UPSON REGIONAL MEDICAL CENTER

LEGAL COMPLIANCE

PROGRAM DOCUMENTS

January 19, 2022

TABLE OF CONTENTS

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 by the use of high quality equipment and facilities combined with compassionate care in a pleasant environment.

The Hospital 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.

Upson Regional Medical Center 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 and again in 2017.

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 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) enacted some substantive changes to the False Claims Act, including the grant to the Secretary of Health and Human Services 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.[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, 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.

---

1 70 Fed. Reg. 4858

2 §6401 of the Patient Protection and Affordable Care Act. Pub. L. 111-148 (2010) (PPACA)

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 new and additional requirements of Congress, CMS and the OIG. In fact, the Patient Protection and Affordable Care Act ("PPACA" or "ACA") requires CMS to promulgate regulations that establish the *core elements* for providers and suppliers of healthcare to meet with respect to the mandatory compliance programs which elements are expected to be forthcoming in the relatively near future. Providers of all sizes will be required to certify that they have an effective compliance program in place as a condition of participation in federal healthcare programs.

PPACA also requires the Secretary of HHS to issue regulations that define the core elements that providers must implement in order to certify compliance with the mandatory compliance program requirement. Thus when, and as, CMS issues core elements it will be essential that the Hospital's Compliance Program be reviewed to determine whether it then meets such core elements requirement, and that it be revised in the event any of the mandatory elements are not included in the Program.

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, and Federal, State and private payor health care program requirements, as well as 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 which is the function of the Compliance Policy Manual to which this Code is appended. 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.

Every person covered by this Code is required to review it and the 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) stating that this Code, the Standards of Practice, the Legal Compliance Program book including the Compliance Policy Manual, are all in a language in which he/she is proficient and that it uses verbiage which is comprehensible (appropriate reading level), that he/she fully and completely understand the Manual and will always abide by the provisions thereof that apply to each such person. 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 there is 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 believes that the Hospital should be a leader in Upson 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 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 obligates 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.

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 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 except in case of emergencies 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.

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

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] and the Supplemental Guidance on Compliance[4] (hereafter "Supplemental Guidance"). The latter 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

3 63 Fed Reg 8987 1998
4 70 Fed Reg 4858 2005

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 level of service claimed. The Supplemental Guidance identifies specific risk areas for out-patient 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 to provide the service.

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 Healthcare 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 CEO in the event of their exclusion, debarment, or becoming ineligible to participate in Federal healthcare programs. 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.

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 I.R.S. 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, anything of value, either in cash or in kind, directly or indirectly, in return for:

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

(ii) leasing, purchasing or ordering or arranging 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 healthcare 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 of the Hospital.

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 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 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.

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 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 supervisor or the manager or director of the employee's department as described in the Compliance Policy Manual. Reports may be made anonymously, however, employees are encouraged to identify themselves in order to aid in the investigative process in which case there will be no retaliation for any reports made in good faith.

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

No employee 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 of the Hospital or its employees.

Any employee 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 appears to be involved in the subject addressed in the legal document the Compliance Officer should advise the employee 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.

Records

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

An employee 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 Record Retention Policy. An employee shall not destroy any patient or Hospital record unless authorized by the Hospital's Record Retention Policy.

General

When questions as to the appropriateness of any action arise, employees 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. 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. COMPLIANCE OFFICER AND COMMITTEE

A. COMPLIANCE OFFICER

The Compliance Program (sometimes referred to as "Program") includes this Compliance Policy Manual (sometimes referred to as "Manual"), 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 present Compliance Officer shall continue in that office subject to future action of the Board. The Compliance Officer shall report directly to the Chief Executive Officer ("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.

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 this entire document on Compliance, 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 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.

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 Elements 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 and existing and new members of the Medical Staff.

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.

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 is responsible to and will report 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 Chief Executive Officer, 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 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 when an Alternate is needed prior to the next Board meeting, the CEO shall make the necessary appointment(s).

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 the Compliance Officer and the recommendations made by the Compliance Officer. From time to time, the

Committee may report to and consult with the Chief Executive Officer 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 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 on the second Thursday in March, June, September, and December at 7:30 o'clock A.M. 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 Chief Executive Officer or the Compliance Officer may call special meetings of the Committee. Meetings and notice thereof must be communicated in compliance with the Sunshine laws of Georgia.

5. REPORTS AND RECORDING KEEPING. All submissions to the Committee by the Compliance Officer shall be marked "Confidential." The Committee will submit to the Hospital 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 WRONG DOING. 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 employee of the Hospital. The Compliance Officer may raise other matters with the Committee, within his or her discretion.

7. COMPLIANCE REVIEWS. The Committee shall periodically review the Hospital's compliance with regulatory requirements and special licensing conditions imposed upon the Hospital and shall report to the Board any findings regarding such matters. The Committee and Compliance Officer also shall review relationships between the Hospital and its Board, employees, agents and independent professional staff.

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.

D. GENERAL POLICY

The Compliance Officer and the Compliance Committee are the primary responsible parties for operating and monitoring the Compliance Program both of which report directly to the CEO and the Board and both of which 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, 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 or independent professional 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.

This Manual includes statements of the Hospital's Policies in a number of specific areas. All employees and professional Staff members must comply with these policies, which define the scope of Hospital employment and professional Staff membership. All employees and Staff members should review this Manual from time to time to make sure that these Policies guide their actions on behalf of the Hospital.

If, at any time, any employee or professional Staff member becomes aware of any apparent violation of the Hospital's policies, he or she must report it to his or her supervisor (in the case of an employee) or to the Compliance Officer in the case of a professional Staff member. All persons making such reports are assured that such reports are treated as confidential; such reports will be shared only on a bona-fide need-to-know basis. The Hospital will take no adverse action against persons making such reports, whether or not the report ultimately proves to be well-founded, unless a determination is made that such report was not made in good faith, that is, that no facts existed that would lead a reasonable person to make the report. If an employee or professional Staff member does not report conduct that violates the Hospital's policies, that employee or professional Staff member may be subject to disciplinary action, up to and including termination of employment or negative action relative to Hospital privileges.

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 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. FRAUD 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 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. In addition to the federal laws that have existed for many years, there now exist a plethora of more recent federal laws as well as laws of the State of Georgia all of which are designed to prevent fraud and abuse in the payments for healthcare.

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

1. THE FEDERAL FRAUD STATUTES

In addition to providing initial funding in the early 1990s, over the past 20 years, Congress has steadily expanded the enforcement agencies arsenal of anti-fraud enforcement tools and limited the industry's defenses. The financial crisis of 2008, involving financial institution fraud, mortgage fraud, and securities fraud, led to the enactment of the Fraud Enforcement and Recovery Act of 2009, (FERA Pub. L. 111–21, S. 386, 123 Stat. 1617) which amended numerous United States Code Sections), to enhance criminal penalties and enforcement of existing federal fraud

laws. In enacting FERA, Congress also took the opportunity to broaden the scope of the False Claims Act ("FCA") and, particularly, to overrule several court decisions interpreting the FCA in favor of defendants.

Although federal criminal law was already quite broad and could capture most healthcare fraud schemes, the Health Insurance Portability and Accountability Act ("HIPAA") created several new criminal offenses, including a new healthcare fraud offense (applicable to defrauding government and private payors alike) with enhanced criminal penalties. In addition, HIPAA authorized federal prosecutors to obtain injunctions and freeze the assets of persons or entities committing healthcare offenses, to issue administrative subpoenas in an investigation without a grand jury, and directed judges sentencing convicted federal healthcare offenders to impose criminal forfeiture on assets obtained as result of the fraud. HIPAA further expanded the Office of Inspector Generals (OIGs) broad authority to impose civil monetary penalties (CMPs) for a variety of infractions and exclude providers from participating in Medicare.

In addition to FERA and HIPAA, the federal government has available for use in its healthcare fraud fighting efforts the following laws and regulations:

Civil FCA (31 U.S.C. 3729);
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 ("CMP") 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. 1964);
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) (18 U.S.C.1395).

2. THE GEORGIA FRAUD STATUTES

The State of Georgia has enacted statutes very similar, but not identical, to some of the federal statutes, designed, to accomplish the same basic purpose, 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 is subject to all of the foregoing federal and State of Georgia laws. Originally enacted in 1972, the federal Anti-Kickback Statute[5] provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive bribes, kickbacks, or other remuneration in order to induce business reimbursed by Medicare, Medicaid, and other federal healthcare programs. Violation of the Anti-Kickback Statute constitutes a felony, which carries a maximum penalty of a $25,000 fine, imprisonment up to five 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. Some forms that are used in seeking remuneration from the public health care programs contain a certification of compliance with applicable statutes and regulations. Such certifications, however, are false if they certify compliance with a statute or regulation that is a condition of government payment, and the Patient Protection and Affordable Care Act 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 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 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 scheme is to influence referrals, and otherwise it 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

5 42 U.S.C. 1320a-7b(b)

a physician who refers patients to the Hospital, or to a patient, without consulting the Compliance Officer, who, if necessary will consult with the Chief Executive Officer and the hospital attorney. The Chief Executive Officer must review and approve any of the preceding practices that may be questionable. The Chief Executive Officer 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 Chief Executive Officer. 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, and specify the compensation in advance. Payment based on a percentage of revenue should be avoided unless it has been approved by a specialist. Any questions about these agreements should be directed to the Compliance Officer and, if questions remain, by the Chief Executive Office 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 Chief Executive Officer 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 for up to five years.

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 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 monitor compliance with applicable billing rules. Any false, inaccurate, or questionable claims should be reported immediately to a supervisor or to the Compliance Officer.

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 these and other errors. It is important to remember that outside consultants only advise the Hospital. The final decision on billing questions rests with the Hospital.

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 follow 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 Chief Executive Officer. 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 Federal False Claims Act [FCA] [31 U.S.C. §§ 3729–3733] is guilty of a felony, may be subject to imprisonment and may be subject to civil monetary penalties 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]. Violations of the assignment and reassignment rules are misdemeanors carrying civil monetary fines or imprisonment of up to six months, or both.

Numerous federal laws prohibit false statements or inadequate disclosure to the government 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 are guilty of a felony and may be subject to fines and imprisonment for up to five years. The Hospital or individual health care providers will be excluded from the Medicare and Medicaid programs for at least five years if convicted of a Medicare or Medicaid related crime or any crime 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.

It is illegal to make any false statement to the federal government in billing for healthcare, including statements on Medicare or Medicaid claim forms. Many of the federal Circuit Courts of Appeal have now expanded liability beyond express certifications of compliance by holding that "the act of submitting a claim for reimbursement itself implies compliance with governing federal rules that are a precondition to payment.", even if the claim itself does not contain an express certification of compliance. Thus, when "an entity has ***previously*** undertaken to expressly comply with a law, rule, or regulation," FCA liability may still be imposed when a person submits a false "claim for payment even though a certification of compliance is ***not*** required in the process of submitting the claim."

It is illegal to use the U.S. mail or wire communications in a scheme to defraud the government. [18 U.S.C. 1341, et seq.] Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government. [18 U.S.C. § 371]

In addition to these federal penalties, fraud and abuse in obtaining state medical assistance

is prohibited by State law. O.C.G.A. §49-4-168, et seq., supra, makes it a misdemeanor for any person to knowingly obtain or attempt to obtain, or who aids or abets any other person to obtain or attempt to obtain by means of a willfully false statement, representation, impersonation, or failure to disclose a material fact, or other fraudulent device, any benefits provided by the Medical Assistance for the Aged program, and is punishable by a fine of up to $1,000.00, and up to twelve months imprisonment, either or both. State law [O.C.G.A. §49-4-146.1], makes it a felony (1) for any person to obtain or attempt to obtain for himself or any other person any medical assistance or other benefits or payments under the state Medical Assistance program to which the person is not entitled, or in an amount greater than that to which the person is entitled, when the assistance, benefit, or payment is obtained, or attempted to be obtained by (A) Knowingly and willfully making a false statement or false representation; (B) Deliberate concealment of any material fact; or (C) Any fraudulent scheme or device; or (2) For any provider knowingly and willfully to accept medical assistance payments to which he is not entitled or in an amount greater than that to which he is entitled, or knowingly and willfully to falsify any report or document required under the law on Medical Assistance. Any person violating these prohibitions shall be punished for each offense by a fine of not more than $10,000.00, or by imprisonment for not less than one year nor more than ten years, or by both such fine and imprisonment. In any prosecution under this Code section, the state has the burden of proving beyond a reasonable doubt that the defendant intentionally committed the acts for which he or she is charged. In addition to the criminal penalties any person committing abuse shall be liable for a civil monetary penalty equal to two times the amount of any excess benefit or payment. Abuse is defined as a provider knowingly obtaining or attempting to obtain medical assistance or other benefits or payments under this Article to which the provider knows he or she is not entitled when the assistance, benefits, or payments are greater than an amount which would be paid in accordance with those provisions of the state's policies and procedures manual which are adopted pursuant to public notice, and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program. Under State law, isolated instances of unintentional errors in billing, coding, and costs reports shall not constitute abuse. Miscoding shall not constitute abuse if there is a good faith basis that the codes used were appropriate under the state's policies and procedures manual and there was no deceptive intent on the part of the provider. Violators may also be subject to a civil penalty equal to the greater of (1) three times the amount of any such excess benefit or payment or (2) $1,000.00 for each excessive claim for assistance, benefit, or payment, plus interest. The Department of Community Health may also refuse to accept a statement of participation, deny a request for reinstatement, refuse to exercise its option to renew a statement of participation, suspend or withhold those payments arising from fraud or willful misrepresentation under the Medicaid program, or terminate the participation of any provider other than a natural person if that provider or any person with an ownership or controlling interest or any agent or managing employee of such provider has been:

(1) Convicted of violating paragraph (1) or (2) of subsection (b) of the Code section;

(2) Convicted of committing any other criminal offense related to any program administered

under Title XVIII, XIX, or XX of the Social Security Act of 1935, as amended; or

(3) Excluded or suspended from participation in the Medicare program for fraud or abuse.

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, 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 the 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"[6]. It applies to any referring physician who has, or whose immediate family member has, a "financial relationship" with an entity such as the Hospital, and prohibits referrals by that physician to the Hospital for the provision of designated health services reimbursed by Medicare and Medicaid, although the applicability to reimbursement by Medicaid results indirectly through the denial of payment by the federal government to the State Medicaid program for such billings (see Section 1903(s) of the Social Security Act). If a financial relationship exist, referrals are prohibited unless a specific exception is met, and the Hospital may not present or cause to be presented a claim under TITLE 42 of the United States Code which is titled "THE PUBLIC HEALTH AND WELFARE, CHAPTER 7. SOCIAL SECURITY ACT TITLE XVIII. HEALTH INSURANCE FOR THE AGED AND DISABLED" [42 USCS §§ 1395 et seq.] or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a prohibited referral. 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 a "financial relationship" 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.

The Stark law applies to the following referred designated health services ("DHS"):

1. Clinical laboratory services;
2. Physical therapy, occupational therapy, and speech-language pathology services;
3. Radiology and certain other imaging services;
4. Radiation therapy services and supplies;
5. Durable medical equipment and supplies;
6. Parenteral and enteral nutrients, equipment, and supplies;
7. Prosthetics, orthotics, and prosthetic devices and supplies;
8. Home health services;
9. Outpatient prescription drugs; and
10. Inpatient and outpatient hospital services.

In its Supplemental Guidance the OIG advised that from a hospital compliance perspective, the Stark law should be viewed as a threshold statute. The OIG pointed out that the statute prohibits the Hospital from submitting a prohibited claim *even* if the prohibited

6 42 U. S. C. §1395nn (section 1877 of the Social Security Act)

financial relationship is the result of inadvertence or error. In addition, the OIG pointed out that hospitals and physicians that *knowingly* violate Stark may be subject to Civil Monetary Penalties 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 federal False Claims Act. Because all inpatient and outpatient hospital services furnished to Medicare or Medicaid patients (including services furnished directly by a hospital or by others "under arrangements" with a hospital) 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 are so severe that it is imperative that financial relationships with referring physicians fit squarely in statutory or regulatory exceptions to the Stark law. To fit in an exception, an arrangement must squarely meet all of the conditions set forth in the exception. Importantly, it is the actual relationship between the parties, and not merely the paperwork, that must fit in an exception. Unlike the anti-kickback safe harbors, which are not absolutely mandatory, fitting in an exception is mandatory under the Stark law.

OIG Guidance provides the following three-part inquiry for purposes of analyzing a financial relationship under the Stark law:

- "Is there a *referral* from a *physician* for a *designated health service*? If not, then there is no Stark law issue (although other fraud and abuse authorities, such as the anti-kickback statute, may be implicated). If the answer is "yes," the next inquiry is:
- "Does the physician (or an immediate family member) have a *financial relationship* with the entity furnishing the DHS (*e.g.*, the hospital)? Again, if the answer is no, the Stark law is not implicated. However, if the answer is "yes," the third inquiry is:
- "Does the financial relationship fit in an *exception*? If not, the statute has been violated."
- The Federal Regulations promulgated under Stark are found at 42 CFR 411.350, et seq. [7]

Though Stark prohibits physicians from referring DHS to entities, including hospitals, with which they have prohibited financial relationships, the billing prohibition and nonpayment sanction apply only to the DHS entity (*e.g.*, the Hospital).

The Georgia Patient Self-referral Act (OCGA §43-1B-1 et seq., supra), 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

---

7 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*.

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 any health care provider or entity solely for referring a patient shall be subject to a civil penalty of not more than ***$15,000.00*** for each such service. A violation of this Code section by a health care provider shall constitute grounds for disciplinary action to be taken by the health care provider's respective board, including the potential for license revocation.

The Georgia "Stark" has a slightly different group of designated health services to which it applies. They are:

1. Clinical laboratory services;
2. Physical therapy services;
3. Rehabilitation services;
4. Diagnostic imaging services;
5. Pharmaceutical services;
6. Durable medical equipment
7. Home infusion therapy services (including related pharmaceuticals and equipment),
8. Home health care services, and
9. Outpatient surgical services.

The Georgia statute, however, applies to all patients, regardless of the source of payment, and to the designated health care services listed above, and defines a "referral" as any referral of a patient for health care services, including, ***without limitation***:

"(A) The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service;

"(B) The request or establishment of a plan of care by a health care provider which includes the provision of designated health services or other health care item or service; or

"(C) The following orders, recommendations, or plans of care *shall not constitute* a referral by a health care provider:

(i) By a radiologist for diagnostic imaging services;

(ii) By a health care provider specializing in the provision of radiation therapy services for such services;

(iii) By a health care provider referring within the health care provider’s group practice;

(iv) By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another health care provider;

(v) By a staff health care provider of a hospital referring a patient to the hospital at which the health care provider has current staff privileges;

(vi) By a health care provider for items or services provided by such health care provider or by a member of such health care provider's group practice to the patients of that health care provider or group practice or items or services provided or performed at the direction or under the supervision of such health care provider or group practice; or

(vii) By a health care provider when the patient is in need of emergency health care services where any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected."

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. No claim for payment may be presented pursuant to a referral prohibited under this Georgia Code section unless an exception applies. Third-party payors may request annually and receive from the health care provider a copy of the disclosure form provided for in subsection (a) of Code Section 43-1B-5, and any amount improperly collected must be refunded. Any person who presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made shall be subject to a civil penalty of not more than ***$15,000.00*** for each such service. Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the health care provider or entity knows or should know has a principal purpose of assuring referrals by the health care provider to a particular entity which, if the health care provider directly made referrals to such entity, would be in violation of this Code section shall be subject to a civil penalty of not more than ***$50,000.00*** for each such circumvention arrangement or scheme. Any health care provider or entity that divides fees or agrees to divide fees received for a designated health service with any health care provider or entity solely for referring a patient shall be subject to a civil penalty of not more than **$15,000.00** for each such service.

A violation of this Code section by a health care provider shall constitute grounds for disciplinary action to be taken by the health care provider's respective board, including the potential for license revocation.

Code §43-1B-5 further provides that (a) A health care provider shall not refer a patient to an entity in which such health care provider has an investment interest unless, prior to the referral, the health care provider furnishes the patient with a written disclosure form approved by the health care provider's respective board, informing the patient of:

"(1) The existence of the investment interest;

"(2) The name and address of each applicable entity in which the referring health care provider is an investor; and

"(3) The patient's right to obtain the items or services for which the patient has been referred at the location or from the health care provider or supplier of the patient's choice unless otherwise restricted by law, including the entity in which the referring health care provider is an investor.

"(b) The health care provider shall post a copy of the disclosure form provided for in subsection (a) of this Code section in a conspicuous public place in the health care provider's office.

"(c) The provisions of this Code section shall apply to all referrals made prior to July 1, 1996, and to referrals expressly exempted from the prohibitions contained in this chapter on and after that date. Nothing in this Code section shall be construed so as to authorize any referral otherwise prohibited by this chapter on and after July 1, 1996.

"(d) A violation of this Code section shall be grounds for disciplinary action by the board.

Code §43-1B-6(a) provides certain other exceptions to the foregoing prohibitions, one of which is that they do not apply to the referral of patients to any entity or facility providing designated health services if there is no entity or facility of reasonable quality, price, or service in the community, alternative financing is not reasonably available, and all the following requirements are met:

"(1) No health care provider shall be required to make referrals or otherwise generate business as a condition for becoming or remaining an investor, and all other individuals are given a bona fide opportunity to invest in the facility on the same terms as a referring health care provider;

"(2) The facility shall not loan funds nor guarantee loans for referring health care providers, nor shall the income from the investment be based on the volume of referrals made by the health care provider;

"(3) The health care provider complies with Code Section 43-1B-5, requiring disclosure of the investment interest to the patient; and

"(4) The facility shall provide uncompensated health services for indigent or charity patients at a standard which meets or exceeds 3 percent of the gross revenues of the facility after provisions for bad debts and third-party adjustments have been deducted. The services offered shall be reasonably financially accessible to the residents of the facility's service area.

"(d) The provisions of this Code section shall be regulated by the State Health Planning Agency."

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, 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.

(a) Anti-Kickback Laws

As discussed above, federal law makes it illegal for the Hospital to provide or accept "remuneration" in exchange for referrals of patients covered by Medicare or Medicaid. Acquisitions of physician practices may implicate the anti-kickback laws because they may constitute illegal payments to induce the referral of Medicare or Medicaid patients.

Generally, acquisitions will comply with federal law when the amounts paid by the Hospital reflect the fair market value of the acquired practice. Fair market value should be determined through an independent appraisal. Payments in excess of fair market value may violate the anti-kickback laws, particularly when there is an ongoing relationship between the Hospital and the acquired practice. Several specific types of payment are subject to scrutiny:

- payment for good will
- payment for value of ongoing business unit
- payment for covenants not to compete
- payment for exclusive dealing agreements
- payment for patient lists
- payment for patient records.

Similar scrutiny must be applied in the sale of medical practices to physicians. Fair market value should be determined through an independent appraisal. Sale of a practice that is below fair market value may violate the anti-kickback laws.

The "safe harbor" protections discussed above may also apply to a particular acquisition or sale. Employees should not, however, make unilateral judgments on the availability of a safe harbor. These situations must be under the control of the CEO and reviewed with legal counsel.

It is possible that O.C.G.A §43-1B-4 could be implicated in a practice acquisition. This statute which 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, and is dealt with in more

detail under Section 5 above.

(b) Stark Law

Physician practice acquisitions also implicate the Stark law discussed earlier. Because the law is particularly complex, all transactions must be reviewed by the CEO and legal counsel to ensure compliance.

(c) IRS Scrutiny

The IRS retains authority to audit the activities of tax-exempt organizations. In particular, the IRS may revoke the Hospital's tax-exempt status or impose intermediate sanctions on the Hospital and the officers involved if payments for the acquisition of group practices are deemed "excessive" or if the sale of a practice is determined to be below “market” value. While current, independent appraisals are important, equally important are the rationale and support for the reasonableness of the assumptions on which the valuation is based. These are issues for the CEO and legal counsel.

8. PATIENT TRANSFERS

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 the Federal Emergency Medical Treatment and Labor Act [EMTALA], also known as COBRA or 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 stabilized. An emergency may include psychiatric disturbances, symptoms of substance abuse, or contractions experienced by pregnant women.

If necessary, the stabilized patient may be transferred to another hospital that is qualified to care for the patient, has space available, and has agreed to accept the transfer. Before transfer, Hospital staff shall provide the medical treatment which minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child. A physician must sign a certification that the medical benefits reasonably expected from treatment at another medical facility outweigh the increased risks to the patient (and, if appropriate, the unborn child). No physician will be penalized for refusing to authorize the transfer of an individual with an emergency condition that has not been stabilized. The transfer must be performed by qualified personnel and transportation equipment, including life support measures during transfer if medically appropriate. A copy of the patient's record, including complete records of the

emergency department encounter and any other records that are available, must be sent to the receiving hospital.

EMTALA carries reporting obligations. Any employee who believes that an emergency patient has been transferred improperly must report the incident to the Compliance Officer. No employee will be penalized for reporting a suspected violation of the patient transfer law. If an employee or professional staff member believes that an emergency patient has been transferred to the Hospital improperly, the suspected violation must be reported to the Compliance Officer and to proper authorities within 72 hours of its occurrence. The name and address of any on-call physician who refuses or fails to appear within a reasonable time to provide necessary stabilizing treatment of an emergency medical condition or active labor is to be reported immediately to the Compliance Officer.

In addition to the Hospital's medical records, the emergency department will maintain an on-call duty roster and a log documenting each individual who comes to the emergency department seeking assistance. The log must document whether the patient refused treatment or was refused treatment, transferred, was admitted and treated, stabilized and transferred, or discharged. When a patient or a patient's legal representative requests a transfer or refuses a transfer, the informed consent or refusal must be documented in writing. If there are questions about the records required under the patient EMTALA LAW, the Compliance Officer will answer them or refer them to legal counsel.

EMTALA is enforced through civil monetary penalties and through damages in private civil actions. If a hospital violates the statute, it can be fined up to $50,000 for each violation. A physician, including an on-call physician, who is responsible for the examination, treatment, or transfer of an emergency patient and who negligently violates the law may be fined up to ***$50,000*** for each violation. If the violation is gross and flagrant or repeated, the physician may be excluded from participation in the Medicare and Medicaid programs.

Georgia law contains what is in effect an anti-dumping law at §31-8-42, dealing exclusively with emergency services to provide care to pregnant women in labor. It provides that any hospital which operates an emergency service shall be required to provide the appropriate, necessary emergency services to any pregnant woman who is a resident of this state and who presents herself in active labor to the hospital, if those services are usually and customarily provided in that facility, which services shall be provided within the scope of generally accepted practice based upon the information furnished the hospital by the pregnant woman, including such information as the pregnant woman reveals concerning her prenatal care, diet, allergies, previous births, general health information, and other such information as the pregnant woman may furnish the hospital. If, in the medical judgment of the physician responsible for the emergency service, the hospital must transfer the patient because the hospital is unable to provide appropriate treatment, the hospital where the patient has presented herself shall:

(1) Within the capabilities of the hospital provide such emergency services as the

circumstances require, which services shall be provided within the scope of generally accepted practice based upon the information furnished the hospital by the pregnant woman, including such information as the pregnant woman reveals concerning her prenatal care, diet, allergies, previous births, general health information, and other such information as the pregnant woman may furnish the hospital;

(2) Contact an appropriate receiving hospital and notify such hospital that the patient is in transit;

(3) Arrange suitable transportation for the patient if necessary; and

(4) Send to the receiving hospital any available information on the patient's history and condition.

The transfer shall not be authorized until the physician considers the patient sufficiently stabilized for transport.

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, depending on the facts and circumstances involved, 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.

(a) Discussion With Competitors

Hospital policy requires that the rates it charges for Hospital care and related items and services, and the terms of its third party payor contracts, must be determined solely by the Hospital. In independently determining prices and terms, the Hospital may take into account all relevant factors, including costs, market conditions, widely used reimbursement schedules, and prevailing competitive prices, to the extent these can be determined in the marketplace. There can be, however, no oral or written understanding with any competitor concerning prices, pricing policies, pricing formulas, bids, or bid formulas, or concerning discounts, credit arrangements, or related terms of sale or service. To avoid the possibility of misunderstanding or misinterpretation, Hospital policy prohibits **any** consultation or discussion with competitors relating to prices or

terms which the Hospital or any competitor charges or intends to charge. Joint ventures and affiliations that may require pricing discussions must be individually reviewed for antitrust compliance. Discussions with competitors concerning rationalization of markets, down-sizing, or elimination of duplication ordinarily implicate market division and must be avoided.

Hospitals are often asked to share information concerning employee compensation. Hospital policy prohibits the sharing with competing hospitals of current information or future plans regarding individual salaries or salary levels. The Hospital may participate in and receive the results of general surveys, but these must conform to the guidelines for participation in surveys provided under Trade Associations below.

Similarly, Hospital policy prohibits consultation or discussion with competitors with respect to its services, selection of markets, territories, bids, or customers. Any agreement or understanding with a competitor to divide markets is prohibited. This includes an agreement allocating shares of a market among competitors, dividing territories, or dividing product lines or customers.

(b) Trade Associations

The Hospital and its health care providers are involved in a number of trade and professional associations. These organizations promote quality patient care by allowing the Hospital and providers to learn new skills, develop policies and, where appropriate, speak with one voice on public issues. However, it is not always appropriate to share business information with trade associations and their members. Sharing information is appropriate if it is used to better inform consumers or to promote efficiency and competition.

The Hospital may participate in surveys of price, cost, and wage information if the survey is conducted by a third party and involves at least five comparably sized hospitals. Any price, cost, or wage information released by the Hospital must be at least three months old. If an employee is asked to provide a trade association with information about the Hospital's charges, costs, salaries, or other business matters, he or she should consult the Compliance Officer. Joint purchasing through a trade association is likely acceptable, but any joint purchasing plan should be reviewed in advance by the Compliance Officer, the CEO and the Board. If an employee or professional staff member has any question or concern about an activity of a trade association, he or she may ask the Compliance Officer to seek guidance from legal counsel.

(c) Boycotts

Hospital policy prohibits any agreement with competitors to boycott or refuse to deal with a particular person or persons, such as a vendor, payor, or other provider. These agreements need not be written to be illegal; any understanding reached with a competitor (directly or indirectly) on such matters is prohibited. All negotiations by Hospital agents and employees must be conducted in good faith. Exclusive arrangements with payers, vendors, and providers must be approved by the Compliance Committee or legal counsel based on an analysis of the relevant market.

(d) Physician Services

Hospital credentialing and peer review activities also may carry antitrust implications. Because of the special training and experience of physicians, their skills may best be evaluated by other physicians. It is appropriate for physicians to review the work of their peers. Because the physicians reviewing a particular physician may, by virtue of their medical specialties, be the physician's competitors, special care must be taken to ensure that free and open competition is maintained. As a result, credentialing, peer review and physician discipline at the Hospital are conducted only through properly constituted committees. Physicians participating in these activities are expected to use objective medical judgment.

If any Hospital employee is involved in negotiating a contract of employment or a personal services contract with a physician or other health care provider, it is important to review with care any non-competition provisions incorporated in the agreement. The appropriate geographic scope and duration of a non-competition agreement may vary from case to case. Questions about the appropriateness of a non-competition provision should be directed to the Compliance Officer for review with legal counsel.

(e) Penalties

Penalties for antitrust violations are substantial. Individuals and corporations can be fined ***$350,000*** and ***$10,000,000*** respectively, for each antitrust violation, and individuals can be sentenced for up to three years in prison for each offense. In addition, actions giving rise to antitrust violations may violate other federal criminal statutes, such as mail fraud or wire fraud, under which substantial fines and even longer prison sentences can be imposed.

Antitrust violations also create civil liability. Private individuals or companies may bring actions to enjoin antitrust violations and to recover damages for injuries caused by violations. If successful, private claimants are entitled to receive three times the amount of damages suffered, plus attorneys' fees. Moreover, if the antitrust violation was a conspiracy, each member of that conspiracy may be liable for the **entire** damage caused by the conspiracy.

(f) Unfair or Deceptive Practices

In addition to the antitrust laws, the Hospital is committed to complying with other federal and state laws governing market competition. Federal law, particularly the Federal Trade Commission Act, prohibits the use of "unfair or deceptive acts and practices," including the distribution of labeling, advertising, and marketing materials that are false or misleading. Hospital employees responsible for preparing and distributing such materials must be familiar with these laws. Specific materials should be approved by the Compliance Committee before distribution.

Sanctions under this law usually take the form of "cease and desist" orders and may include civil penalties.

Georgia has enacted the Uniform Deceptive Practices Act (O.C.G.A. §10-1-370 through 375), and has a Fair Business Practices Act (O.C.G.A. §10-1-390 through 407) which deal with the same general subject matters. The Uniform Deceptive Practices Act provides that:

(a) A person engages in a deceptive trade practice when, in the course of his business, vocation, or occupation, he:

(1) Passes off goods or services as those of another;

(2) Causes likelihood of confusion or of misunderstanding as to the source, sponsorship, approval, or certification of goods or services;

(3) Causes likelihood of confusion or of misunderstanding as to affiliation, connection, or association with or certification by another;

(4) Uses deceptive representations or designations of geographic origin in connection with goods or services;

(5) Represents that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation, or connection that he does not have;

(6) Represents that goods are original or new if they are deteriorated, altered, reconditioned, reclaimed, used, or secondhand;

(7) Represents that goods or services are of a particular standard, quality, or grade or that goods are of a particular style or model, if they are of another;

(8) Disparages the goods, services, or business of another by false or misleading representation of fact;

(9) Advertises goods or services with intent not to sell them as advertised;

(10) Advertises goods or services with intent not to supply reasonably expectable public demand, unless the advertisement discloses a limitation of quantity;

(11) Makes false or misleading statements of fact concerning the reasons for, existence of, or amounts of price reductions; or

(12) Engages in any other conduct which similarly creates a likelihood of confusion or of misunderstanding.

(b) In order to prevail in an action under this part, a complainant need not prove competition between the parties or actual confusion or misunderstanding.

(c) This Code section does not affect unfair trade practices otherwise actionable at common law or under other statutes of this state.

The Fair Business Practices Act (O.C.G.A. §10-1-390 through 407) is a very extensive and broad prohibition against deceiving those with whom you deal in business. One of the specific examples of an unfair practice set out in the act applies specifically to hospitals, and is found at §10-1-393(b)(14), and reads as follows:

"(14) Failure of a hospital or long-term care facility to deliver to an inpatient who has been discharged or to his or her legal representative, not later than six business days after the date of such discharge, an itemized statement of all charges for which the patient or third-party payer is being billed;"

In addition, the Georgia Constitution prohibits anti-competitive agreements in Article III,

Sec. VI, Par. V, which provides:

"(c) The General Assembly shall not have the power to authorize any contract or agreement which may have the effect of or which is intended to have the effect of defeating or lessening competition, or encouraging a monopoly, which are hereby declared to be unlawful and void." This same principle is carried forward in the Georgia Code at §13-8-2(2).

10. TAX-EXEMPT ORGANIZATIONS

As a non-profit hospital serving charitable purposes, the Hospital holds federal tax-exempt status. That is, the Hospital 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 cost.

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 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 the employee's supervisor or to the Compliance Officer.

Any income derived from activities unrelated to the Hospital's charitable purposes shall be reported, and appropriate tax 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 of up to ***$1,000,000***, and imprisonment for up to 10 years. 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

A hospital produces waste of various types. 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 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 as high as ***$50,000*** per day per violation, imprisonment for up to two years, 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.

Federal law may impose sentences of up to twenty years in prison and fines of up to ***$1,000,000.*** 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 up to ***$20,000*** and imprisonment for life. (O.C.G.A. §16-13-30).

14. CONFIDENTIALITY & HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA").

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 the Health Insurance Portability and Accountability Act of 1996 [42 U.S.C. 1320d-1320d-9] ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information, which is referred to as "protected health information" 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 Office for Civil Rights ("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. The U.S. Department of Health and Human Services (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 Act) 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 not

only under federal laws but under Georgia law and the Georgia Constitutional right of privacy. All of this means that 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. 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, 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.

O.C.G.A. §34-1-2 provides that no person carrying on within this state any business requiring the employment of labor shall refuse to hire, employ, or license any individual between the ages of 40 and 70 years, solely upon the ground of age, when the reasonable demands of the position do not require such an age distinction, provided that such individual is qualified physically, mentally, and by training and experience to perform satisfactorily the labor assigned to him or for which he applies.

O.C.G.A. §34-5-3 prohibits discrimination by an employer with ten or more employees against any person on the basis of their sex, and requires equal pay for equal work. Certain violations of this act constitute a misdemeanor punishable by a fine of ***$100.00.***

O.C.G.A. §34-6A-4 prohibits discrimination in employment against any individual with disabilities with respect to wages, rates of pay, hours, or other terms and conditions of employment unless such disability restricts that individual's ability to engage in the particular job or occupation for which he or she is eligible.

O.G.C.A. §45-19-29 provides that it is an unlawful practice for a public employer, which, under current case law, URMC is, to fail or refuse to hire, to discharge, or otherwise to discriminate against any individual with respect to the individual's compensation, terms, conditions, or privileges of employment because of such individual's race, color, religion, national origin, sex, disability, or age, or to limit, segregate, or classify employees in any way which would deprive or tend to deprive an individual of employment opportunities or otherwise adversely affect an individual's status as an employee because of such individual's race, color, religion, national origin, sex, disability, or age, or to hire, promote, advance, segregate, or affirmatively hire an individual solely because of race, color, religion, national origin, sex, disability, or age.

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 up to one year in jail and a fine of ***$25,000*** or three times the amount of the illegal contribution, whichever is greater. Civil penalties also may be assessed.

State law contains the following limits on the extent to which corporations may contribute to political candidates:

§ **21-5-41**. Contributions of persons, corporations, political committees, or political parties limited.

(a) No person, corporation, political committee, or political party shall make, and no candidate or campaign committee shall receive from any such entity, contributions to any candidate for state-wide elected office which in the aggregate for an election cycle exceed:

(1) Five thousand dollars for a primary election;

(2) Three thousand dollars for a primary run-off election;

(3) Five thousand dollars for a general election; and

(4) Three thousand dollars for a general election runoff.

(b) No person, corporation, political committee, or political party shall make, and no candidate or campaign committee shall receive from any such entity, contributions to any candidate for the General Assembly or public office other than state-wide elected office which in the aggregate for an election cycle exceed:

(1) Two thousand dollars for a primary election;

(2) One thousand dollars for a primary run-off election;

(3) Two thousand dollars for a general election; and

(4) One thousand dollars for a general election runoff.

(c) No business entity shall make any election contributions to any candidate which when aggregated with contributions to the same candidate for the same election from any affiliated corporations exceed the per election maximum allowable contribution limits for such candidate as specified in subsection (a) of this Code section.

(d) Candidates and campaign committees may separately account for contributions pursuant to Code Section 21-5-43. Candidates and campaign committees not separately accounting for contributions pursuant to such Code section shall not accept contributions for any election in an election cycle prior to the conclusion of the immediately preceding election in such cycle; provided, however, that contributions may be accepted for a primary election at any time in the election cycle prior to and including the date of such primary election. Upon conclusion of each election, contributions remaining unexpended may be expended on succeeding elections in the election cycle, and contributions not exceeding the contribution limits of this Code section may continue to be accepted for repayment of campaign obligations incurred as a candidate in

that election except as provided in subsection (h) of this Code section.

(e) Candidates and campaign committees shall designate on their disclosure reports the election for which a contribution has been accepted. Any contribution not so designated shall be presumed to have been accepted for the election on or first following the date of the contribution.

(f) A contribution by a partnership shall be deemed to have been made pro rata by the partners as individuals for purposes of this Code section, as well as by the partnership in toto unless the partnership by proper action under its partnership agreement otherwise directs allocation of the contribution among the partners. At such direction of the partnership, the contribution may be allocated in any proportion among the partners, including to one or some but not all. Such allocation shall be indicated on the face of any instrument constituting the contribution or on an accompanying document referencing such instrument.

(g) The contribution limitations established by this Code section shall not apply to a loan or other contribution made to a campaign committee or candidate by the candidate or a member of the family of the candidate.

(h) Any candidate or campaign committee who incurs loans on or after January 9, 2006, in connection with the candidate's campaign for election shall not repay, directly or indirectly, such loans from any contributions made to such candidate or any authorized committee of such candidate after the date of the election for which the loan was made to the extent that such loans exceed $250,000.00.

(i) The contribution limits established by this Code section shall not apply to a bona fide loan made to a candidate or campaign committee by a state or federally chartered financial institution or a depository institution whose deposits are insured by the Federal Deposit Insurance Corporation if:

(1) Such loan is made in the normal course of business with the expectation on the part of all parties that such loan shall be repaid; and

(2) Such loan is based on the credit worthiness of the candidate and the candidate is personally liable for the repayment of the loan.

(j) The contribution limitations provided for in this Code section shall not include contributions or expenditures made by a political party in support of a party ticket or a group of named candidates.

(k) At the end of the election cycle applicable to each public office as to which campaign contributions are limited by this Code section and every four years for all other elections to which this Code section is applicable, the contribution limitations in this Code section shall be raised or lowered in increments of $100.00 by regulation of the commission pursuant to a determination by the commission of inflation or deflation during such cycle or four-year period,

as determined by the Consumer Price Index published by the Bureau of Labor Statistics of the United States Department of Labor, and such limitations shall apply until next revised by the commission. The commission shall adopt rules and regulations for the implementation of this subsection.

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. In addition, the prohibitions discussed in Section 2 of this Manual entitled "Payments, Discounts, and Gifts," apply to purchasing decisions made on behalf of the Hospital. 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.

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 that it is aware of and will comply with the Hospital's Compliance Program Policy Manual. Should any independent contractor and/or vendor refuse to sign the Certification and Agreement of Compliance attached hereto as Exhibit "A", then and in such event, the independent contractor and/or vendor shall provide the Compliance Officer with a written statement which certifies that said independent contractor and/or vendor has a valid compliance plan, that said independent contractor and/or vendor complies with its Plan, and based on its compliance with its plan, refuses to execute the Certification attached hereto. 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, or a professional staff member 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 Chief Executive Officer, 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 of Upson County Hospital, Inc. do hereby certify that I have examined the above and foregoing Code of Conduct, Standards of Practice and Legal Compliance Program book including the Compliance Policy Manual and that each of them are in a language in which I am proficient and their 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

_____

Universal ID (e.g., 3-4 UID or Social Security Number)

_____

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 **Ambulatory Payment Classification (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 **National Correct Coding Initiative (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.