ONSLOW MEMORIAL HOSPITAL
COMPLIANCE PLAN

A Part of the Onslow Memorial Hospital
Compliance Program

"**Where People Care**" ®

About
Compliance

OVERVIEW

Onslow Memorial Hospital ("Hospital") is an organization that strives to be fully compliant with all applicable federal and state laws, rules, and regulations. To meet this objective, the Hospital has a Compliance Plan. This Plan has been carefully designed to assure, to the maximum extent possible, that Hospital employees, governing body and those with whom they transact business act in accordance with all known laws, rules, regulations and the highest standards of ethical conduct.

The Compliance Plan includes policies and procedures applicable to all Hospital employees, agents, or other persons associated with the Hospital as well as department specific policies and procedures. The Hospital's Compliance Plan is consistent with the United States Office of the Inspector General's *Compliance Program Guidance for Hospitals*. The Hospital will seek to exceed the Office of the Inspector General's standards in establishing an effective Compliance Program.

Mission Statement

The Hospital is committed to the care and improvement of the lives of the people of Onslow County and surrounding areas. In recognition of this commitment, the Hospital will strive to deliver high quality, cost-effective healthcare to the community.

The Hospital affirms the following values:

- Recognizing the unique worth of each individual;
- Treating those served with compassion and kindness;
- Promoting teamwork and pledging to treat each other with respect and dignity; and
- Acting with absolute honesty, integrity and fairness in the way the Hospital conducts business in our community.

Adherence to the Plan

This Compliance Plan has been prepared with the assistance of Hospital employees under the supervision of Compliance Counsel. The Hospital has made every effort to assure compliance with the law. The Compliance Plan is designed with the expectation that it will be modified to accommodate changes in laws, rules, or regulations. At a minimum, the Hospital will review the Compliance Plan annually for modification. Therefore, the Hospital encourages comments and suggestions from employees, agents, or other persons associated with the Hospital who believe the Compliance Plan can be improved or who find errors or mistakes in the Compliance Plan. Any employee, agent, or other person wishing to suggest a change in the Compliance Plan should contact the Compliance Officer.

Purpose of the Compliance Plan and Program

The purpose of the Compliance Plan and Program is twofold. First, the Compliance Plan and Program create uniform policies and procedures to aid all Hospital employees, agents or other persons associated with the Hospital in complying with the complex laws, rules, and regulations governing the healthcare industry. Second, the Compliance Plan and Program aid in the identification and correction of any actual or perceived violations of law, rule, regulation, or Hospital policy and procedure. The Compliance Plan and Program impose a duty upon all employees, agents, or other persons associated with the Hospital to report any actual or perceived violation of law, rule, regulation, or Hospital policy and procedure.

The Hospital's Compliance Plan is reasonably designed, implemented, and enforced to effectively prevent and detect wrongful conduct. Failure to prevent or detect an offense, by itself, does not mean that the Plan is ineffective. The hallmark of an effective Plan is the exercise of due diligence in seeking to prevent and detect wrongful conduct by employees, agents, or other persons associated with the Hospital.

Standards of Conduct

There are five principles that govern conduct at the Hospital:

1. **Obey the Law**. Every individual is expected to be familiar with the basic legal requirements relevant to his or her role at the Hospital. If there are any questions, the individual should ask a supervisor for guidance or ask questions of the Compliance Officer.

2. **Keep Accurate Records**. Every individual is expected to comply with Hospital and government requirements regarding record keeping. All records and reports are to be accurate and prepared in a timely manner.

3. **Behave Ethically**. Every individual is expected to adhere to high ethical standards when acting on behalf of the Hospital. Individuals are expected to be loyal to the Hospital and must avoid using their position for personal gain.

4. **Maintain Confidentiality**. Every individual is expected to follow Hospital policies regarding confidentiality and treat sensitive information with deserved respect.

5. **Report Possible Violations**. Every individual is expected to report any activities believed to be in violation of the law, ethical standards or Hospital policies. Reporting enables the Hospital to investigate potential problems quickly and take prompt action to resolve the situation. Reporting is critical to the success of an effective compliance program.

The United States Department of Health and Human Services, Office of the Inspector General ("OIG") provides Compliance Guidance for Hospitals that require, at a minimum, that an organization establish seven compliance elements. The Hospital's Compliance Plan meets the OIG Guidance for each of the following elements:

OIG Guidelines

1. Compliance Standards & Procedures

The Hospital has compliance standards and procedures for its employees, agents, or other persons associated with the Hospital that are reasonably capable of reducing the prospect of unethical or wrongful behavior or criminal conduct. The Compliance Plan implements procedures to safeguard against the hiring of employees with a propensity to engage in illegal activities.

2. Oversight Responsibilities

The Compliance Officer has the responsibility of administering the Compliance Program.

3. Employee Training

The Hospital communicates its compliance standards and procedures to all employees or agents. A copy of the Hospital's Compliance policies and other relevant policies and materials, including current compliance guidance resources can be accessed via the Hospital's Compliance website: www.omhcompliance.org. In addition, the Compliance Program requires employees' participation in compliance training and education plans.

4. Effective Lines of Communication

The Compliance Plan creates open lines of communication for all employees, agents, or other persons associated with the Hospital to report suspected violations of law, rule, regulation, or policy without fear of retaliation. These lines of communication allow direct access to the Compliance Officer, as well as an anonymous reporting mechanism through the Compliance Hotline (866-631-5718).

5. Enforcement & Discipline

The Compliance Plan creates standards of conduct and establishes mechanisms for consistently enforcing disciplinary actions. Disciplinary actions include discipline of individuals who commit an offense and the discipline of individuals who fail to detect or report an offense. The form of discipline will be appropriate to the offense, up to and including discharge.

6. Monitoring & Auditing

The Compliance Plan creates routine monitoring and auditing mechanisms to detect unethical or wrongful behavior, or criminal conduct by its employees, agents, or other persons associated with the Hospital.

The Chief Executive Officer and the Compliance Officer are authorized to conduct random audits of any process, as needed. The Compliance Hotline serves as a continuous monitoring device to detect unethical or wrongful behavior.

7. Response & Prevention

If an offense is detected, the Hospital will take all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. Such response will include any necessary modifications to the Compliance Plan to prevent and detect violations of law.

The Hospital expects all employees, agents, or other persons associated with the Hospital to communicate their concerns freely to the Compliance Officer or the Compliance Hotline. Reports will be held confidential to the maximum extent possible. Reports must contain enough information for the Compliance Officer to conduct a thorough investigation of the alleged violation. It is the Hospital's policy that no adverse action or retaliation will be taken against any employee, agent, or other person associated with the Hospital due solely to the good faith reporting of a suspected violation or irregularity.

All Hospital employees should familiarize themselves with the Compliance Plan. The Compliance Officer is available to answer any questions that may arise.

ONSLOW MEMORIAL HOSPITAL COMPLIANCE CODE OF CONDUCT

Purpose

The following Compliance Code of Conduct affirms the Hospital's policy of conducting its business and operations in accordance with both the law and the highest standards of professional ethics. This Compliance Code of Conduct is a complement to, and not a replacement of, the Staff Code of Conduct. The Compliance Code of Conduct is the foundation for the Hospital's Compliance Program.

Policy

Every employee, agent, or other persons associated with the Hospital is required to understand and comply fully with both the rules and approval procedures established by the Compliance Plan and this Compliance Code of Conduct. This Compliance Code of Conduct applies to all Hospital employees, agents, or other persons associated with the Hospital regardless of their position. Any employee, agent, or other person violating any provision of this Compliance Code of Conduct will be subject to disciplinary action, up to and including discharge from employment or other appropriate sanction. To the extent that any additional policies are set forth in any other policy and procedure manual, those policies should be consistent with this Compliance Code of Conduct. In case of any inconsistency, this Compliance Code of Conduct shall govern.

Organizational Responsibilities

The Hospital's Compliance Program is evidence of a commitment to the community and the organization that the Hospital will conduct business in accordance with the highest ethical standards. In doing so, the Hospital will abide by all applicable federal and state laws, rules, and regulations.

The goals of the Hospital's Compliance Plan are:

- To safeguard the Hospital's tradition of strong moral, ethical and legal standards of conduct;
- To provide the Hospital with a more accurate view of its corporate behavior;
- To identify any criminal and unethical conduct;
- To create a plan for efficient dissemination of information relating to changes in government requirements; and
- To establish a structure which encourages employees to report concerns internally rather than externally.

The Hospital exercises a code of ethical conduct, which includes, but is not limited to, ethical billing, admission, transfer and discharge practices, and documentation that describes only the care or services provided.

The Hospital strives to provide high quality care in a compassionate manner. In addition to other standards of conduct, in providing patient care, the Hospital pledges that all patients:

- Will be appropriately assessed and treated with respect and kindness by competent professionals.
- Will be transferred to another facility when a higher level of care is required, when this facility is unable to provide care, or when the patient requests a transfer. The patient will be stabilized and informed of risks and benefits prior to transfer.
- Will receive medical care rendered by the Hospital credentialed physicians or physician extenders.
- Will receive medically necessary services without regard for their ability to pay, race, creed, color, national origin, age, sex, or actual or perceived disability.
- Will be educated regarding their diagnosis, treatment plan and expected outcomes. When dealing with referrals of patients to various providers for continued or follow-up treatment, patients will be fully informed and given a choice, to the extent possible, for their care.
- Will be provided with a statement of their rights and responsibilities, and all staff will honor their rights.
- Will receive information related to Advanced Health Care Directives, and all staff will honor these directives if designated.

The Hospital will comply with all regulations governing the management and distribution of controlled substances.

The Hospital is committed to treating all employees and job applicants fairly and equitably, in accordance with state and federal laws. Employment will not be denied to anyone on the basis of race, creed, color, national origin, age, sex, and actual or perceived disability. No form of harassment whatsoever by a manager, co-worker, physician or others performing contract services will be tolerated.

The Hospital will provide and maintain a safe and healthy environment. The Hospital will comply with all environmental laws and operate its facilities with the necessary permits, approvals and controls. The Hospital will diligently employ the proper procedures with respect to handling and disposal of hazardous and bio-hazardous wastes. The Hospital is committed to protecting all patients, guests, community and staff members from any exposure or contamination from medical, infectious or hazardous waste.

All proposed acquisitions, referrals, joint ventures, and other major transactions between the Hospital and other entities will be structured to ensure compliance with the federal and state laws, including antitrust and tax laws. Business deals, contracts and agreements will be structured in a manner to ensure market competition is not affected by collusive and noncompetitive arrangements.

The Hospital will not offer or extend any business courtesies that might jeopardize compliance with billing and coding or any other regulation.

The Hospital is committed to meeting all licensure requirements for the Hospital and all Hospital related operations. The Hospital is also committed to maintaining national accreditation for its operations, including accreditation of the Hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

The Hospital will maintain all corporate and patient records, documents, reports and bills in accordance with all governmental and third-party payor requirements. Complete records will be maintained. The Hospital will not permit the alteration, falsification or manipulation of any record or document.

The Hospital will comply with all federal and state laws in the submission of cost reports. The Financing Department will coordinate all cost report activities.

Individual Responsibilities

The Hospital requires every employee, agent, or other person associated with the Hospital to comply with all laws, rules, and regulations to which they are subject. When the application of a law, rule, or regulation is uncertain, the guidance and advice of the Compliance Officer shall be sought.

The Hospital looks to its employees to assume responsibilities for preserving the Hospital's assets, property, equipment and supplies. Employees are accountable for the proper expenditure of funds and for the proper use of property. The Hospital will not tolerate the theft of property, embezzlement of money or the unauthorized use or destruction of Hospital equipment or property.

All employees, agents, or other persons associated with the Hospital will endeavor to keep accurate and reliable records of all clinical and financial transactions. No employee, agent, or other person associated with the Hospital shall falsify financial or clinical records. Any changes to clinical or financial documentation will be consistent with prescribed policy and procedure under the guidance of a supervisor or manager.

All employees, agents, or other persons associated with the Hospital responsible for coding and billing activities will perform their duties with care and professionalism to ensure that only services that are supported by documentation, e.g., physician orders, are coded and billed to payors. Coding and billing practices will conform to all pertinent federal and state laws, rules, and regulations.

All professional employees and affiliates will be required to maintain their professional licensure status as necessary to perform their duties in the Hospital. All employees are responsible for ensuring ongoing compliance with all standards and minimum criteria required for licensure and accreditation.

The Hospital requires the avoidance of a conflict of interest for any Hospital Board member, employee, physician or vendor due to an interest or activity outside of the scope of their affiliation with the Hospital, which could impair or impede their ability to make ethical and objective business decisions. Subject to North Carolina law, board members, employees and physicians who have a conflict of interest will not be permitted to be involved in making or influencing decisions regarding external relationships or contracts related to conflict. Hospital employees are required to disclose in writing any substantial interest in any property included or planned to be included in any Hospital contract or proposed contract. When in doubt about personal investments or other activities, the guidance and advice of the Hospital's Compliance Officer shall be sought. If the matter is of a confidential nature, the advice of the Hospital's Compliance Counsel shall be sought.

No employee may accept gifts or favors intended to influence decisions regarding business relationships or designed to influence the care given to patients. Employees may not accept nor offer money or gifts to patients or their families in exchange for providing healthcare services. Nominal tokens, such as coffee mugs, flowers or holiday cookies are permitted.

No employee, agent, or other person associated with the Hospital shall engage in any activity that rewards or compensates any individual for the referral of patients to the Hospital or its subsidiaries.

All employees, agents, or other persons associated with the Hospital will strive to protect the confidentiality and security of patient, financial, and operational information. Employees and individuals affiliated with the Hospital will discuss confidential information only as required in the normal course of business in an appropriate setting and manner, and will refrain from casual conversations about patients and their health status. Confidential information will not be disclosed unless the individual has a need to know or is authorized to access the confidential information.

All employees, agents, or other persons associated with the Hospital will report to the Compliance Officer or Compliance Hotline (866-631-5718) any known or suspected violations of law, rule, regulation, or Hospital policy.

The Hospital's Board of Directors has adopted the foregoing Compliance Code of Conduct to apply to the Hospital and its related entities. All employees, agents, and other persons associated with the Hospital are expected to adhere to its terms.

POLICY FOR THE COMPLIANCE OFFICER

Authority

The Compliance Officer is appointed by the Chief Executive Officer and is responsible for the oversight of the Compliance Plan and Compliance Program. The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to: patient records, billing records, records concerning marketing efforts relating to the Hospital, and the Hospital's arrangements with other parties, including employees, professionals on staff, independent contractors, suppliers, agents, and hospital-based physicians, etc. This policy enables the Compliance Officer to review contracts and obligations (seeking the advice of Compliance Counsel) that may contain referral and payment issues that could violate the anti-kickback laws, the physician self-referral prohibitions, and other legal or regulatory requirements.

Duties and Responsibilities

1. Manages the day-to-day operations of the Hospital Compliance Program.

2. Reviews the content and performance of the Compliance Plan on a continuing basis and takes appropriate steps to ensure its effectiveness to prevent and detect illegal, unethical, or improper conduct within the Hospital.

3. Conducts or manages the independent investigations of alleged violations of law, rule, regulation, and the Compliance Code of Conduct, in consultation with Compliance Counsel.

4. Develops, implements and maintains an effective compliance communication and multifaceted educational and training plan that focuses on the elements of the Compliance Program and seeks to ensure that all appropriate employees, agents, or other persons associated with the Hospital are knowledgeable of and comply with pertinent federal and state laws, rules and regulations. Such plan should be closely coordinated with the Hospital Human Resources Department and other departments, as required, and include appropriate introductory training, as well as ongoing training, for all new employees, agents, or other persons associated with the Hospital.

5. Supervises the Compliance Hotline operation and works in consultation with Compliance Counsel to resolve legal compliance issues reported.

6. Develops, implements, and maintains an effective compliance audit and monitoring plan. Such a plan would coordinate closely with each division to conduct periodic and regular compliance self-assessments and compliance audits.

7. Reports to the Compliance Committee on the operation and development of the Hospital Compliance Plan.

8. Serves as Chairman of the Compliance Committee, which serves in an advisory capacity to keep Senior Management informed on the operation and progress of the Hospital's compliance efforts, and to ensure the Compliance Plan is meeting the needs of each Hospital operational unit effectively.

9. Reports on a regular basis to the Hospital's Chief Executive Officer on the progress of implementation and the development of methods to improve the Hospital's compliance performance, and to reduce vulnerability to fraud, abuse and waste.

10. Reports to the Compliance Committee and Chief Executive Officer regarding matters of business ethics, legal compliance and the operations of the Compliance Plan.

11. Periodically revises the Compliance Plan based on specific need or in light of changes in the law or policies and procedures of government and private payor health plans.

12. Ensures that employees, independent contractors, agents, or other persons associated with the Hospital who furnish medical and billing services to the Hospital are aware of the requirements of the Compliance Plan with respect to coding, billing and marketing, among other things.

13. Coordinates personnel issues with the Human Resources Department and the Medical Staff to ensure that all employees, agents, Medical Staff, and other persons associated with the Hospital have been adequately screened for previous Medicare fraud or exclusion from other federally funded Plans.

14. Maintains a confidential log of all reported allegations of wrongdoing.

15. Investigates (or manages independent investigations) and acts on matters related to compliance, including exercising the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all Hospital departments, providers and sub-providers, agents, or other persons associated with the Hospital.

16. Develops policies and plans that encourage employees, agents, or other persons associated with the Hospital to report suspected fraud and other improprieties without fear of retaliation.

17. Ensures that reasonable steps are taken to respond appropriately to ethical or legal compliance violations, to prevent further violations and to discipline violators appropriately and consistently.

18. To assure that all delegations of responsibility under the Compliance Plan are made in proper form and content to persons reasonably believed to be morally fit, honest, and capable of making the judgments called for in the delegation.

19. To consult with Compliance Counsel to obtain interpretations of any requirements under the Compliance Plan which are unclear, vague and which the Compliance Officer believes to be potentially void, outdated, unclear, or unworkable.

20. To bring to the attention of Compliance Counsel all changes in circumstances which could reasonably suggest that the Compliance Plan should be modified.

21. To promptly carry out all duties expressly assigned to the Compliance Officer by the Compliance Plan.

22. To coordinate monitoring and auditing for adherence to the Compliance Plan.

23. Performs such other appropriate functions as may be assigned from time to time by the (a) Board of Directors, (b) Compliance Committee, and (c) Executive leadership of the Hospital.

POLICY FOR THE COMPLIANCE COMMITTEE

Purpose

The purpose of the Compliance Committee is to provide a Senior Management forum for advice, discussion and the exchange of information between the Hospital Compliance Officer and managers and employees who represent specific functional areas within the organization. The Compliance Committee shall advise the Compliance Officer and assist in the implementation of the Compliance Program.

Goal

The goal of the Compliance Committee should be to build consensus and support for the structure, organization, design and effective implementation of the Compliance Plan starting with the managers and employees who comprise the Compliance Committee.

Composition

The Compliance Committee shall consist of managers and employees from the Hospital, who from time to time may be appointed by the Chief Executive Officer:

Administration of the Committee

The Hospital Compliance Officer will serve as the Chairman of the Compliance Committee. The Compliance Officer is responsible for scheduling Compliance Committee meetings, preparing agendas, and taking minutes for each meeting.

Compliance Committee meetings should be scheduled on an as-needed basis with a minimum of one meeting every three months.

Hospital Compliance Counsel will serve as counsel to the Compliance Committee and advise the Committee on any relevant legal matters that arise from issues discussed by the Committee or reported to the Compliance Officer.

The Compliance Officer should ensure that the Compliance Committee is kept fully informed of current developments and plans that affect the structure, organization, design and implementation of the Compliance Plan.

Function

The Compliance Committee functions as an advisory body to the Compliance Officer. The Committee is not vested with any independent decision-making or supervisory authority with respect to the Compliance Plan or the Compliance Officer. The Compliance Committee's functions include:

• Analyzing the Hospital's environment, the legal requirements with which it must comply, and specific risk areas;

• Assessing existing policies and procedures that address legal requirements and specific risk areas for possible incorporation into the Program;

• Working with appropriate departments to develop standards of conduct and policies and procedures to promote compliance with the Plan;

• Recommending and monitoring, in conjunction with the relevant departments, the operation of internal systems and controls to carry out the Hospital's standards, policies and procedures as part of its daily operations;

• Determining the appropriate strategy/approach to promote compliance with the Plan and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and

• Advising in the operation of a hotline system to solicit, evaluate and respond to complaints and problems.

The Compliance Committee may also address other functions, as compliance is an integral part of the overall Hospital operating structure and daily routine.

DUTIES OF OTHER KEY PROGRAM PARTICIPANTS

In order for this Compliance Plan and Compliance Code of Conduct to work effectively, cooperation between the officers, directors, employees, counsel, and consultants is essential.

Duties of Compliance Counsel

The term "Compliance Counsel" as used in these policies and procedures will generally refer to the Hospital legal counsel. The Hospital legal counsel serves as the Compliance Counsel, responsible for the legal oversight of the Hospital's Compliance Program, including:

1. Rendering legal opinions and taking other action necessary to the effective and prompt application of the Compliance Plan. When deemed necessary, Compliance Counsel is authorized to secure the opinions and other assistance of outside consultants and other experts;

2. To carry out all duties set forth elsewhere in the Compliance Plan;

3. To request, oversee, and direct any and all audits, both internal and external, and investigations or examinations relating to the Hospital's compliance efforts;

4. To monitor developments and changes in relevant federal and state laws, rules, regulations, and court rulings which may affect the terms of the Compliance Plan or operations of the Hospital; and

5. To promptly bring all such changes in law, rule, or regulation to the attention of the Compliance Officer and to prepare proposed changes in the Compliance Plan for submission to the Compliance Officer.

Duties of Board of Directors

The Board of Directors shall make every effort to assure its complete support and appropriate funding for the policies, procedures and personnel identified in the Compliance Program.

Duties of Human Resources Department

The Human Resources Department will be responsible for developing and implementing employee hiring and screening procedures and disciplinary procedures that meet the requirements of the Compliance Plan. In developing the hiring and screening procedures required by this section, the Human Resources Department will establish minimum standards for the hiring and screening process which may include but will not be limited to:

1. Substance abuse testing;

2. Criminal background checks;

3. Reference checks;

4. HHS/OIG List of Excluded Individuals/Entities; and

5. National Practitioner Databank checks.

The screening process shall be completed on all new employees before hiring. The requirement of the screening and hiring process may not be waived for any employee, except by the Chief Executive Officer.

Duties of the HIPAA Privacy Officer

The Risk Manager serves as the Privacy Officer and is responsible for coordinating activities associated with HIPAA Privacy Regulation adherence, including:

1. Provide administrative leadership to conduct risk assessment, review regulatory requirements, and create policies to ensure compliance with HIPAA privacy regulations.

2. Present findings, recommendations, and actions regarding privacy standard adherence to the Compliance Committee for review or approval.

Duties of the HIPAA Security Officer

The Manager, M.I.S. and Telecommunications serves as the Security Officer and is responsible for coordinating activities associated with HIPAA Security Regulation adherence, including:

1. Conduct risk assessment, review regulatory requirements, and create policy associated with HIPAA security standards.

2. Present findings, recommendations, and actions regarding security standard adherence to the Compliance Committee for review or approval.

TRAINING AND EDUCATION

The training and education of the Hospital Compliance Plan shall be conducted in accordance with the provisions of Organizational Policy 1203 and shall include:

•Dissemination to all employees, agents, or other persons associated with the Hospital the information contained in the Hospital Compliance Code of Conduct;

•Appropriate dissemination of other sections of the Compliance Plan to selected employees;

•Classroom, lecture, and other instruction on the purpose, scope and importance of the Corporate Compliance Plan;

•Written acknowledgement by employees, agents or other persons associated with the Hospital confirming:

- Completion of training (verified by appropriate training personnel);
- Pledge to adhere to the Compliance Plan; and
- Acknowledgment that each individual understands that failure to comply with the Compliance Plan may lead to disciplinary action;

•Periodic manager/supervisor acknowledgment confirming:

- Adherence to the Compliance Plan by themselves and subordinates since their last certification;
- Pledge to exercise a best effort to assure continued compliance by subordinates, and confirmation that subordinates have been advised of the importance of adhering to the Compliance Plan.

No employee, agent, or other person, whether full-time, part-time, contracted or temporary, shall be authorized to act for the Hospital without first completing the employee screening and training process unless written authorization is given by the Compliance Officer after consulting Compliance Counsel.

Every Hospital employee, agent, or other person associated with the Hospital will receive training appropriate to his or her position and discipline. This training will include organization-wide training to all Hospital employees, agents, or other persons associated with the Hospital and focused technical training to specific departments as necessary to ensure an effective Compliance Plan.

Organization-Wide In-House Training

Goal

An explicit goal of the Compliance Plan is the development of a culture of compliance. It is important that all Hospital employees, agents, or other persons associated with the

Hospital are aware of the Compliance Plan, understand their role in the Plan, and know when and how to access the Compliance Plan. Organization-wide training will be developed and conducted in-house to enhance internalization of a culture of compliance.

Training

All Hospital employees will receive training on the following Compliance Plan elements:

• The structure and purpose of the Compliance Plan;

• The standards of conduct and their relevance to all managers, supervisors, and employees;

• The policy on non-retaliation;

• How to report known or suspected violations of the standards of conduct, laws, rules, regulations, and other Hospital policies; and

• How to use the Compliance Hotline.

Agent, vendors, independent contractors, and other persons associated with the Hospital will be advised about and made aware of the Compliance Plan.

Methods

Several methods will be used for organization-wide training, including, but not limited to:

• The Compliance Plan has been presented to Hospital department managers.

• All employees, agents, or other persons associated with the Hospital have received written information describing the Compliance Plan and the Compliance Code of Conduct.

• Department managers will be responsible for training employees, agents, or other persons associated with the Hospital in their respective areas. This training will include presentation of the Compliance Plan documents in addition to other materials as required.

• New employees, agents, or other persons associated with the Hospital will receive their introduction and education about the Compliance Plan during their employment orientation.

Methods and materials will change as required to meet the needs of the intended audience.

Assessment

Periodic assessment of employee awareness of Compliance Plan functions will be conducted to ensure the development of a culture of compliance throughout the organization. Additional training and education will be conducted as needed to ensure all employees are aware of Compliance Plan function and operation.

Technical Training

In addition to the organization-wide training mentioned above, Hospital employees, agents, or other persons associated with the Hospital will receive technical training relevant to their positions and departments. Technical training will focus on special risk areas as defined by the Office of the Inspector General's Annual Work Plan, through identification from the risk assessment, by communication through fraud alert or carrier/intermediary bulletin, or by Compliance Plan monitoring activities to improve overall compliance and system performance.

Resources

Given the complexity of laws, rules, and regulations, outside assistance may be used as needed to conduct technical training. Selection of consultants/experts will be made by the Compliance Officer with the assistance of the department head for the discipline involved.

Examples

Examples of technical training include, but are not limited to:

- DRG and CPT/HCPCS coding accuracy;
- Three day window bundling requirements;
- DRG transfers vs. discharges;
- Clinical laboratory unbundling;
- Medical necessity documentation;
- Medicare secondary payor requirements;
- Fraud & Abuse (Anti-Kickback) Law and Regulations;
- Stark (Self-Referral) Law and Regulations;
- Emergency Medical Treatment and Active Labor Act (EMTALA) Law and Regulations; and
- The Deficit Reduction Act of 2005.

Whenever appropriate, specific policies and procedures will be created and retained in this Compliance Plan to address areas of special concern or potential exposure to compliance risk.

POLICY FOR THE COMPLIANCE HOTLINE

The Compliance Hotline (866-631-5718) provides employees, supervisors, managers, agents and other persons associated with the Hospital a mechanism to report concerns about suspected or known violations of laws, rules, regulations, policies, procedures, and the Hospital Compliance Code of Conduct without fear of retaliation.

The Hospital Compliance Officer is responsible for the proper administration of the Compliance Hotline. The operation of the Hospital Compliance Hotline shall be conducted in accordance with the specific provisions of Organizational Policy Number 1201. Calls to the Compliance Hotline will be acted upon in a timely fashion. The Compliance Officer will ensure that, within legal and practicable limits, callers to the Compliance Hotline will be assured anonymity, or in the case where they identify themselves, confidentiality.

The Compliance Officer is responsible for developing and implementing operating procedures for the Compliance Hotline. He or she is also charged with the following related responsibilities:

1. To ensure that those who answer the Compliance Hotline are properly trained to act with discretion, integrity and courtesy,

2. To maintain accurate and complete records and logs relating to Compliance Hotline calls received,

3. To take all appropriate steps to avoid compromising Compliance Hotline callers,

4. To have an appropriate document destruction and retention system that removes and deletes information that identifies or could lead to the identification of callers. Destruction of any Hotline related documents shall be done in consultation with Compliance Counsel,

5. To coordinate investigations and responses with Compliance Counsel,

6. To coordinate with other internal departments, such as the Human Resources Department, as provided by Organizational Policy Number 1201, for advice or further investigation,

7. To ensure that all Compliance Hotline calls are appropriately followed-up and resolved,

8. To report concerns relating to Compliance Hotline calls to the Compliance Committee or Senior Management when needed, and

9. To report quarterly to the Chief Executive Officer a summary of Compliance Hotline activity and the status of responses relating to calls received.

The Compliance Officer also has the responsibility to report to the Chief Executive Officer, the Compliance Committee, and to the Hospital Board of Directors any matter that the Compliance Officer believes requires external reporting to a regulatory or law enforcement agency. The Compliance Officer will work with Compliance Counsel, independent consultants, and appropriate Senior Management on matters that may require disclosure.

Verified reports of illegal conduct by any Hospital employee, agent, or other person associated with the Hospital will result in strict disciplinary action, to include possible immediate termination and referral to appropriate law enforcement agencies, or other appropriate sanction.

Verified abuse of the Compliance Hotline by a Hospital employee, agent, or other person associated with the Hospital will result in strict disciplinary actions, to include possible immediate termination.

REPORTING ALLEGED MISCONDUCT OR UNETHICAL BEHAVIOR

All employees are required to report acts of non-compliance. The Hospital has established a dedicated toll-free Compliance Hotline for use by employees, agents, or other persons associated with the Hospital wishing to report suspicious conduct, violations of law, rules, regulations, Hospital policies and procedures, or information the employee, agent, or other person feels he/she cannot otherwise report to a supervisor.

Common sense and sound business judgment are the keys to determining whether conduct complies with ethical and legal standards. If you find yourself in a situation where you are unsure or uncomfortable with your current conduct, ask yourself a few simple questions:

- Is the conduct legal?
- Are the parties being fair and honest?
- Is the conduct in the best interest of the Hospital or the patients we serve?

If the answer to any of these questions is "no" then an employee has a duty and an obligation to report the potentially non-compliant conduct.

Employees should make reports to their supervisor or by calling the Compliance Hotline at 1-866-631-5718.

Employees who are uncomfortable using the Compliance Hotline may telephone the Compliance Officer at (910-577-2345) or may submit a report in writing to:

Compliance Officer
c/o Onslow Memorial Hospital, Inc.
P.O. Bow 1358
Jacksonville, N.C. 28541-1358

Whether reporting by phone or in writing, employees should provide as much detail as possible including activities, dates, times, places and the specific conduct that may violate laws, rules, regulations, or Hospital policies and procedures. If calling, employees should be prepared to fax any relevant documents to the Compliance Officer, or if writing, should include copies of those documents.

The following are some **DOs** and **DON'Ts** for employees who report violations or unethical behavior:

1. **DO** immediately report what you know or suspect;

2. **DON'T** confront an employee suspected of acting illegally;

3. **DON'T** attempt to "investigate" the conduct yourself;

4. **DON'T** discuss your suspicions with anyone, whether an employee of the Hospital or an outsider. This creates the possibility for damaging rumors or other adverse and potentially detrimental results which may have a significantly negative and harmful impact on innocent persons and may produce other irreparable harm;

5. **DON'T** look the other way and hope the problem will fix itself;

6. **DON'T** panic; reporting suspected wrongdoing is your ethical and legal duty.

HOSPITAL POLICY ON NON-RETALIATION

It is the policy of the Hospital that no employee, agent, or other person associated with the Hospital shall be punished solely on the basis that he/she reported what he/she reasonably believed to be an act of wrongdoing or a violation of the Compliance Plan or the Compliance Code of Conduct.

However, an employee, agent, or other person associated with the Hospital will be subject to disciplinary action if it is reasonably concluded that the report of wrongdoing was knowingly fabricated or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect himself/herself.

HANDLING REPORTS OF WRONGDOING

The following shall be the policy and procedure for dealing with reports of wrongdoing. It shall be the policy of the Hospital to take all reports of wrongdoing seriously. Reports of wrongdoing may be made verbally (through the Compliance Hotline) or in writing. All such reports must be directed to the Compliance Officer, who shall handle all such reports according to Organizational Policy 1202 and assure that the steps described herein are taken.

A written record of the report shall be made using a form approved for use by Compliance Counsel. The Compliance Officer shall endeavor to obtain all information called for on the form. No promises will be made to the party making the disclosure regarding his/her liability or what steps the Hospital may take in response to the report of wrongdoing.

The Compliance Officer shall report all allegations of criminal wrongdoing immediately to Compliance Counsel. Compliance Counsel and the Compliance Officer shall, at a minimum, determine whether the alleged wrongdoing is a violation of federal or state law, rule, regulation, Hospital Compliance Plan, or otherwise puts the Hospital at risk for economic injury or injury to reputation. Thereafter, the Compliance Officer and Compliance Counsel will take action commensurate with the gravity of the allegation to determine if the allegation has a basis in fact and what remedial action and/or punishment is to be imposed.

If Compliance Counsel believes that the allegation, if true, would constitute a violation of federal or state law, rule, or regulation, the Chief Executive Officer will be immediately notified. As part of Compliance Counsel's periodic reports to the Chief Executive Officer, Compliance Counsel shall include a report on all reports of employee wrongdoing posing a risk of civil or criminal liability for the Hospital, including the results of investigations and any subsequent punishments or remedial actions taken.

For all reports, the Compliance Officer shall record the nature of the investigation carried out, if any, and the results of same. The Compliance Officer will present a summary of all reports to the Compliance Plan and any subsequent response to the Compliance Committee.

CONTACTS WITH NON-EMPLOYEES

Unless it is a part of a written job description to have contact with the following categories of individuals or entities, all employees, agents, or other persons associated with the Hospital are governed by the following rules as they pertain to the Hospital's business.

Contact with the Media

All contacts by or with anyone from the media regarding compliance related issues MUST be referred to the Compliance Officer and the Director of Public Relations. Employees should politely, but firmly, decline to engage in any discussion with media representatives, no matter how seemingly harmless, relating to any compliance-related matter.

Contact with Attorneys

All contacts by or with anyone claiming to be an attorney should be immediately referred, before response, to Hospital Compliance Counsel at (252)-633-3131.

Contact with Competitors

All contacts by or with anyone representing a competitor of the Hospital or employed by a competitor should be reported, before response, to the employee's immediate supervisor. Employees should not allow competitors to engage them in conversation about confidential Hospital practices, policies or confidential information concerning customers or patients. A supervisor to whom such contacts are reported shall immediately report the incident to Compliance Counsel or the Compliance Officer.

Contact with Government Agents/Investigators

All contacts on compliance related matters, by or with anyone claiming to represent any federal, state, or local agency shall be immediately reported, before response, to Compliance Counsel, who shall promptly report it to the Chief Executive Officer.

It has been, and will continue to be, the Hospital's policy to cooperate appropriately with law enforcement personnel and other authorities. Nevertheless, government regulations and their enforcement is a very complex area of the law. Because such inquiries are important and often complicated, employee adherence to this requirement is extremely important.

AUDIT POLICY

Purpose

The purpose of the audit policy is to establish the authority of the Chief Executive Officer, the Compliance Officer and Compliance Counsel to investigate any process or procedure for discovery of suspected violation of regulation, rule, or Hospital policy. Any investigation or audit will be conducted in cooperation with Compliance Counsel.

Resources

The Compliance Officer will have any necessary internal resource at his disposal for auditing existing processes or procedures to effectively assess current performance or potential exposure to risk.

Investigative Methods

The Compliance Officer may conduct audits based on reported or suspected violations of law, rule, regulation, or policy either by direct communication or through the Compliance Hotline. In addition, the Compliance Officer has the authority to randomly audit any process or procedure to assess compliance with applicable law, rule, regulation, or policy.

Records

Audit records will be logged and retained by the Compliance Officer unless the audit is in response to litigation risk, in which case records will be maintained by Compliance Counsel.

Reporting

Compliance Counsel will report results of audits relating to litigation to the Chief Executive Officer. Results of audits not relating to litigation will be reported to the Compliance Committee, as necessary.

Audit Procedures and Internal Billing Controls

The billing, claims processing, and reimbursement procedures and practices will be audited internally on an as needed basis under the direction of the Hospital Vice President of Finance and the Director of Patient Financial Services, subject to the direction of Compliance Counsel. These internal audits shall consist of a review of all internal billing, claims processing and reimbursement matters, and confirm that all billing and regulatory compliance policies are being followed. The Compliance Officer will determine any additional areas upon which the audit will focus.

On a periodic basis, external auditors will conduct an audit of all billing, claims processing, and reimbursement procedures and practices. The Compliance Officer shall assist in conducting these audits subject to the direction of Compliance Counsel. These audits may focus on, but are not limited to, claims processing and submission, government billing, reimbursement matters, secondary payor issues, or any other issues deemed appropriate by the external auditors. The Compliance Officer has the authority to initiate additional audits if the need arises. Any such additional audits shall be performed subject to the direction of Compliance Counsel.

On an annual basis, the top thirty (30) DRG codes shall be analyzed for percentage growth, under the direction of the Compliance Officer and subject to the direction of Compliance Counsel. Included in the audit shall be a review of all DRG codes that have experienced unusual growth and a determination of the reason for the growth rate. If any illegal or un-permitted activity contributed to the growth rate, the Hospital shall take corrective action.

A yearly external audit of medical records to ensure appropriate coding and DRG assignment will be conducted. Additional records may be examined periodically under the direction of the Compliance Officer to ensure that all medical record documentation, coding, DRG assignment, and E&M coding is consistent and appropriate. These audits may include both inpatient and outpatient records, and Medicare, Medicaid, commercial, and self-pay patients. All such external audits or examinations shall be performed subject to the direction of Compliance Counsel.

At the conclusion of any audit, the Compliance Officer shall present to the Compliance Committee a review of the audit findings at the first regularly scheduled committee meeting after the conclusion of the audit.

The Compliance Officer or Compliance Counsel may request retrospective audits of any potential risk exposed during random audits or by report and investigation from any employee, agent or other person.

The Compliance Officer or Compliance Counsel may request focused monitoring of any process where potential risk is suspected.

Audit findings that indicate the Hospital may have been paid for claims incorrectly shall be evaluated fully, and amounts ultimately determined to be due and owing to payors shall be repaid promptly.

Amounts determined in the ordinary course of Hospital operations to have been incorrectly paid also shall be returned to payors on a regular basis.

POLICY ON EMPLOYEE DISCIPLINE

An effective Compliance Plan must include procedures to assure the discipline of employees who fail to detect wrongdoing as well as for those who commit an offense or crime. Therefore, all employees will receive education and training relating to the importance of adherence to the Compliance Plan and will be required to acknowledge that adherence to the Compliance Plan is a material condition of employment.

Employees will be informed that failure to comply with the requirements of the Compliance Plan will result in discipline up to and including immediate discharge. Violations of the Compliance Plan will be handled by Human Resources in accordance with the Human Resources Disciplinary Action Policy (Human Resources Policy, HR VI-605).

POLICY ON ARRESTS AND CONVICTIONS

An employee must report to their department manager any criminal charge or conviction within twenty-four (24) hours of its occurrence. An employee need not report offenses such as traffic violations that are punishable only by fine unless the traffic violation occurred while driving a Hospital vehicle or the employee receiving the traffic violation regularly drives a Hospital vehicle.

Convictions reported by an employee shall be reviewed by the Compliance Officer, Compliance Counsel, and the Director of Human Resources to determine whether the employee's unlawful conduct requires employee reassignment or otherwise affects or violates the requirements of this Compliance Plan.

Compliance Counsel shall establish a procedure to ensure the confidentiality and privacy of information regarding arrests and convictions.

POLICY ON MONITORING THE OIG LIST OF EXCLUDED INDIVIDUALS/ENTITIES

Policy

It is the policy of the Hospital to employ, do business with, or have as Medical Staff members, individuals who have not been excluded by the Office of Inspector General from participation in government health care plans. To ensure that all employees, agents, suppliers, or other individuals have not been excluded from Federal Health Care Plans all employees, agents, suppliers, or other persons associated with the Hospital will be screened against the OIG List of Excluded Individuals/Entities, as set forth in Organizational Policy No. 1206.

Procedure

The Human Resources Department will ensure that all new employees are screened against the OIG List of Excluded Individuals/Entities as part of normal background screening. Any individual who appears on the List of Excluded Individuals/Entities will not be employed.

The Medical Staff Coordinator will ensure that all new Medical Staff applicants are screened against the OIG List of Excluded Individuals/Entities as part of the normal credentialing process. If an applicant appears on the List of Excluded Individuals/Entities, the Chief of Staff will be immediately notified.

The Compliance Officer or his or her designee will review monthly the OIG List of Excluded Individuals/Entities. If an employee or contractor appears on the List of Excluded Individuals/Entities, then the Compliance Officer will take appropriate action.

Upon notice of an excluded individual or contractor, the Compliance Officer will initiate necessary audits or investigation to determine if any reimbursement was inappropriately received from the government health care plans for services rendered by an excluded individual or entity.

POLICY ON SELF REPORTING

It is the policy of the Hospital to investigate thoroughly any report of noncompliance with federal or state laws, rules, or regulations. Investigations of wrongdoing will be conducted under the authority of the Compliance Officer and Compliance Counsel. The Hospital will self report material violations of law, rule, or regulation under the guidance of Compliance Counsel.

BILLING POLICIES AND PROCEDURES

Policy

The Hospital is committed to ensuring that its billing practices comply with all federal and state laws, rules, and regulations. The Hospital is also committed to developing and maintaining policies and procedures that ensure both accurate billing and submission of claims only for services that are actually rendered and medically necessary and that any cost reports filed accurately reflect costs incurred for furnishing health care services. Furthermore, the Hospital desires to develop billing policies and procedures that reflect current payment methodologies for particular services. As billing is an area governed by complex laws, rules, and regulations and as billing practices could result in legal liability, this policy sets forth specific billing procedures with which all billing, reimbursement and claims processing personnel ("Billing Personnel") must comply.

The Hospital is committed to only generating bills and claims that accurately reflect services rendered and supported by relevant documentation in accordance with third party payer requirements. Improper, false, fictitious or fraudulent claims shall never be acceptable. Improper or fraudulent claims can include:

- Cost report falsification;
- Misrepresentation of services;
- Duplicate billing;
- Multiple coverage and secondary payer fund;
- False claim and statements;
- Billing for non-approved treatments or equipment usage;
- Improper coding;
- Non-ordered/Non-performed claim submission for tests;
- Improper physician referrals; and
- Improper discounting.

Duties of the Director of Patient Financial Services

The Director of Patient Financial Services has the primary responsibility of ensuring that all reimbursement and billing policies and procedures are accurate and integrated into business office operations.

The Director of Patient Financial Services has the following responsibilities:

1. Answering all employee questions concerning reimbursement and billing issues that cannot readily be answered from this policy. Billing Personnel will be informed of the existence and identity of the Director of Patient Financial Services during training sessions and will be directed to contact the Director of Patient Financial Services with any question regarding reimbursement or billing practices that are not adequately addressed by immediate supervision.

2. Ensuring that all of the Hospital reimbursement and billing manuals and materials are up-to-date and reflect current government laws, rules, regulations, and practices.

3. Ensuring that government policies and procedures are reviewed in order to verify that all policies reflect any changes in coverage determinations or payment alerts.

4. Ensuring that all government and carrier reimbursement and billing manuals that Hospital employees, agents, or other persons associated with the Hospital utilize are current and are updated on a regular basis. In this regard, it is the Hospital's policy that outdated government or intermediary carrier or billing and reimbursement manual provisions will not be discarded. Instead, the Hospital will keep separate chronological binders in which superseded government, intermediary or carrier policies and procedures will be retained. In lieu of the above, the Hospital may transfer such information to an electronic or optical storage media.

5. Ensuring the proper documentation for billed services is being maintained and that documentation/information required from physicians is obtained only from the treating physician.

6. Ensuring that appropriate and reasonable mechanisms are in place regarding beneficiary deductible or co-payment collection efforts.

7. Ensuring that procedures are in place and documented for the timely and accurate reporting of Medicare and other federal health care plan credit balances.

8. Advising Hospital Staff and Medical Staff Physicians that only medically necessary services should be ordered/provided.

9. Developing policies and procedures that comply with Local Medical Review Policies. The Director of Patient Financial Services will distribute and maintain records of current and past LMRP and develop policies and procedures to obtain Advance Beneficiary Notice for tests or procedures ordered, without supporting medical necessity. The Director of Patient Financial Services will assist other ancillary and clinical departments in creating operating procedures that comply with Local Medical Review Policies relevant to their areas of responsibility.

10. Developing a review system which ensures that claims, and particularly billing codes are accurate, and that standing orders are monitored.

11. Ensuring that compensation for Billing Personnel does not provide financial incentives to improperly upcode claims.

Training of Billing Personnel

All Billing Personnel are required to attend periodic training sessions devoted specifically to issues involving claims processing and submission, billing, coding, medical necessity, and reimbursement matters. The Director of Patient Financial Services is responsible for this training session and shall work jointly with the Compliance Officer in developing and organizing training sessions. In addition, the training session will provide a summary of legal sanctions for improper billing.

All current Billing Personnel were required to attend an orientation session within thirty (30) days of the implementation of this Compliance Plan at which time all Billing Personnel were provided with a copy of this policy.

All new Billing Personnel will participate in a training session specific to billing policies and procedures within thirty (30) days of beginning employment at the Hospital.
At the conclusion of each training session, Billing Personnel will be required to sign a Billing Training Acknowledgment and Disclosure Form. Such form shall be retained by the Director of Patient Financial Services and a copy shall also be placed in the employee's personnel file.

Billing Reimbursement Issues

The Hospital strives to adhere to the highest ethical and legal standards. Any Billing Personnel who identifies any potential billing or reimbursement discrepancies with respect to claims already submitted to government or private payors is required to immediately report those discrepancies to his/her immediate supervisor, to the Compliance Officer or to the Compliance Hotline.

Reports of discrepancies with respect to past claims or reimbursements shall promptly be brought to the attention of the Compliance Officer. The Compliance Officer shall obtain all information from any Billing Personnel or others known to be involved in making the report, shall evaluate the report, and make a determination as to whether plan repayment is warranted.

Billing Personnel may encounter uncertainties as to whether particular health care services are covered, or the appropriate manner in which to claim reimbursement for services. In such circumstances, Billing Personnel shall first bring the issue to the attention of their supervisor, who if uncertainty still exists, shall discuss the issue with the Director of Patient Financial Services. If uncertainty still exists, the payor or Medicare carrier will be contacted either by phone or mail, or both, in an attempt to resolve the issue. Such contact shall be initiated only by the Director of Patient Financial Services who may consult with the Compliance Officer for such purposes.

Billing Personnel shall report immediately to their supervisors any billing instruction received from payors, either verbally or in writing, which is inconsistent with current Hospital billing policy or procedures. Billing supervisors, in turn, shall promptly bring

such reports to the attention of the Director of Patient Financial Services and the Compliance Officer for immediate resolution.

Whenever speaking to a carrier or private payor by telephone, all Billing Personnel must document the date and purpose of the call, the person spoken to, the telephone number of the person, and a summary of the conversation, to ensure a written record of such contacts.

POLICY ON COST REPORTS

Policy

The Hospital is committed to ensuring full compliance with applicable federal and state laws, rules, regulations, and Plan requirements with regard to cost report issues.

Duties of the Vice President of Finance

The Vice President of Finance has the primary responsibility of ensuring that all cost report policies and procedures contained in this policy are accurate and integrated into Hospital operations.

The Vice President of Finance is responsible for ensuring that:

1. Costs are not claimed on the cost report that are not based on appropriate and accurate documentation.

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

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

4. Costs are properly classified.

5. Prior Year Fiscal Intermediary adjustments are implemented and either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report.

6. All related parties are identified on the cost report and all related party costs are reduced to cost.

7. The Hospital has not claimed as bad debts routinely waived co-payments and deductibles.

8. Procedures are in place and documented for notifying promptly the Medicare fiscal intermediary for errors discovered after the submission of the cost report.

9. Requests relating to exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the routine cost limits are properly documented and supported by verifiable and auditable data.

CODING POLICIES AND PROCEDURES

Policy

The Hospital is committed to ensuring that its coding practices comply with all federal and state laws, rules, and regulations. The Hospital is also committed to developing and maintaining policies and procedures that ensure accurate coding based on documentation in the medical record and reflect current coding guidelines, thus protecting the integrity of claims. As billing is an area governed by complex laws, rules, and regulations and as coding practices could result in legal liability, this policy sets forth specific coding procedures with which all coding personnel must comply.

Duties of the Director of Medical Records

The Director of Medical Records has the primary responsibility for ensuring that all coding policies and procedures are accurate and integrated into Hospital operations.

The Director of Medical Records has the following responsibilities:

1. Answering all employee questions concerning coding issues that cannot readily be answered from this policy. Coding Personnel will be informed of the existence and identity of the Director of Medical Records during training sessions and will be directed to contact the Director of Medical Records with any question regarding coding practices that are not adequately addressed by immediate supervision.

2. Ensuring that all of the Hospital's coding manuals and materials are up-to-date and reflect current federal and state laws, rules, and regulations.

3. Ensuring that proper documentation for billed services is being maintained and that documentation information required from physicians is obtained only from the treating physicians.

4. Developing a review system that ensures accurate coding.

5. Ensuring that compensation for coders does not provide financial incentive to improperly upcode claims.

Training of Coding Personnel

All coding personnel are required to attend periodic training sessions devoted specifically to issues involving coding. The Director of Medical Records is responsible for this training session and shall work jointly with the Compliance Officer for developing and organizing training sessions. The training sessions will provide a summary of legal sanctions for improper coding.

All current coding personnel were required to attend an orientation session within thirty (30) days of the implementation of this Compliance Plan at which time all coding personnel were provided with a copy of this policy.

All new coding personnel will participate in a training session specific to coding policies and procedures within thirty (30) days of beginning employment at the Hospital.

At the conclusion of each training session, coding personnel will be required to sign a Coding Training Acknowledgment and Disclosure Form. Such form shall be retained by the Director of Medical Records and a copy shall also be placed in the employee's personnel file.

Coding Issues

Any coding personnel who identifies any potential coding or reimbursement discrepancies with respect to claims already submitted to government or private payors, is required to report immediately those discrepancies to his/her immediate supervisor, to the Compliance Officer or to the Compliance Hotline.

Reports of discrepancies with respect to past claims or reimbursement shall be brought to the attention of the Compliance Officer promptly. The Compliance Officer shall obtain all information from any billing / coding personnel or others known to be involved in making the report, shall evaluate the report, and shall make a determination as to whether Plan repayment is warranted.

Coding personnel may encounter uncertainties when coding medical records. In such circumstances, coding personnel shall first bring the issue to the attention of their supervisor who, if uncertainty still exists, shall discuss the issue with the Director of Medical Records. If uncertainty still exists, the Director of Medical Records with the direction of the Compliance Officer may contact third party experts for an opinion or other assistance relating to the coding uncertainty.

Coding personnel shall report immediately to their supervisors any coding instruction received from third parties, either verbally or in writing, which is inconsistent with current Hospital coding policy or procedures. Coding supervisors, in turn, shall bring such reports promptly to the attention of the Director of Medical Records and the Compliance Officer for immediate resolution.

PLAN INTEGRITY VALIDATION

Policy

It is the Policy of the Hospital to verify the integrity of its Compliance Plan upon the completion of implementation. Billing and coding audits will serve as ongoing validation of a functioning Compliance Plan. The Hospital may also periodically test its Plan with outside analysis and recommendations for improvement.

The Compliance Officer will determine when the Plan requires third party or other external validation. The Compliance Officer will be responsible for selecting the outside firm or other resource to conduct an analysis of the Compliance Plan. Any such analysis or validation shall be performed subject to the direction of Compliance Counsel.
The results of any outside analysis or validation will be provided to the Compliance Committee upon completion of such analysis.