- Federal Law or Regulation
- Conditions of Participation (Medicare)
- Occupational Safety & Health Administration (OSHA)
- Accrediting Agency Standards (The Joint Commission "TJC")
- Contractual or Advisory Provisions of the Facilities' Liability Insurance Carrier

3. The retention schedule shall be reviewed every two years or as needed in order to comply with any change in regulation. Individual Department Directors will be responsible for notifying the Director of MIS of regulatory changes for inclusion in the policy.

B. Destruction Procedures:

1. Planned Destruction:

a. Planned destruction of records/documents will be carried out as part of the normal business routine of CVPH Medical Center.

b. The Offsite Record Center (hereafter referred to as ORC) staff will coordinate with the Department Director regarding the appropriate destruction process.

c. No further approval for the destruction of records/data shall be required when such destruction is in accordance with the approved Record Retention Schedule.

d. Confidential patient data shall be destroyed in such a way that there is no possibility of reconstructing any of the information. One of the following methods shall be used: shredding, incineration, pulping or burial. The Materials Management Director shall determine the specific method annually, based on the availability of confidential, timely, cost-effective record destruction services.

e. The use of contractual arrangements with a commercial record destruction company shall be permitted provided the appropriate guarantees of confidentiality of data are included in the contractual agreement.

f. The confidentiality of the data shall be maintained throughout the stages of the destruction process.

2. Inadvertent Destruction:

a. The President will be notified of such destruction.

b. A Certificate of Destruction (Attachment B) will be completed to document the information regarding the destruction.

c. For records that do not meet NYS State retention requirements, the Risk Manager will report such destruction to the state.

IV. DISTRIBUTION

This policy will be available in Policy Manager to all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten (10) days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation may be referred to your immediate supervisor.

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
RECORD RETENTION SCHEDULE

Record/Document	Form	Where Filed	Retention Policy	Based on What
CLINICAL RECORDS				
Master Patient Index	Computerized	Computer	Permanent	AHIMA Standards
Medical Records	paper & microfilm	MIS, FCC, HCC, Rehabilitation Medicine, ORC,	10 years. After 10 years the Discharge Summary, Operative Report and Anesthesia Record will be kept for an additional 15 years. Death records will be kept for 6 years after the date of death.	NYS Code 405 requires 6 years or until the age of majority plus 3 years. (Hospital Attorney recommended at least 7 years)
Radiology Films	Film	Department & ORC	6 years or until the age of majority plus 3 years	NYS Code 405
Radiology Films - Mammography films	Film	Department & ORC	For the life of the patient	ACR, MQSA
Fetal Monitor Strips	Paper	ORC	3 years after the age of majority	NYS Code 405
Simulation Films	Film	Department & ORC	Permanent	NYS Code
Register of Births	Paper	OB/Gyn Dept	Permanent	Permanently per AHIMA
Death Log	Paper	Nursing Admin	Permanent	Permanently per AHIMA
Register of Surgical Patients	Paper	Surgical Services	Permanent	Permanently per AHIMA

Record/Document	Form	Where Filed	Retention Policy	Based on What
Emergency Department Logs	Paper & Computer disc	Emergency Department	Permanent	Per AHIMA
Health Care Clinic Logs	Paper & Computer disc	Health Clinic	Permanent	Per AHIMA
Fitzpatrick Cancer Center Logs	Paper	Fitzpatrick Cancer Center	Permanent	
MD Orders filed in Pharmacy	Paper	Pharmacy	7 years	
HUMAN RESOURCES				
Personnel Records	Paper	Human Resources, ORC	Permanent	OSHA 30 year requirement
Employment Applications	Paper	Human Resources, ORC	7 years	EEOC
Arbitration Files	Paper	Human Resources, ORC	Permanent	EEOC
Labor Files	Paper/Computer discs	Human Resources, ORC	7 years after CBA expires	Practice needs
Time Cards--Accounting	Paper/Computer	Education, Human Resources, ORC	3 years	Wage & Hour Laws
Education Files/Schedules	Paper	Human Resources	5 years	OSHA 5 year requirement
ADMINISTRATIVE REPORTS				
Corporate records, including Board and Board Committee Minutes	Paper	Administration	Permanent	
Monthly Statistical Reports	Paper	Accounting Office	Permanent	

Record/Document	Form	Where Filed	Retention Policy	Based on What
Annual Report	Paper	Administration	Permanent	
Incident Reports--Risk	Paper	Risk Management	3 years	Statute of Limitations
Administrative Policies & Procedures--Administration	Paper/Computer disc	Administration	7 years	
Press Ganey Reports--Administration	Paper	Nursing Administration	7 years	
Insurance Policies—Risk	Paper	Risk Management	Permanent	
Medical Department & Committee Meeting Minutes--Medical Staff Office	Paper	Medical Staff Office	Permanent	
Credentialing Records--Medical Staff Office	Paper	Medical Staff Office	Permanent	
Original Standing Committee Minutes	Paper	Committee Dependent	3 years	
Performance Improvement /Quality Assurance/Peer Review	Paper	Quality Management	4 years	
Code 66 Reports--Security	Computer disc	Engineering Department	3 years	
FINANCE				
Budgets	Paper/Computer disc	Accounting Office	7 years	
Plant Ledgers	Paper/Computer disc	Accounting Office	20 years	
Bad Debts	Paper/Computer disc	Service Company	Permanent	

Record/Document	Form	Where Filed	Retention Policy	Based on What
Check Registers	Paper/Computer discs	Accounting Office	Permanent	
Payroll	Paper/Computer discs	Accounting Office	Permanent	
Census Activity Reports	Paper/Computer discs	Accounting Office	Permanent	
Purchase Journals	Paper/Computer discs	Accounting Office	20 years	
Inventories	Paper/Computer discs	Accounting Office	20 years	
Billing Records	Inpatient - paper Outpatient - computer	Accounting Office	7 years	
DEPARTMENTAL RECORDS				
Performance Improvement Reports	Paper/Computer discs	Departments	3 years	NYS Law
Policies & Procedures (except OB/GYN)	Paper/Computer discs	Departments	Current and previous policies kept 3 years, OB/GYN policies kept 21 years.	
Staffing (i.e. schedules, calendars, time & attendance, sick call records)	Paper	Departments	Keep previous calendar year	
Meeting Minutes	Paper/Computer discs	Departments		
NURSING ADMINISTRATION				
Medicus Reports	Paper	Nursing Administration	1 year	

Record/Document	Form	Where Filed	Retention Policy	Based on What
Daily 24 Hour Patient Care Report	Paper	Nursing Administration	1 year	Internal Needs
Daily Patient Care Coordinator Report	paper	PCC Office	1 year	Internal Needs
Daily Sick Call Records	Paper	Staffing Office/Units	1.5 years	Discipline Policy and Contract
Daily Patient Care Assignment Sheets	Paper	Nursing Departments	3 years	TJC/Legal
Maternal Newborn/Pediatric Policies	Paper, Computer discs and Microfilm	Nursing Administration	21 years	NYS code
Nursing Policies and Procedures	Paper, Computer discs and Microfilm	Nursing Administration	7years	Legal
ENGINEERING RECORDS				
Construction Records	Paper	Facilities Services Office	20 years	OSHA
Asbestos Records	Paper	Facilities Services Office	30 years	EPA under NESHAP

JGB/jgb 092600 g:mis\policies\medrec\recordret.p&p

ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

Policy No.: 8-080199
Title: DOCUMENT RETENTION AND DESTRUCTION POLICY
Page 1 of 2 & Attachment A & B
☐ **New X Revision** ☐ **Name Change**

Responsible Department: Administration
Administrative Approval:
Date:

I. Purpose

The purpose of this policy is to ensure that Elizabethtown Community Hospital (ECH) records and documents are available as needed, comply with regulatory and accrediting agencies' standards and are disposed of properly.

II. Policy

All records and documents shall be retained according to an established Record Retention schedule. The schedule shall comply with Title 10 NYCRR §415.22(b) and accrediting agency requirements.

III. Procedure

A. Retention Procedure:

1. Records/Documents shall be retained as paper or digital documents in accordance with Title 10 NYCRR §415.22(b) and the Facility record Retention Schedule. (Attachment A)
2. In the case of paper records for a deceased person or the patient whose records are considered inactive, the above retention procedure (#1) would be applicable. Inactive records by definition would be those records for patients who have not obtained care thru ECH or one of the ECH satellite facilities within a contiguous ten-year period.

B. Record Destruction Procedure:

1. In the first quarter of every year, records shall be checked against Record Retention Schedule and records shall be marked by Health Information Services for destruction.
2. Records will be destroyed by shredding under observation of an ECH employee.
3. All digital records shall be removed from all available digital sources by means of purging the records in accordance with Health Information Services (HIS) policy as it pertains to Title 10 NYCRR §415.22(b) by Information Services and Support personnel with HIS personnel verification.

4. The confidentiality of the data shall be maintained throughout each stages of the destruction process.

C. Inadvertent Destruction or Loss:

1. The Administrator must be notified of such destruction/loss.
2. A Certificate of Destruction (Attachment B) will be completed to document the information regarding the destruction.
3. For records that do not meet New York State retention requirements, the Facility Risk Manager will report such destruction to the State.

IV. Definitions (if applicable)

V. Distribution

This policy must be distributed to all Administrative Staff members, Managers and Nurse Managers by their immediate supervisor.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

DATE:	REVIEWED BY:	REVISION:	RELATED POLICY #:
6/15/09	R. Boula		
8/2001	E. McCann		

Attachment A

ELIZABETHTOWN COMMUNITY HOSPITAL
RECORD RETENTION SCHEDULE

Citation:
AHIMA: American Health Information Management Association
CFR: Code of Federal Regulation
EEOC: Equal Employment Opportunity Commission
HFMA: Healthcare Financial Management Association
OSHA: Occupational Safety and Health Administration
USC: United States Code

Years:
P = Permanent

Category		Years	Citation
Accounting	Accounts Payable Ledger	7	HFMA
	Accounts Receivable Ledger	7	HFMA
	Audit Reports	P	HFMA
	Balance Sheets	P	HFMA
	Bank Deposit, Signature Authorized	P	HFMA
	Bank Deposit Books	3	HFMA
	Bank Deposit Slips	3	HFMA
	Bank Deposit Reconcilements	3	HFMA
	Bank Statements	7	HFMA
	Bills, Paid	P	HFMA
	Budget, Authorizations	7	HFMA
	Budget, Statistical Analysis of Expense	7	HFMA
	Cash Books	P	HFMA
	Cash Disbursements	P	HFMA
	Cash Payroll	P	HFMA
	Cash Receipts	P	HFMA
	Cash Register	10	HFMA
	Check Register	6	AHIMA
	Check Stubs	7	HFMA
	Checked, Cancelled	7	HFMA
	Checked, Payroll	7	HFMA
	Checked, Petty Cash	7	HFMA
	Correspondence	5	HFMA
	Memos, Credit	7	HFMA
	Memos, Debit	7	HFMA
	Expense Records	7	HFMA
	Financial Statements	P	HFMA
	Invoices	7	HFMA
	Journals & Ledgers	P	HFMA
	Notes Paid	P	HFMA
	Operating Statements	P	HFMA
	Payroll Journals	10	HFMA
	Petty Cash Reports	7	HFMA

	Trial Balances	P	HFMA
	Accounts Payable	7	HFMA
	Accounts Receivable	7	HFMA
	General Ledger	P	HFMA
	Voucher Register (Journal)	P	HFMA
Administrative Reports	Admission register	P	AHIMA
	Annual Reports	P	AHIMA
	Accident/ Incident Reports	6 (from the date of creation or the last effective date)	AHIMA
	Administrative Policies & Procedures – Admin	6 (from the date of creation or the last effective date)	AHIMA
	Claims and litigation files	10	HFMA
	Copyright, patent and trademark registration	P	HFMA
	Corporate records, including Board and Board Committee Minutes	P	HFMA
	Corporate – Articles of Incorporation; Charter; Constitution & Bylaws; Documents with Register	P	HFMA
	Daily census	5	AHIMA
	Insurance policies	6 Following expiration	AHIMA
	Insurance - Fidelity	8	HFMA
	-Fire	8	HFMA
	-Hospital	7	HFMA
	-Inspection Certificates	7	HFMA
	-Liability	8	HFMA
	-Workmen's Compensation	10	HFMA
	Inventory - Inventory Control	7	HFMA
	- Plant & Fixtures	P	HFMA
	Legal Contracts:	10	HFMA
	-Customers (non-government)	10	HFMA
	-Government Contracts	10	HFMA
	-Employees	P	HFMA
	-Royalties	P	HFMA
	Medical Department & Committee Meeting Minutes – Medical Staff Office	P	AHIMA
	Property -Inventories	P	HFMA
	-Depreciation records	P	HFMA
	Statistics on admissions and services	P (though daily and monthly reports can be destroyed after year-end statistics are compiled)	AHIMA

	Taxes: Income	P	HFMA
	Property	P	HFMA
	Sales	P	HFMA
	Social Security	P	HFMA
Health Information	Disease Index	P	AHIMA
	ER, paramedic communication	6	AHIMA
	Master patient index	P	AHIMA
	Operative index	10	AHIMA
	Register of Births	10 required P recommended	AHIMA
	Register of deaths (including fetal deaths)	10 required P recommended	AHIMA
	Register of surgical procedures	P	AHIMA
Pharmacy	Controlled substances inventory and orders	5	NYSED-Pharmacy Guide to Practice
	Controlled substances dispensed and administered	5	NYSED-Pharmacy Guide to Practice
	Other prescriptions	5	NYSED-Pharmacy Guide to Practice
Laboratory	Appointment books	3	AHIMA
	Blood and blood component disposition	5	AHIMA
	Blood and blood product testing	5 After processing records are completed Or 6 months After the latest expiration date Whatever is later	42 CFR § 493.1105
	Immunohemotology records and transfusion records	5 After processing records are completed Or 6 months After the latest expiration date Whatever is later	42 CFR § 493.1105
	Patient record index	10 P for unusual cases	AHIMA
	Patient testing records and instrument printouts	2	42 CFR § 493.1105
	Refrigeration and blood	5	AHIMA

	inspection records		
	Chronological test register	5 Or until statistics are complete	AHIMA
	Requests for tests	2	AHIMA
Radiology	Appointment books	3	AHIMA
	Patient record index	10 Or P for unusual cases	AHIMA
	Radioisotopes records	P	AHIMA
	Chronological test register	5 Or until statistics are complete	AHIMA
	Requests for tests	2 weeks	AHIMA
Clinic	Appointment books	3	AHIMA
	Encounter statistics	1	AHIMA
	Patient name index	P	AHIMA
Emergency Dept	On-call physician list	5	42 CFR § 489.20(r)(1-3)
	Central patient log	5	42 CFR § 489.20(r)(1-3)
	Medical and other records of individuals transferred to/from hospital	5	42 CFR § 489.20(r)(1-3)
Nursing	Operation index	P	AHIMA
	Patient records index	P	AHIMA
	Physician index	10	AHIMA
	Surgery log	P	AHIMA
	Tumor registry files	P	AHIMA
	Private duty name file	6 After last use	AHIMA
	Examinations	P	AHIMA
Human Resources	Absence reports	5	AHIMA
	Attendance ; time records; time cards	2	AHIMA
	Applications	7	EEOC
	Arbitration Files	P	EEOC
	Earnings Records	P	HFMA
	Education Files/Schedules	5	OSHA
	Employee Benefit summaries	6 After filing	29 USC § 1027
	Employee Contracts	10	HFMA
	Employment Releases	P	HFMA
	Garnishments	10	HFMA
	Government reports	6	HFMA
	Job classifications	P	AHIMA
	Overtime reports	5	AHIMA
	Payroll analysis	7	HFMA
	Payroll records	5	AHIMA
	Payroll tax returns	4	HFMA
	Pensions	P	AHIMA

	Personnel Records	6 Following employment termination	AHIMA
	Service records	P	HFMA
	Social Security reports	4 After taxes paid Or 4 After taxes were due whichever is later	26 CFR § 31.6001.21
	Wage Rate Changes	8	HFMA
	Withholding certificates	P	HFMA
Public Relations	Advertising, Contracts	5	HFMA
	Correspondence	2	HFMA
	Drawing & Artwork	2	HFMA
	Annual report	P	HFMA
Purchasing			
	Correspondence	5	HFMA
	Invoices	7	HFMA
	Packing slips	3 Months	AHIMA
	Purchase Orders	7	HFMA
	Sales:		
	Purchase Journal/Register	7	HFMA
	Accounts Receivable Register	7	HFMA
	Correspondence	5	HFMA
	Customer Orders	7	HFMA
	Invoices	7	HFMA
	Remittance statements	2	HFMA
	Sales journal/register	7	HFMA
	Summaries of expense	7	HFMA
	Traffic Department:		
	Bills of lading	4	HFMA
	Freight bills	4	HFMA

Revised as per Pharmacy Director, 8/10/09

Attachment B

Certificate of Destruction

The information described below was destroyed in the normal course of business pursuant to a proper retention schedule and destruction policies and procedures.

Date of destruction: _____

Description of records or record series disposed of:

_____

_____

_____

Inclusive dates covered: _____

Method of destruction:

( ) Shredding

( ) Demagnetizing

( ) Overwriting

( ) Other _____

Records destroyed by: _____

Witness signature: _____

Department Manager: _____

BIBLIOGRAPHY

Journal of Health and Hospital Law, Vol. 30, No. 2, Model Corporate Compliance Plan for Clinical Laboratories

Work Plan - Fiscal Year 2007, Department of Health and Human Services, Office of Inspector General

The Office of Inspector General's Compliance Program Guidance for Hospitals

A Manual for Compliance for Health Care Executives, Coopers & Lybrand, American Hospital Association

Regulatory Standards Manual, American Hospital Association

OIG Compliance Program Guidance for Ambulance Supplies

OIG Compliance Program Guidance for Third Party Medical Billing Companies

GLOSSARY

CPT	Physicians Current Procedural Terminology
HCPCS	Centers for Medicare and Medicaid Services Common Procedure Coding System
Upcode	The selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service.
DRG Creep	Increased average case mix index due to coding changes.
Unbundling	Billing of tests that have traditionally been done as a group with one charges, separated into individual tests with separate charges that add up to more than the one fee.