UPSON REGIONAL MEDICAL CENTER

LEGAL COMPLIANCE

PROGRAM DOCUMENTS

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PART ONE

MISSION STATEMENT OF
UPSON REGIONAL MEDICAL CENTER

Upson Regional Medical Center ("URMC") is the registered trade name of Upson County Hospital, Inc. (the "Corporation"). The Corporation is an Internal Revenue Code §501(c)(3) charitable corporation that operates Upson County Hospital. The Corporation is also the sole member of numerous other healthcare entities which provide a variety of healthcare services including physician and wellness services.

The mission of URMC is to provide the public with high quality technologically advanced healthcare in an efficient, cost effective and ethical manner to which the Board of Directors, the Administration, the Medical Staff and all personnel are fully committed. We subscribe fully to the highest standards of both medical and business ethics.

We are devoted to patient satisfaction through the use of high quality equipment and facilities combined with compassionate care in a pleasant environment.

URMC makes no distinction in the admission, transfer, or discharge of patients or in the care it provides based upon a patient's race, color, religion, or national origin.

We collectively strive to be in total compliance with all applicable local, state and federal laws, guidelines and regulations.

We are vigilant in our efforts to avoid fraud and abuse in all our endeavors and devote special care in order to assure that our billing practices meet the highest standards of integrity and that they are in conformity with all applicable laws, rules and regulations.

We provide education, monitoring, and oversight to ensure that all Administration, Medical Staff, and other staff are fully informed and committed to these standards.

We encourage a pleasant, open and collegial work environment in the belief that such will result in our ultimate mission of rendering the best in patient care.

UPSON REGIONAL MEDICAL CENTER
LEGAL COMPLIANCE PROGRAM
PURPOSE

Corporate compliance for healthcare means meeting the statutory and regulatory requirements that govern the provision of healthcare. The Compliance Program of Upson Regional Medical Center reflects acceptance of the duty and the commitment of resources to meet and exceed those requirements.

The Corporation and its affiliated corporations and limited liability companies (collectively, the "Hospital") believe that conscientious dedication to the highest ethical medical and business standards is essential to its Mission. This dedication is imperative in order that the Hospital function within the parameters of today's healthcare regulatory environment. Operation in accordance with the highest ethical standards is not only the right thing to do it is mandatory because the Hospital is a charitable Hospital organized as such under the provisions of Section 501(c)(3) of the Internal Revenue Code and is a participant in both State and Federal healthcare funding programs.

In order to emphasize the responsibility of each person affiliated with the Hospital to conduct themselves honestly, ethically and professionally in all of their actions performed as a part of their duties for the Hospital a Code of Conduct and Standards of Practice has been established as a part of the Compliance Program.

The Board of Directors (the "Board") of the Hospital early on recognized the benefits that could be derived from the adoption and implementation of a voluntary Compliance Program and on September 17, 1997, the Board adopted a Resolution directing the creation and implementation of a Compliance Program along with a Legal Compliance Plan, and pursuant to that Resolution a formal Legal Compliance Program Policy Manual was completed and adopted in 1999. The Program and the Policy Manual have since been updated in 2001, 2004, 2013, 2017, and 2023.

The Board and Administration have determined that the Program and Policy Manual should again be updated and improved in order to integrate into the Program changes in healthcare and the laws and regulations governing healthcare.

The Compliance Program is intended to establish a culture within the Hospital that promotes prevention, detection and resolution of instances of conduct that do not conform to Federal and State law, and Federal, State and private payor health care program requirements, as well as the Hospital's ethical and business policies.

The Board hereby establishes as a policy that adherence to the Compliance Program shall be an element in evaluating managers and employees. Every applicant for employment shall be

carefully screened for prior violations of Federal and State laws, particularly those involving healthcare compliance issues.

In 2005, the Office of Inspector General of the Department of Health and Human Services in its Supplementary Guidance on compliance, declared:

"A successful compliance program addresses the public and private sectors' mutual goals of reducing fraud and abuse; enhancing health care providers' operations; improving the quality of health care services; and reducing the overall cost of health care services." Attaining these goals benefits the hospital industry, the government, and patients alike. Compliance programs help hospitals fulfill their legal duty to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs or engaging in other illegal practices. A hospital may gain important additional benefits by voluntarily implementing a compliance program, including:

- Demonstrating the hospital's commitment to honest and responsible corporate conduct;
- Increasing the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage;
- Encouraging employees to report potential problems to allow for appropriate internal inquiry and corrective action; and
- Through early detection and reporting, minimizing any financial loss to government and taxpayers, as well as any corresponding financial loss to the hospital."[1]

The intent and purpose of this Compliance Program is the attainment of the goals and benefits described by the U.S. Department of Health and Human Services Office of Inspector General ("OIG") in its foregoing Guidance.

Compliance programs are now no longer voluntary. The 2010 health reform law, the Patient Protection and Affordable Care Act ("PPACA" or "ACA"), enacted some substantive changes to the False Claims Act, including the grant to the Secretary of Health and Human Services of the authority to compel healthcare providers and suppliers to adopt compliance programs as a condition of enrollment in Medicare, Medicaid and the Children's Health Insurance Program.[2]

The Hospital's revised Compliance Policy Manual is intended to expand and improve the compliance program that has been in place at URMC for more than a decade and to bring the program in line with current requirements.

The Compliance Program, which includes this Compliance Manual and all of the rules, regulations and Policies of the Hospital governing the conduct of those affiliated with the Hospital

1 70 Fed. Reg. 4858.
2 §6401 of the Patient Protection and Affordable Care Act (Pub. L. 111-148 (2010)).

(collectively, “Compliance Program” or “Program”), is designed to set standards for, and monitor the conduct of, all persons subject to the Program in all of their activities related to the Hospital. Although the implementation and enforcement will be centrally directed, the responsibility for compliance rests with each department or service and is ultimately the responsibility of every Hospital employee and every independent professional who enjoys Hospital Staff privileges.

The success of the Program depends upon the active participation of the Board, the Hospital’s senior executives, financial and claims staffs, officers and Managers of the Hospital’s affiliates, and the leadership of the departments and the professional Staff. Through the dissemination of information on the Compliance Program and the Compliance Policy Manual, together with appropriate mandatory training, all such persons shall be fully advised regarding their responsibilities under the Program, and the circumstances in which they should notify the Compliance Officer on a timely basis of matters subject to review under the Program. Going forward the Board, the Executive Staff, the Compliance Committee and Compliance Officer will continue to devote themselves to not only complying with the Compliance Program, but to continually review and revise it to meet any applicable new and additional requirements of Congress, CMS, OIG and any other related governmental entities.

UPSON REGIONAL MEDICAL CENTER
CODE OF CONDUCT AND STANDARDS OF PRACTICE

The Hospital has revised and improved its Compliance Program in an effort to significantly advance its efforts in the prevention of fraud, abuse and waste in health care while at the same time furthering the fundamental mission of all hospitals, which is to provide quality care to patients as economically as possible. This Program has been designed to establish a culture within the Hospital which promotes prevention, detection and resolution of instances of conduct which do not conform to federal and state law, federal, state and private payor health care program requirements, and the Hospital's ethical standards. In relation to the Compliance Program, the Hospital has established this Code of Conduct and Standards of Practice (hereafter "Code") for its managers, governing body, officers, nurses, physician, other healthcare providers, its team members, agents and independent contractors. The Code has at its core the Hospital's commitment to compliance and high ethical standards.

This part contains the Code, which sets forth the standards that govern the conduct of all Hospital personnel and other persons affiliated with the Hospital. These standards are a summary of the Hospital's expectations for its employees and are not meant to be all-inclusive. Each department of the Hospital is encouraged to propose to the Compliance Committee standards and guidance specific to the functions of their Department. Employees should refer to the Compliance Policy Manual, as well as to the other applicable Hospital and Department Policies, Procedures and protocols, when a specific question or issue arises. Consultation with the Compliance Officer and the Compliance Committee is also encouraged. Failure to follow this Code or other Hospital Policies may result in disciplinary action, up to and including termination of employment.

Medical Staff and Allied Health Professionals must certify that they have read this document as part of such individual's initial and reappointments to the hospital medical staff. All other hospital employees, officers, directors, board members, and any other individual who the Hospital determines to be a relevant covered individual under this Code and who has not otherwise certified their review and understanding of this Code shall review this document and complete Compliance Policy Manual (hereafter "Manual") and execute the STATEMENT OF COMPREHENSION**, CERTIFICATION AND AGREEMENT OF COMPLIANCE** (attached as Exhibit "A" to the COMPLIANCE POLICY MANUAL). Notwithstanding the fact that the covered person has executed such statement, neither the Code, the Manual, the Policies nor the statement form create a contract of employment between the Hospital and the covered person. At all times the covered employee remains an employee at will unless otherwise provided in a written employment agreement.

This Code is intended to be a summary of rules of the conduct expected of all Hospital employees and other persons affiliated with the Hospital. Employees should make themselves

familiar with the specific Hospital Policies and Procedures which apply to the employee's particular duties at the Hospital. All employees, officers and Directors are responsible for being familiar with and abiding by the applicable provisions of this Code and the other Policies, Procedures and protocols governing their conduct at the Hospital. Further, professionals shall follow the ethical standards dictated by their respective professional organizations.

Core Principles of Conduct

The foremost principle guiding the Hospital in all of its activities is to do the right thing, the first time, and all the time. The entire healthcare team must continue to strive to conduct all activities with integrity and honesty and in accordance with applicable laws and high ethical business practices. We must always strive to provide our patients the best and most ethical service possible. The culture of the Hospital should be one of honor, and all of our activities should at all times exemplify our commitment to ethics, integrity and quality services.

Core Beliefs

The Board, the Officers and the personnel of the Hospital believe that the Hospital should be a leader in Upson County and the surrounding counties. We believe that the integrity and quality of our employees is the major strength of our organization. As a business, we are accountable for our financial viability. As a healthcare partner, we endeavor to have a good relationship with other healthcare providers, physicians, and hospitals. As a member of the community, we strive to be a good community citizen. As a visionary, we try to anticipate trends and take the initiative in responding to change.

Ethics

The Hospital strives to earn the trust and respect of our patients, their families, our healthcare providers, our affiliated physicians, our regulators, our third party payers, our suppliers, and our volunteers. We are guided by the general principles of professionalism, compassion, and justice. Employees and other persons affiliated with the Hospital are responsible for being familiar with and following all of the Hospital's Policies applicable to them, specifically including the Ethics and Conflicts Policies, which obligate all employees and others affiliated with the Hospital to provide quality patient care and respect for all persons, to comply with all Federal and State laws, rules and regulations, to avoid conflicts of interest, and to follow ethical business practices.

Professional Ethics and Patient Care

Employees, medical professionals, agents, subcontractors and other healthcare providers shall at all times perform their functions while adhering to the highest ethical and professional standards and promote workplace health and safety.

Care providers shall also follow the Codes of Conduct and Standards of Practice and licensing requirements of their respective professional organizations.

All patients shall be treated with dignity and respect. The Hospital will respect each patient's religious, spiritual and cultural values and beliefs consistent with the law and ethical behavior.

All patient information shall be kept confidential as required by law.

Appropriate informed consent will be obtained from patients or other appropriate persons as required by law. The applicable state and federal laws affecting healthcare providers will be reviewed at employee orientation and training sessions. Laws and regulations specific to particular department functions will be incorporated in department procedures and protocols and reviewed at department training and education sessions. Employees and other persons affiliated with the Hospital are responsible for knowing and following all legal requirements relevant to performance of their job duties.

All employees, medical professionals, agents, subcontractors and other healthcare providers shall deal with all accrediting and external agency bodies in a direct, open and honest manner.

All employees, medical professionals, agents, subcontractors and other healthcare providers providing care or services in the emergency medical department shall at all times comply with all state and federal laws and requirements specifically including but not limited to the Emergency Medical Treatment and Active Labor Act ("EMTALA").

All employees, medical professionals, agents, subcontractors and other healthcare providers are responsible for the integrity and accuracy of the Hospital's documents and records, for compliance with regulatory and legal requirements and also to ensure records are available to support our business practices and actions. No one may alter or falsify information on any record or document.

Employees, medical professionals, agents, subcontractors and other healthcare providers shall not use Hospital communication systems, *i.e.* computers, electronic mail, intranet, internet access, telephones and voicemail, except for legitimate Hospital business, and shall never use the

Hospital communication systems for the purposes of the viewing, posting, storing, transmitting, downloading, or distributing any threatening materials; knowingly, recklessly, or maliciously false materials; obscene materials; or anything constituting or encouraging a criminal offense or which may give rise to civil and/or criminal liability.

Some of our colleagues routinely have access to prescription drugs, controlled substances, and other medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by order of professionals specifically licensed to do so. Prescription and controlled medications and supplies must be handled properly and only by authorized individuals to minimize risks to patients and the Hospital. If one becomes aware of inadequate security of drugs or controlled substances or the diversion of drugs from the organization, the incident must be reported immediately.

Employees, medical professionals, agents, subcontractors and other healthcare providers shall not engage in harassment (sexual or otherwise, or workplace violence) nor comment or take any action based on the diverse characteristics or cultural backgrounds of those who work with them, nor make degrading or humiliating jokes, slurs, intimidating words or behavior or other harassing conduct while on the Hospital campus, affiliated locations, or accessory buildings nor at work related events at other locations. Any actions or speech that create an intimidating, hostile or offensive working environment are prohibited and may be subject to disciplinary action(s).

The Hospital is committed to an alcohol, drug and tobacco free work environment. All employees, licensed practitioners, healthcare professionals, vendors, agents and subcontractors shall report to work free of the influence of alcohol or drugs. A violation of this mandate may result in termination of employment or contractual services.

The Hospital's Internal Revenue Code §501(c)(3) charitable designation carries with it special rules and regulations as to its involvement in political activity. Employees, medical professionals, agents, subcontractors and other healthcare providers shall not engage in political activity while on campus or at a Hospital function off campus in order to avoid jeopardizing the Hospital's tax exempt status.

Claims Submission and Payment; Documentation

Accuracy in charging and billing for services is an absolute imperative. The OIG considers the preparation and submission of claims for reimbursement from the federal health care programs to be the largest risk area for hospitals. Information on specific risks as viewed by the OIG is contained in both the original OIG Compliance Program Guidance for Hospitals,[3] the

3 63 Fed Reg 8987 1998

Supplemental Guidance on Compliance[4] (hereafter "Supplemental Guidance"), and the General Compliance Program Guidance.5 The Supplemental Guidance places emphasis on what are termed "evolving risks," such as outpatient procedure coding, admissions and discharges, supplemental payment considerations and use of information technology, all of which will be receiving special scrutiny from the OIG going forward. This dictates additional focus by the Hospital on keeping abreast of the current rules including the National Correct Coding Initiative ("NCCI") guidelines and implementing periodic reviews of actual practices, including keeping the computer systems and software related to coding, billing, and the generation or transmission of information to the federal health care programs updated**.** The Hospital may be liable under the False Claims Act or other statutes imposing sanctions for the submission of false claims or statements, including liability for civil money penalties ("CMPs") or exclusion from the federal and state healthcare programs. Underlying assumptions used in connection with claims submission should be reasoned, consistent, and appropriately documented, and the Hospital should retain all relevant records reflecting efforts to comply with federal and state health care program requirements.

All billing and collection activities shall be performed in accordance with all applicable state and federal laws, contractual requirements and Hospital policy. The OIG has expressed concern about possible abuse of "Supplemental Payment Considerations." The situations in which a different rate or additional payment can be claimed are limited, and extra care must be given to cases where such payments are claimed.

All services provided by the Hospital and its employees shall be properly and adequately documented in accordance with applicable laws and contractual requirements.

Claims for payment to a government program or private payer shall be submitted only for services which were performed and only where there is adequate and proper documentation that the service was performed in accordance with applicable laws and/or contractual requirements and in accordance with the latest guidance from the appropriate government agencies. Unless otherwise permitted by law or a private payer contract, claims shall be submitted for payment only if the services provided were medically necessary and ordered by a physician or other appropriately licensed provider. Employees are responsible for being familiar with the applicable documentation and medical necessity requirements for the services they provide or for which they are responsible for submitting claims. Outpatient coding and billing shall be in accordance with the latest Ambulatory Payment Classification ("APC") codes. Care shall be taken to make sure that the Hospital's coders are qualified and properly trained. Outpatient documentation practices shall be reviewed periodically to avoid coding with incomplete medical records that do not support the

4 70 Fed Reg 4858 2005

5 U.S. Dep't of Health and Human Svs. Office of Inspector General, *General Compliance Program Guidance* (Nov. 2023), https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf.

level of service claimed. The Supplemental Guidance identifies specific risk areas for outpatient procedure coding which are set forth in an endnote.[i]

No employee shall submit or cause to be submitted false information to a patient, third party payer, vendor, or to the Hospital. This includes presenting claims for an item or service the employee knows or should know was not provided, was fraudulent, was not medically necessary, was based on a code which would result in greater payment than the code appropriate for the item or service, or is otherwise not authorized.

Periodic audits and reviews of billing practices will be conducted to assure that accurate and appropriate bills are submitted to Medicare, Medicaid, other Federal health programs, private payers and patients. Employees are responsible for cooperating with and participating in these reviews as requested.

The Hospital shall monitor patient and payer credit balances and shall promptly refund all amounts due. The Hospital shall promptly refund, in accordance with the time requirements imposed by the payer, any payments made by state or federal agencies or private payers which were made or billed erroneously and of which the Hospital is aware.

Employees shall not steal, embezzle or otherwise convert to the benefit of themselves or another person, or intentionally misapply any funds, money, premiums, credits or other assets of the Hospital or any healthcare benefit program, including Medicare, Medicaid or any private payer.

The Hospital does not contract with, employ or bill for services rendered by an individual or entity that is excluded or ineligible to practice in Federal health care programs; suspended or debarred from Federal Government contracts and has not been reinstated in a Federal healthcare program after a period of exclusion, suspension, debarment or ineligibility. Colleagues, vendors and privileged practitioners are required to report to the Hospital Chief Executive Officer ("CEO") in the event of their exclusion, debarment, or becoming ineligible to participate in Federal healthcare programs. The Hospital conducts regular reviews of the OIG List of Excluded Individuals/Entities and/or the Excluded Provider List Service List of Parties Excluded from Federal programs to determine if any names on these lists match Hospital personnel or contractors. No employee shall submit or cause to be submitted false information to a government agency or was rendered by a provider the employee knows has been excluded from participating in a federal health program. Should it be determined that a debarred or excluded individual or entity (including contractors) is working or proposes to work for the Hospital, the Hospital will take appropriate action, including but not limited to termination of the employee and self-disclosure to the OIG as appropriate.

Relationships with Third Parties

Arrangements with physicians, vendors and other third parties will comply with all applicable federal, state and local laws and regulations, including Internal Revenue Services ("IRS") rules which apply to the Hospital as a tax-exempt organization. Employees who perform contracting services should be familiar with the applicable laws and regulations affecting their area of contracting and should consult with their supervisor or the Compliance Officer if they have any questions or are unsure about a particular contractual arrangement.

No employee shall knowingly and willfully solicit, offer to pay, pay or receive, either in cash or in kind, directly or indirectly, overtly or covertly, anything of value in return for:

(i) referring an individual for any item of services covered by a State health program or a Federal health care program, including the Medicare, Medicaid or the Tricare programs; or

(ii) leasing, purchasing ordering or arranging for or recommending leasing, purchasing or ordering any goods, facility, service or item covered by a State health program or a Federal health program, including the Medicare, Medicaid or Tricare programs.

Physicians who have a financial relationship with the Hospital shall not refer certain designated health services, as defined by law, covered by a Federal health program, including Medicare, Medicaid or Tricare, to the Hospital unless the arrangement is permitted by law.

Certain relationships (*e.g.*, employment contracts, certain leases and other independent contractor agreements) are permitted if they comply with Federal laws and regulations. Employees who deal with contractual relationships with physicians should be familiar with the laws and regulations governing such contracts and should consult with their supervisor or the Compliance Officer for the rules which apply to a particular arrangement.

All contracts between the Hospital and a physician, and other contracts as specified by Hospital policy, shall be approved in accordance with applicable Hospital contracting policies.

All marketing services and materials distributed by the Hospital shall be honest, clear, fully informative, and of a non-deceptive nature.

Conflicts of Interest

Employees must avoid any activity or conduct which conflicts or appears to conflict with the interests of the Hospital. All employees shall be familiar with and abide by the Code and the Hospital's separate Conflict of Interest Policy.

Employees may not directly or indirectly participate in any personal business or professional activity or have a direct or indirect financial interest which conflicts with the Hospital's interests or the employee's duties and responsibilities as an employee, Director or affiliate of the Hospital. All employees and staff have a duty to avoid conflicts with the interests of the Hospital and may not use their positions and affiliations with the Hospital for personal benefit.

There are many types of conflicts of interest and no definition or set of guidelines can anticipate all of them. Examples of the types of activities which may create a conflict of interest are described in the Hospital's Conflict of Interest Policy. Employees should consult with their supervisor if they are unsure whether a particular activity creates a conflict of interest.

Reporting Compliance Matters

In order to assure compliance with applicable laws, the Hospital encourages all employees and other persons affiliated with the Hospital to ask questions, clarify their responsibilities and bring to the Hospital's attention suspected wrongdoing and areas for improvement which may be done confidentially by use of the Hospital's Value Line at **1-800-673-0087.**

All employees and other persons affiliated with the Hospital have an obligation to assist the Hospital in promoting and assuring compliance with applicable laws, and to assist and cooperate with the Hospital in any compliance investigation.

It is the responsibility of the Hospital and each member of the Hospital team, including employees, volunteers, physicians, agents, representatives, contractors and vendors, to follow all applicable laws and regulations and to maintain a health care and business environment that is committed to integrity and ethical conduct. All employees and agents of the Hospital have a duty to report any suspected wrongdoing or violation of applicable laws or Hospital policies or procedures. Employees and other persons affiliated with the Hospital should be familiar with and follow the guidance contained in the Compliance Policy Manual of which this Code is a part, particularly the provisions related to the Compliance Officer and Committee for reporting compliance issues and concerns which further address how reports are made and responded to.

Reports may be made directly to the Compliance Officer at ext. 1240, the Compliance Committee, the employee's/agent's supervisor or the manager or director of the employee's/agent's department as described in the Compliance Policy Manual. Reports may be made anonymously; however, employees and other persons affiliated with the Hospital are encouraged to identify themselves in order to aid in the investigative process. The Hospital shall not retaliate for any reports made in good faith.

No employee or other person affiliated with the Hospital shall make a report he or she knows or reasonably should know is false. No employee or other person affiliated with the Hospital shall make a report for the purpose of harassing or retaliating against another person.

No employee or other person affiliated with the Hospital shall retaliate against any employee or other person for making a report, requesting clarification about applicable laws or policies, or participating in any investigation.

Government Investigations

The Hospital is committed to full compliance with all State and Federal laws and will cooperate appropriately with government authorities in any investigation involving the Hospital.

Any employee or other person affiliated with the Hospital who receives a subpoena, inquiry or other legal document regarding the Hospital's business, whether at home or in the workplace from any government agency, shall immediately notify his or her supervisor, who shall immediately notify the Compliance Officer. The Compliance Officer will be responsible for coordinating the Hospital's response to a government inquiry or investigation. If the employee or other person affiliated with the Hospital appears to be involved in the subject addressed in the legal document the Compliance Officer should advise the employee or other person affiliated with the Hospital that legal counsel for the Hospital will discuss the matter with them if they desire, and shall fully inform the employee that counsel for the Hospital cannot serve as their personal counsel and that they are free to consult with personal counsel of their choosing. For additional information, refer to the Compliance Policy Manual regarding cooperation with government agencies.

Discharge Planning

The Hospital recognizes that the discharge of a patient is an important decision. In developing and implementing discharge plans, the Hospital shall act in the best interests of the patient, in the judgment of the health care provider. This includes the involvement and consent of the patient or patient's legal representative.

Records

Each employee and contractor shall maintain the necessary patient or business records required for the employee's/contractor's position. All patient records shall comply with the applicable legal requirements.

An employee or contactor shall not create any false patient or other Hospital record or falsify any information in a patient or other Hospital record.

All patient and other Hospital records shall be retained as required by law and the Hospital's Control of Records. An employee shall not destroy any patient or Hospital record unless authorized by the Hospital's Control of Records Policy.

General

When questions as to the appropriateness of any action arise, employees and other persons affiliated with the Hospital should consult their managers, the Hospital Compliance Manual, Hospital general policies, any member of management, or the Compliance Officer.

The conduct of all of the Hospital's business should reflect the ethical conduct of business in any venue. The intent is to treat others, whether government or non-government, as we would expect to be treated.

Any question pertaining to this Code should be referred to the Director of the appropriate department or, his or her designee, the Compliance Officer at Ext. 1240 or a member of Administration.

Violations and Correction Action

All Hospital employees, as well as those professionals who enjoy professional Staff membership, must carry out their duties for the Hospital in accordance with the entire Compliance Program, including this Code. To ensure that the compliance program operates in a meaningful fashion, violations of the standards set forth in this document or matters set forth herein will include, without limitation, the following items:

1. Remediation and education and appropriate disciplinary action of all relevant personnel to understand lack of compliance with any applicable rules of regulations;

2. All necessary steps to refund any payments received that were a result of submission of improper billing in any fashion;

3. Provision of follow-up reviews and as applicable follow-up auditing to ensure that there is no recurrence of a problem;

4. If necessary, suspension of billing of services provided until any relationship that has been identified as potentially unlawful is remediated;

5. When circumstances support the same, self-disclosure of improper conduct to appropriate federal and state governmental agencies; and,

6. Discipline of any clinical or non-clinical personnel, up to and including termination from employment and termination from the applicable Medical Staff in accordance with appropriate affiliated disciplinary policies.

Any violation of this Code, any provisions of the Compliance Policy Manual, applicable laws, or deviation from appropriate ethical standards, will subject an employee or independent professional to disciplinary action, which may include oral or written warnings, disciplinary probation, suspension, reduction in salary, demotion, dismissal from employment, and in the case of non-employee professionals limitation, suspension or revocation of privileges. Disciplinary actions also may apply to an employee's supervisor (or a staff member's department chief) who directs or approves the improper actions, or is aware of those actions but does not act appropriately to deal with them; or who otherwise fails to exercise appropriate supervision. Violations of this Code, the Compliance Policy Manual, other Hospital policies, regulations, standards, federal, state and local laws and rules and regulations will be dealt with in accordance with the applicable Hospital policy.

PART TWO

UPSON REGIONAL MEDICAL CENTER
COMPLIANCE POLICY MANUAL

IMPLEMENTATION, OPERATION, AND ENFORCEMENT OF THE COMPLIANCE PROGRAM

I. RESOURCES FOR THE EXECUTION OF THE COMPLIANCE PLAN.

The Hospital will devote necessary and appropriate personnel and resources, both internally and externally, to implement and operate a robust compliance plan for the Hospital and its affiliates. To that end, the Hospital will use seven foundational elements to ensure the effectiveness of the Compliance Plan.

1. First, the Hospital has set forth written standards of conduct through the Compliance Plan and written policies of the Hospital and its affiliates to ensure the commitment to compliance of the Hospital, its affiliates, providers and employees.

2. The Hospital has a Chief Compliance Officer that is responsible for implementation and operation of the Compliance Program.

3. The Hospital has in place regular compliance, education and training programs on matters that are the subject of the compliance plan.

4. The Hospital and its affiliates maintain a hotline to receive complaints and to respond to any questions and ensure that there is a mechanism for anonymous communications, and to ensure non retaliation for any person making such hotline complaints and inquiries.

5. The Hospital has appropriate policies to discipline personnel who violate federal, state and local laws.

6. The Hospital employs or is capable of contracting with an appropriate audit team to monitor compliance and to make voluntary refunds. To that end, the Hospital will also engage external auditing support on an ongoing basis to assist the Hospital's compliance officer to probe and audit the areas set forth herein.

7. The Hospital with the assistance of its internal and external auditing teams investigates, addresses, and remediates issues of non-compliance, and the Hospital has appropriate personnel policies in place to sanction individuals who do not comply.

In addition to the foregoing principles, the Hospital will comprehensively and meaningfully review this Compliance Plan annually and edit and update the compliance plan based on both new guidance as well as internal needs and target areas of focus for the coming year.

II. COMPLIANCE OFFICER AND COMMITTEE

A. COMPLIANCE OFFICER

The Compliance Program includes this Compliance Policy Manual and the other written Polices of the Hospital, and includes the duties imposed by this Manual, the other written Policies of the Hospital, as well as the duties imposed by all applicable laws and regulations. The Compliance Program and the implementation of this Manual shall be directed by the Compliance Officer who shall be appointed, from time to time, by the Board and shall serve at the pleasure of the Board. The Compliance Officer shall report directly to the CEO and the Board. The CEO may appoint an Acting Compliance Officer during temporary absences of the Compliance Officer or in the event the Compliance Officer is implicated in a report. The Compliance Officer shall be vested with the authority, and an appropriate and reasonable budget, to engage outside counsel, as needed, to evaluate specific issues related to compliance.

B. DUTIES OF THE COMPLIANCE OFFICER

Due to the importance of understanding and abiding by all of the Hospital's policies, standards and procedures, the Compliance Officer shall make available to all employees and other persons affiliated with the Hospital this entire document, including this Compliance Policy Manual, as well the Hospital Policies not contained in this Manual. ***This Manual and the other written Policies are available in Policy Manager on the Intranet.*** In addition, the Compliance Officer shall distribute hard copies of this Manual to the following designated recipients:

- Hospital Board Members
- Chief Executive Officer
- Chief Financial Officer
- Supervisors and Managers, Billing, Claims, and Patient Accounts Personnel
- Chief Clinical Officer
- Director of Facilities Management
- Chief of Staff

- Director/Manager/Coordinator of each Department or Clinical Service
- President, Hospital Auxiliary
- Others Designated by the Compliance Officer or the CEO

All recipients of the Manual who are employees shall provide to the Human Resources Department a duly executed original of the **STATEMENT OF COMPREHENSION,** Certification and Agreement of Compliance that appears as Exhibit "A" to this Manual.

The Compliance Officer's duties shall also include the following:

1. Oversee and monitor all aspects of compliance including education, training, and compliance monitoring and audit activities.
2. Attend all meetings of the Compliance Committee, unless excused therefrom by the Committee, and report to the Board at least semi-annually on the progress of the Program.
3. Ensure that the Program has been properly implemented and that revisions are made as appropriate.
4. Periodically review the Manual and recommend revisions as necessary to meet changes in the business and healthcare legal and regulatory environment.
5. Coordinate compliance training and related educational activities for the Hospital employees and Medical Staff as necessary.
6. Develop, periodically review and update education or training materials to reflect current laws and regulations applicable to health care programs, specifically including Special Fraud Alerts issued by the OIG and Core Elements issued by CMS and confirm that any new materials are incorporated into this Manual and included in the appropriate education and training materials.
7. Coordinate internal auditing and monitoring of activities within the scope of the Compliance Program and report to the CEO and HR Director any individuals who have been determined to have committed serious violations sufficient that consideration should be given to the imposition of sanctions.
8. Review compliance in departments on a periodic basis as needed.
9. Coordinate the drafting and updating of the Code of Conduct and Standards of Practice, and related policies and procedures.
10. Coordinate with the CEO the review of contracts with independent contractors.
11. Ensure that the Program has been effectively communicated to present and new employees of the Hospital, existing and new members of the Medical Staff, and other persons affiliated with the Hospital.
12. Administer the HEALTHCARE VALUE LINE POLICY, the title of which Policy is Healthcare Values and available *in Policy Manager on the Intranet***,** including the confidential toll free Value Line phone reporting system, the current number of which is 1-800-673-0087, that shall be available to employees to confidentially report any

suspected illegal conduct or other conduct that violates the applicable compliance rules or the Code without fear of retribution or retaliation.

13. Receive and investigate reports of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other health care professionals and consultants including alleged illegal conduct and violations of the Code, and initiate immediate and appropriate corrective action in conjunction with the Compliance Committee and CEO.
14. Notify appropriate law enforcement agency(ies) of possible illegal misconduct as directed by the Board or the CEO.
15. Develop and propose benchmarks that demonstrate implementation and achievements of the Compliance Program.
16. Compile data on recurring issues related to defects in this Compliance Plan and propose amendments to cure the defects.
17. Monitor the websites that list sanctioned individuals and follow up on any necessary action with the Human Resources Director, and, if necessary, with the CEO and Board.
18. Act as Chair of the Compliance Committee.
19. The Compliance Officer will be provided with the resources necessary to fulfill the responsibility for operation of the Program. The Compliance Officer may inquire into any matters arising or appearing to arise within the purview of the Program including, but not limited to, matters involving unethical and illegal conduct; irregular billing, claims, or payments; and regulatory compliance. The Hospital's other personnel, accountants, and legal counsel shall be available to assist the Compliance Officer and the Compliance Committee.

The Compliance Officer will provide reports to the Compliance Committee on all reports received, inquiries conducted, recommendations for action, and all related matters, and may also report directly to the Board or the CEO.

C. COMPLIANCE COMMITTEE

1. COMPOSITION. The Compliance Committee shall consist of the Hospital's CEO, Compliance Officer/Risk Manager, Chief Clinical Officer, Chief Financial Officer, Controller, Chief Information Officer, Director of Physician Services, Director of Human Resources, Patient Financial Services Director, Director of Hospital Information Management, Director of Clinical Resource Management, Compliance Specialist, Chief of Staff or a Designee, a Board Member appointed from time to time by the Chair, and such other members as may be appointed by the Board. The members of the Committee shall serve at the discretion of the Board, and may be removed and replaced by memorandum from the Board. Alternate members of the Committee may be designated in the following circumstances: (i) by the Board for the purpose of participating in Committee matters when a quorum of regular Committee members cannot be assembled or are disqualified; and (ii) by the CEO when an Alternate is needed prior to the next Board meeting.

2. DUTIES. The Committee, acting through and with the assistance of the Compliance Officer, shall periodically review the overall Compliance Program and recommend to the Board and CEO any changes or improvements determined to be advisable, and shall concentrate on issues implicating fraud and abuse in regard to billing for healthcare services. The Committee, in conjunction with the Compliance Officer, is empowered to investigate, evaluate and report facts relating to fraud and abuse, as well as any other issues of misconduct involving the Hospital and its personnel, and to make recommendations to Management of possible responses or initiatives, including disciplinary or other adverse action, for such misconduct by Hospital employees or agents. The Committee shall review and evaluate the information developed by and the recommendations made by the Compliance Officer. From time to time, the Committee may report to and consult with the CEO and with the Board or its appropriate committees.

3. QUORUM. A quorum shall consist of a number of persons present that is equivalent to a majority of the regular members then serving and alternates present shall count in determining the presence of a quorum. In the absence of a quorum, the Committee may discuss issues; however, the only vote allowed is one to schedule a subsequent meeting. All actions by the Committee require a majority vote of those present. The Compliance Officer shall communicate the Committee's actions and recommendations to the Board, the CEO and such others as directed by the Board or the CEO.

4. MEETINGS. The Committee shall meet at least four times per year at a pre-determined time to be posted on the Hospital's website. to review and consider any inquiries conducted or supervised by the Compliance Officer and any other business that may come before. Prior to such meetings, the Compliance Officer shall submit to each member of the Committee an agenda enumerating matters to be reviewed by the Committee. The CEO or the Compliance Officer may call special meetings of the Committee. Meetings and notice thereof must be communicated in compliance with the Georgia Open Records and Meetings Acts.

5. REPORTS AND RECORDING KEEPING. All submissions to the Committee by the Compliance Officer shall be marked "Confidential." The Committee will submit to the Board, or a committee of Board members designated by the Board, an annual written report of its activities.

In conducting investigations, the Compliance Officer and Compliance Committee shall respect the confidentiality of privileged records and information and shall comply with applicable confidentiality laws and ethical standards.

All files on inquiries shall be marked "Confidential" and maintained by the Compliance Officer on a confidential basis in accordance with the Open Records laws. They shall not be disclosed except to: (1) the Board; (2) members of the Committee; (3) members of management or management

representatives having a need to know; and (4) as may be required by law or order of a court of competent jurisdiction.

6. ACTS OF WRONGDOING. The Compliance Officer shall report to the Committee any prosecutions or administrative actions commenced against the Hospital or its affiliates, its professional staff, any officer, director or manager of the Hospital, any affiliate, or professional staff, which involve or are alleged to involve any of the following circumstances:

a. Any criminal action involving (i) a felony, (ii) any crime against the Hospital or one of its affiliates or (iii) violation of any law or regulation relating to any governmental program.
b. Administrative actions by a regulatory body relating to a finding of illegal or improper conduct by such person.

The Compliance Officer shall report to the Committee demonstrated instances of violations of the Compliance Program, Manual or Policies that should result in any action by the Committee or acts of wrongdoing by any Hospital employee or other person affiliated with the Hospital. The Compliance Officer may raise other matters with the Committee, within his or her discretion.

7. COMPLIANCE REVIEWS. The Compliance Officer, with the assistance of the Compliance Committee will conduct various monitoring activities to measure compliance. Such activities may include, for example, periodic and systematic auditing of various areas such as contracts and billing claims. All personnel are expected to cooperate fully with any such monitoring activities. The purpose of monitoring is constructive as it provides an opportunity to identify and correct any systemic problems or misunderstandings about regulatory requirements so that the same incident of non-compliance does not recur.

On an annual basis, the Compliance Department will prepare an annual work and audit plan designed to assess and monitor compliance of the various Hospital entities and departments by performing a series of scheduled proactive audits and related compliance activities. The work plan will be designed annually to focus on potential new or existing areas of concern as well as any areas of focus or interest expressed by the federal or state government via the ongoing OIG work plans or any pattern of government audit focus revealed through government task forces or settlements. In developing the work plan, the Compliance Officer will work with individual departments through interviews, inquiries, surveys or other methods to ascertain any areas of active concern or areas for improvement.

In addition, there will be regular evaluations of this Compliance Program itself. At least annually, the Compliance Committee and the Compliance Officer will meet to review the Compliance Program, this Compliance Plan, its use and effectiveness over the previous year, and to identify

any areas for improvement or needed updating due to changes in laws, new government guidance, or the need for on-going modernization and updating of this Plan.

This plan will be updated as the Hospital may change and require additional resources. Such updates or need for updates shall be evaluated annually.

8. AGENDA AND MINUTES. Written agendas for all meetings of the Committee shall be prepared and maintained in the office of the Compliance Officer along with minutes of each meeting all in accordance with the "Sunshine Laws" of Georgia.

9. Remedial Actions.. The Chief Compliance Officer (or their designee) will investigate and retain outside counsel, as necessary, to investigate instances of possible non-compliance which come to the attention of the Chief Compliance Officer. In the event that investigation reveals that there has been noncompliance with laws, regulations, or other provisions of the Compliance Plan, the Chief Compliance Officer, with input from the Compliance Committee, will take appropriate steps to remediate the violation. Appropriate steps may include, but are not be limited to, recommending changes in policies or procedures to prevent recurrence, recommendations for appropriate personnel action to be taken with respect to persons involved in non-compliant activity and reporting investigation results to the CEO. Verified overpayments will be repaid, as appropriate in accordance with relevant policies. There may be additional reporting to and cooperating with governmental authorities with respect to violations of law or regulation in appropriate circumstances after obtaining the advice of counsel, including but not limited to self-disclosure of STARK or Anti-Kickback Statute violations.

D. GENERAL POLICY and INTERNAL CULTURE OF COMPLIANCE

The Compliance Officer and the Compliance Committee are the primary responsible parties for operating and monitoring the Compliance Program. The Compliance Officer and the Compliance Committee report directly to the CEO and the Board and are charged with the duty to see that the Hospital's Compliance Policies are consistently applied, periodically reviewed and updated. All Hospital employees, as well as those professionals who enjoy professional Staff membership or are otherwise affiliated with the Hospital, must carry out their duties for the Hospital in accordance with the Compliance Program and all of its constituent parts. Any violation of applicable law or deviation from appropriate ethical standards will subject an employee, independent professional, or other person affiliated with the Hospital to disciplinary action in accordance with the rules applicable to their status with the Hospital, which may include oral or written warning, disciplinary probation, suspension, reduction in salary, demotion, dismissal from employment, or limitation, restriction or revocation of privileges. These disciplinary actions also may apply to an employee's supervisor (or a Staff member's department Chief) who directs or approves the employee's or Staff member's improper actions, or is aware of those actions but does not act appropriately to correct them, or who otherwise fails to exercise appropriate supervision.

The Hospital maintains internal reporting hotlines and encourage employees to report any concerns of any violation of any policy or procedure. In this connection, the Hospital recognizes that internal lines of communication between employees, physicians, residents, and their managers must remain open. The Hospital is committed to creating a culture, through education and example, of internal openness. This does not mean encouraging a culture of "tattle-tales." Instead, this means that the Hospital is committed to creating a culture where every employee, whether an internal coder, biller, nurse, member of the medical staff, or otherwise, feels free to engage in a dialogue about whether a particular policy has been met. Such a culture will encourage dialogue and discourage all retaliation or other covert actions that discourage open dialogue. This policy goes both ways: just as the CEO will encourage dialogue from each nurse, coder, medical assistant and employee of the Hospital, at the same time, all employees of the Hospital will accept and encourage their own receipt of education and information from the CEO and Compliance Officer with the understanding that all laws involved in this Compliance Plan are complex, and no one person is capable of decreeing what is or is not compliant. In addition, such a culture will promote education and remediation, to ensure, for example, that physicians feel free to self-report mistakes rather than hide or cover up mistakes. Such a culture will encourage questions and communication, understanding that open lines of communication help rather than hurt the Hospital.

The Hospital fosters an organizational culture that values raising concerns about workplace conditions and activities. Therefore, the Hospital adheres to an anti-retaliation and anti-intimidation policy for good faith participation in its compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits, and remedial actions, and reporting to appropriate officials. All employees are encouraged to report any suspicion of improper or wrongful activity, including acts of retaliation, and such reports will be treated confidentially. The Hospital maintains that individuals who in good faith make a report, ask a question, or voice a concern, shall not be retaliated against or intimidated by any member of the organization. The Hospital further maintains that intimidation or retaliation against any employee who cooperates in a compliance investigation is prohibited.

The laws discussed in this Policy Manual are complex, and many of the concepts are developed in case-by-case determinations. In addition, this Manual deals only generally with some of the more important legal principles. Their mention is not intended to minimize the importance of other applicable laws, professional standards, or ethical principles, which may be covered in other Hospital policies. Consequently, any employee or other person affiliated with the Hospital who is in doubt as to the propriety of a course of action must promptly communicate with his or her supervisor or with the Compliance Officer before taking action.

II. TRAINING AND EDUCATION

The Compliance Officer and Compliance Committee will develop and provide a multi-faceted educational and training program for delivery to providers, employees, and stakeholders/governance team members. This includes training and education for Compliance policies and procedures, and policies from collaborating departments such as Legal Affairs, Human Resources, the Chief Medical Officer and Clinical Quality. The goals of the training and education program are to:

- Ensure a comprehensive review of the compliance plan and code of conduct is shared at the onset of their appointment or hire and regularly thereafter.
- Targeted training to the administrative team members, managers, other employees and clinical staff and providers.
- Educational information and materials for independent contractors, vendors and agents who furnish services or supplies to the institution.
- Compliance training should be mandatory. Failure to comply with training requirements may result in disciplinary action.

APPENDIX I: SPECIFIC COMPLIANCE AREAS OF FOCUS AND EXPLANATION OF RELEVANT LAWSFRAUD AND ABUSE - PAYMENTS, REFERRALS, DISCOUNTS, AND GIFTS

The overarching purpose of a Compliance Program is to aid in the avoidance of fraud related to payments for healthcare. The Hospital participates in the Medicare program, a federal program which provides health insurance to the aged and disabled, and the Medicaid program, a federal/state program which provides health care coverage to low income persons. Both state and federal laws make it illegal for the Hospital to provide or accept "remuneration" in exchange for referrals of patients covered by Medicare, Medicaid or other publically funded healthcare programs. These laws also bar the payment or receipt of such remuneration in return for directly purchasing, leasing, ordering, or recommending the purchase, lease, or ordering of any goods, facilities, services, or items covered under the Medicare, Medicaid or other state or federally funded healthcare programs.

The so-called "fraud and abuse," "anti-kickback" and "self-referral" laws are all designed to prevent fraud in the Medicare and Medicaid programs and abuse of the public funds supporting health care programs. The Hospital is committed to carefully observing these laws and the related regulations and avoiding any practice that may be interpreted as abusive. All employees, medical staff members, and contractors of the Hospital, and, in particular, those in the finance department, purchasing and facilities departments, laboratory, pharmacy, Medical Staff, administration, and any department entering into personal service contracts are expected to be vigilant in identifying potential violations and bringing them to the attention of the Compliance Officer.

A. THE ANTI-FRAUD STATUTES AND DISCUSSION OF THEIR EXTENSIVE APPLICATION TO THE PROVISION OF HEALTH CARE

1. THE FEDERAL FRAUD STATUTES

The federal government has available for use in its healthcare fraud fighting efforts the following laws and regulations:

- False Claims Act ("FCA") (31 U.S.C. 3729–3733);
- Criminal False Claims Relating to Medicare/Medicaid (42 U.S.C.1320a-7b(a));
- The Anti-Kickback Statute (42 U.S.C. 1320a-7b(b));
- Physician Self-Referral ("Stark") Prohibitions (42 U.S.C. 1395nn);
- Permissive and Mandatory Exclusion (42 U.S.C. 1320a-7);
- Civil Monetary Penalties Law (42 U.S.C. 1320a-7a);
- Payment Suspension (42 C.F.R. 405.370);
- Racketeer Influenced and Corrupt Organizations Act ("RICO") (18 U.S.C. 1961 *et seq.*);

- Mail and Wire Fraud (18 U.S.C. 1341, 1343);
- Conspiracy (18 U.S.C. 371);
- State Children's Health Insurance Program ("SCHIP") – now known more simply as the Children's Health Insurance Program ("CHIP"); (42 U.S.C. 1397(a) thru 1397mm).
- Medicare Prescription Drug, Improvement, and Modernization Act (also called the Medicare Modernization Act or MMA) (Pub. L. 108-173).
- The Health Insurance Portability and Accountability Act ("HIPAA") which includes a healthcare fraud offense (applicable to defrauding government and private payors alike), with enhanced criminal penalties.

2. THE GEORGIA FRAUD STATUTES

The State of Georgia has enacted similar statutes to some of the federal statutes designed to accomplish the same basic purposes (*i.e.*, to prevent anyone from obtaining public funds through fraudulent means).

The relevant Georgia statutes are:

- OFFICIAL CODE OF GEORGIA ANNOTATED ("OCGA") TITLE 43. PROFESSIONS AND BUSINESSES; CHAPTER 1B. PATIENT SELF-REFERRAL O.C.G.A. § 43-1B-1 et seq. Short title: This chapter shall be known and may be cited as the "Patient Self-referral Act of 1993."

- OCGA TITLE 49. SOCIAL SERVICES CHAPTER 4. PUBLIC ASSISTANCE ARTICLE 7B. STATE FALSE MEDICAID CLAIMS ACT O.C.G.A. § 49-4-168 et seq. (2012)

- OCGA TITLE 49-4-1 ARTICLE 7. MEDICAL ASSISTANCE GENERALLY Effective: January 1, 2010 OCGA § 49-4-146.1. Unlawful to obtain benefits and payments under certain circumstances; penalties; procedures

- OCGA TITLE 23. EQUITY CHAPTER 3. EQUITABLE REMEDIES AND PROCEEDINGS GENERALLY; ARTICLE 6. TAXPAYER PROTECTION AGAINST FALSE CLAIMS O.C.G.A. § 23-3-120, et seq. (2012)

The Hospital may be subject to the foregoing federal and State of Georgia laws.

Originally enacted in 1972, the federal Anti-Kickback Statute[6] provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive any

6 42 U.S.C. 1320a-7b(b)

remuneration (including bribes, kickbacks, or rebates) directly or indirectly, overtly or covertly, in cash or in kind (i) in return for referring and individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare, Medicaid, or other federal healthcare programs; or (ii) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by Medicare, Medicaid, or other federal healthcare programs. Violation of the Anti-Kickback Statute constitutes a felony, which carries a maximum penalty of a $100,000 fine, imprisonment up to ten years, or both. A conviction under the Anti-Kickback Statute also will cause automatic exclusion from Medicare, Medicaid, and other federally funded healthcare programs. Violations of the Anti-Kickback Statute can also lead to civil liability under the False Claims Act. In seeking remuneration from federal health care programs, some forms contain a certification of compliance with applicable statutes and regulations. Such certifications, however, can be false if they certify compliance with a statute or regulation that is a condition of government payment and the certifier is actually noncompliant, and the PPACA has made it clear that the Anti-Kickback Statute is such a statute.

Both the federal and state anti-kickback laws are broadly written to also prohibit the Hospital and its representatives from knowingly and willfully offering, paying, asking, or receiving any money or other benefit, directly or indirectly, in return for obtaining or rewarding favorable treatment in connection with the award of a government contract. The anti-kickback laws must be considered whenever something of value is given or received by the Hospital or its representatives or affiliates that is or could be in any way connected to patient services or reimbursement under any government funded program. This is particularly true when the arrangement could result in over-utilization of services or a reduction in patient choice. Even if only one purpose of a payment structure is to influence referrals and it otherwise appears to be a legitimate, appropriate business arrangement, the payment is likely unlawful.

There are many transactions that may violate the anti-kickback rules. For example, no one acting on behalf of the Hospital may offer gifts, loans, rebates, services, or payment of any kind to a physician who refers patients to the Hospital, or to a patient, without consulting the Compliance Officer, who, if necessary will consult with the CEO and the hospital attorney. The CEO must review and approve any of the preceding practices that may be questionable. The CEO should review and approve any discounts offered to the Hospital by suppliers and vendors, as well as discounts offered by the Hospital to insurance companies or other third party payors. Patient deductibles and co-payments may not be waived without the prior authorization of the CEO or their authorized designee. Rentals of space and equipment must be at fair market value, without regard to the volume or value of referrals that may be received by the Hospital in connection with the space or equipment. Fair market value should be determined through an independent and known reliable source.

Agreements for professional services, management services, and consulting services must, in general, be in writing, have at least a one-year term, specify the compensation in advance, cover all services the agent is to provide for the term of the agreement and specify the services to be provided. The methodology for determining the compensation paid to the agent over the term of the agreement must be consistent with fair market value and must not be determined in a manner that takes into account the volume or value of any referrals. Moreover, the services performed under the agreement must not involve counseling or the promotion of an unlawful business arrangement or other activity, and the aggregate services contracted for must not exceed those which are reasonably necessary to accomplish the business purpose of the services. Payment based on a percentage of revenue should be avoided unless it has been approved by the Compliance Officer, the CEO, or the Hospital attorney. Any questions about these agreements should be directed to the Compliance Officer and, if questions remain, by the CEO or the Hospital attorney. Joint ventures with physicians or other health care providers, or investment in other health care entities, must be approved by the CEO with advice from the Hospital attorney. These comments are not intended to be detailed or exhaustive as to the rules governing these types of activities. The applicable laws and regulations are complex and should be interpreted only by persons specially trained to do so.

The U.S. Department of Health and Human Services has described a number of payment practices that will not be subject to criminal prosecution under the anti-kickback laws. These so-called "safe harbors" are intended to help providers protect against abusive payment practices while permitting legitimate ones. If an arrangement fits within a safe harbor, it will not create a risk of criminal penalties and exclusion from the Medicare and Medicaid programs. However, the failure to satisfy every element of a safe harbor does not in itself make an arrangement illegal. Analysis of a payment practice under the anti-kickback laws and the safe harbors is detailed and complex, and depends upon the specific facts and circumstance of each case. Employees should not make unilateral judgments on the availability of a safe harbor for a payment practice, investment, discount, or other arrangement. These situations must be brought to the attention of the Compliance Officer for review with the Compliance Committee and/or the CEO and Hospital attorney.

Violation of the law could also mean that the Hospital and/or a physician are excluded from participating in the Medicare and Medicaid programs.

3. ENTERTAINMENT AND GIFTS

The Hospital recognizes that business dealings may include a shared meal or other similar social occasion, which may be proper business expenses and activities. More extensive entertainment, however, only rarely will be consistent with Hospital policy and should be reviewed in advance by the Compliance Officer and, if questions remain, reviewed by the Compliance Committee. Hospital employees may not receive any gift, including from external business

partners of the hospital or potential business partners, under circumstances that could be construed as an improper attempt to influence the Hospital's or an employee's decisions or actions. When an employee receives a gift that violates this policy, the gift should be returned to the donor and reported to the Compliance Officer. Gifts may be received by Hospital employees when they are of such limited value that they could not reasonably be perceived by anyone as an attempt to affect the judgment of the recipient. For example, token promotional gratuities from suppliers, such as advertising novelties (*e.g.*, key chains) marked with the donor's name, are not prohibited under this policy.

Whenever an employee is not sure whether a gift is prohibited by this policy, the gift must be reported to the Compliance Officer upon its receipt.

4. BILLING AND CLAIMS

When claiming payment for Hospital or professional services, the Hospital has an obligation to its patients, third party payors, and the state and federal governments to do so with 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 must not be abused. The Hospital is, and every employee must be, committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout the Hospital, have responsibility for entering charges and procedure codes. Each of these individuals is expected to act in compliance with applicable billing rules to the best of their knowledge and training. Any questions regarding individual claims or broader billing practices should be reported immediately to a supervisor or to the Compliance Officer who will elevate the questions, as appropriate, and seek appropriate legal counsel.

False billing is a serious offense. In addition to the statutes, 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 Hospital cost reports
- Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not
- Billing for a length of stay beyond what is medically necessary
- Billing for services or items that are not medically necessary
- Failing to provide medically necessary services or items

- Billing excessive charges

Hospital employees and agents who prepare or submit claims should be alert for potential billing errors and should report any concerns through the hotline or to the Compliance Officer. Because billing laws are complex and constantly evolving, the final decision on billing questions rests with the Hospital in consultation with legal counsel and not with individual employees.

In compliance with federal law, the Hospital does not permit charging for any 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 the Hospital.

The Hospital is committed to carefully following the Medicare rules on assignment and reassignment of billing rights. If there is any question whether the Hospital may bill for a particular service, either for services provided by a physician or on its own behalf, the question should be directed to the Compliance Officer for review by appropriately credentialed persons. Hospital employees should not submit claims for other entities or claims prepared by other entities, including outside consultants, without approval from the CEO. Special care should be taken in reviewing these claims, and Hospital personnel should request documentation from outside entities if necessary to verify the accuracy of the claims.

A provider, supplier, or other persons who violates the FCA [31 U.S.C. §§ 3729–3733] is subject to civil monetary penalties (including treble damages) as identified in the Federal Civil Penalties Inflation Adjustment Improvement Act of 2015. **The person(s) (as well as the Hospital) may be excluded from participating in the Medicare and Medicaid programs.** [42 U.S.C. § 1320a-7]. Such violations may also carry criminal penalties.

Numerous federal laws prohibit false statements or inadequate disclosure to the government, including in billing for healthcare, and mandate exclusion from the Medicare and Medicaid programs. For instance, neither the Hospital nor its agents are permitted to make, or induce others to make, false statements in connection with the Hospital's Medicare certification. Persons doing so could be subject to fines and imprisonment. The Hospital or individual health care providers also could be excluded from the Medicare and Medicaid programs if convicted of a Medicare or Medicaid related crime or any crime relating to patient abuse. Medicare and Medicaid exclusion may result if the Hospital or a provider is convicted of fraud, theft, embezzlement, or other financial misconduct in connection with any government financed program.

In addition to these federal penalties, fraud and abuse in obtaining state medical assistance is prohibited by State law and violators may be subject to civil fines or criminal penalties. See O.C.G.A. §49-4-168, *et seq*., ; O.C.G.A. §49-4-146.1. The Hospital 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 are involved in submitting charges, preparing claims, billing, and documenting services is expected to maintain the highest standards of personal, professional, and institutional responsibility.

5. PATIENT REFERRALS: THE PHYSICIAN SELF-REFERRAL LAW (THE "STARK" LAW), THE FEDERAL ANTI-KICKBACK STATUTE AND THE GEORGIA PATIENT SELF-REFERRAL ACT OF 1993.

Patient referrals are important to the delivery of appropriate health care services. Patients are admitted or referred to the Hospital by their physicians. Patients leaving the Hospital may be referred to other facilities, such as skilled nursing or rehabilitation facilities. Patients may also need durable medical equipment, home care, pharmaceuticals, or oxygen, and may be referred to qualified suppliers of these items and services. The Hospital's policy is that patients, or their legal representatives, are free to select their health care providers and suppliers (subject to any requirements of their health insurance plans), and the Hospital does not engage in influencing those decisions by the patient. The choice of a hospital, a diagnostic facility, or a supplier should be made by the patient, with guidance from his or her physician, as to which providers are qualified and medically appropriate.

Physicians and other health care providers may have financial relationships with the Hospital or its affiliates. These relationships may include compensation for administrative or management services, income guarantees, loans of certain types, or free or subsidized administrative services. In some cases, in the future, a physician may invest as a part-owner in a piece of diagnostic equipment with the Hospital or a Hospital affiliate. Importantly, a financial relationship can be almost any kind of direct or indirect ownership or investment relationship (*e.g.*, stock ownership, a partnership interest, or secured debt) or direct or indirect compensation arrangement, whether in cash or in-kind (*e.g.*, a rental contract, personal services contract, salary, gift, or gratuity), between a referring physician (or immediate family member) and a Hospital. Moreover, the financial relationship need not relate to the provision of designated health services (*e.g.*, a joint venture between a hospital and a physician to operate a hospice would create an indirect compensation relationship between a hospital and the physician for Stark Law purposes). The determination of whether such a financial relationship exists is quite technical and should be analyzed only by persons with specialty training on the subject.

There are several laws, both State and federal, that deal with these relationships and prohibit referrals for many health care services from healthcare providers to entities with which the provider has a financial relationship, unless an exception applies. The laws not only prohibit the referral, they also prohibit the Hospital from billing for the services provided pursuant to a prohibited referral.

The "threshold federal" law dealing with these financial relationships is the Physician Self-Referral Prohibitions law known as the "Stark Law"[7]. It applies to any referring physician who has, or whose immediate family member has, a "financial relationship" with an entity such as the Hospital. The Stark Law prohibits referrals by such a physician to the Hospital for the provision of designated health services payable by Medicare and Medicaid unless an exception applies The Hospital requires that each financial relationship with a referring physician or his or her family member fit squarely within one of the exceptions to the Stark law or the regulations promulgated under that law and the State laws referred to herein. Although responsibility at the administrative level for determining whether such a financial relationship with a physician may exists is vested in the Compliance Officer and the Compliance Committee, the Chief of each Department, the Medical Staff administration, and the payroll department are expected to be vigilant in recognizing relationships that may potentially be "financial relationships" that should be reported to the Compliance Officer for further review. Determining whether a relationship fits within an exception requires special knowledge and should be determined only by those possessing such knowledge.

In addition, hospitals and physicians that *knowingly* violate Stark Law may be subject to CMPs and exclusion from the Federal health care programs. Furthermore, under certain circumstances, a knowing violation of the Stark law may give rise to liability under the FCA. Because all inpatient and outpatient hospital services furnished to Medicare or Medicaid patients are DHS under the statute, all Hospital personnel must be diligent in scrutinizing all financial relationships with referring physicians for compliance with the Stark Law. The possible consequences of violating Stark Law are so severe that it is imperative that financial relationships with referring physicians fit squarely in statutory or regulatory exceptions to the Stark Law. The Federal Regulations promulgated under Stark Law are found at 42 CFR 411.350, *et seq.* [8]

The Georgia Patient Self-Referral Act (OCGA §43-1B-1 *et seq.*), might rightly be called the Georgia "STARK" law. It, as does the federal Stark Law, deals primarily with so-called "self-referral" and prohibits, with specified exceptions, the referral by a health care provider of a patient for the provision of designated health services to an entity in which the health care provider has an investment interest. This Code section, however, also provides that any health care provider or other entity that divides fees or agrees to divide fees received for a designated health service with

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7 42 U. S. C. §1395nn (section 1877 of the Social Security Act)

8 Substantial additional explanatory material appears in the regulatory preambles to the final regulations: 66 FR 856 (January 4, 2001); 69 FR 16054 (March 26, 2004); and 69 FR 17933 (April 6, 2004)). Further information about the Stark law and applicable regulations can be found on CMS's Web page at *http:// cms.gov/medlearn/refphys.asp*. Information regarding CMS's Stark advisory opinion process can be found at *http://cms.gov/physicians/aop/ default.asp*.

any health care provider or entity solely for referring a patient shall be subject to civil penalties.

This prohibition includes any consideration paid as compensation or in any manner which is a product of, or incident to, or in any other way related to any membership, proprietary interest, or co-ownership with an individual, group, or organization to whom patients, clients, or customers are referred or to any employer-employee or independent contractor relationship including, without limitation, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any person with a health care license to whom these patients are referred.

6. PHYSICIAN RECRUITMENT

The recruitment and retention of physicians require special care to comply with Hospital policy and applicable law and regulations. Physician recruitment has implications under the anti-kickback laws, the Stark law, and the IRS rules governing the Hospital's tax-exempt status. Each recruitment package or commitment should be in writing, consistent with guidelines established with the Hospital. New or unique recruitment arrangements must be reviewed by the CEO, who may require legal counsel review and approval. In general, support provided to a new physician is most likely to be acceptable if it is provided in order to persuade the physician to relocate to the Hospital's geographic service area in order to become a member of the professional staff, or if it is provided to a new physician completing his or her training or to retain a current physician if such complies with the governing regulations. Support should be of limited duration. The physician cannot be required to refer patients to the Hospital to receive such support, and the amount of compensation or support cannot be related to the volume or value of referrals. Income guarantees present special issues and should be reviewed by the CEO and counsel on a case-by-case basis.

7. PHYSICIAN PRACTICE ACQUISITION AND SALE

To improve the delivery of health care services, the Hospital may, from time to time, acquire or sell physician practices. These acquisitions require special care to comply with applicable law because they have implications under the anti-kickback laws, the Stark law, and the IRS rules governing the Hospital's tax-exempt status. It is therefore the policy of the hospital that all such sales or acquisitions must be reviewed and approved by the CEO and legal counsel at a minimum.

8. PATIENT TRANSFERS; EMTALA

Operation of the emergency department is an integral part of the Hospital's service to the community under its charitable mission. The emergency department is known as a place where

any sick or injured person may come for care regardless of his or her ability to pay. The federal government has enacted EMTALA (also known as the Patient Anti-Dumping Law [42 U.S.C. 1395dd]) to ensure that patients are not transferred from a hospital emergency room to another facility unless it is medically appropriate.

Prompt and effective delivery of emergency care may not be delayed in order to determine a patient's insurance or financial status. Each patient who presents at the emergency department must receive an appropriate medical screening examination. Patients with emergency medical conditions and patients in active labor must be cared for in the Hospital's emergency department until their condition has been stabilized. An emergency may include psychiatric disturbances, symptoms of substance abuse, or contractions experienced by pregnant women.

The Hospital and its employees, personnel, and medical staff will follow its EMTALA and Obstetrics EMTALA Policies.

Georgia law contains what is in effect an anti-dumping law at O.C.G.A. §31-8-42 with similar requirements that deals exclusively with emergency services to provide care to pregnant women in labor.

9. MARKET COMPETITION

The Hospital is committed to complying with all state and federal antitrust laws. The purpose of the antitrust laws is to preserve the competitive free enterprise system. The antitrust laws in the United States are founded on the belief that the public interest is best served by vigorous competition, free from collusive agreements among competitors on price or service terms. The antitrust laws help preserve the country's economic, political, and social institutions; they apply fully to health care services provided by hospitals and physicians, and the Hospital is firmly committed to the philosophy underlying those laws.

While the antitrust laws clearly prohibit most agreements to fix prices, divide markets, and boycott competitors, which are addressed below, they also proscribe conduct that is found to restrain competition unreasonably. This can include certain attempts to tie or bundle services together, certain exclusionary activities, and certain agreements that have the effect of harming a competitor or unlawfully raising prices. Any questions that might arise should be addressed to the Compliance Officer for review by the Compliance Committee or legal counsel.

10. TAX-EXEMPT ORGANIZATIONS

As a non-profit hospital serving charitable purposes, the Hospital holds federal tax-exempt status, meaning it is exempt from paying federal income tax on most of its revenue. The Hospital also may accept tax-deductible charitable contributions from members of the community. Loss of

exempt status would result in penalties, interest, and significant costs.

In order to qualify for tax exemption, the Hospital must be operated exclusively for charitable purposes. The Hospital must provide a community benefit, such as the promotion of health and the operation of an emergency department open to all. None of its earnings may inure to the benefit of any private individual. Any such "private inurement" could cause the Hospital to lose its tax-exempt status. A private person may not receive more than an incidental benefit from Hospital assets, measured against the overall community benefit provided by the Hospital.

Because the Hospital is dedicated to its charitable purposes, all contracts and agreements must be negotiated at arm's length. Compensation provided to health professionals for recruitment, retention, employment, and personal services must be reasonable in the context of the services provided and the need for them. Reasonableness must be analyzed based on overall compensation and benefits. Areas of particular concern are below-market rents, compensation tied to Hospital or department revenues, income guarantees (especially where there is no obligation to repay), below-market loans, and loan guarantees. Any compensation arrangement involving one of these benefits must be approved by the CEO and the Board. If an employee or any other person affiliated with the Hospital is aware of payments by the Hospital to a private individual or organization that may be unrelated to the Hospital's mission or in excess of fair market value, these circumstances should be disclosed to a supervisor or to the Compliance Officer.

Any income derived from activities unrelated to the Hospital's charitable purposes should be reported, and appropriate tax should be paid. Failure to report accurate compensation information may constitute fraud and could result in criminal prosecution as well as loss of exempt status for the Hospital.

11. TAX-EXEMPT BONDS

Because the Hospital's tax-exempt bonds (the "Bonds") are publicly traded securities, certain activities of the Hospital are subject to certain provisions of the federal securities laws. These laws govern the dissemination or use of information about the affairs of the Hospital or its affiliates. Federal securities laws also address the dissemination or use of information which might be of interest to persons considering the purchase or sale of the Bonds.

(a) Continuing Disclosure

The Securities and Exchange Commission ("SEC") requires continuing disclosure on municipal securities transactions by relevant parties. The Hospital is committed to carrying out its continuing contractual disclosure obligations involving health care revenue bond transactions, and shall make appropriate annual disclosures and all necessary periodic or material disclosures in a

timely manner. In accordance with the Hospital's policy on insider trading and confidential information, employees will be reminded each year of their obligation to refrain from insider trading and disclosure.

(b) Insider Trading

It is generally illegal for any person, either personally or on behalf of others, (i) to buy or sell securities such as the Bonds while in possession of material non-public information, or (ii) to communicate (to "tip") material non-public information to another person who trades in the Bonds on the basis of the information or who in turn passes the information on to someone who trades. All employees, trustees, and professional staff members must comply with these "insider trading" restrictions.

Penalties for violating the insider trading rules include civil fines of up to three times the profit gained or loss avoided by the trading, criminal fines, and imprisonment. There can also be civil liability to those damaged by the trading. An employer whose employee violates the insider trading prohibitions may be liable for a civil fine of up to the greater of ***$1,000,000*** or three times the profit gained or loss avoided as a result of the employee's insider trading violation.

All information that an investor might consider important in deciding whether to buy, sell, or hold securities is considered "material." Examples of some types of material information are:

- financial and operating results for the month, quarter or year
- financial forecasts, including proposed or approved budgets
- utilization statistics such as occupancy rates, payor mix, number of discharges and ambulatory visits, etc.
- awarding or loss of major research funding
- possible mergers, acquisitions, joint ventures and other purchases and sales of companies and investments in companies
- obtaining or losing important contracts
- major personnel or medical staff changes
- major litigation developments.

Information that is likely to affect the price of securities is almost always material.

Information is considered to be non-public unless it has been effectively disclosed to the public, for example by a press release. The information must not only be publicly disclosed, but there must also be adequate time for the market as a whole to digest the information. All information about the Hospital or its business plans is potentially "insider" information until publicly disclosed or made available by the Hospital. Thus, Hospital employees may not disclose

it to others, such as relatives, friends, or business or social acquaintances, who do not need to know it for legitimate business reasons.

When an employee (or a member of the professional staff or trustee) knows material non-public information about the Hospital, he or she is prohibited from three activities:

· trading in the Bonds for his or her own account or for the account of another (including any trust of which the employee, member of the professional staff, or trustee is a trustee, or any other entity that buys or sells securities, such as a mutual fund)

· having anyone else trade for the employee

· disclosing the information to anyone else who then trades or in turn "tips" another person who trades.

Neither the employee nor anyone acting on the employee's behalf, nor anyone who learns the information from the employee, may trade for as long as the information continues to be material and non-public.

If an employee, member of the professional staff, or trustee is considering buying or selling the Bonds and has a question as to whether the transaction might involve the improper use of material non-public information, that individual should obtain specific prior approval from the Compliance Committee. Consultation with the individual's own attorney is also strongly encouraged.

All of us should remember that outsiders may be listening to us or watching us and may be able to pick up information they should not have. We should not, for example, discuss the Hospital's affairs in places where we can be overheard by others (such as corridors, elevators, the cafeteria, other restaurants, and on cellular phones), and we should be careful about how we handle and dispose of sensitive papers. Any questions or concerns about disclosure of non-public information should be brought to the Compliance Officer.

12. WASTE DISPOSAL

The Hospital is committed to safe and responsible disposal of biomedical waste and other waste products. Compliance with applicable federal and state environmental regulations requires ongoing monitoring and care. The Hospital uses a medical waste disposal system, biohazard labels, and biohazard containers for the disposal of infectious or physically dangerous medical or biological waste. Failure to follow the system could result in significant penalties to the Hospital. Employees who come into contact with biological waste should be familiar with the Hospital's Hazardous Materials & Waste Management Plan and all Infection Control Policies & Procedures,

and should report any deviations from the policies to their supervisor or the Compliance Officer.

The Hospital complies with the Clean Air Act, the Clean Water Act, the Resource Conservation and Recovery Act, and other federal and state laws and regulations governing the incineration, treatment, storage, disposal, and discharge of Hospital waste. If an employee suspects noncompliance or violation of any of these requirements, the circumstances should be reported to a supervisor or to the Compliance Officer. Spills and releases of hazardous materials must be reported immediately, so that necessary reports can be made and cleanup can be initiated. The Hospital will cooperate with appropriate authorities to remedy environmental contamination for which the Hospital is found to be responsible.

The Hospital supports ongoing legal and technical review to identify and correct environmental problems. The Hospital will initiate environmental assessments and compliance audits as appropriate. Failure to prevent, report, or correct environmental problems can result in criminal and civil penalties, imprisonment, or both. Even merely negligent violations can result in imprisonment and substantial fines if they pose a serious threat to human health.

13. CONTROLLED SUBSTANCES

The Hospital, through its pharmacy, is registered to compound and dispense narcotics and other controlled substances. Improper use of these substances is illegal and extremely dangerous.

The Hospital requires that its employees comply with the terms of the Hospital's controlled substances registration and with federal and state laws regulating controlled substances. Under Hospital policy, access to controlled substances is limited to persons who are properly licensed and who have express authority to handle them. No health care practitioner may dispense controlled substances except in conformity with state and federal laws and the terms of the practitioner's license. Employees should carefully follow record keeping procedures established by their departments and the pharmacy. Unauthorized manufacture, distribution, use, or possession of controlled substances by Hospital employees is strictly prohibited, and may be prosecuted to the full extent of the law. Any employee who knows of unauthorized handling of controlled substances is to provide the information immediately to his or her supervisor or the Compliance Officer. Violations of federal law with respect to improper use of controlled substances can result in imprisonment and fines.

If the Hospital or its employee is convicted under federal or state law of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance, the Hospital can be excluded from the Medicare and Medicaid programs.

These acts are also made unlawful under Georgia law and can be punishable by fines and

imprisonment. See O.C.G.A. §16-13-30.

14. CONFIDENTIALITY & HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

Hospital employees and health care professionals possess sensitive, private and privileged information about patients and their care. Patients properly expect that this information will be kept confidential. The Hospital takes very seriously any violation of a patient's confidentiality. Discussing a patient's medical condition, or providing any information about patients to anyone other than Hospital personnel who need the information and other authorized persons, will have serious consequences for an employee and the Hospital. Employees should not discuss patients with anyone anywhere who is not legally entitled to the information, including their family members of the patient's family members.

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") established, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of HIPAA [42 U.S.C. 1320d-1320d-9]. The Privacy Rule standards address the use and disclosure of individuals' health information, which is referred to as "protected health information" ("PHI") possessed by organizations subject to the Privacy Rule which are called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the OCR has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and wellbeing. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

HIPAA and the multitude of rules and regulations issued in regard to it are complex and no mere summary can be relied on as fully informing the reader. The Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on a summary. No one should ever disclose PHI unless they have been trained in the intricacies of the law and the rules and regulations promulgated thereunder, including the rules governing Business Associates and their use and duties relative to PHI. HHS released the final omnibus rule on January 17, 2013 to increase HIPAA privacy and security protections by implementing provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and

Genetic Information Nondiscrimination Act of 2008 ("GINA"). A principal change under these new rules is the creation of new duties and enlarged obligations and liability under the HIPAA Privacy and Security Rules to business associates and their subcontractors of covered entities. The laws and rules carry with them tremendous civil monetary penalties and criminal penalties and fines making compliance with them an absolute imperative.

The Hospital is the owner of the medical record which documents a patient's condition and the services received by the patient at the Hospital. Medical records are strictly confidential under both federal and state law. PHI may not be released except with the consent of the patient or in accordance with these laws and regulations. Special protections apply to mental health records, records of drug and alcohol abuse treatment, and records relating to HIV infection. Medical records should never be physically removed from the Hospital except under court order and should never be altered or destroyed (except in accordance with Hospital records destruction policies). Employees who have access to medical records must take pains to preserve their confidentiality and integrity, and no employee is permitted access to the medical record of any patient without a legitimate Hospital-related reason for so doing. Any unauthorized release of or access to medical records should be reported to a supervisor which will be dealt with in accordance with the Personnel Policies of the Hospital.

The Georgia Computer Systems Protection Act, contained in O.C.G.A. §16-9-90 *et seq.* is designed to prohibit and punish computer crime.

In compliance with the law, the Hospital prohibits unauthorized access to its computer system, either directly or by network or telephone. An individual who does not have a legitimate password will be held to know that access is unauthorized. The Hospital prohibits the destruction or corruption of electronically stored or processed data. Persons who violate these rules may be prosecuted to the full extent of the law. Reference should always be made to the HIPAA Policies of the Hospital.

15. DISCRIMINATION

The Hospital and its affiliates are committed to a policy of nondiscrimination and equal opportunity for all qualified applicants and employees, without regard to race, color, sex, religion, age, national origin, ancestry, disability, gender identity or expression, or sexual orientation. Our policy of non-discrimination extends to the care of patients. Discrimination may also violate state and/or federal anti-discrimination laws and trigger substantial civil penalties.

If an employee feels he or she or any patient has been discriminated against or harassed on the basis of his or her race, color, sex, or other protected category, he or she should contact the Director of Human Resources or Compliance Officer so that an investigation may be initiated in

accordance with Hospital policies and procedures. A patient who feels he or she has been the subject of unlawful discrimination or harassment is encouraged to contact the Clinical Resources Management Director, who will refer the matter to the appropriate Hospital personnel for investigation.

The Hospital is also strongly committed to complying with other federal and state laws governing employment. These laws include:

- the Americans with Disabilities Act
- the Employee Retiree Income Security Act
- the Occupational Safety and Health Act
- the Labor Management Relations Act
- the Age Discrimination in Employment Act
- the Fair Labor Standards Act
- the Immigration Reform and Control Act

State law also contains several prohibitions against discrimination. See O.C.G.A. §34-1-2; O.C.G.A. §34-5-3; O.C.G.A. §34-6A-4; and O.G.C.A. §45-19-29. The Compliance Officer and the Director of Human Resources can provide employees with information on these laws and can direct questions to the proper person.

16. POLITICAL CONTRIBUTIONS

The Hospital believes that our democratic form of government benefits from citizens who are politically active. For this reason, the Hospital encourages each of its employees to participate in civic and political activities in his or her own way.

The Hospital's direct political activities are, however, limited by law. Corporations may not make any contributions – whether direct or indirect – to candidates for federal office. Thus, the Hospital may not contribute any money, or lend the use of vehicles, equipment, or facilities, to candidates for federal office, nor may the Hospital make contributions to political action committees that make contributions to candidates for federal office. The Hospital may not require any employees or professional staff members to make any such contribution. Finally, the Hospital cannot reimburse its employees or professional staff members for any money they contribute to federal candidates or campaigns.

Violation of federal election laws carries potential criminal penalties of imprisonment and fines. Civil penalties also may be assessed. State law also limits the extent to which corporations may contribute to political candidates.

Consistent with its charitable purpose, the Hospital does not carry on "propaganda" or attempt to "influence legislation," as these acts are defined under the Internal Revenue Code. The Hospital and its representatives may not participate in or intervene in any political campaign for or against any candidate.

17. PURCHASING

Purchasing decisions must be made in accordance with applicable Hospital policy. Purchasing decisions must in all instances be made free from any conflicts of interest that could affect the outcome. See Part One 3(f) and (g). The Hospital is committed to a fair and objective procurement system which results in the acquisition of quality goods and services for the Hospital at a fair price. Any concerns about the legality of a proposed transaction should be discussed with a supervisor or the Compliance Officer.

18. INDEPENDENT CONTRACTORS & VENDORS

The Hospital purchases goods and services from many consultants, independent contractors, and vendors. The Hospital's policy is that all contractors and vendors who provide items or services to the Hospital must comply with all applicable laws and Hospital policies, specifically including its Compliance Plan. Each consultant, vendor, contractor, or other agent furnishing items or services and each shall comply with the Policy. The Hospital shall exercise its best efforts to insure that all independent contractors and vendors provide a written certification, which may include a signed contract including a provision stating, that it is aware of and will comply with the Hospital's Compliance Program Policy Manual or that the contractor otherwise maintains an adequate compliance plan. Contractors should bring any questions or concerns about Hospital practice or their own operations to the Compliance Officer.

Hospital employees who work with consultants, contractors, and vendors or who process their invoices should be aware that the Hospital's compliance policies apply to those outside companies as well. Employees are encouraged to monitor carefully the activities of contractors in their areas. Any irregularities, questions, or concerns on those matters should be directed to the Compliance Officer.

19. REGULATION

The Hospital operates in a highly regulated industry, and must monitor compliance with a great variety of highly complex regulatory schemes. The Hospital needs the cooperation of

employees and professional staff members in complying with these regulations and bringing lapses or violations to light. While some of the regulatory requirements may not carry criminal penalties, they control the licenses and certifications that allow the Hospital to deliver care to its patients. The Hospital's continued ability to operate and serve the community depends upon each employee's help in legal and regulatory compliance.

Some of the regulatory programs which employees may deal with in the course of their duties include the following:

- Georgia Department of Human Resources, Hospital Licensure Section
- DET NORSKE VERITAS accreditation
- Medicare certification and conditions of participation
- Certificate of Need
- Controlled substance registration
- Pharmacy licensure and registration
- Clinical laboratory licensure and regulation
- Occupational Safety and Health regulation
- Building, safety, food service and fire codes
- Securities regulation
- Medical waste disposal

The Compliance Officer can provide employees with information on these rules and can direct questions or concerns to the proper person.

20. RESPONSE TO INVESTIGATIONS

State and federal agencies have broad legal authority to investigate the Hospital and review its records. The Hospital will comply with subpoenas and cooperate with governmental investigations to the full extent required by law. The Compliance Officer is responsible for coordinating the Hospital's response to investigations and the release of any information.

If a department, an employee, a professional staff member, or any other person affiliated with the Hospital receives an investigative demand, subpoena, or search warrant involving the Hospital, it should be brought immediately to the Compliance Officer. Do not release or copy any documents without authorization from the Compliance Officer or Hospital counsel. If an investigator, agent, or government auditor comes to the Hospital, contact the Compliance Officer immediately. In the Compliance Officer's absence, contact the Hospital's CEO, Risk Manager or a member of the Compliance Committee. Ask the investigator to wait until the Compliance Officer or his designee arrives before reviewing any documents or conducting any interviews. The Compliance Officer, his designee, or Hospital counsel is responsible for assisting with any

interviews, and the Hospital will provide counsel to employees, where appropriate. If Hospital employees are approached by government investigators and agents, the employee has the right to insist on being interviewed only at the Hospital, during business hours or with counsel present.

If a professional staff member receives an investigative demand at his or her private office and the investigation may involve the Hospital, the staff member is asked to notify the Compliance Officer immediately.

Hospital employees are not permitted to alter, remove, or destroy documents or records of the Hospital. This includes paper, tape, and computer records.

Subject to coordination by the Compliance Officer, the Hospital and its employees will disclose information required by government officials, supply payment information, provide information on subcontractors, and grant authorized federal and state authorities with immediate access to the Hospital and its personnel. Failure to comply with these requirements could mean that the Hospital will be excluded from participating in the Medicare and Medicaid programs.

Subcontractors of the Hospital who provide items or services in connection with the Medicare and/or Medicaid programs are required to comply with the Hospital's policies on responding to investigations. Subcontractors must immediately furnish the Compliance Officer, Hospital attorney, or authorized government officials with information required in an investigation.

21. FEDERALLY FUNDED GRANTS

The Hospital from time to time receives various federal grants. Federal regulations impose duties and obligations upon the recipients of federal grants. As a recipient institution, the Hospital expects its personnel to abide by all applicable federal regulations, including but not limited to regulations relating to accurate reporting and appropriate expenditure of grant funds. Questions relating to matters concerning federal grants should be directed to the Compliance Officer to ensure that all regulations are observed.

EXHIBIT "A"

UPSON COUNTY HOSPITAL, INC. d/b/a

UPSON REGIONAL MEDICAL CENTER

STATEMENT OF COMPREHENSION,

CERTIFICATION AND AGREEMENT OF COMPLIANCE

I, the undersigned, being either an employee, licensed independent healthcare professional, vendor, agent, officer, director, contractor or subcontractor, or other affiliate of Upson County Hospital, Inc. do hereby certify that I have examined the above and foregoing Compliance Plan which includes the Code of Conduct. The Plan is in a language in which I am proficient and the verbiage is comprehensible (appropriate reading level for me), that I fully and completely understand each of said documents and shall always abide by each and every thereof that apply to me. I further affirm that I understand that abiding by the terms of each of said documents that apply to me is a condition of my employment, privileging, contract, or other position or status that I occupy at, or in relation to, Upson County Hospital, Inc. and its affiliated organizations and that my execution of this Statement does not create a contract of employment or other obligation of Upson County Hospital, Inc. toward me.

_____

Signature

_____

Printed Name (as listed in the records of the Hospital)

_____

Department, Status, or Relation to Upson County Hospital, or its affiliated organizations

_____

Facility

_____

Date

END NOTES

[i] **1. Outpatient Procedure Coding**

Under the Medicare Outpatient Prospective Payment System ("OPPS"), hospitals are no longer reimbursed based on their charges for services, but are paid based on procedure codes. More specifically, procedures are assigned corresponding APC codes and hospitals receive a predetermined amount for each APC. In association with implementing the OPPS system and the use of APCs, CMS developed new rules for outpatient coding. The OIG emphasizes that hospitals should ensure that its coders are qualified and properly trained. Hospitals also are encouraged to review their outpatient documentation practices and to avoid coding with incomplete medical records that do not support the level of service claimed. In addition, the Supplemental Guidance identifies specific risk areas for out-patient procedure coding:

Billing on an outpatient basis for "inpatient-only" procedures;

Submitting claims for medically unnecessary services by failing to follow local policies for coverage determinations by the local fiscal intermediary;

Submitting duplicate claims or failing to follow the NCCI guidelines. Hospitals are encouraged to ensure that their software includes up-to-date NCCI edit files;

Submitting incorrect claims for ancillary services based on outdated Charge Description Masters (CDMs). Hospitals are advised to update their CDMs regularly to account for changes in the Healthcare Common Procedure Coding System (HCPCS) codes and the APCs;

Circumventing the multiple procedure discounting rules. Hospitals are urged to review the OPPS annual rule update to understand the discounting rules;

Making improper evaluation and management (E/M) code selection;

Improperly billing for observation services. The OIG explains that, in order to avoid liability, hospitals should become familiar with CMS policies because certain diagnoses have a separate APC for observation while in other situations observation is inappropriate.