Community Memorial Hospital

Hamilton, New York

CORPORATE COMPLIANCE MANUAL

COMMUNITY MEMORIAL HOSPITAL
CORPORATE COMPLIANCE MANUAL
TABLE OF CONTENTS

Dear Employees:

Community Memorial Hospital (CMH) is subject to a wide variety of legal, regulatory and professional requirements with which we all must comply. This Corporate Compliance Manual includes information about how the Compliance Program affects you and where you may go for assistance in order to have your questions or concerns addressed.

In this changing and challenging era for health care, the public's trust and confidence in and respect for CMH requires the commitment of each of us to uphold standards of excellence and ethical behavior. Now more than ever before, we believe it is important to reaffirm CMH's long-standing commitment to comply with regulations and to conduct business affairs with honesty and integrity. We want to ensure that there continues to be no basis for charges of noncompliance with laws and regulations against our organization and Employees.

This Corporate Compliance Manual should be utilized as a resource on an ongoing basis. We expect you to take the time to review this Manual. This Manual and other compliance-related documents will be available through the Office of the Corporate Compliance Coordinator. Thank you for your continuing efforts to provide quality healthcare close to home.

PURPOSE

The purpose of this Corporate Compliance Manual is to provide guidelines designed to reflect CMH's commitment to promoting prevention, detection and resolution of instances of potential misconduct. In addition, the Corporate Compliance Program will assist conformity with Federal and state law and health care program requirements through an effective internal control structure.

The goals of the Corporate Compliance Program initiative are to:

- Build upon our mission and our values;
- Provide a common understanding of CMH's expectations for proper conduct;
- Provide a process for addressing concerns;
- Provide a framework for dealing with difficult, complex or confusing issues; and
- To ensure that Federal and state regulatory guidelines are followed.

COMMITMENT STATEMENT

CMH has demonstrated a commitment to compliance through the following actions:

1) The development and distribution of compliance policies and procedures that promote CMH's commitment to compliance.

2) The designation of a Corporate Compliance Coordinator and a Corporate Compliance Committee charged with the responsibility of operating and monitoring the Corporate Compliance Program.

3) The development and implementation of periodic compliance-related training and education programs for all employees and agents[1], as necessary.

4) The implementation of an employee compliance hotline to receive reports of potential non-compliance or concerns.

5) The implementation of a process to respond to allegations of potential non-compliance, improper or illegal activities.

6) The use of periodic reviews (e.g., monitoring and auditing) to monitor compliance in certain departments.

7) The investigation of identified systemic problems and a process that addresses the non-employment or retention of OIG sanctioned individuals.

[1] Agents are defined as contracted employees such as physicians, social service staff, speech pathologists, etc.

IDENTIFIED COMPLIANCE RISK AREAS FOR COMMUNITY MEMORIAL HOSPITAL

The Office of Inspector General (OIG), a part of the Federal Government has developed numerous Compliance Program Guidances for many health care industry segments. There are similarities with all the Guidances; all are structured with the seven elements of a Compliance Program (refer to Commitment Statement above) and all have topics that the OIG has designated as high-risk areas for potential healthcare fraud and abuse. The Compliance Program Guidances are an example of the OIG's concern for healthcare fraud and abuse and their commitment to decreasing the instances of healthcare fraud and abuse.

There are three OIG Compliance Program Guidances that are applicable to Community Memorial Hospital's scope of business:

- Hospitals (which can also be applied to CMH clinics),
- Clinical Laboratories and
- Nursing Facilities.

All employees and agents should be aware of the risk areas, definitions and/or examples listed below and should bring any potential instance of non-compliance or concern to the attention of his or her direct supervisor or the Corporate Compliance Coordinator.

DESIGNATION OF A COMPLIANCE PROGRAM OVERSIGHT STRUCTURE

The Compliance Program Oversight Structure consists of:

- Corporate Compliance Committee, and
- Corporate Compliance Coordinator.

The (above) compliance-related roles have been added to existing positions at Community Memorial Hospital. The roles have been developed to ensure appropriate oversight of planning, designing, implementing, and maintaining organization-wide Compliance Programs and associated policies and procedures.

The Corporate Compliance Coordinator role requires the Compliance Coordinator to have complete and unrestricted access to information, employees and agents required to complete the designated corporate compliance responsibilities.

The Corporate Compliance Committee

The Corporate Compliance Committee members consist of department managers and senior management personnel who, in the Corporate Compliance Committee capacity, will serve as an oversight body for our Corporate Compliance Program. These individuals have dual roles, to compliance and to their other area of operational responsibility.

The Committee's primary responsibilities include:

- Review the Corporate Compliance Program on an annual basis, including the annual work plan, training sessions and policies.
- Oversee organizational response and corrective actions that address instances of non-compliance.
- Oversee and support periodic auditing activities to detect wrongdoing or weaknesses in the organization with respect to corporate compliance.
- Oversee enforcement of compliance standards and procedures through the use of the existing disciplinary process.

The Corporate Compliance Coordinator

The Corporate Compliance Coordinator serves as Chair of the Corporate Compliance Committee and reports in an advisory capacity to the Board of Trustees. The Corporate Compliance Coordinator is the Vice President of Administration.

The Corporate Compliance Coordinator's primary responsibilities include:

- Review the Corporate Compliance Program on an annual basis, including the annual compliance work plan, training sessions and compliance-related policies.
- Meet with Community Memorial Hospital personnel, as requested, to discuss concerns of potential non-compliance.
- Hire external auditors who have expertise in Federal and state statutes, regulations and Federal Health Care Program requirements to conduct compliance-related audits, as necessary.
- Respond to compliance-related questions, concerns and reports of possible instances of non-compliance received through the hotline or other forms of communication.
- Attend staff meeting for each department to discuss department specific compliance initiatives as required or as requested.
- Assign employees who have expertise in Federal and state statutes, regulation and Federal Health Care Program requirements to conduct internal audits, as necessary.
- Oversee and coordinate ongoing monitoring and auditing of the Corporate Compliance Program and provide periodic reports regarding compliance activities.
- Coordinate with the Compliance Committee to develop corrective action plans to address instances of non-compliance and monitor the implementation of corrective action plans, as necessary.

EMPLOYEE ROLE AND RESPONSIBILITY

CMH relies on all employees to ensure that we continue to operate in a legal and ethical manner. Without you, the Corporate Compliance Program cannot succeed. As such, you are responsible for:

- Being honest in your dealings with patients, physicians, providers, vendors, payors and fellow employees and agents;
- Becoming familiar with and acting in accordance with the Corporate Compliance Program, including the Compliance Manual, policies, procedures, laws and regulations related to your job;
- Seeking guidance when you are uncertain about how to apply the Corporate Compliance Program, Compliance Manual or what action to take in a certain situation;
- Listening and responding to questions, complaints or concerns expressed by patients, family members, visitors or co-workers; and
- Promptly reporting violations of the Corporate Compliance Program including the Compliance Manual, policies, procedures, laws or regulations to your supervisor or the Compliance Coordinator.

WHERE TO GO FOR ASSISTANCE

Since many of the laws and regulations that apply to CMH are complex, you may have questions or concerns. If you have a question, would like to report a concern or a potential circumstance of non-compliance, the following options are available:

- Discuss the question or concern with your direct supervisor.
- Call the Corporate Compliance Coordinator directly at 824-6083.
- Call the Community Memorial Hospital Hotline at 824-7016

** For employee relation matters, please contact your direct supervisor as you normally would.*

The Hotline and Corporate Compliance Coordinator are not there to deter you from utilizing the usual reporting structure of contacting your direct supervisor with a concern. However, in the event the concern deals with your direct supervisor, you feel uncomfortable going to your direct supervisor or your past reports to your direct supervisor remain unresolved, then it is suggested that you use another available option, like the hotline.

When making a report to the Hotline you have the option of remaining anonymous. However, it will help the Corporate Compliance Coordinator in responding to your concern if you identify yourself. The Corporate Compliance Coordinator will do his or her best to keep all questions and reports confidential to protect the individual making the report.

It is your responsibility to promptly raise questions or report concerns. It's the only way our Corporate Compliance Program will be effective. Community Memorial Hospital will not tolerate retribution or retaliation against any employee or agents whom acts in good faith in raising a question or concern. Community Memorial Hospital requires your assistance to discover if there are mistakes being made so that CMH has an opportunity to correct them.

The Corporate Compliance Coordinator will initiate a response to all reports made within ten business days. If necessary, the Corporate Compliance Coordinator will seek advice from external legal counsel based on the severity of allegations.

If the reported incident(s) requires disciplinary action, the disciplinary process will follow the normal Community Memorial Hospital disciplinary policy. If necessary, the Corporate Compliance Coordinator, Chief Executive Officer, and Chief Financial Officer will consult with legal counsel with respect to the enforcement of the disciplinary process and policy.

If it is determined that criminal misconduct has occurred, the matter will immediately be referred to external legal counsel to initiate contact with the appropriate law enforcement agency. Community Memorial Hospital is committed to returning any overpayment obtained in error from a Federal Health Care Program or other payor.

The Corporate Compliance Coordinator is responsible for evaluating the training and education needs and ongoing monitoring activities which will be enhanced, to the extent necessary, to prevent any reoccurrence of non-compliance.

Please refer to the Compliance Hotline Policy and the Internal Investigation Policy for additional guidance.

WHAT TO DO IN THE CASE OF A GOVERNMENT INVESTIGATION

While it is very unlikely, an on-site Federal Government fraud and abuse investigation could occur at Community Memorial Hospital. Community Memorial Hospital is committed to preparing employees and agents in the unlikely event it should happen.

An investigation could be commenced during any time of the day, evening or night. Government officials could be from the OIG, DOJ, Federal Bureau of Investigations (FBI), United States Attorneys Office, the Fiscal Intermediary (FI) (Empire Medicare), the State Attorney General's Office, the State Department of Health and/or Medicaid. All employees and agents should follow the appropriate steps should a Government Agent present himself or herself at Community Memorial Hospital. It is important to note that in the past, Government Agents have attempted to use intimidation to obtain confidential information about providers that includes questioning an employee or agent at his or her home residence. Therefore, the following steps apply to Government Agents who may contact an employee or agent on or off the CMH property.

Employees and agents should:

1. Immediately notify their direct supervisor or the Nursing Supervisor on duty (if the direct supervisor is not on duty).
2. The direct supervisor (or Nursing Supervisor) should immediately notify the Corporate Compliance Coordinator after receiving a contact from governmental agencies that may be conducting an investigation of Community Memorial Hospital. (Contact is defined to include presenting a search warrant, any requests from governmental agencies to schedule

future interviews or meetings with employees and agents or for written information under circumstances where the request seems out of the ordinary.)

3. Do not inadvertently waive your personal or CMH rights such as the attorney-client privilege, the right to counsel and the right against self-incrimination.
4. Upon initial contact, the employee or agent should only provide the name and location of the Corporate Compliance Coordinator. Employees and agents do not have to answer any questions prior to the appropriate party's arrival.

The Corporate Compliance Coordinator will notify external legal counsel, the Chief Financial Officer and Chief Executive Officer. External legal counsel will direct the investigation, in consultation with the Corporate Compliance Coordinator.

Please refer to External Investigation Policy for additional guidance.

BILLING AND CLAIMS SUBMISSION STANDARDS

When claiming payment for Community Memorial Hospital or professional services, Community Memorial Hospital has an obligation to its patients, third party payors, and the Federal and state governments to exercise diligence, care and integrity with respect to billing and claims submission. The right to bill the Medicare and Medicaid programs, conferred through the award of a provider number or supplier number, carries a responsibility that may not be abused. Community Memorial Hospital is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout CMH, have responsibility for entering charges and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules.

Any false, inaccurate, inappropriate or questionable claims should be reported immediately to the Chief Financial Officer or to the Corporate Compliance Coordinator. Examples of false claims include:

- Claiming reimbursement for services that have not been rendered,
- Filing duplicate claims,
- "Upcoding" to more complex procedures than were actually performed,
- Including inappropriate or inaccurate costs on cost reports,
- Billing for an inappropriate length of stay beyond what is medically necessary,
- Billing for inappropriate services or items that are not medically necessary and
- Failing to provide medically necessary services or items.

There are steep fines, penalties and exclusions from the Federal Health Care Program that can be assessed for providers who are found to have submitted false claims under the Civil and Criminal False Claims Act.

OIG EXCLUSION CHECKS

The OIG has authority to exclude individuals and entities from the Federal Health Care Programs. The OIG also has the authority to assess penalties to providers that violate the law

by employing or contracting with an excluded individual or entity. Examples of reasons for exclusions include civil or criminal health care fraud and abuse and defaulting on student loans.

Community Memorial Hospital is prohibited from employing or contracting with any employee, agent or vendor who is listed by the OIG as debarred, excluded or otherwise ineligible for participation in Federal Health Programs. This prohibition is necessary to ensure Community Memorial Hospital receives appropriate Federal Health Care Program reimbursement for items and/or services provided to patients.

Any employee, agent or vendor who is charged with criminal offenses related to health care, must be removed from direct responsibility for or involvement in any Federal Health Care Program until resolution occurs. If resolution results in conviction, debarment or exclusion of the employee, agent or vendor, CMH's Corporate Compliance Committee must immediately review the case and proceed with termination of the contract or employment.

COMPLIANCE TRAINING & EDUCATION STANDARDS

Community Memorial Hospital's initial compliance training program shall:

- Highlight the importance of a Corporate Compliance Program;
- Highlight our customized Corporate Compliance Program and Manual, and
- Summarize fraud and abuse laws.

This initial training will be provided to employees and agents in April 2001. This initial compliance training will be incorporated into the General Orientation process for all future employees and agents.

Periodic compliance training and education sessions will be developed and scheduled by the Corporate Compliance Coordinator. Attendance and participation in these education programs is a condition of continued employment. Attendance will be tracked and enforced.

DISCIPLINARY STANDARDS

Upon discovery of non-compliance with the Corporate Compliance Program, employees and agents are subject to the existing CMH disciplinary process and policies. As necessary, the Corporate Compliance Coordinator, Chief Executive Officer and Chief Financial Officer will consult with legal counsel with respect to the need to enforce CMH's disciplinary policy, as appropriate.

COMPLIANCE PROGRAM EFFECTIVENESS

This Corporate Compliance Program shall be reviewed annually by the Corporate Compliance Committee and Corporate Compliance Coordinator to evaluate the effectiveness of the plan

and to determine if changes and/or revisions are necessary. The annual evaluation shall be promptly submitted to the Board of Trustees for consideration.

MONITORING & AUDITING STANDARDS

Community Memorial Hospital recognizes the importance of performing regular, periodic compliance audits.

Compliance monitoring and auditing procedures will be implemented that are designed to determine the accuracy and validity of the billing and coding submitted to Federal, state and private health care programs and to detect other instances of potential misconduct by employees and agents. Specific monitoring and auditing plans will be included in the annual compliance work plan.

FREQUENTLY ASKED QUESTIONS

The following questions and answers provide examples of how to apply Community Memorial Hospital's Corporate Compliance Program:

Q: *Physicians or nurses often call the Medical Records Department to correct or change a diagnosis in response to a patient complaint about claim reimbursement. Should providers or their employees call to correct or change information related to patient accounts?*

A: Only the provider who submitted the original information should make corrections to medical claim information. In addition, all changes to claim information must be supported by medical record documentation prior to initiating changes to the claim for reimbursement.

Q: *What should I do if, in preparation for an accreditation visit, my supervisor asks me to review medical records and to fill in any missing signatures?*

A: It is against the law to attempt to authenticate a signature that is not your own. You may not sign another health care provider's name in the medical record. Our basic integrity obligation stipulates that only complete and fully accurate information may be provided to accrediting groups. If a supervisor asks you to sign another person's name in a medical record, you should contact your supervisor's supervisor or call the Hotline.

Q: *May a department or individual accept a basket of fruit or flowers sent by a patient, resident, physician or family member?*

A: Yes. Gifts to an entire department or an individual may be accepted if they are consumable or perishable.

Q: *What do I do if a resident's family member attempts or would like to provide a monetary donation to the CMH?*

A: Community Memorial Hospital appreciates donations because it assists us in carrying out our not-for-profit mission. Therefore, refer the family member to the Business Office where the family member can be advised on completing the required paperwork.

Q: *We live in a small town, and most people in the community know one another. There is a physician in our hospital that sometimes requests medical records, whether he is taking care of the patient or not. Is he allowed to do this?*

A: No. Only the attending, covering or consulting physician may have access to a patient's medical records. Patients are entitled to expect confidentiality, the protection of their privacy and the release of information only to authorized parties.

Q: *I received a phone call from a co-worker from home after she completed her shift. She told me she forgot to enter an order for a change in medication for a patient that had been phoned in at 9:00 a.m. by the patient's physician. She asked me to log the changes into the patient's chart at the appropriate time, 9:00 a.m., and to use her initials. Is this okay?*

A: While your co-worker did the right thing by calling to note the chart error, the error should be promptly reported to your shift supervisor. You should never record an order you did not hear and never sign someone else's signature or initials. Even if no harm occurred in this case, the error needs to be reported. Community Memorial Hospital will not tolerate retaliation against employees who promptly report errors or omissions.

Compliance Coordinator
JOB DESCRIPTION

JOB TITLE: Compliance Coordinator

REPORTS TO: Chief Executive Officer (CEO) and Board of Trustees

General Summary:

In coordination with the Board of Trustees, the CEO and the Management Compliance Committee, the Compliance Coordinator is jointly responsible for the design, development and implementation of the Hospital's corporate compliance program. Community Memorial Hospital acknowledges that the Compliance coordinator shall have complete and unrestricted access to information and individuals required to complete the designated corporate compliance activities.

Principal Duties & Responsibilities:

- Facilitate and coordinate development and implementation of the overall corporate compliance program which addresses all of the elements of the U.S. Federal Sentencing Guidelines including the implementation of the Healthcare Center's programs, policies and procedures to ensure system compliance with applicable Federal and state laws and regulations.
- Report on a regular basis to the Board of Trustees and CEO regarding ongoing compliance activities and provide recommendations for improvement to the corporate compliance program annually, at a minimum.
- Serve as the Chairperson of the Management Compliance Committee and regularly communicate progress of hotline reports, corrective action plans, progress of the annual plan and ongoing compliance activities.
- Assist in communication of the elements of the compliance program, including written materials and training programs designed specifically to promote understanding of compliance issues, laws and regulations and consequences of non-compliance, as necessary.
- Maintain an awareness of laws and regulations, keeping abreast of current changes and applicable government fraud and abuse enforcement initiatives that may affect healthcare systems through personal initiative, seminars, training programs and peer contact.
- Review policies and procedures that identify standards for compliance.
- Direct efforts to communicate elements of the compliance program, utilizing written materials and training programs designed specifically to promote an understanding of compliance issues, laws and regulations and consequences of non-compliance.
- Meet with Community Memorial personnel, as requested, to discuss concerns of potential noncompliance.
- Oversee the coordination of all government or other payor inquiries and/or investigations.

- Interact with legal counsel to manage the organization's billing compliance initiatives, including all government or other payor inquiries or investigations and legal duties imposed by government agencies and others.
- Oversee ongoing monitoring and auditing of the corporate compliance program including periodic reports specifying compliance activities among various service areas.
- Commission compliance audits by external auditors who have expertise in Federal and state statutes, regulations and Federal healthcare program requirements, as necessary.
- Review corrective action plans that address noncompliance and monitor, as necessary.
- Provide input and present annual work plan to the Board of Trustees, CEO and Management Compliance Committee.
- Perform an annual compliance review to ensure corporate compliance program elements are operating effectively.
- Review the annual compliance work plan to ensure it appropriately addresses and prioritizes potential compliance risks.
- Other duties as assigned by the Board of Trustees and Chief Executive Officer.

Approved by:

Sean M. Fadale, FACHE President & Chief Executive Officer	4/25/14 Date	Denise Hummer VP, Corporate Compliance Coordinator	4/25/14 Date

Compliance Liaison
JOB DESCRIPTION

JOB TITLE: Compliance Liaison

REPORTS TO: Compliance Coordinator and Management Compliance Committee

General Summary:

Each department director, manager or supervisor of the Hospital with the assistance of other departmental personnel, as appropriate, will be responsible for serving as a Compliance Liaison to the Management Compliance Committee, in connection with the Hospital's Corporate Compliance Program. Each Liaison will have a dual reporting responsibility to the Compliance Coordinator, Management Compliance Committee and their current supervisor, manager, director or vice-president. Compliance Liaisons are responsible for the managerial and administrative tasks involved in the ongoing development and implementation of the Corporate Compliance Program at the Hospital and at the departmental level.

The purpose of the Corporate Compliance Program is to promote adherence to applicable Federal and state law, and the requirements of Federal, state and private health plans, through an effective internal control structure. The Compliance Liaison's role is to provide ongoing support and assistance to the Corporate Compliance Coordinator and Management Compliance Committee from a departmental perspective. This individual should maintain a working knowledge of the Hospital's Corporate Compliance Program and applicable government fraud and abuse enforcement initiatives.

Principal Duties & Responsibilities:

- Identify regulatory compliance risk areas and/or issues impacting the department and communicate them to the Corporate Compliance Coordinator.
- Adequately instruct department personnel to comply with relevant laws and regulations.
- Lead coordination of training and education related to specific regulatory compliance issues at each respective departmental level.
- Detect instances of potential noncompliance with applicable policies, laws and regulations and report issues identified to the Corporate Compliance Coordinator.
- Encourage individuals in the department to request guidance or report suspected compliance violations appropriately.
- Respond to questions and concerns in coordination with the Corporate Compliance Coordinator, if necessary.
- Interact frequently with and routinely report to the Corporate Compliance Coordinator on any potential noncompliant activities.
- Be prepared to present reports to Management Compliance Committee on departmental compliance risks and monitoring and auditing results, if requested.

- Develop and write policies and procedures that identify standards for compliance and provide specific guidance to management, medical staff and individual departments, as appropriate.
- Actively lead and/or conduct monitoring and auditing procedures to evaluate and enforce compliance standards at each respective department and report results to the Corporate Compliance Coordinator and the Management Compliance Committee.
- Assist with compilation of annual compliance work plan.
- Oversee monitoring of regulatory changes affecting the department and lead development of solutions to address any resulting issues.
- With guidance from the Corporate Compliance Coordinator and/or Management Compliance

Approved by:

Sean M. Fadale, FACHE
President & Chief Executive Officer

4/25/14
Date

Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

4/25/14
Date

Management Compliance Committee
Role & Responsibilities

The Management Compliance Committee consists of individuals with varying responsibilities at CMH. These members consist of management and senior management personnel who, in the Management Compliance Committee capacity, will serve as an oversight body for our Corporate Compliance Program. This committee is a subcommittee of the Professional Activities Committee. These individuals have dual roles, in compliance and in their other area of operational responsibility. The Corporate Compliance Coordinator will report to the Board of Trustees on at least an annual basis. This committee is responsible for providing necessary support to the Corporate Compliance Coordinator in the day-to-day execution and maintenance of the Corporate Compliance Program and Standards of Conduct.

The objective of the Program is to promote adherence to applicable Federal and state law, and to the program requirements of Federal, state and private health plans through an effective internal control structure. The responsibilities of the Committee include:

- Establish and maintain the oversight structure for the Program.
- Establish oversight authority and create procedures for meetings of the oversight body.
- Ensure due care is exercised in assignment of responsibilities.
- Oversee due diligence procedures that address the compliance risks of any potential merger or joint venture partner.
- Oversee development and maintenance of compliance standards and procedures.
- Oversee training and education programs for organization-wide compliance to ensure standards and procedures are effectively communicated.
- Maintain awareness of laws and regulations and keep abreast of current changes and applicable government frauds and abuse enforcement initiatives that may affect the Hospital.
- Establish and oversee a reporting system to address compliance issues.
- Oversee organizational response and corrective actions that address instances of noncompliance.
- Oversee and support periodic auditing activities to detect wrongdoing or weaknesses in the control environment with respect to corporate compliance.
- Oversee enforcement of compliance standards and procedures through the use of appropriate disciplinary policies.
- Provide support to implement requested monitoring and auditing activities to address potential noncompliance report and/or annual work plan.

- Review and revise the annual compliance work plan.
- Review and revised the compliance program.

Approved by:

Sean M. Fadale, FACHE President & Chief Executive Officer	4/25/14 Date	Denise Hummer, BS, RN VP, Corporate Compliance Coordinator	4/25/14 Date

Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Compliance Monitoring and Auditing Protocol	**PAGE** 1 of 1
FORMULATED: 5/01	**REVIEWED:** 3/15
DATE ISSUED:	**REVISED: 7/11, 4/14**

PURPOSE

Community Memorial Hospital (CMH) believes that auditing and monitoring is critical to the success of the compliance program. Part of the Corporate Compliance Program is to plan for and conduct routine ongoing monitoring and auditing activities identified by the Office of Inspector General (OIG) Program Guidance and OIG Work Plans in addition to any areas of suspected noncompliance.

POLICY

The Corporate Compliance Coordinator, with the assistance of the Corporate Compliance Committee is primarily responsible for commissioning ongoing monitoring and auditing procedures by internal designees such as Department Managers in addition to external independent consultants in order to fulfill the Corporate Compliance Program goal.

PROCEDURE

Compliance monitoring will be conducted through the use of existing reports and customized reports that are designed primarily to detect areas of potential risk areas based on outliers, utilization differences, etc. Compliance auditing will be conducted through verification of the accuracy and validity of the billing, coding and associated medical record documentation (i.e. requisition, physician order) submitted to Federal, state and private healthcare programs. Random samplings of records drawn from a cross-section of departments will be conducted on an annual basis. In addition, special attention will be given to reviewing claim denials and other facts that may suggest inappropriate conduct.

CMH will promptly repay any overpayment that it discovers. CMH will establish a reserve account to hold any disputed funds until the results of an internal investigation to determine whether the money is an overpayment to be repaid or whether it was properly paid and should be returned to general funds. All overpayments and disputed funds discovered must be brought to the attention of the Chief Financial Officer immediately

Any suspected incidents of non-compliance shall be brought to the attention of the Corporate Compliance Coordinator for review and action.

Approved by:

Sean M. Fadale, FACHE
President and Chief Executive Officer

Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

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Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Billing and Claims Submission Protocol	**PAGE** 1 of 3
FORMULATED: 5/01	**REVIEWED:** 3/15DK
DATE ISSUED:	**REVISED: 7/11, 4/14**

PURPOSE:

Employees and agents[1] should be aware of and comply with this protocol in order to prevent accidental or intentional submission of false claims.

POLICY:

When claiming payment for Community Memorial Hospital (CMH) or associated professional services, CMH has an obligation to its patients, third party payors, and the state and federal governments to exercise diligence, care and integrity. The right to bill the Medicare and Medicaid programs, conferred through the award of a provider or supplier number, carries a responsibility that may not be abused. CMH is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout CMH, have responsibility for entering charges and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules. Any false, inaccurate or questionable claims should be reported immediately to a supervisor or to the Compliance Coordinator.

False billing is a serious offense. Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made any false statement or representation of a material fact in an application for benefits or payment. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. Examples of false claims include:

- Claiming reimbursement for services that have not been rendered
- Filing duplicate claims
- "Upcoding" to more complex procedures than were actually performed
- Including inappropriate or inaccurate costs on CMH cost reports
- Falsely indicating that a particular healthcare professional attended a procedure or that services were otherwise rendered in a manner they were not
- Billing for an inappropriate length of stay beyond what is medically necessary
- Billing for inappropriate services or items that are not medically necessary
- Failing to provide medically necessary services or items

A provider or supplier who violates the false claims rules is guilty of felony, and may be subject to fines of up to $25,000 per offense, imprisonment for up to five years, or both. Other persons guilty of false claims may face fines of up to $10,000 per offense, imprisonment for up to one year, or both. In addition to the criminal penalties, the Federal False Claims Act permits substantial civil monetary penalties against any person who submits false claims. The Ace provides a penalty of triple damages as well as fines up to $10,000 for each false claim submitted. The person (as well as the CMH) may be excluded from participating in the Medicare and Medicaid programs. Violations of the assignment and reassignment rules are misdemeanors carrying fines up to $2,000 and imprisonment of up to six months, or both.

[1]Agents are defined as contracted employees such as physicians, social service staff, speech pathologists, etc.

In addition to these federal prohibitions and penalties, New York State, likewise prohibits knowingly, by means of a false statement or representation, or by other fraudulent scheme or device, attempting to obtain benefits or payments. Violations of State Law may be punishable by civil damages equal to three times the amount by which any figure is falsely overstated or $5,000, whichever is greater or monetary penalty not to exceed $2,000 to the Medicaid program.

Numerous other federal laws prohibit false statements or inadequate disclosure to the government and mandate exclusion from the Medicare and Medicaid programs. For instance, neither CMH nor its agents are permitted to make, or induce others to make, false statements in connection with CMH's Medicare certification. Persons doing so are guilty of a felony and may be subject to fines of up to $25,000 and imprisonment for up to five years. CMH or individual healthcare providers will be excluded from the Medicare and Medicaid programs for at least five years if convicted of a Medicare or Medicaid related crime or any crime related to patient abuse. Medicare and Medicaid exclusion may result if CMH or a provider is convicted of fraud, embezzlement, or other financial misconduct in connection with any government financed program.

It is illegal to make a false statement to the federal government, including statements on Medicare or Medicaid claim forms. It is illegal to use the U.S. mail in a scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government.

PROCEDURE:

1. CMH employees and agents who prepare or submit claims should be alert for these and other errors. It is important to remember that outside consultants only advise CMH. The final decision on billing questions rests with CMH.

2.. In compliance with federal law, CMH does not permit charging for a Medicaid service at a rate higher than that approved by the state or accepting any payment as a precondition of admitting a Medicaid patient to CMH.

3. CMH carefully follows the Medicare rules on assignment and reassignment of billing rights. If there are any questions regarding whether CMH may bill for a particular service, either on behalf of a physician or on its own behalf, the questions should be directed to the Chief Financial Officer or Corporate Compliance Coordinator for review.

4. CMH employees should not submit claims for other entities or claims prepared by other entities, including outside consultants, without approval from the Compliance Officer. Special care should be taken in reviewing these claims, and CMH personnel should request documentation from outside entities if necessary to verify the accuracy of the claims.

5. CMH promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity and accuracy in all its financial dealings. Each employee and professional, including outside consultants, who is involved in submitting charges, preparing claims, billing and documenting services is expected to maintain the highest standards of personal, professional and institutional responsibility.

Approved by:

Sean M. Fadale, FACHE
President and Chief Executive Officer

4/25/14
Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Compliance Monitoring and Auditing Protocol	**PAGE** 1 of 1
FORMULATED: 5/01	**REVIEWED:** 3/15(DH)
DATE ISSUED:	**REVISED: 7/11, 4/14**

PURPOSE

Community Memorial Hospital (CMH) believes that auditing and monitoring is critical to the success of the compliance program. Part of the Corporate Compliance Program is to plan for and conduct routine ongoing monitoring and auditing activities identified by the Office of Inspector General (OIG) Program Guidance and OIG Work Plans in addition to any areas of suspected noncompliance.

POLICY

The Corporate Compliance Coordinator, with the assistance of the Corporate Compliance Committee is primarily responsible for commissioning ongoing monitoring and auditing procedures by internal designees such as Department Managers in addition to external independent consultants in order to fulfill the Corporate Compliance Program goal.

PROCEDURE

Compliance monitoring will be conducted through the use of existing reports and customized reports that are designed primarily to detect areas of potential risk areas based on outliers, utilization differences, etc. Compliance auditing will be conducted through verification of the accuracy and validity of the billing, coding and associated medical record documentation (i.e. requisition, physician order) submitted to Federal, state and private healthcare programs. Random samplings of records drawn from a cross-section of departments will be conducted on an annual basis. In addition, special attention will be given to reviewing claim denials and other facts that may suggest inappropriate conduct.

CMH will promptly repay any overpayment that it discovers. CMH will establish a reserve account to hold any disputed funds until the results of an internal investigation to determine whether the money is an overpayment to be repaid or whether it was properly paid and should be returned to general funds. All overpayments and disputed funds discovered must be brought to the attention of the Chief Financial Officer immediately

Any suspected incidents of non-compliance shall be brought to the attention of the Corporate Compliance Coordinator for review and action.

Approved by:

Sean M. Fadale, FACHE
President and Chief Executive Officer

Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

4/25/14DH:pc
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COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Compliance Training and Education Protocol	**PAGE** 1 of 2
FORMULATED: 5/01	**REVIEWED:** 3/15(DH)
DATE ISSUED:	**REVISED: 7/11, 4/14**

PURPOSE

Community Memorial Hospital (CMH) is committed to providing ongoing training and education about our Corporate Compliance Program, Federal and state regulations, current billing guidelines, coding and documentation processes and internal controls. As part of its compliance program, CMH will require employees and agents[1] to attend specified training sessions at general orientation and on a periodic basis, thereafter. Sessions will provide appropriate training in corporate ethics, federal and state regulations, compliance program elements, and the policies of private and third party payors.

POLICY

General and specialized compliance training and education sessions will be developed and scheduled by the Compliance Coordinator. Attendance and participation in these education programs is a condition of continued employment. Attendance will be tracked and enforced. Failure to meet minimum prescribed requirements will result in disciplinary action, including possible termination.

Examples of specialized training may include documentation and coding guidelines for physicians and coding modification for the Medical Records Department personnel. These sessions are designed to provide opportunities for all participants to ask questions regarding compliance issues.

All compliance training and education efforts should be planned in conjunction with the Compliance Coordinator to ensure adequacy and consistency.

PROCEDURE

1. Community Memorial Hospital's Compliance Program Manual will be distributed to all employees and agents at a general training and education session.

2. New employees will be required to participate in compliance training and education upon commencement of employment and will receive a copy of the Compliance Manual, at that time.

3. Topics to be covered at the general training and education sessions will include the following, as deemed appropriate for the audience:

   - The current healthcare regulatory environment and areas of government scrutiny;
   - The importance of an effective compliance program and industry trends in developing and implementing such programs;
   - An overview of Community Memorial Hospital's Compliance Program Manual;
   - The roles and responsibilities of the Corporate Compliance Coordinator, Corporate Compliance Committee, physicians, employees, vendors and agents with respect to ongoing compliance; and

[1] Agents are defined as contracted employees such as physicians, social service staff, speech pathologists, etc.

- Specific areas of risk to Community Memorial Hospital;
- Other areas as deemed appropriate

4. Current employees and agents will be required to complete varying amounts of ongoing compliance training and education, depending on areas of responsibility. It is the responsibility of department managers to assess training and education needs for personnel and develop a department-specific training program accordingly. This may involve modifying job descriptions to incorporate compliance, adding potential compliance risk areas to an orientation checklist, distributing compliance policies and procedures, and/or incorporating compliance topics into regular department meetings. The Compliance Coordinator will provide assistance and support, as requested.

5. After completing formal reviews and assessments, the Compliance Coordinator may deem it necessary for certain employees and agents to complete targeted training and education about specific or reoccurring areas of weakness. Department Managers may assist in identifying areas that require targeted training and in carrying out associated training efforts.

Approved by:

Sean M. Fadale, FACHE
President & Chief Executive Officer

4/25/14
Denise Hummer, BS, MHA RN
VP, Corporate Compliance Coordinator

Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Excluded Providers/Employee and Vendor Screening	**PAGE** 1 of 4
FORMULATED: 1/10	**REVIEWED:** 3/15
DATE ISSUED:	**REVISED: 8/10, 4/14**

POLICY:

Community Memorial Hospital does not hire, employ or enter into any business arrangement with any entity or person who is excluded from participating in any government healthcare benefits program, including without limitation, Medicare or Medicaid. The Hospital screens all applicants and employees, candidates for, and current Members of, the Medical Staff, independent contractors, and vendors for exclusion from government healthcare programs and monitors the exclusion lists on an ongoing basis. An "Excluded Provider" is anyone who appears on the screening database lists, found under the Procedures, Section B.

PURPOSE:

The purpose of this Policy is to ensure that the Hospital does not conduct business or have relationships with companies or individuals who are Excluded Providers, and to ensure that the Hospital remains in compliance with applicable laws and regulations and provides safe and quality care to its patients.

SCOPE:

This policy applies to all Hospital business arrangements, including, but not limited to, employment relationships, physician and provider credentialing activities, and contractual arrangements with third parties. This Policy does not override or replace other Hospital screening procedures such as those pertaining to criminal background checks.

PROCEDURE:

A. General Requirement – The Hospital (through Nursing Administration, the Medical Staff Office, Purchasing, the Business Office or other department) shall screen all individuals and companies with whom the Hospital has business relationships and/or employment relationships prior to the start of the business/employment relationship. Monthly thereafter the administrative secretary will facilitate screening via a contracted service.

B. Various Screening Data Bases – The CCO, or his/her designee, shall ensure that one or more of the following, or other websites as applicable, are queried in accordance with this Policy:

1. United States Department of Health and Human Services, Office of Inspector General (OIG) website – List of Excluded Individuals/Entities (LEIE) – This database provides information regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal healthcare programs;

2. New York State Office of the Medicaid Inspector General (OMIG) website – OMIG's website provides access to the list of individuals or entities whose participation in the Medicaid program has been restricted, terminated or excluded;

3. New York State Department of health, Office of Professional Medical Conduct and Physician Discipline (OPMC) website – Verification of practitioners who have been disciplined by OPMC;

4. National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank – Flagging systems intended to facilitate a comprehensive review of healthcare practitioners' professional credentials or past actions;

5. Excluded Parties List System (EPLS) website – General Services Administration's (GSA) verification of practitioners excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non-financial assistance and benefits.

Purchasing Department Verification

1. Individual sales representatives are the responsibility of the companies they are employed by. Upon Community Memorial Hospital's request, these companies will be required to provide verification that exclusion checks of their sales reps are performed.

2. All new companies to Community Memorial Hospital are checked against the above mentioned websites prior to doing business with the organization.

C. Ongoing Obligation to Report – All Members of the Medical Staff are required to disclose if they become Excluded Providers subsequent to appointment/reappointment. All current employees, independent contractors and vendors of the Hospital have an obligation to notify the

CCO immediately upon receipt of any information indicating that they have been charged with a crime relating to health care or are facing debarment, exclusion or other ineligibility from participation in any state or federal healthcare program. Failure to notify the CCO may result in disciplinary action.

D. Notification to CCO – If it is determined that an individual or company is listed as excluded or disqualified, the department conducting the query shall immediately notify the CCO. The CCO, or his/her designee shall ensure that appropriate action is taken immediately to ensure the excluded or disqualified individual/company no longer conducts business with the Hospital, including but not limited to the ordering, furnishing or prescribing of medical care or treatments for Hospital patients. Community Memorial Hospital shall give the individual the opportunity to further identify themselves in order to verify that the name on the list is in fact that person.

DOCUMENTATION:

The CCO, or his/her designee, shall ensure that a record of each screening query made under this Policy will be maintained in accordance with the Hospital's record retention policies and procedures.

REFERENCES:

1. US Department of Health and Human Services, Office of Inspector General, LEIE Website: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp

2. New York State Office of Medicaid Inspector General; Restricted, Terminated or Excluded Individuals or Entities Website: http://www.omig.ny.gov/data/content/view/72/52/

3. New York State Department of Health, Links to the OPMC and Physician Profile Websites: http://www.health.state.ny.us/professionals/doctors/conduct/

4. National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank: http://www.npdb-hipdb.hrsa.gov/

5. General Service Administrations's Excluded Parties List System: https://www.epls.gov/

Approved by:

Sean M. Fadale, FACHE
President and Chief Executive Officer

4/24/14
Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: External Investigations	**PAGE** 1 of 2
FORMULATED: 5/01	**REVIEWED:** 3/15
DATE ISSUED:	**REVISED: 7/11, 4/14**

PURPOSE

To further Community Memorial Hospital (CMH) compliance efforts, the Corporate Compliance Coordinator should be fully informed about any inquiries or pending governmental investigations concerning Community Memorial Hospital and any of its affiliates. This policy is not meant in any way to deter employees from cooperating or assisting with any governmental investigation. However, if employees or agents of Community Memorial Hospital have been contacted, this information will allow the Corporate Compliance Coordinator and/or Members of Management to promptly take any corrective actions that may be necessary.

POLICY

Employees and agents[1] shall immediately notify the Corporate Compliance Coordinator after receiving a contact from governmental agencies who may be conducting an investigation of Community Memorial Hospital or its affiliates. Contact is defined to include any requests from governmental agencies to schedule future interviews or meetings with employees and agents or for written information under circumstances where the request seems out of the ordinary.

Contact from governmental agencies may occur at work or outside of normal working hours. The government agencies conducting an investigation may include the Office of the Inspector General (OIG), the Federal Bureau of Investigations (FBI), the Department of Justice (DOJ), the United States Attorneys Office, the Fiscal Intermediary (FI) (Empire Medicare), the State Attorney General's Office, the State Department of Health and/or Medicaid.

PROCEDURE

1. Initial Contact

   The initial contact made by the government is critical. It is important at this time that the employee or agent contacted does not inadvertently waive personal or Community Memorial Hospital rights such as the attorney-client privilege, the right to counsel and the right against self-incrimination. Upon initial contact, the employee or agent should only give the name and location of the Corporate Compliance Coordinator.

Once the Corporate Compliance Coordinator meets with the government agents, the following steps should be taken:

- Request to see the agent's identification. The name, title, agency and telephone number of each federal or State representative should be documented.
- Request as to why the investigation was initiated, what the nature of the investigation is and whether the investigation is civil or criminal.

- Inform the agents that legal counsel will be contacted and that counsel will coordinate the investigation.

[1]Agents are defined as CMH contracted employees such as physicians, social service staff, speech pathologists, etc.

2. Search Warrants

In situations where the governmental agencies have a search warrant, the Corporate Coordinator should be the escort for the agents. If the search warrant is presented to someone other than the Corporate Compliance Coordinator, that person should immediately contact the Corporate Compliance Coordinator.

Once the Corporate Compliance Coordinator is made aware that governmental agents have arrived with a search warrant, legal counsel should be notified immediately and faxed a copy of the warrant. The search warrant should then be thoroughly read and a copy of it should be obtained. The agents will then be taken to the area to be searched. An escort is necessary because it is imperative that the search remains within the confines of the warrant and that a record is made of seized documents and other evidence.

3. Employee and Agent Rights

Employees and agents have the choice to refuse to participate in any interviews with government agencies. A court may later compel testimony, but an employee or agent has a right not to submit to an interview by law enforcement agents. An employer may not, under any circumstances, instruct an employee or agent to refuse to submit to an interview. An employer (or supervisor) may only advise employees and agents of their right to refuse to an interview and that they may speak with legal counsel prior to making that choice.

4. External Legal Counsel

Hancock Estabrook
Health Law Department
315-471-3151

Marguerite Massett (Cel)315-415-0808

Approved by:

Sean M. Fadale, FACHE
President & CEO

Denise Hummer, BS, RN
VP, Corporate Compliance Coordinator

COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Internal Investigations	**PAGE** 1 of 4
FORMULATED: 5/01	**REVIEWED:** no change
DATE ISSUED:	**REVISED: 7/11, 4/14,** 5/15

PURPOSE

The Corporate Compliance Coordinator is able to effectively respond to a report of potential non-compliant activity and CMH will follow the reporting requirements as defined in the Office of Inspector General's Compliance Program Guidance for Hospitals.

POLICY

As part of its Corporate Compliance Program, Community Memorial Hospital (CMH) has developed and publicized a reporting system whereby employees and agents[1] can pose compliance-related questions and/or report perceived "Non-Compliance" by others within the organization confidentially without fear of retribution or adverse consequences. Non-Compliance is defined as failure to comply with applicable Federal and state laws, and requirements of Federal and state health programs (including, but not limited to Medicare and Medicaid laws, regulations and various interpretations which apply to CMH).

PROCEDURE

Receipt of Hotline Reports

1. Hotline reports can be made to the established CMH hotline number (824-7016) at any time.

2. The Hotline reports received, by their nature, will encompass varying degrees of severity. It is the Compliance Coordinator's responsibility to rank each incident as to the priority in which it will be handled based on the potential severity of non-compliance. Hotline reports will not be responded to on a first-come, first-serve basis, rather by the nature and potential extent of potential non-compliance.

3. In certain instances, there may be vague reports made that lead to more questions. In these situations, some further inquiry and/or research must be conducted to determine if a serious matter exists and rank the potential severity of the non-compliance.

4. When a report is received, the Compliance Coordinator will review available evidence to determine the severity of the issue and the extent of further investigation deemed necessary, if any.

5. When a medical record review is warranted, there is a potential for overpayment or intentional wrongdoing, the Corporate Compliance Coordinator should immediately seek advice from CMH's external legal counsel.

6. In cases where the issue raised is clearly an instance of non-compliance, the matter will be remedied expeditiously (for example, duplicate payment from Medicare occurred and repayment is required).

[1]Agents are defined as CMH contracted employees such as physicians, social service staff, speech pathologists, etc.

Notification of Internal Investigation

7. When the decision is made to seek legal advice from CMH's external legal counsel, the Compliance Coordinator will notify the Chief Executive Officer (CEO) in a memorandum of the nature of the investigation.

8. The CEO will initial the memorandum as documentation of notification. Legal advice may be sought to determine the amount of CMH's liability and to determine the proper course of corrective action, disclosure responsibility and disciplinary actions, etc. Additionally, attorney-client privilege[1] considerations will be made at this time.

9. However, if the CEO objects to the investigation, the Compliance Coordinator has the authority to unilaterally commence an investigation. The Compliance Coordinator would notify the Board of the Trustees in a timely manner if this occurred.

Implementation of Internal Investigation

10. The Corporate Compliance Coordinator may determine that a "Designee" will be assigned to assist in conducting the investigation. The Designee may include, but is not limited to, external legal counsel, external consultant(s), Management Compliance Committee Members or other individuals from within the organization.

11. An inquiry and/or investigation may include interviews of the complainant(s), department staff, other involved departments, etc. The interview(s) typically are followed by a review of the applicable laws and regulations in order to make an initial assessment of whether non-compliance has occurred. If the findings from the interview process clearly do not support the complaint, a medical record review may be commenced or the case may be closed.

12. If the findings from the interview do support the complaint, further steps will be taken to obtain additional evidence to verify the factual information in order to confirm that non-compliance has occurred.

13. In general, the investigation will include determining the nature, scope and frequency of non-compliant activity, as well as the financial impact, if any. This may include conducting additional inquiries, performing a review of the sample claims or other documents as deemed necessary to confirm whether non-compliance actually occurred and to what extent. Additional inquiries may also be necessary to clarify the responsibility of individuals involved, assess the possibility of criminal misconduct, determine the nature and extent of civil/criminal liability, etc.

14. While undertaking the investigation, the Corporate Compliance Coordinator may feel that the integrity of the investigation could be at stake because of the presence of employees under investigation. In these instances, the individuals should be removed from their

[1]The primary purpose of attorney-client privilege is to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice. The major benefit of the privilege is that the person asserting it, who could be the client or the client's attorney, can refuse to disclose confidential communications that were made for the purpose of obtaining or providing legal advice.

current work activity until the investigation is finalized (unless an internal or governmental undercover operation is in effect). The Corporate Compliance Coordinator should also take sound measures to secure or prevent the destruction of documents or other evidence necessary for the investigation.

Compliance Report Form Completion

15. The investigation will be documented in a *Compliance Report Form* that will be prepared by the Corporate Compliance Coordinator and will contain the following:

    A. Documentation of the alleged violation;
    B. Description of the interview process;
    C. Copies of the interview notes and key documents
    D. A log of the witnesses interviewed and the documents reviewed; and
    E. The results of the investigation including any disciplinary action taken and the course of corrective action implemented or to be implemented.

16. The Compliance Coordinator should also consider further review of the reasons for the investigation to determine if there is a relationship with other pending matters or closed investigations.

17. After the *Compliance Report Form* is completed and reviewed with legal counsel, follow-up actions will be taken according to 'Measures to prevent non-compliance' and 'Closing the case' outlined below.

Specific Cases

18. If the case involves billing non-compliance, and non-compliance is confirmed, CMH will cease billing for the services included in the investigation until corrective action can be implemented effectively. If it is determined that improper payment has been received, the appropriate repayment would be calculated and reported to external legal counsel. Legal counsel will work with CMH to notify the fiscal intermediary and return any overpayment.

19. If it is determined that criminal misconduct has occurred, the matter will immediately be referred to CMH's external legal counsel to initiate contact to the appropriate law enforcement agency.

20. If the incident requires disciplinary action, the disciplinary process will follow normal CMH disciplinary policy. If necessary, the Compliance Coordinator, the Chief Executive Officer and the Chief Financial Officer will consul with legal counsel with respect to the CMH disciplinary process.

Measures to Prevent Future Non-Compliance

21. The Compliance Coordinator is responsible for evaluating CMH training and education needs and ongoing monitoring activities which will be enhanced, to the extent necessary, to prevent any reoccurrence. If there has not been an improper payment and disciplinary action is not warranted, training and education may still be necessary so as to prevent any reoccurrence.

Closing the Case

22. The Compliance Coordinator is responsible for determining when the case is closed. This determination is a matter of judgment based on the facts and circumstances of each case.

23. In all cases where the identity of the complainant is known, the complainant will be notified upon closing of the case.

Approved by:

Sean M. Fadale, FACHE
President & Chief Executive Officer
Coordinator

4/25/14
Denise Hummer, BS, RN
VP, Corporate Compliance

COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Compliance Plan for Outpatient Services	**PAGE** 1 of 7
FORMULATED: June 22, 1998	**REVIEWED: February 15, 2000, 4/14** 4/15(DH)
DATE ISSUED: June 22, 1998	**REVISED: February 15, 2000**

A. SCOPE

Providers and suppliers have an obligation under law, to conform to the requirement of the Medicare program. Fraud and abuse committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines and, in some instances, imprisonments. In addition, there is also a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties that may be imposed when ignoring Medicare compliance requirements.

The Office of 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 voluntary developed and implemented compliance plans.

The OIG recommends that clinical laboratories implement a number of substantive changes such as developing better requisitions forms and policies that promote the physicians' right to order only medically necessary tests.

At the direction of the Health Care Financing Administration (HCFA), 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.

B. POLICY

It shall be the policy and procedure of Community Memorial Hospital that when ordering tests for which Medicare reimbursement will be sought, physicians or other individuals authorized by law to order tests will only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. All claims for outpatient services submitted to Medicare or other federally funded health care programs must be accurate and correctly identify the services ordered by the physician (or other individual authorized by law to order tests). CPT or HCPCS codes that are used to bill Medicare or Medicaid will accurately describe the service that was ordered and performed.

Community Memorial Hospital will only bill for medically necessary outpatient services actually ordered by a physician only after those services are performed.

CMH individual departments (Laboratory, Radiology, Cardiopulmonary, Physical Therapy) who provide outpatient services will maintain appropriate documentation such as the requisition forms containing ICD-9-CM codes and/or diagnoses, supporting the medical necessity of a service they have provided and billed to a federal program.

C. PROCEDURE

I. Laboratory Services

1. Complete Demographic Data: Patient Name, DOB, Phone Number and Address

2. Complete Insurance/Billing Information. If the patient is covered by primary or secondary Medicare, and the diagnosis does not meet Medicare criteria, the Waiver of Liability statement must by signed by the patient. The Waiver of Liability statement informs Medicare patients that it will only reimburse those tests that are deemed medically necessary for the diagnosis or treatment of the patient, rather than screening purposes. Under Sect 1862(A)(1) of the Medicare Law, Medicare will only pay for services they deem to be "Reasonable and Necessary". If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny payment for this service. Having the [patient sign this statement gives the hospital authority to bill the patient for the non-covered tests.

3. There is a line provided for the ordering provider's signature on the requisition form. A signature is required for all outpatient testing.

4. Ordering labs on the requisition slip.

    a. Check the appropriate box for ordering STAT, Routine, Standing Orders or Pre-op. Unless otherwise indicated, all tests are considered routine.
    b. Record an ICD-9-CM code and/or diagnosis for each test ordered that supports the medical necessity of the test.
    c. The tests that are starred (*) on the requisition form require an ICD-9-CM code and/or diagnosis from the approved Medicare Coverage Criteria list in order for the hospital to be reimbursed. The following list is targeted services that are frequently denied by Medicare. Please check the approved Medicare coverage criteria book for approved diagnosis. If the diagnosis does not meet Medicare criteria, the patient will be asked to sign a Medicare Waiver of Liability statement. By doing so, this gives the hospital the authority to bill the patient for those services.

        - Prothrombin Time (PT)
        - Partial Thromboplastin Time (PTT)
        - Qualitative & Quantitative HCG
        - Alpha-fetoprotein
        - Carcinoembryonic Antigen
        - Immunoassays for Tumor Antigen
        - PSAs
        - Blood counts
        - Ionized Calcium

- Glycated Hemoglobin
- Lipid Profile & Cholesterol Testing
- Serum Iron Studies
- Serum Magnesium
- Thyroid Testing including TSH
- Glucose Testing
- Prostatic Acid Phosphatase
- Digoxin Assay
- Platelet Count
- Reticulocyte Count

5. If an additional test is requested, that is not on the original requisition form, the physician will provide when necessary, additional documentation regarding the necessity of the test ordered. Laboratory personnel will be responsible for documenting the conversation with the physician on the original requisition form. Documentation will include the date, time, who they spoke to and what test was ordered.

Services provided at the hospital

1. The patient will be directed to the Laboratory where the phlebotomist who is performing the procedure will review the requisition.

2. If an ICD-9-CM code and/or diagnosis is not provided for the test ordered, the following will occur:

   a. The patient will be asked to wait until the physician's office is called to obtain the ICD-9-CM code and/or diagnosis;
   b. If the office is closed, the patient will be informed and given the opportunity to come back on a different day when their physician can be reached; or the patient will be asked to sign the waiver of liability in case the diagnosis that is given does not meet Medicare criteria;
   c. If the diagnosis, which is provided, does not meet Medicare criteria, the patient will be asked to sign the Medicare Waiver of Liability form. A pamphlet explaining the Waiver form will be distributed to the patient;
   d. In the event that the patient refuses to sign the waiver form, there must be two witnesses that will attest to this action. Documentation of the refusal to sign the waiver form will result in the test not being performed. A letter signed by the hospital administrator will be handed to the patient explaining the hospital policy.

3. All laboratory requisition forms will be kept on file for seven (7) years.

Specimens sent to the hospital for processing

1. Prior to obtaining the specimen, the patient must be informed if the diagnosis will not meet Medicare criteria. If the diagnosis does not meet criteria, the patient must be asked to sign the Medicare Waiver of Liability form.
2. If the patient refuses to sign the waiver form, there must be two witnesses that will attest to this action. Documentation of the refusal to sign the form must be clearly documented on the waiver form.

3. If the patient agrees to sign the waiver form, please submit the waiver form along with the specimen and requisition to the laboratory for processing.

II. Radiology

1. Complete Demographic Data: Patient Name, DOB, Phone Number and Address.

2. Complete Insurance/Billing Information. If the patient is covered by primary or secondary Medicare, and the diagnosis does not meet Medicare criteria, the Waiver of Liability statement must be signed by the patient. The Waiver of Liability statement informs Medicare patients that it will only reimburse those tests that are deemed medically necessary for the diagnosis or treatment of the patient, rather that screening purposes. Under Sect 1862(A)(1) of the Medicare Law. Medicare will only pay for services they deem to be "Reasonable and Necessary". If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny payment for this service. Having the patient sign this statement gives the hospital authority to bill the patient for the non-covered tests.

3. There is a line provided for the ordering provider's signature on the requisition form. A signature is required for all outpatient services.

4. Record an ICD-9-CM code and/or diagnosis for each exam ordered that supports the medical necessity of that exam or service.

5. The service that is starred (*) on the requisition form requires an ICD-9-CM code and/or diagnosis from the approved Medicare Coverage Criteria list in order for the hospital to be reimbursed. The following list is targeted services that are frequently denied by Medicare. Please check the approved Medicare coverage criteria book for approved diagnoses. If the diagnosis does not meet Medicare criteria, the patient will be asked to sign a Medicare Waiver of Liability statement. By doing so, this gives the hospital the authority to bill the patient for those services.

    - Mammography (diagnostic vs. screening)

6. The Radiology Technician will be responsible for reviewing the requisition prior to the test being performed. If an ICD-9-CM code and/or diagnosis is not provided for the service ordered, the following will occur:

   a. The patient will be asked to wait until the physician's office is called to obtain the ICD-9-CM code/diagnosis;
   b. If the office is closed, the patient will be informed and given the opportunity to come back on a different day when their physician can be reached; or the patient will be asked to sign the waiver of liability in case the diagnosis the diagnosis that is given does not meet Medicare criteria;
   c. If the diagnosis, which is provided, does not meet Medicare criteria, the patient will be asked to sign the Medicare Waiver of Liability form. A pamphlet explaining the Waiver form will be distributed to the patient;
   d. In the event that the patient refuses to sign the waiver form, there must be two witnesses that will attest to this action. Documentation of the refusal to sign the form must be clearly documented on the waiver form in order for the hospital to bill the patient. A letter signed by the hospital administrator will be handed to the patient explaining the hospital policy.

7. All radiology requisition forms will be filed with the written report and radiographic films.

8. If an additional radiology exam is requested, that is not on the original requisition form, the physician will need to provide an ICD-9-CM code and/or diagnosis. If requested, the physician will provide when necessary, additional documentation regarding the necessity of the test ordered. Radiology personnel will be responsible for documenting the conversation with the physician on the original requisition form. Documentation will include the date, time, who they spoke to and what test or exam was ordered.

IV. Physical Therapy

1. Complete Demographic Data: Patient Name, DOB, Phone Number and Address. Patients book in on initial visit and face sheet is placed in their chart.

2. Complete Insurance/Billing Information. If the patient is covered by primary or secondary Medicare, and the diagnosis does not meet Medicare criteria, the Waiver of Liability statement must be signed by the patient. The Waiver of Liability statement informs Medicare patients that it will only reimburse those treatments that are deemed medically necessary for the diagnosis or treatment of the patient, rather than screening purposes. Under Sect 1862(A)(1) of the Medicare Law, Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny

payment for this service. Having the patient sign this statement gives the hospital authority to bill the patient for the non-covered treatment.

3. There is a line provided for the ordering provider's signature on the requisition form. A signature is required for all outpatient services.

4. Record an ICD-9-CM code and/or diagnosis for each service ordered that supports the medical necessity of that service.

5. Physical Therapy personnel will be responsible for reviewing the requisition prior to the treatment being performed. If an ICD-9-CM code and/or diagnosis are not provided for the service ordered, the following will occur:

    a. The patient will be asked to wait until the physician's office is called to obtain the ICD-9-CM code/diagnosis;
    b. If the office is closed, the patient will be informed and given the opportunity to come back on a different day when their physician can be reached; or the patient will be asked to sign the waiver of liability in case the diagnosis that is given does not meet Medicare criteria;
    c. If the diagnosis, which is provided, does not meet Medicare criteria, the patient will be asked to sign the Medicare Waiver of Liability form. A pamphlet explaining the Waiver form will be distributed to the patient;
    d. In the event that the patient refuses to sign the waiver form, there must be two witnesses that will attest to this action. Documentation of the refusal to sign the form must be clearly documented on the waiver form in order for the hospital to bill the patient. A letter signed by the hospital administrator will be handed to the patient explaining the hospital policy.

6. All requisition forms will be filed with the patient's records.

7. If additional treatments are requested, which are not on the original requisition form, the physician will need to provide an ICD-9-CM code and/or diagnosis. If requested, the physician will provide when necessary, additional documentation regarding the necessity of the treatment ordered. Physical Therapy personnel will be responsible for documenting the conversation with the physician on the original requisition form. Documentation will include the date, time, who they spoke to and what treatment was ordered. The referring practitioner must re-certify the need for continued skilled services every 30 days with a renewal script.

D. ADMINISTRATION

Administration with the support of the Medical Staff will be ultimately responsible for the coordination of this policy.

E. DISTRIBUTION

This policy shall be distributed to the Medical Staff of CMH.

F. REVISION

Revisions of this policy shall be the responsibility of Administration.

Approved by:

Sean M. Fadale
President & Chief Executive Officer

Denise Hummer, BS, RN
VP, Corporate Compliance Officer

Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Corporate Compliance Reporting and Response System	**PAGE** 1 of 3
FORMULATED: 5/01	**REVIEWED:** 3/15
DATE ISSUED:	**REVISED: 7/11 4/14**

PURPOSE:

Employees and agents should be knowledgeable about the procedures for reporting a potential non-compliant activity and maintain an open line of communication to the Corporate Compliance Coordinator.

POLICY:

As part of our Corporate Compliance Program, Community Memorial Hospital (CMH) has developed and publicized a reporting system whereby employees and agents can pose compliance-related questions and/or report perceived "non-compliance" by others within the organization anonymously and/or confidentially without fear of retribution or adverse consequences. Non-compliance is defined as failure to comply with applicable Federal and state laws and requirements of Federal and state health programs (including, but not limited to, Medicare and Medicaid, regulations and various interpretations which apply to Community Memorial Hospital).

All employees and agents are encouraged to promptly report all instances of perceived non-compliance for which there is a reasonable indication that non-compliance has occurred. Consequently, CMH will promptly investigate reports received in a thorough manner. The Corporate Compliance Coordinator should retain all records of any subsequent investigation of reported non-compliance matters in confidence until such time that the investigation may require disclosure of the reporting person in accordance with Federal and state law.

PROCEDURE:

1. Employees and agents should call **824-7016** to leave a message on the Compliance Hotline. This Hotline is secure and located in the Corporate Compliance Coordinator's office. Only the Corporate Compliance Coordinator has access to this Hotline.

2. The Compliance Coordinator will listen to any reports on a weekly basis and will initiate a response within ten business days.

3. Employees and agents may also contact the Corporate Compliance Coordinator or a Member of the Corporate Compliance Committee directly by phone or schedule an appointment to pose a compliance-related question and/or report any potential non-compliant incident.

Corporate Compliance Coordinator's Response

4. Once a report has been received, the Corporate Compliance Coordinator will review the available evidence and undertake an appropriate inquiry process and investigate. The Corporate Compliance Coordinator will implement appropriate steps to correct the situation. The investigation may include interviews, review of relevant documents and consultation with external legal counsel. Records of the investigation shall include, but are not limited to, documentation of the alleged violation, key documents, findings and results of the investigation, corrective actions implemented and disciplinary actions taken.

5. While undertaking the investigation, the Corporate Compliance Coordinator may feel that the integrity of the investigation could be at stake because of the presence of employees under investigation. In these instances, the individuals should be removed from their current work activity until the investigation is finalized (unless an internal or governmental undercover operation is in effect). The Corporate Compliance Coordinator should also take sound measures to secure or prevent the destruction of documents or other evidence necessary for the investigation.

6. The results of the investigation may necessitate the development of a corrective action plan and/or a referral to criminal and/or civil law enforcement agencies.

7. If the incident(s) requires disciplinary action, the disciplinary process will proceed with the *Compliance Disciplinary Policy.*

8. The Corporate Compliance Coordinator, along with relevant department managers and Members of the Corporate Compliance Committee, are responsible for evaluating Community Memorial Hospital's training and education needs and ongoing monitoring activities to prevent the reoccurrence of any incidents of non-compliance.

9. In cases where the complainant is known, the complainant will be notified of the outcome of the investigation, to the extent deemed appropriate, by the Corporate Compliance Coordinator.

Administrative	
COMMUNITY MEMORIAL HOSPITAL	
SUBJECT: Corporate Compliance Reporting and Response System	**PAGE** 3 of 3
FORMULATED: 5/01	**REVIEWED:**
DATE ISSUED:	**REVISED: 7/11 4/14**

Approved by:

Sean M. Fadale, FACHE
President and Chief Executive Officer

4/25/14
Denise Hummer, BS, RN
VP, Corporate Compliance
Coordinator

4/25/14DH:pc
S:\Admin Policies and Procedures\Corporate Compliance Policies\Reporting and Response System.doc

Compliance Reporting Form Part III (To be initiated by the Corporate Compliance Coordinator within ten business days of the receipt of the report)

The Compliance Coordinator completes this form and attaches all relevant documents.

Report Number Assigned: _____

Designated Investigator: _____

Others Assisting Investigation: _____

Details of the investigation (supply date, time, persons involved, witnesses, etc. for every interaction of the investigation)

_____

_____

Others Notified: CFO _____ Legal Counsel _____

Board _____ CEO _____

Disposition (include dates) _____

Referred to Legal Counsel _____

Follow-Up Conducted _____

Corrective Action _____

Employment Action _____

Disclosure to Intermediary or Other _____

Formal Investigation by Government _____

Sanctions by Government _____

Reportee notified of outcome? _____ Yes _____ No

Closed _____

Signature of Compliance Coordinator _____ Date _____

Attorney-Client Privilege
Attorney Work Product