

COLQUITT REGIONAL MEDICAL CENTER

POLICY MANUAL

Dept: ADMINISTRATION

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Subject: COMPLIANCE PROGRAM POLICIES

1. POLICIES AND PROCEDURES

1.A STANDARDS OF CONDUCT

1.A.1 Commitment of Hospital Authority and Upper Management

The Hospital Authority of Colquitt County (the “Authority”) is committed to conducting the operations of Colquitt Regional Medical Center (the “Hospital”) and all its affiliated providers in compliance with all federal, state, and local statutes, regulations, guidelines and policies. In some circumstances the interpretation and application of such statutes, regulations, guidelines, and policies is highly technical in nature, and the common concepts of right and wrong lend little guidance. Therefore, employees, physicians, agents, and independent contractors who believe they are acting within the boundaries of compliance may, in fact, be in violation. Such violations may put the Authority at risk of significant penalties, sanctions, and public embarrassment.

To avoid violations of applicable statutes, regulations, guidelines and policies, the Authority has adopted this Corporate Compliance Program and directed administration to implement, monitor and report on the program. This was authorized on April 26, 1999. Effective January 1, 2006, Jessica Jordan, Internal Auditor, was named Compliance Officer. She may be reached at **229-891-9455**. Additionally, the Hospital utilizes a Compliance Committee with the structure and duties as set forth herein.

This compliance plan represents the Authority’s continued commitment to quality and performance and should not be construed as concern that present management systems are inadequate. It applies to all applicable employees, physicians, agents, and contractors with regard to compliance with all federal, state and local statutes, regulations, guidelines and policies, and applies to the Hospital and all its affiliated providers, including Colquitt Regional Health, Inc. (“CRH”), Colquitt Regional Medical, Inc. (“CRM”), Colquitt Regional Medical Foundation, Inc., and Colquitt Regional Senior Home Care (“Foundation”; CRH, CRM, Foundation, and Senior Home Care collectively, “Affiliates”).

1.A.2 Commitment to Comply

The Hospital and its Affiliates will attempt to comply with all applicable statutes, regulations, guidelines, and policies with a special emphasis on the detection and prevention of fraud and abuse.

1.A.3 Values

The Medical Center and all its affiliated providers are committed to compliance with all applicable federal, state, and local statutes, regulations, guidelines and policies.

1.A.4 Expectations For All Hospital Officials, Staff, Physicians, Contractors and Other Agents

Hospital Authority Board of Trustees and Affiliated Board Members

The Hospital Authority Board of Trustees provides governance for the Hospital. A separate board of directors exists for CRH, CRM and the Foundation.

The Hospital.

All trustees and board members are required to sign conflict of interest statements and required to disclose any potential conflict of interest. Authority members will receive routine reports on compliance activities by the compliance officer and have full expectation that the Hospital and its Affiliates will operate in compliance with applicable statutes, regulations, guidelines and policies.

Hospital Management

On April 26, 1999, the Authority authorized the implementation of a corporate compliance program. Management has the task of implementation and monitoring and is expected to take all steps necessary to ensure compliance with all federal, state and local statutes, regulations, guidelines and policies. Management is expected to provide routine reports on compliance activities to the Authority. Managers and supervisors are expected to adequately instruct their subordinates and to detect noncompliance with applicable policies and legal requirements. Managers and supervisors may be disciplined for compliance violations or for failure to detect a violation that could have been detected with reasonable diligence on the part of the manager or supervisor, in accordance with the Hospital's Personnel Policies. Such discipline may include suspension or termination. In the event of a violation of law, upon consultation with the Hospital's attorney, the manager or supervisor may be reported to the appropriate authority.

Medical Staff Members

Physicians having privileges at the Hospital will be kept informed of compliance activities and are expected to comply, in all dealings with the Hospital or its Affiliates, with all applicable federal, state, and local statutes, regulations, guidelines and policies. Physicians are expected to provide appropriate and timely documentation of all services provided, including diagnosis and procedures, and to document the medical necessity. Physicians are expected to adhere to the Medical Staff Bylaws, Rules and Regulations. The Hospital will take all appropriate steps to ascertain a physician's standing at the time of initial appointment to the medical staff including, but not limited to, reference checks and utilization of the National Practitioners Data Bank. Physicians found to be out of compliance will be disciplined in accordance with the Medical Staff Bylaws, Rules and Regulations. Discipline may include sanctions and revocation of privileges.

Hospital Based Physicians

The Hospital and its affiliates may contract with certain physicians in specific specialties to provide services. No person or entity will provide financial incentives in exchange for patient referrals and all contracts will be reviewed with the Hospital's attorneys to ensure compliance with all federal, state, and local statutes, regulations, guidelines and policies. Such review will include review for potential violation of applicable anti-kickback rules, physician self-referral rules and associated safe-harbor regulations. All contracts will be kept on file and will be routinely reviewed and updated for any changes necessitated by changes in statutes, regulations, guidelines and policies.

Employees of the Hospital and its Affiliates

All employees are expected to be knowledgeable of the Hospital's compliance program and to be knowledgeable of applicable policies and legal requirements pertaining to their job. All employees are required to attend initial and all follow-up training regarding the compliance program.

Employees who suspect a violation have the responsibility of reporting their suspicion to the compliance officer or compliance committee, and may do so anonymously. Reporting may be through Meditech or internet e-mail to the compliance officer, written document, telephone call to the compliance officer, or telephone call to the compliance hotline at 1-866-370-5993.

Employees who are found to be in noncompliance may be disciplined in accordance with the Hospital's Personnel Policies. Such discipline may include suspension or termination. In the event of a violation of law, upon consultation with the Hospital's attorney, the employee may be reported to the appropriate authority.

Contractors and Other Agents

Any contractor or agent, dealing with or acting on behalf of the Hospital, is expected to be knowledgeable of the Hospital's compliance program. The Hospital's attorney will review all contracts to ensure compliance with all federal, state, and local statutes, regulations, guidelines and policies. Contractors and agents are expected to be knowledgeable of applicable policies and legal requirements. A contractor or agent found to be in noncompliance may be sanctioned and their contract terminated. Discovery of a violation of law, upon consultation with the Hospital's attorney, may result in the contractor or agent being reported to the appropriate authority.

340 B Drug Program Participation

Participation in the HRSA 340B drug program through the in-house pharmacy or through an outside pharmacy with which we contract includes overall compliance with Colquitt Regional Medical Center's Compliance Program Policies as well as compliance with 340 B Program policies and procedures developed specifically for the 340B Program. The Compliance Officer and Compliance Committee will monitor the 340 B activities as defined by the requirements of the program. The 340B Program Manager will monitor the Program and maintain records to support compliance. (See 340B Policy and Procedure Guidelines)

1.A.5 Distribution

These Standards of Conduct will be distributed to all trustees, management, staff, medical staff, contractors and other agents, when appropriate.

1.A.6 Understanding the Standards of Conduct

Any trustee, manager, supervisor, staff member, medical staff member, contractor or agent who is unable to understand these Standards of Conduct may contact the compliance officer or the compliance committee to receive explanation or clarification. If a copy is required in other languages, the Hospital will make one available.

1.A.7 Updating Standard of Conduct

The Standards of Conduct will be updated regularly when applicable statutes, regulations, and government healthcare program requirements are modified.

1.B RISK AREAS

The Hospital and its Affiliates will ensure that written policies and procedures are developed and maintained in the appropriate departments that specifically address limiting exposure in each of the risk areas related to the Hospital and its Affiliates' areas of operation as identified through periodic risk analyses, in the annual OIG Work Plan, and otherwise.

1.C CLAIM DEVELOPMENT AND SUBMISSION

1.C.1 Proper and Timely Documentation

Prior to claim submission, proper and timely documentation supporting all physician and professional services rendered will be provided to ensure that only accurate and properly documented services are billed.

1.C.2 Maintenance of Documentation for Audit and Review

Claims will be submitted only when appropriate documentation supports the claim and only when such documentation is maintained and available for audit and review. Such documentation will include the length of time spent in conducting the activity and the individual providing the service.

1.C.3 Organized and Legible

Consistent with appropriate guidance from the medical staff, physician and hospital records and medical notes used

as a basis for claim submission will be appropriately organized in a legible form so they can be audited and reviewed.

1.C.4 Based on Medical Record and Other Documentation

The diagnosis and procedures reported on the reimbursement claim will be based on the medical record and other documentation as is necessary for accurate code assignment.

1.C.5 Compensation for Coders and Billing Consultants

Compensation for coders and billing consultants will not provide any financial incentive to improperly upcode or otherwise falsify any claims.

1.C.6 Additional Guidance

The Hospital will review all new guidance as issued pertaining to submission of claims for services as well as monitor policies already in place. Policies and procedures will be updated as necessary. The Hospital will submit claims only when in compliance with all applicable laws, rules, regulations, and payor policies and procedures including, but not limited to, the following requirements as applicable:

- Outpatient services rendered in connection with an inpatient stay (3-day rule);
- Submission of claims for laboratory service;
- Physician issues related to teaching and graduate medical education programs;
- Cost reports;
- Medical necessity & reasonable and necessary services;
- Anti-kickback and self-referral compliance, including all relationships with referral sources;
- Bad debts;
- Credit balances;
- Retention of records
- Privacy.
- 340 B Drug Discount Program Requirements
- Nursing Home Regulations

1.D PHYSICIAN, REFERRAL SOURCE AND CONTRACTOR RELATIONSHIPS

The Hospital is committed to complying with all laws that prohibit illegal remuneration, such as kickbacks, bribes, improper or excessive payments, free or below market rents or fees for administrative services, or interest-free loans. Hospital personnel are prohibited from offering, providing, accepting or asking for anything of value with the intent to influence or be influenced by patients, their families, suppliers, contractors, vendors, physicians, third party payors, managed care organizations or government officials. Hospital personnel may not offer, provide, accept, or ask for anything of value for the referral of individuals for services covered by Medicare, Medicaid, or other federal health care programs. Hospital personnel are also prohibited from accepting or requesting payment for the purchase or lease of any good, item, or service covered under any federal or state health care program.

The federal Stark physician self-referral law generally prohibits a physician from referring a Medicare or Medicaid patient to an entity for certain “Designated health services” if the physician (or an immediate family member) has a financial relationship with the entity providing the “designated health services” unless certain limited exceptions apply. In addition, Georgia has similar self-referral prohibitions. To ensure compliance with these self-referral prohibitions, all financial relationships between the Hospital, or its Affiliates, and a physician, or his or her family members, must be reviewed and approved by the Hospital’s attorney. The Hospital and its Affiliates do not pay physicians, or anyone else, either directly or indirectly for patient referrals. The decision to refer patients is a separate and independent clinical decisions made by the referring physician.

1.E COMPLIANCE AS AN ELEMENT OF A PERFORMANCE PLAN

Promotion and adherence to the elements of the compliance program are or will be a factor in evaluating the performance of managers and supervisors. Managers and Supervisors involved in the coding of claims and in cost

report preparation will:

- Discuss with all employees supervised, the compliance policies and legal requirements applicable to their functions, and;
- Inform all supervised employees that strict compliance with these policies and requirements is a condition of employment, and;
- Disclose to all employees supervised that the hospital will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

Managers and Supervisors will be sanctioned for failure to adequately instruct their subordinates or for failure to detect noncompliance with applicable policies and legal requirements, where any reasonable diligence on the part of the manager or supervisor would have led to the discovery of any problems or violations and given the hospital the opportunity to correct them earlier.

2. DESIGNATION OF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

2.A COMPLIANCE OFFICER

2.A.1 The Authority has designated the following individual as Compliance

Officer: Jessica Jordan
Internal Auditor
229-891-9455

2.A.2 The Compliance Officer will have direct access to the Authority Trustees and to the Hospital's Chief Executive Officer. The Compliance Officer will report to the Finance Committee of the Authority.

2.A.3 The Authority will ensure that the Compliance Officer has sufficient funding to carry out her responsibilities fully.

2.A.4 The Compliance Officer's primary responsibilities will include:

- Overseeing and monitoring the implementation of the compliance plan.
- Reporting on a regular basis to the Authority, the Chief Executive Officer of the Hospital and the Compliance Committee on the progress of implementation, assisting these components in establishing methods to improve the hospital's efficiency and quality of services, and reducing the Hospital's vulnerability to fraud, abuse and waste.
- Periodically revise the program in light of changes in the needs of the organization, and in the law and policies and procedures of government and private payer health plans.
- Develop, coordinate, and participate in a multifaceted education and training program that focuses on the elements of the compliance program and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards.
- Ensure that independent contractors and agents who furnish medical services to the hospital are aware of the requirements of the hospital's compliance program with respect to coding, billing, and marketing, among other things.
- Coordinate personnel issues with the Human Resource department to ensure that the National Practitioner Data Bank and Cumulative Sanction Reports have been checked with respect to all employees, medical staff, and independent contractors.
- Assist the Hospital's financial services in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments. Independently investigate and act on matters related to compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with all Hospital departments, providers, sub-providers, agents and, if appropriate, independent contractors.
- Develop policies and procedures that encourage managers and employees to report

suspected fraud and other improprieties without fear of retaliation.

2.A.5 The Compliance Officer has full and complete access to the following in relation to compliance activities:

- Patient records.
- Billing records.
- Records concerning the marketing efforts of the facility.
- Contracts and arrangements with other parties, including professionals on staff, independent contractors, suppliers, agents, and hospital-based physicians.
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2.B COMPLIANCE COMMITTEE

2.B.1 The Compliance Committee currently consists of the following:

- Compliance Officer
- Representative from Patient Services
- Representative from Professional Services
- Representative from Home Care Services
- Representative from Patient Financial Services
- Representative from Accounting
- Representative from Information Services
- Representative from Performance Improvement/JACHO
- Representative from Clinic Services
- Representative from Skilled Nursing Services
- Hospital Attorney and CEO will attend as required

Other persons may be added as necessary.

2.B.2 The Compliance Committee's functions include:

- Analyzing the organizations industry environment, the legal requirements with which it must comply, and specific risk areas.
- Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program.
- Working with appropriate Hospital departments to develop standards of conduct and policies and procedures to promote compliance with the institution's program.
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems, policies, and procedures as part of its daily operations.
- Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud-reporting mechanisms.
- Developing a system to solicit, evaluate, and respond to complaints and problems.

3 EFFECTIVE TRAINING AND EDUCATION

3.A The compliance program requires all affected employees, physicians, independent contractors, and other significant agents to complete specific training on a periodic basis. Such training should include, but not limited to, highlights of the Compliance Program, summaries of applicable laws, rules and regulations, department specific coding requirements, claim development and processes, and marketing processes.

3.B Primary training to appropriate corporate officers, managers, and other hospital staff will be conducted on, but not limited to, the following topics:

- Government and private payer reimbursement principles

- General prohibitions on paying or receiving remuneration to induce referrals
- Proper confirmation of diagnoses
- Submission of a claim for physician services when rendered by a non-physician
- Signing a form for a physician without the physician's authorization
- Alterations to the medical record
- Prescribing medications and procedures without proper authorization
- Proper documentation of services rendered
- Duty to report misconduct
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3.C Attendance and participation in training programs is mandatory and is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action in accordance with Personnel Policies. Adherence to the training requirements in the compliance program will be a factor in the annual evaluation of each employee.

4 EFFECTIVE LINES OF COMMUNICATION

4.A ACCESS TO THE COMPLIANCE OFFICER

4.A.1 Written confidentiality and non-retaliation policies are in effect and distributed to all employees to encourage communication and the reporting of incidents of potential fraud.

4.A.2 Employees may report fraud, waste, or abuse through Meditech e-mail, Internet e-mail, written correspondence, or telephone call either directly or through use of the toll-free hotline, to the compliance officer or the compliance committee.

4.A.3 Employees can obtain clarification from the compliance officer or members of the compliance committee to resolve any confusion or answer questions about a Hospital policy.

4.A.4 Questions and responses will be documented and dated and, if appropriate, shared with other staff so that standards, policies, and procedures can be updated and improved to reflect any necessary changes or clarification.

4.B HOTLINES AND OTHER FORMS OF COMMUNICATION

4.B.1 The hospital has established a compliance hotline and employees and independent contractors are given the telephone number. The telephone number is 1-866-370-5993 and will be posted in common work areas.

4.B.2 Employees may report matters anonymously.

4.B.3 Matters suggesting compliance violations that are reported through the hotline or other reporting mechanisms will be documented and investigated promptly to determine their veracity, and the outcome of any investigation will be reported back to the individual if possible.

4.B.4 The compliance officer will maintain a log of reported matters, including the nature of any investigation and its results.

4.B.5 Information contained in the log will be included in reports to the Authority, the CEO, and the compliance committee.

4.B.6 While the Hospital will always strive to maintain an individual's confidentiality, there may be a point when the individual's identity may become known or may have to be revealed.

4.B.7 Exit interviews are conducted with departing employees. Efforts are made to follow-up on issues that surface during the exit interview. Attempts to contact the departing employee will be made to relay the outcome of the follow-up.

5 ENFORCEMENT OF STANDARDS

5.A DISCIPLINE POLICY AND ACTIONS

- 5.A.1** Failure to comply with the compliance program's standard and policies and applicable statutes and regulations may result in progressive disciplinary action in accordance with the Personnel Policies. Such action may include termination. In some cases that involve the violation of a law, upon review with the Hospital's attorney, the employee in violation may be reported to the appropriate authorities.
- 5.A.2** The compliance officer and compliance committee are responsible, in conjunction with the employee's supervisor, for taking appropriate disciplinary action.
- 5.A.3** Consequences for non-compliance will be consistently applied and enforced for all levels of employees.

5.B NEW EMPLOYEES

- 5.B.1** A reasonable and prudent background investigation, including a reference check according to Personnel Policy, will be conducted on all new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight.
- 5.B.2** Hospital policy prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in federal healthcare programs.
- 5.B.3** The Hospital has the right to terminate employment or other contractual arrangement with an individual or contractor who becomes convicted, debarred, or excluded during the course of employment.
- 5.B.4** In accordance with Hospital policy and Medical Staff Bylaws and Rules and Regulations, the credentials of individuals with whom the Hospital contracts will be checked, including physicians with privileges, vendors, nursing staff agencies, and others doing business with the Hospital.
- 5.B.5** Accountants responsible for completion and submission of the Medicare Cost Report will make every effort to ensure that any debarred or excluded employee or contractor is not listed on the hospital's cost report.

6 AUDITING AND MONITORING

- 6.A** Regular, periodic compliance audits will be conducted by internal or external sources.
- 6.B** These audits will focus on the areas determined to be at risk through internal risk assessments, analysis of new legislation, the OIG Work Plan or otherwise. Such risk areas may include, but not be limited to, the following:
- The hospital's programs or divisions, including external relationships with third-party contractors
 - Laws governing kickback arrangements
 - Physician self-referral prohibition
 - CPT/HCPCS ICD coding
 - Claim development and submission
 - Reimbursement
 - Cost reporting
 - Marketing practices
 - Areas highlighted specifically by OIG Special Fraud Alerts, OIG audits and evaluations, and law enforcement initiatives
 - Areas of concern identified by any entity, i.e. federal, state, or internally, specific to the hospital and its affiliates

6.C The Hospital will review annually whether the program's elements have been satisfied. The compliance committee will address program deficiencies identified in the annual review. Such review may include, but shall not be limited to, the following:

- On-site visits
- Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities
- Questionnaires to solicit impressions from a broad cross-section of employees and staff
- Review of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports
- Review of written materials and documentation prepared by the different divisions of the hospital
- Trend analyses, or other studies, that seek deviations, positive or negative, in specific areas over a given period

6.D Written evaluation reports on compliance activities will be made to the CEO, the Hospital Authority Board of Trustees, and members of the compliance committee on a regular basis. Reports will include and specifically identify areas where corrective actions are needed.

6.E The hospital will document its efforts to comply with applicable statutes, regulations, and federal healthcare program requirements.

7 RESPONDING TO DETECTED OFFENSES AND CORRECTIVE ACTION INITIATIVES

7.A VIOLATIONS AND INVESTIGATIONS

7.A.1 Upon reports or reasonable indication of suspected non-compliance, the compliance officer and/or other management officials will initiate prompt steps to investigate the conduct in question.

7.A.2 Should the investigation determine that a violation has occurred, prompt steps will be taken to correct the problem.

7.A.3 Records of the investigation will contain the following documentation:

- On-site visits
- Description of the alleged violation;
- Description of the investigation process;
- Copies of interview notes and key documents;
- A log of the witnesses interviewed and the documents reviewed;
- The results of the investigation and disciplinary action taken;
- Corrective action implemented;

7.A.4 The compliance officer will take all appropriate steps necessary to secure or prevent the destruction of documents or other evidence relevant to the investigation.

7.B REPORTING

7.B.1 If credible evidence of misconduct that may violate criminal, civil, or administrative law is discovered and verified, the Hospital will, upon review with its legal counsel, promptly report the existence of the misconduct to the appropriate governmental authority no more than 60 days after the verification.

7.B.2 When reporting misconduct to the government, the Hospital will provide all evidence relevant to the alleged violation and the potential cost impact.