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OVERVIEW OF THE COMPLIANCE PROGRAM

1. **Policy -** It is the policy of Lane Regional Medical Center to provide services in compliance with all state and federal laws governing its operations, and consistent with the highest standards of business and professional ethics. This policy is a solemn commitment to our patients, to our community, to those government agencies that regulate the Hospital, and to ourselves. In order to ensure that the Hospital's compliance policies are consistently applied, the Hospital has established a legal and regulatory Compliance Program.

   a. All Hospital Directors, Officers, Managers, professional staff and employees, must carry out their duties for the Hospital in accordance with this policy. Any violation of applicable law, or deviation from appropriate ethical standards, will subject the employee or independent profession to disciplinary action. 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 improper actions, or is aware of those actions but does not act appropriately to correct them; or who otherwise fails to exercise appropriate supervision.

   b. This manual includes statements of the Hospital's policy 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.

2. **Structure of the Compliance Program** - The Compliance Program is designed to promote an awareness of compliance at every level of Hospital operation. Accordingly, the Hospital has implemented a structured program to effectuate this policy which is comprised of the following offices and committees:

   a. **Compliance Officer**. The Controller of the Hospital shall act as the Compliance Officer and is charged with the day-to-day administration of the Compliance Program including:

      I. Initiating and/or overseeing compliance investigations;

      II. Supervising compliance audits and updates;

      III. Generating compliance reports including:

      -Quarterly report to the Chief Executive Officer of the Hospital and the Chair of the Board Compliance Committee.

      -Compliance Investigation Reports to the Hospital Compliance Committee (See Sec. 6, No. 5. (a)).

      -Reports to the Chair or Vice Chair of the Board Compliance Committee of serious compliance violations or significant events. (See Sec. 6, No. 5. (b)).

      IV. Oversee compliance training and education efforts.

   b. **Hospital Compliance Committee**. The Hospital Compliance Committee shall be charged with assisting the Compliance Officer with ongoing Compliance efforts. Committee members should include representatives of various hospital departments.

c. **Board Compliance Committee**. The Board Compliance Committee shall consist of Board members who shall meet on a quarterly basis to review the compliance program. The Board Compliance Committee will receive quarterly reports from the Compliance Committee or Compliance Officer. The Board Compliance Committee shall also receive reports directly from the Compliance Officer involving serious compliance violations involving Hospital Administrators or Officers.

d. **Chairperson of the Board Compliance Committee**. The Chairperson of the Board Compliance Committee shall preside over the Board Compliance Committee meetings and shall report directly to the Board of Directors relative to ongoing compliance efforts and any significant compliance violations.

e. **Interim Compliance Officer**. In the event the Compliance Officer is absent or otherwise unavailable, the Chief Financial Officer (CFO) shall act as the Interim Compliance Officer and empowered with the powers, privileges, duties and responsibilities of the Compliance Officer until such time as the Compliance Officer is able to resume his or her duties, or another Compliance Officer is appointed.

CODE OF CONDUCT

1. **Corporate Commitment to Compliance**- Lane Regional Medical Center has adopted a Compliance Program to ensure that it operates in full compliance with all applicable laws governing the delivery of health care. Compliance with the law, including state, federal and local laws means not only following the law, but conducting business in such a manner that Lane Regional Medical Center will deserve recognition as a good corporate citizen. The Board of Directors adopted this plan on October 16, 2000, and in doing so, acknowledged by its adoption that compliance is an attitude which must be adhered to by all directors, officers, employees and agents of Lane Regional Medical Center.

2. **Individual Commitment to Compliance-** The success of Lane Regional Medical Center's commitment to compliance depends on each individual's willingness to comply with Lane Regional Medical Center's compliance policies. It is not expected that every employee, or every member of management, will be fully versed concerning the details of every aspect of law which governs our corporate existence. It is expected however, that every employee with significant responsibilities will have a working knowledge of permissible and prohibited activities involved in his or her work responsibilities and will seek guidance from a supervisor or the Compliance Officer before acting on any matter for which there is any question.

3. **Scope of Compliance Plan Code of Conduct-** The Hospital Compliance Plan adopted by Lane Regional Medical Center sets out the basic principles which all of the Hospital, and Hospital subsidiaries, directors, officers, and employees must follow. This Code applies to all business operations and personnel, and any agents, advisors and consultants acting on behalf of Lane Regional Medical Center.

4. **Standards of Conduct**-

a. Lane Regional Medical Center adheres to the fundamental principle that the Hospital will operate its business in full compliance with applicable laws and conduct its business in conformance with sound ethical standards. All personnel shall act in compliance with the requirements of applicable law and this Code and in a sound ethical manner when conducting business and operations.

b. In the spirit of Lane Regional Medical Center's zero tolerance for illegal, improper, or unethical behavior, disciplinary measures (as defined in section 4) will apply to any Hospital personnel regarding any clear infraction of applicable laws or of recognized ethical business standards. Moreover, the appropriate disciplinary measures may also apply to any supervisor or employee who fails to carry out his or her management responsibility to

assure that employees under his or her supervision are adequately informed about Lane Regional Medical Center's policy on legal and ethical conduct.

c. Lane Regional Medical Center shall maintain a copy of the Hospital Compliance Plan and ensure that a copy of same is made accessible to all personnel by posting in Meditech Library under Administration policies and procedures section.

d. Lane Regional Medical Center shall take reasonable steps to communicate any detailed or specific policies covering particular business units or subject matter to personnel who are particularly affected by and who must comply with such policies in the course the Hospital's business. Such policies shall be maintained in an orderly fashion to allow personnel within the Hospital's different units or departments to access this information.

e. Each supervisor or manager is responsible for ensuring that the personnel within their supervision are acting ethically and in compliance with applicable law and this Code, which is to be made available by placement in Meditech Library to all personnel. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties and for appropriately seeking advice regarding such regarding such issues.

f. Personnel shall not offer or give any bribe, payment, gift, or thing of value to any person or entity with whom the Hospital is seeking any business or regulatory relationship except for gifts of nominal value which are legal and given in the ordinary course of business.

g. Personnel shall not directly or indirectly authorize, pay, promise, deliver, or solicit any payment, gratuity, or favor for the purpose of influencing any political official or governmental employee in the discharge of that person's responsibilities.

h. Personnel shall not accept any bribe, payment, gift, item or thing of more than nominal value (in accordance with Section 20 of the Corporate Compliance Plan) from a person or entity with which the Hospital has or is seeking any business or regulatory relationship. Personnel must promptly report the offering or receipt of gifts above a nominal value to their supervisor.

i. Personnel shall be completely honest in all dealings with government agencies and representatives. No misrepresentations shall be made and no false bills or other requests for payment or other documents shall be submitted to government agencies or representatives. Personnel certifying the correctness of records submitted government agencies, including bills or requests for payment, shall have knowledge that the information is accurate and complete before giving such certification.

j. All of the Hospital's business transactions shall be carried out in accordance with management's general or specific directives. All of the books and records shall be kept in accordance with generally accepted accounting standards or other applicable standards. All transactions, payments, receipts, accounts and assets shall be completely and accurately recorded on the Hospital's books and records on a consistent basis. No payment shall be approved or made with the intention or understanding that it will be used for any other purpose other than that described in the supporting documentation for the payment. All information recorded and submitted to other persons must not be used to mislead those who receive the information or to conceal anything that is improper.

k. All personnel shall maintain the confidentiality of Hospital and patient records in accordance with the applicable state, federal, and local laws pertaining to the protection of such confidential materials. Personnel shall not use any such confidential or proprietary information except as is appropriate or necessary for

the carrying on of business. Personnel shall not seek to improperly obtain or to misuse confidential information or to distribute such information to non-authorized third parties.

EMPLOYEE SCREENING

1. **Purpose.** Lane Regional Medical Center recognizes the importance of implementing a program designed to identify and eliminate risks associated with employment of individuals who have a propensity to engage in illegal activities or who pose a substantial risk to the well-being of the hospital's patients or employees. Accordingly, Lane Regional Medical Center shall exercise due diligence to prevent and detect violations in the law and shall seek to prevent and detect criminal conduct by its employees or agents. Lane Regional Medical Center shall make a reasonable inquiry into the prior conduct and sanctions imposed on any potential employee, agent, or contractor, and recognize that a comprehensive background verification process helps ensure that the hospital's hiring and internal promotion decisions are made with the most reliable information available.

2. **Approach**. Lane Regional Medical Center seeks only information that is factual, objective and job-related. Investigations should be conducted in a non-discriminatory manner and shall avoid invading a candidate or employee's privacy.

3. **Consent**. The candidate or employee is to be advised in writing that a background verification check will be conducted and sign a release in accordance with the directives of the Fair Credit Reporting Act of 1996, this contains the following information:

Full name
Date of birth
Other names used, such as aliases or maiden name
Social Security Number
Current address
Addresses for the past 10 years
Professional license(s) or certification(s) and state issued numbers
Driver's license number and state of issue
Signature

4. The **candidate shall answer in writing the following questions:**

Have you ever been convicted of a crime other than a minor traffic violation?
Yes/No
Have you ever been sanctioned, suspended, or barred from Medicare/Medicaid?
Yes/No
Have you ever had a professional license denied, suspended, or revoked?
Yes/No
Have you ever been suspended or debarred from doing business with any government or government agency or participating in any government program?
Yes/No

5. **Background Verification**.

State and Federal statutes provide grounds for denial or revocation of enrollment in the medical assistance programs to a health care provider if any of the following are found to be applicable to the health care provider,

his agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the healthcare provider.

Previous or current exclusion, suspension, termination from, or the involuntary withdrawing from participation in, the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

Conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

Conviction under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

Conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

Conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involves moral turpitude, or acts against the elderly, children, or infirmed.

Conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense above.

Sanction pursuant to a violation of federal or state laws or rules relative to the medical assistance programs, any other state's Medicaid program, Medicare, or any other public health care or health insurance program.

6. **Excluded Individuals**. The background verification process shall include a review of the OIG Cumulative Sanction Report and the General Service Administration's list of debarred contractors which can be accessed via the internet at the following addresses:

OIG Cumulative Sanction Report:
www.dhhs.gov/proorg/oig/cumsan/index.htm

General Service Administration List of Debarred Contractors:
www.arnet.gov/epls

If the individuals or candidates are listed in one or both of the above reports, that individual may not be

(1) employed by Lane Regional Medical Center or its affiliates,
(2) may not contract with Lane Regional Medical Center; and
(3) may not have an ownership in interest in Lane Regional Medical Center.

7. **Termination.** If any director, officer, manager, or employee charged with a health care offense is convicted, pleads guilty, or enters a plea which does not contest the allegations of a health care offense such director, officer, manager, or employee will be terminated.

EMPLOYEE DISCIPLINE

1. **Purpose.** Lane Regional Medical Center recognizes that an effective compliance program include a written policy statement regarding disciplinary action that may be imposed upon corporate officers, managers, employees, physicians and other health care professionals for failing to comply with the hospital's compliance standards and policies and applicable statutes and regulations.

2. **Policy**. Lane Regional Medical Center shall take disciplinary action against individuals who have failed to comply with the hospital's compliance policies, or any applicable statutes and regulations. Such action, shall, if possible, be uniformly applied; however, the hospital recognizes that the specific facts or conduct involved should be taken into account in determining the appropriate disciplinary action to be taken.

3. **Disciplinary Action.** Disciplinary measures may include the following:

a. oral warnings
b. written warnings which are to be maintained in the employee's permanent file
c. transfers
d. demotion
e. reduction in pay
f. suspension
g. suspension without pay
h. termination
i. institution of legal actions against the responsible employee and/or advising the appropriate authorities of the conduct involved.

4. **Factors To Be Considered**. Some the factors the hospital may consider in determining how to institute discipline will include the following:

a. whether the conduct is a crime
b. whether the crime is a misdemeanor or felony
c. whether the conduct is ethical even if not illegal
d. the knowledge and intent of the employee
e. whether there were any victims of the conduct
f. the amount of money involved
g. the length of the individual's employment
h. the employee's prior track record for compliance
i. the attitude and acceptance of responsibility by the employee
j. whether the employee is senior management or not
k. the nature of the conduct
l. any other relevant circumstances

5. **Failure to Report Non-compliance**. Disciplinary action may be taken against employees who deliberately fail to report compliance violations.

6. **Discipline of Supervisors**. Disciplinary action may also be taken against an employee's supervisor if said supervisor's conduct demonstrated a lack of leadership or lack of diligence with regard to compliance policies or issues, and has resulted in non-compliance within his or her department.

TRAINING AND EDUCATION

1. **Policy**. The proper education and training of corporate officers, managers and employees, physicians and other health care professionals is vital to the continued effectiveness of the Lane Regional Medical Center Compliance Program. Accordingly, Lane Regional Medical Center shall implement a training and education program that will ensure that corporate officers, managers and employees, physicians and other health care professionals are knowledgeable of the applicable statutes, rules and regulations affecting the hospital in the delivery of health care.

2. **Employee Training**. To ensure that employees are familiar with the Compliance Plan, there will be ongoing training and education regarding the Compliance Plan. This training will emphasize Lane Regional Medical Center's commitment to compliance with all laws, regulations, and guidelines of federal and state agencies and will stress and reinforce the fact that strict compliance with the law and the Compliance Plan is a condition of employment. Employees will be informed the failure to comply may result in disciplinary action, including termination. Training of employees shall highlight those areas of non-compliance which have occurred in the past and those which have the greatest potential for occurring in the future.

3. **Board of Directors**. In furtherance of the Board's commitment to conduct the business and affairs of Lane Regional Medical Center in an ethical and moral manner, each member of the Board of Directors shall receive a copy of the Lane Regional Medical Center Compliance Plan and will have the opportunity to attend any compliance training or education program that is available to the corporate officers, managers, employees, physicians or other health care providers.

4. **Coordination of Training**. The Compliance Officer shall be responsible for coordinating the training efforts for the Compliance Program. The initial training for all employees shall include an initial seminar and explanation of this Compliance Plan and how the plan will work.

5. **Distribution of Compliance Plan**. The Compliance Plan shall be available to department managers, senior managers and all employees through the Meditech Library system. Additionally, an updated copy of the plan shall be maintained by the Compliance Officer and made available to all employees through Meditech. Prospective employees shall be given the opportunity to review a copy of the Compliance Plan and must certify that the plan was read as a condition of employment.

6. **Training Seminars**. In addition to the availability of the Compliance Plan, Lane Regional Medical Center shall, at least annually, hold seminars or educational meetings for managers, departmental heads, physicians or any other employees which are to be conducted by outside professionals, including attorneys, consultants, or accountants, to raise the level of awareness regarding compliance in the healthcare industry and the repercussions of non-compliance. Targeted training shall be provided to the managers and other employees whose actions affect the accuracy of the claims being submitted to Government and private payors (for example, employees involved in coding, billing, cost reporting and marketing processes). These seminars should highlight identified risk areas and should also include such topics as:

Government and private payor reimbursement principles
General prohibitions on paying or receiving remuneration to induce referrals (kickback issues)
Proper confirmation of diagnoses
Billing "incident to" services or supervision requirements
Proper documentation of visits and procedures
Duty to report misconduct

7. **Ongoing Compliance Developments.** The Compliance Officer, or his or her designee, will disseminate relevant bulletins, memoranda, and other pertinent materials from governmental and other agencies to the appropriate managers, supervisors or employees on an ongoing basis relating to current developments or changes in applicable statutes, rules, regulations or guidelines which are relevant to the hospital's compliance.

8. **Documentation.** The Compliance Officer shall maintain adequate documentation of training and education of employees, including attendance logs and material distributed at training sessions.

9. **Mandatory Attendance**. All personnel shall attend at least one compliance training or education session annually. The failure to attend may result in discipline, including termination when such failure is serious.

AUDITS AND COMPLIANCE MONITORING

1. **Policy.** Lane Regional Medical Center is committed to maintaining an effective Compliance Program and recognizes that critical components of an effective plan include ongoing evaluation and reporting with respect to the plan's implementation.

2. **Baseline Audit**. A baseline audit should be performed following the implementation of the Compliance Plan which is to be performed by an outside law firm, accounting firm, or consultant that is designed to ensure compliance the hospital's Compliance Plan and policies, and all applicable federal, state, and local laws, regulations, rules or guidelines. This audit is to provide the Compliance Officer with a set of "benchmarks" which will allow the Compliance Officer to judge the hospital's progress in reducing or eliminating potential areas of vulnerability. As part of the baseline audit and any subsequent compliance audits, the auditor should employ the following techniques:

On-site visits, interviews with personnel involved in management, operations, coding, claim development and submission, patient care and other related activities

Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports

Reviews of written materials and documentation prepared by the different divisions or departments of the hospital

Trend analyses that seek deviations, positive or negative, in specific areas over a given period of time (tracking and trending MS-DRG, CPT usage).

Review of results of any previous audits or investigations involving the hospital or its staff performed by any government agency, fiscal intermediary or carrier.

3. **Audit Report**. A formal audit report should be prepared and presented to the Compliance Officer and the Board of Directors to ensure that the hospital is aware of the audit results and can take whatever corrective action is necessary. The report should identify any potential risk areas and make recommendations for any corrective actions that are needed.

4. **Compliance Audits**. Periodic compliance audits are to be performed no less than once per year. The audits are performed internally by department managers and compliance officer in the following areas:

Hospital compliance with laws governing kickback arrangements
Physician self-referral prohibition
MS-DRG, CPT, HCPCS, APC, ICD-9 coding
Claim development and submission
Reimbursement
Cost Reporting and Marketing

Specific rules or regulations that have been the focus of fiscal intermediaries or carriers
Conduct which has been the focus of law enforcement initiatives
Significant deviations identified in review of utilization data for MS-DRG, CPT, and HCPCS codes

5. **Hotline Number**. To encourage reporting of compliance violations and prevent retribution against employees who report noncompliance, Lane Regional Medical Center will establish a mechanism by which it may receive anonymous reports of compliance violation or complaints. All complaints or reported violations will be taken seriously; accordingly, any employees who knowingly make false or frivolous complaints will be disciplined, including the possibility of termination.

a. The Compliance Officer, upon receipt of a complaint or reported violation shall conduct a preliminary investigation of the alleged noncompliance and prepare a report containing the documentation of the alleged violation, and a synopsis of initial steps taken by the Compliance Officer to determine whether or not the reported violation merits additional investigation. The preliminary report is to be presented in writing to the Compliance Committee within 72 hours. Matters that appear to involve serious compliance violations, regardless of the lack of any intentional behavior are to be investigated in accordance with the directives of the section entitled "Response and Corrective Action" and a report is to be made to the Chairperson of the Board Compliance Committee.

b. The hospital shall post notices in conspicuous places for employees to view regarding the existence of the procedures to report noncompliance.

RESPONSE AND CORRECTIVE ACTION

1. **Hospital Integrity**. Violations of the Hospital's Compliance Program, failures to comply with applicable federal or state law, and other types of misconduct threaten Lane Regional Medical Center's status as a reliable, honest and trustworthy provider capable of participating in federal and state health care programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation and legal status of the hospital. Consequently, upon reports or reasonable indications of suspected noncompliance, it is important that the proper steps be taken to ensure that the Compliance Officer or other management officials initiate steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred, and if so, take steps to correct the problem. Instances of noncompliance must be determined on a case-by-case basis. The existence, or amount, of a monetary loss to a health care program is not solely determinative of whether or not the conduct should be investigated and reported to governmental authorities.

2. **Compliance Officer's Duties**. The Compliance Officer shall be charged with initiating investigations into any reported conduct that appears to violate the terms of the Lane Regional Medical Center Compliance Plan. Within 72 hours of receiving a complaint or reported violation, the Compliance Officer is to issue a written report to the Compliance Committee. Such report is to be disseminated only to the members of the Compliance Committee and is not to be made available to any other individuals with the exception of the hospital's counsel.

The report shall include the following information, if available:

1. A copy of the complaint or reported violation received by the Compliance Officer

2. The date the complaint or report was received by the Compliance Officer

3. If available, the report should include copies of any documentation referred to in the complaint, including but not limited to billing claims, superbills, physician notes,

etc that pertain to the alleged violation or noncompliance

4. Names of witnesses interviewed

5. Any Notes or observations made by the Compliance Officer in the preliminary investigation

6. Analysis as to whether the noncompliance appears to have been intentional or unintentional and the basis of such analysis

7. Recommendation as to whether further investigation is warranted

3. **Compliance Investigation Initiation**. Upon completion of a preliminary investigation, the Compliance Officer, the Compliance Committee shall determine whether to proceed with a full investigation of the reported violation or noncompliance.

a. Upon the commencement of an investigation, if the Compliance Officer reasonably believes the integrity of the investigation undermined or at risk because of the presence of the employee(s) under investigation, the Compliance Officer may, after consulting and receiving approval from the Human Resources Director and Administrative Director, remove said employee(s) from their work activity until the investigation is complete. The Compliance Committee and the Chief Executive Officer must approve removal of employed physicians.

b. The Compliance Officer should make appropriate arrangements to prevent destruction of relevant documents. This activity may include, depending on the circumstances, confiscating the key of the alleged violator, changing the locks on the doors, changing the password on computers, locking crucial documents for safekeeping, and other necessary measures.

c. The Compliance Officer should make a recommendation to Administration to engage outside counsel, auditors or health care experts to assist in the investigation and upon approval by the Chief Executive Officer, retain such assistance. Records of the investigation should be maintained for at least six (6) years and should include documentation of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed and the documents reviewed. Finally, the records should contain the results of the investigation (i.e., disciplinary action taken, and the corrective action implemented).

4. **Investigation Tools.** The Compliance Officer shall have at his or her disposal, all necessary tools available to conduct a proper, prompt, and thorough investigation. Such tools shall include recommending and enlisting the aid of outside counsel (if approved by the Chief Executive Officer); access to necessary documents (including, but not limited to billing information, claims information, physician notes, superbills, nurses notes, etc.), access to pertinent hospital contracts, access to employees, and access to, or copies of, correspondence to and from intermediaries and carriers, and any other information or tools which aid the Compliance Officer in his or her investigation.

5. **Corrective Action**. Once a complaint or reported violation is made and a preliminary investigation evidences a violation or noncompliance, the Compliance Officer shall immediately take steps to ensure that no further violations or noncompliance occur. Any staff, employees, or independent contractors involved in the work activity shall be advised of the ongoing investigation (unless an internal or Government-led undercover operation is in effect) and shall be given immediate instructions to complete the work activity in a compliant manner. If the Compliance Officer or responsible supervisor is unable to provide such instructions, the work activity shall be suspended until the Compliance Officer, or his or her designee, can provide instructions as to the proper way to complete the work activity in question.

6. **Investigation Report**. Upon completion of the investigation, the Compliance Officer shall issue a report to the Compliance Committee, which reviews the allegations made, the findings and conclusions of the Compliance Officer, together with a recommendation for disciplinary action. If disciplinary action is recommended, the Compliance Officer, after acquiescence from the Compliance Committee, may institute such remedial and/or disciplinary action, and report on such action to the Board.

7. **Reporting Misconduct**. In determining whether to report misconduct to law enforcement or regulatory agencies, Lane Regional Medical Center shall consider several factors, including:

a. whether the hospital has reasonable grounds to believe the conduct violates criminal, civil or administrative law, in which case the conduct shall be reported to the appropriate authorities within (60) days of receipt of credible evidence of misconduct; receipt of credible evidence of misconduct;

b. whether the conduct is
(1) a clear violation of criminal law;
(2) has a significant adverse effect on the quality of care provided to program beneficiaries;
(3) indicates evidence of a systemic, failure to comply with applicable laws, the Compliance Plan, or other standards of conduct, they may warrant immediate notification and the hospital should seek the advice of outside counsel.

8. **Overpayments**. The hospital shall make reasonable efforts to identify overpayments it may have improperly received from intermediaries or carriers and should take the appropriate corrective action to ensure that the hospital does not continue to receive improper payments. Overpayments should be refunded to the affected payor promptly through normal repayment channels in accordance with the guidance from the fiscal intermediary or carrier.

RISK AREAS FOR CLAIM DEVELOPMENT AND SUBMISSION

1. **Policy**. Lane Regional Medical Center recognizes that an effective Compliance Plan must begin with a commitment that includes all the applicable elements of a compliance program and recognizes and addresses specific areas of potential noncompliance. The Office of Inspector General ("OIG") believes that a hospital compliance program should take into consideration the regulatory exposure for each function or department of the hospital. The Office of Inspector General's Compliance Program Guidance for Hospitals, p.7, 2/98, therefore, Lane Regional Medical Center shall seek to identify hospital risk areas and educate and train hospital employees, managers, and officers to recognize these risk areas and to take reasonable action to prevent such conduct from occurring or recurring in the future.

2. **Billing Compliance Issues**. Proper billing is vital to Lane Regional Medical Center's compliance program. Improper billing may occur through human error, improperly programmed software, etc. Such errors, whether intentional or not, may result in false claims and subject the hospital or physicians to fines and penalties under the **False Claims Act** of up to $11,000 per violation.

a. False Claims Act, 31 U.S. C. 3729 provides for liability for triple damages and a penalty from $5,000 to $11,000 per claim for anyone who knowingly submits or causes the submission of a false or fraudulent claim to the United States.

b. Section 3730 states "The Attorney General diligently shall investigate a violation under section 3729 if the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person. A person may bring a civil action for a violation

of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General gives written consent to the dismissal and their reasons for consenting."

c. Allows people not affiliated with the government to file action against federal contractors claiming fraud against the government.

d. Provides a legal tool to counteract fraudulent billings turned in to the federal government. Claims under the law have been filed by persons with insider knowledge of false claims which have typically involved health care or other government spending programs.

e. "Qui tam" provides for an individual who assists prosecution to receive all or part of the penalty imposed.

f. Whistleblower is any person who reveals misconduct by his or her employer. A whistleblower who exposes fraud on the government can bring a qui tam lawsuit on behalf of the government.

g. An employee is entitled to relief necessary to make the employee whole, if the employee is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee.

2B. **Federal/State Compliance**: The Deficit Reduction Act (DRA) of 2005 went into effect 1/1/2007. Any Medicaid provider receiving more than $5million in reimbursement must attest that employees have been educated on false claims and that procedure and policies are in place to detect fraud, waste and abuse. In addition employees must be aware that there is whistleblower protection under federal and state laws.

2C. **Louisiana Medical Assistance Programs Integrity Law 46RS 437-440 [MAPIL]:** This law requires "health care providers to provide goods, services, or supplies only if medically necessary and that are with the scope and quality of standard care [437.11B]."

MAPIL also requires providers maintain records for five years and safeguard the use and disclosure of protected health information (PHI). MAPIL prohibits soliciting or providing kickbacks, bribes, and payments for referrals. MAPIL also prohibits presenting a false claim, including false records, concealments, and conspiring or attempting to defraud the medical assistance program. Claims for medically unnecessary services are also prohibited by MAPIL. False statements for qualifying a person for medical assistance and unauthorized persons from obtaining recipient lists are also prohibited.

3. **Qualifications of Billing and Coding Staff**. Only qualified staff using appropriate resources should be assigning diagnostic and procedural codes for billing purposes. Lane Regional Medical Center billing and coding staff should annually attend internal or external educational or training seminars specifically addressing billing and coding issues.

4. **Special Areas of Concern**. The OIG has identified areas of special interest to hospitals including the following: Updated: September 2011

a. **Capital Payments**. Inpatient capital payments will be under review by OIG. Capital payments reimburse a hospital's expenditures for assets such as equipment and buildings. It will be determined if the capital payments to hospitals are appropriate.

b. **Provider-Based Status.** Cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities will be reviewed. It will be determined if the provider-based designation is appropriate.

c. **Wage Indexes**. Review hospital and Medicare controls over the accuracy of the hospital wage data used to calculate wage indexes for the Inpatient Prospective payment System (IPPS). Hospitals must accurately report wage data for CMS to properly calculate the wage index in accordance with the Social Security Act, [1886 (d) (3).

d. **Inpatient Rehabilitation Facility Submission of Patient Assessment Instruments**. Review Medicare payments for inpatient rehabilitation facilities (IRF) stays in which patient assessments were transmitted to CMS late to determine whether payments were correctly made. IRF claims will be reviewed to determine whether patient assessments were submitted in accordance with Medicare regulations.

e. **Medicare Disproportionate Share Payments**. Review Medicare Disproportionate Share Payments (DSH) made to hospitals. Under the Social Security Act, [1886(d) (5) (F) (i) (I), Medicare makes additional payments to acute care hospitals that serve a significantly disproportionate number of low-income patients. Medicare DSH payments have been steadily increasing. OIG will determine whether these payments were made in accordance with Medicare methodology set forth in the Social Security Act. The total amounts of uncompensated care costs that the hospitals incur will also be examined.

f. **Provider Bad Debts.** Medicare bad debts claimed by acute care inpatient hospitals, long term care hospitals (LTCH), inpatient rehabilitation facilities, inpatient psychiatric facilities, and SNFs will be reviewed to determine whether they were reimbursable. Pursuant to Federal regulations at 42CFR [413.89, uncollectable debts related to unpaid deductible and coinsurance amounts may be claimed as Medicare bad debt if specific criteria are met. It will be determined whether the bad debt payments were appropriate under Medicare regulations and whether recoveries of prior year write-offs were properly used to reduce the cost of beneficiary services for the period in which the recoveries were made.

g. **Medicare Secondary Payer** . The Medicare payments for beneficiaries, who have other insurance, will be reviewed. Medicare payments for such beneficiaries are required to be secondary to certain types of insurance coverage. Procedures for identifying and resolving credit balance situations will be evaluated. This occurs when payments from Medicare and other insurers exceed the providers' charges or the allowed amounts.

h. **Hospital-Reported Quality Measure Data**. Hospitals' controls for ensuring the accuracy of data related to quality of care that the hospital submits to CMS for Medicare reimbursement will be reviewed. The Social Security Act {1886(b)(3)(B)(vii), requires that hospitals report quality measures for a set of 10 indicators established by the Secretary as of November 1, 2003. The Social Security Act, {1886(b)(3)(viii), as added by the Deficit Reduction Act of 2005 (DRA), {5001(a), expanded the payment reduction to 2% effective at the beginning of FY 2007. Hospitals will be reviewed to determine if there are sufficient controls to ensure that their quality measurement data are valid.

i**. Hospital Readmissions.** Medicare claims will be reviewed to determine trends in the number of hospital readmission cases. If a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one diagnosis-related group payment and should combine the original and subsequent stays into a single claim. Providers are permitted to override this edit in certain situations. The effectiveness of this edit will be tested. The extent of oversight of readmission cases will also be determined. A readmission is defined as a case in which the beneficiary is readmitted to a hospital less than 31 days after being discharged from a hospital.

j. **Adverse Events**. Adverse event describes harm to a patient as a result of medical care. The terms "never events" or "serious reportable events" refer to a subcategory of adverse events that the National Quality Forum (NQF) deemed "should never occur in a health care setting," such as surgery on the wrong patient. The Tax

Relief and Health Care Act of 2006 (TRHCA), Division B, {203, requires that OIG study serious reportable events and their impact on Medicare beneficiaries and program costs.

k. **Payments for Diagnostic X Rays in Hospital Emergency Departments**. Medicare Part B paid claims and medical records for diagnostic x-rays performed in hospital emergency departments will be reviewed to determine the appropriateness of payments.

l. **Coding and Documentation Changes Under the Medicare Severity Diagnosis Related Group System (MS-DRG).** The impact of the changes implemented October 1, 2007 will be reviewed. The number of DRGs increased from 538 to 745. Coding trends and patterns under the new system will be examined and also specific MS-DRGs will be reviewed to determine if they are vulnerable to potential upcoding.

RISK AREAS FOR FINANCIAL REPORTING

1. **Policy.** Lane Regional Medical Center recognizes that an effective Compliance Plan must begin with a commitment that includes all the applicable elements of a compliance program and recognizes and addresses specific areas of potential noncompliance. The Office of Inspector General ("OIG") believes that a hospital compliance program should take into consideration the regulatory exposure for each function or department of the hospital. The Office of Inspector General's Compliance Program Guidance for Hospitals, p.7, 2/98. Therefore, Lane Regional Medical Center shall seek to identify hospital risk areas and educate and train hospital employees, managers, and officers to recognize these risk areas and to take reasonable action to prevent such conduct from occurring or recurring in the future.

2. **Cost Reporting in General**. Lane Regional Medical Center promotes full compliance in all aspects of financial reporting. Cost Reports shall be prepared under the following guidelines:

a. All costs to be claimed are to be based on appropriate and accurate documentation;

b. Allocation of costs to various cost centers must be accurate and supported by verifiable and auditable data;

c. Accounts containing both allowable and unallowable costs are analyzed to determine any unallowable amounts that should not be claimed for reimbursement;

d. Costs are to be properly classified;

3. **Cost Reporting Issues**. Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Institutional fraud can show up in the way items or services are billed on a provider's cost report. Medicare Intermediary Manual 3951 Part A Medicare Fraud.

Examples of cost report fraud may include:

a. Incorrectly apportioning costs on cost reports;

b. Including costs of noncovered services, supplies, or equipment in allowable costs;

c. Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge Medicare through various devices (commissions, fee splitting) to siphon-off or conceal illegal profits;

d. Billing Medicare for costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses;

e. Repeatedly including unallowable cost items on a cost report except for purposes of establishing a basis for appeal;

f. Manipulation of statistics to obtain additional payment, such as increasing the square footage in the outpatient areas to maximize payment;

g. Claiming bad debts without first genuinely attempting to collect payment;

h. Certain hospital-based physician arrangements and amounts actually paid to physicians;

i. Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;

j. Days that have been improperly reported and would result in an overpayment if not adjusted;

k. Depreciation for assets that have been fully depreciated or sold;

l. Depreciation methods not approved by Medicare;

m. Interest expense for loans that have been repaid for an offset of interest income against the interest expense;

n. Program data where provider program amounts cannot be supported;

o. Improper allocation of costs to related organizations that have been determined to be improper; and

p. Accounting manipulations.

HOSPITAL - PHYSICIAN RELATIONSHIPS

1. **Policy**. In an effort to provide the surrounding community with quality health care, Lane Regional Medical Center periodically employs and conducts business with a number of different physicians and/or physician groups. The Hospital's interactions with physicians can affect a variety of issues, including the anti-kickback law, the IRS rules on employee and independent contractor status, and the "Stark II" self-referral law. The Hospital is committed to complying with all applicable laws in it relationships with physicians, maintaining the highest ethical standards, and ensuring that the physicians practicing at the Hospital's facilities also adhere to the highest ethical standards.

2. **Potential Fraud and Abuse Issues**. A number of issues may arise when examining the nature of the relationships between a hospital and physicians with whom a hospital has entered into an employment or professional services agreement. Before entering into agreements with physicians or other health care providers, the hospital should examine these agreements to ensure compliance with the following policies or procedures:

a. **The Anti-kickback Law**. Physicians and employees are strictly prohibited from accepting gifts,

favors, payments, services, or anything else of value which might appear to influence the actions of the physician or of the Hospital. Physicians and employees may retain gifts of nominal value, such as pens, coffee mugs, and other similar novelties, but must refuse any gift of more than nominal value and should report any inappropriate offers to the Corporate Compliance Officer. Physicians and employees are strictly prohibited from soliciting or accepting anything of value in exchange for patient referrals or in exchange for purchasing or leasing any item or service which may be reimbursed by Medicare, Medicaid, or any other federal or state health care program.

b. **The Stark II Self-Referral Law**. The Stark II self-referral law prohibits physicians from referring patients to entities with whom the physician, or a physician's family member, has a financial relationship for certain health services. A financial relationship may include an ownership interest or compensation arrangement.

c. **Excluded Health Care Providers**. Federal law prohibits the Hospital from employing or contracting with physicians who are excluded from participation in Medicare and other federal health care programs. All agreements should be reviewed by the Compliance Officer who shall ensure that background checks are conducted in accordance with the Employee Screening policy in Section 3.

d. **Reassignment of Medicare Benefits**. Medicare benefit payments for physician services may normally only be paid to the physician providing services or to the Medicare beneficiary. Such benefit payments may, however, be assigned to the Hospital if the Hospital employs the physician or of the physician's services are provided in any of Lane Regional Medical Center's facilities. In order for the Hospital to receive Medicare benefit payments for physician services, the physician should sign an agreement allowing the Hospital to receive payment for the services.

e. **Independent Contractors**. If the physician is an independent contractor, in order for the Hospital to receive payment for the physician's services, the services must be provided within the Hospital's facilities, and the physician must sign an agreement whereby the Hospital submits the bill for services.

3. **Review by Compliance Officer**. All arrangements involving the reassignment to the Hospital of Medicare benefit payments should be reviewed by the Compliance Officer in order to ensure compliance with recognized exceptions to the basic reassignment prohibition. Suspected violations should be reported to the Compliance Officer immediately.

4. **Hospital-Based Physicians**. All arrangements involving hospital-based physicians should be reviewed by the Compliance Officer with the assistance of legal counsel because of the complexity of the laws governing compliance and physician issues. Such arrangements should be structured to comply with the Stark II self-referral prohibition law where the ordering of "designated health services" is contemplated. Any payments between the Hospital and hospital-based physicians should be consistent with fair market value and should not be based on the volume or value of any referrals and should be structured to comply with the anti-kickback law. The arrangement must be approved by the Board of Directors.

5. **Mandatory Compliance**. Compliance with these policies is a required condition of employment or continued engagement with the Hospital. Violations of these policies should be reported immediately to the Compliance Officer.

6. **Penalties**. Failure to adhere to the policies may result in discipline and/or termination, as described in section 4.

Third Party Contracts

1. **Policy**. Lane Regional Medical Center recognizes that the provision of quality health care to the community from time to time requires the Hospital to enter into contracts with various health care providers to provide items or services,

which may be paid for by federally funded health care programs. Lane Regional Medical Center shall not enter into any agreements with individuals or entities which violate federal or state laws, rules or regulations.

2. **Contract Approval**. The Board of Directors shall adopt a policy for approval of third party contracts or agreements which shall delineate the contracts or agreements which require approval by the Board of Directors (such as physician contracts, lease agreements) and those which do not require approval by the Board of Directors.

3. **Legal Guidance**. Because of the complexity of the laws governing compliance, it may be necessary for legal counsel to review certain contracts or agreements. The following contracts shall be reviewed by counsel to avoid potential violations or liability under the various compliance laws, rules, or regulations:

a. **Physician Agreements**. Any employment or professional service contracts or agreements between the Hospital and a physician or physician group shall be reviewed by legal counsel to ensure compliance with the various state and federal statutes, rules and regulations governing the relationships between the Hospital and health care providers.

i. Medical Directorships or Administrative Functions. Agreements requiring physicians to provide medical director services, or other administrative functions should also be reviewed by counsel.

ii. Purchase of Physician Practices. Any agreements pertaining to physician practice acquisitions shall be reviewed with the assistance of counsel and structured to comply with an exception to the anti-kickback statute and the Stark II self-referral prohibition.

b. Lease Agreements. Any lease agreements between the Hospital and any individuals or entities shall be reviewed by counsel in order to determine whether such agreement complies with the various statutes, rules and regulations.

c. **Joint Ventures**. Any agreement relating a joint venture or partnership in which the Hospital is a party to the Agreement shall be reviewed by counsel prior to approval by the Hospital Board of Directors or other authorized person under Hospital policy.

d. **Independent Contractors**. Any agreement between the Hospital and an independent contractor for the provision of health care services shall be reviewed by counsel, including, but not limited to agreements for provision of Dental services, home health services, etc.

4. **Excluded Parties**. Federal law prohibits the Hospital from contracting with individuals or entities which are excluded from participation in Medicare and other federal health care programs. Background checks shall be conducted in accordance with the Employee Screening Policy in Section 3 to ensure that the Hospital does not employ or contract with any individual or entity that has been excluded from participation in the Medicare program.

5. **Excess Benefits**. State constitutional provisions prohibit the Hospital, as hospital service district (i.e., a political subdivision) from entering into agreements in which excess payments are made for items or services for the private benefit of individuals or entities. Officers, directors, trustees, and other individuals having similar powers or duties within the Hospital should ensure that individuals and entities with whom the Hospital enters into contracts or agreements are paid based on the fair market value of the goods and services provided. Any suspected violations of this policy should be reported to the Compliance Officer.

PATIENTS' RIGHTS

1. **Policy**. Lane Regional Medical Center recognizes its responsibility to protect and promote each patient's rights and is committed to ensuring that the Hospital staff and employees are knowledgeable and respectful of these rights. Accordingly, the Hospital is incorporating patients' rights into the Compliance Program. The policy shall include a comprehensive, systematic and timely mechanism to respond to and track patient concerns and complaints. The system should provide feedback to staff and thereby facilitate and foster an environment that minimizes the potential for complaints and ensures that patients receive quality health care.

2. **Notice of Rights**. The Hospital must inform patients, or their representatives, of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. Upon admission of any inpatient to the hospital, the admitting registrar will provide the patient with written information about his or her rights under state law to control decisions about his or her own health care.

3. **Privacy and Safety**. The patient has a right to personal privacy and the right to receive care in a safe setting, free from all forms of abuse and harassment. Employees or staff who violates this policy is to be terminated or disciplined.

4. **Confidentiality of Records**. The patient has the right to the confidentiality of his or her patient records. The Hospital shall take reasonable efforts to ensure the privacy of these records by limiting access to those areas in which patient's records are maintained. Electronic records should only be accessible by authorized personnel and computers should, if possible, be located in areas that are not easily accessible or viewed by non-authorized personnel.

5. **Grievance Procedure**. The hospital must maintain a process for the prompt resolution of patient grievances, which includes the following:

a. Procedure for Submission of Grievance. The Hospital must maintain a procedure for the submission of the patient's written or verbal grievance to the Hospital with specified time frames for review of the grievance and the provision of a response.

b. Hospital Response. The Hospital must provide the patient with written notice of its decision which contains the following:

i. name of the hospital contact person;

ii. the steps taken on behalf of the patient to investigate the grievance;

iii. the results of the grievance process; and

iv. the date of completion.

c. Log Maintenance. The chair of each department shall maintain a log containing the complaint forms and the Hospital response to each complaint to assist the hospital in identifying any negative trends. The patient complaint logs should be reviewed periodically as part of the annual compliance audits.

6. **Advance Directives**. The Hospital must provide patients with written information concerning the patient's right to make decisions regarding the right to formulate an advance directive regarding medical care. Any written directives are to be made in accordance with Louisiana law, specifically, R.S.40:1299.58.3, and the Hospital's written policy. Upon admission, the registrar should inquire as to whether the patient has an advance directive and document the patient's response on a form to be included in the patient's medical record. If the patient indicates that he or she has an advance directive, the patient will be requested to provide a copy for the medical record.

a. Written Declarations. Any adult person may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal and irreversible condition. The declaration shall be signed by the declarant in the presence of two witnesses.

b. Oral or Nonverbal Declaration. An oral or nonverbal declaration may made by an adult in the presence of two witnesses by any non-written means of communication at any time subsequent to the diagnosis of a terminal and irreversible condition.

c. Notification of Directive. It shall be the responsibility of the declarant to notify his attending physician that a declaration has been made.

i. In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of the declaration. In addition, the attending physician or the Hospital may directly contact the registry to determine the existence of any such declaration.

ii. Any attending physician who is so notified, or who determines directly or is advised by the Hospital that a declaration is registered shall promptly make the declaration or a copy of the declaration, if written, or a notation of the existence of a registered declaration, a part of the declarant's medical records.

iii. If the declaration is oral or nonverbal, the physician shall promptly make a recitation of the reasons the declarant could not make a written declaration and make the recitation a part of the declarant's medical record.

7. **Patient Restraints**. Hospital patients shall not be subjected to physical restraints unless such restraint is medically necessary. The term "restraint" includes either a physical restraint or a drug that is being used as a restraint. Restraints can only be used in the following circumstances:

a. if needed to improve the patient's well-being and less restrictive measures have been found to be ineffective to protect the patient or others from harm;

b. in accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order a restraint;

i. the order must not be in the form of a standing order or on an as needed basis (PRN); and

ii. the order must be followed by a consultation with the patient's treating physician;

iii. in accordance with a written modification to the patient's plan of care;

iv. if ended at the earliest possible time;

v. if continually assessed, monitored and reevaluated; and

vi. all staff who have direct patient contact should have ongoing education and training in the proper and safe use of restraints.

Home Health Services

1. **Policy.** Lane Regional Medical Center shall provide Home Health services in accordance with all applicable state and federal laws, rules and regulations.

2. **Risk Areas**. The OIG, through Compliance Guidance, special fraud alerts and other published materials, has identified several risk areas for Home Health services, including but not limited to the following:

a. Billing for Services Not Rendered. Submitting a claim that represents the provider performed a service all or part of which was simply not performed is improper. No claims may be submitted by the Hospital for Home Health services until the Hospital has appropriate documentation that such a service was actually provided.

b. Coding and Documentation. Diagnosis and procedure codes for home health services reported on the reimbursement claim should be based on the patient's medical records and other documentation and should accurately describe the services that was provided and be available to the billing staff.

c. Financial Incentives. Billing Department personnel or consultants should not receive any financial incentives to submit claims that do not meet applicable coverage criteria for reimbursement.

d. Periodic Review of Claims. Claims for home health services should periodically be reviewed prior to submission and post-submission to ensure that claims submitted for reimbursement accurately represent medically necessary services that were actually provided, supported by sufficient documentation, and in conformity with any applicable coverage criteria. The review should include an examination of the following items:

i. Physician Signatures. A Physician must sign a certification that the individual needs or needed intermittent skilled nursing care; speech or physical therapy or speech-language pathology services; or occupational therapy or a continued need of occupational therapy (payment for occupational therapy under Medicare will be made only upon an initial certification that includes intermittent skilled nursing, speech or physical therapy);

ii. Patient Homebound. Records should indicate that the beneficiary should be homebound;

(1) The homebound requirement may not be necessary for some payors, however, the Home Health Agency should request written guidance prior to submitting a claim in which the homebound requirement is not met.

iii. Services Furnished Under Physician's Care. The services must be furnished while the patient is under the care of the physician;

iv. Plan of Care. The plan of care for furnishing the services was documented and has been periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine and does not have a significant ownership interest in, or significant financial or contractual relationship with the Home Health Services or Agency.

(1) Significant Financial Interest. A significant financial interest exists when:

(a) the physician receives any compensation as a corporate officer or director of the home health services or agency; or

(b) the physician has direct or indirect business transactions that amount to more than $25,000.00 per year or 5% of the total operating expenses of the home health service, whichever is less.

(2) Uncompensated Officer or Director. A physician who serves as an uncompensated corporate director is not precluded from performing physician certification and plan of treatment functions.

e. Necessity of Home Health Services. In order for a patient to be eligible for home health services under Medicare, the law requires that a physician certify in all cases that the patient is confined to his/her home. An individual does not have to be bedridden; however, the condition of theses patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort Examples of homebound patients included:

i. A patient paralyzed from a stroke that is confined to a wheelchair or requires the aid of crutches in order to walk;

ii. A patient who is blind or senile and requires the assistance of another person to leave his/her residence;

iii. A patient who has lost the use of his/her upper extremities and, therefore, is unable to open doors, use handrails on stairways and requires the assistance of another person to leave his/her residence.

f. Plan of Care. The Plan of Care must contain all pertinent diagnoses, including the patient's mental status, the types of services, supplies, and equipment required, the frequency of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any additional items the physician chooses.

i. Specificity of Orders. The orders on the plan must specify the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services as well as the frequency of services (ex. SN x 7/wk x 1 wk; 3/wk x 4 wk).

ii. Signature. The physician must be qualified to sign the plan of care (see d above) and it must be signed prior to being submitted for payment. A signature is not necessary for the submission of a "Request for Anticipated Payment" based on verbal orders if:

(1) The verbal orders are put in writing;

(2) The verbal orders reflect the agreement between the Home Health Agency and the physician with the appropriate detail regarding the patient's condition and the services to be rendered;

(3) The orders are compatible with existing regulations governing the plan of care;

(4) A copy of the plan of care with all physician verbal orders placed in writing and dated with the date of receipt by the registered nurse or qualified therapists, which includes the verbal orders, is transmitted to the physician for his or her records; and

(5) Signed orders are obtained as soon as possible and before the submission of the claim for services is submitted for the final percentage payment for each episode.

iii. Oral Orders. Services furnished on oral orders from a physician must be put in writing by personnel who are authorized to do so and must be signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services. The order may be signed by the supervising registered nurse or qualified therapist after the services has been rendered as long as the home health personnel who receive the oral orders notify the nurse before the service is rendered. Oral orders must be countersigned and dated by the physician before the claim is submitted.

iv. Need of Skilled Services. The beneficiary should require intermittent skilled services;

v. Definite Length of Services. A finite and definite endpoint is documented for skilled services in excess of 35 hours per week.

g. **Screening of Beneficiaries**. The OIG has included within its Work Plan, a review of home health agencies to determine whether home health providers are "dumping" patients who are very ill before it is medically warranted in order to keep costs down under the prospective payment system.

h. **Physician Incentives**. Incentives given to actual or potential referral sources (physicians, patients, and other hospitals) may violate the anti-kickback statutes or regulations. Examples of improper incentives may include fees given to physicians for each plan of care certified, items or services provided for free or below fair market value to beneficiaries of federal health care programs, excessive salaries to a referring physician for services rendered.

i. Billing for unallowable Costs of Home Health Coordination. Home health coordination is intended to manage and facilitate the transfer of patients from a hospital or skilled nursing facility to the care of a home health agency. While some of these costs are allowable under Medicare, the costs of services performed by home health agency personnel that constitute patient solicitation or activities that are duplicative of an institution's discharge planning responsibilities are not allowable.

j. **Disregard of Willing Caregivers**. According to Medicare reimbursement principles, where a family member or other person is or will be providing services that adequately meet a patient's needs, it is not reasonable and necessary for a home health agency to furnish such services. Therefore, if home health employees or staff has first hand knowledge of an able and willing person to provide the services being rendered, or the patient objects to the provision of such services, the Hospital should not bill for such services.

Laboratory Services

1. **Policy**. Lane Regional Medical Center is committed to providing clinical laboratory services within an atmosphere that promotes prevention, detection, and resolution of instances of conduct that may not conform to federal and state law, and federal, state and private payor health care program requirements, as well as with Lane Regional Medical Center's ethical and business policies.

2. **Medical Necessity**. Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or

treatment of an illness or injury or to improve the functioning of a malformed body member." Providers and patients should be advised that tests submitted for Medicare reimbursement must meet program requirements or the claim will be denied.

a. Diagnosis Information. The laboratory shall require physicians or other authorized individuals to submit diagnosis information for all tests ordered, as documentation of the medical necessity of the service.

b. Routine Screening. Requisition forms or other notices should be provided to the physicians or other authorized individuals which indicate that Medicare generally does not cover routine screening tests.

c. Annual Notice. The Lane Regional Medical Center Staff should provide physicians who routinely order lab tests with annual written notices that set forth: (1) the Medicare national policy and local medical review policy for lab tests; (2) that organ or disease related panels will only be paid and will only be billed when all components are medically necessary; and (3) the Medicare laboratory fee schedule and a statement informing the physician that the Medicaid reimbursement amount will be equal to or less than the amount of Medicare reimbursement. The notice should also contain the name and phone number of the clinical consultant which is required under the Clinical Laboratory Improvement Amendment (CLIA) certification.

d. Customized Profiles. If the Hospital laboratory offers physicians the opportunity to request customized profiles, the Hospital should annually provide written notices to physician who request such services explaining the Medicare reimbursement paid for each component of each such profile and inform the physicians that using a customized profile may result in the ordering of tests which are not covered, reasonable or necessary and that tests will not be billed or may require the use of an advance beneficiary notice (ABN).

3. **Authorized Testing**. Only those tests which are ordered by an authorized individual or physician, are performed and meet Medicare's conditions coverage, are reimbursable by Medicare. Any specimens which have test orders that are vague or ambiguous should be verified by lab personnel before performing the tests. Where diagnostic information is obtained after receipt of the specimen and request for services, the receipt of such information is documented and maintained.

4. **Selection of CPT or HCPCS Codes**. Intentional or knowing upcoding (i.e., selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service) or unbundling (i.e., billing paneled tests as if they were performed independently rather than as part of a panel) could violate the False Claims Act and other civil or criminal statutes. The CPT or HCPCS code that is used to bill for a particular service should accurately describe the service that was ordered and performed.

5. **Alteration of Physicians' Orders**. Laboratory personnel cannot alter the physician's order without the express consent of the ordering physician or other authorized individual. If verbal consent to alter an order is given by the physician, the person to whom the consent was given should document the date and time such consent was given and attach such documentation to the patient's record.

6. **Advance Beneficiary Notices**. Advance Beneficiary Notices (ABN) are used when there is a likelihood that an ordered service will not be paid. Before the service is furnished, the beneficiary should be notified, in writing, of the likelihood that the specific services will be denied. After being so informed the beneficiary has the choice to either (1) decide to receive the services and sign the agreement to pay on the ABN or (2) decide not to receive the service and therefore does not sign the ABN. If the beneficiary has signed the ABN, the service should be billed with the GA modifier, which indicates that the beneficiary has signed an ABN.

a. Blank ABNs. Beneficiaries should not be asked to sign blank ABNs.

b. Form of ABN. The notice must be in writing, must clearly identify a particular service, must state that payment for the particular service likely will be denied and must give the reason(s) for the belief that payment is likely to be denied.

c. Routine Use of ABNs. ABNs should only be used when there is some genuine doubt regarding the likelihood of payment as evidenced by the reasons stated on the ABN. Giving notice for all claims or services are not an acceptable practice.

7. **Claim Submission.** The Hospital will bill for laboratory services only after they are performed.

8. **Test Utilization Monitoring**. As part of Lane Regional Medical Center's ongoing compliance efforts, the Hospital will monitor and analyze the utilization data from the top 30 tests performed each year by CPT or HCPCS codes. Any increase greater than 10% per year shall be investigated by the Compliance Officer to determine whether the increased utilization is the result of any improper billings.

9. **Billing of Calculations**. Under Medicare coverage rules, it is improper to bill both for calculations (e.g., calculated LDLs, T7s, and indices) and the tests that are performed to derive such calculations.

10. **Reflex Testing**. Occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. The Hospital should seek to identify those circumstances under which reflex testing is proper.

11. **Standing Orders**. Standing orders should be reviewed during any external or internal audits to determine whether such orders are still valid or have expired.

Skilled Nursing Facility-closed 6/30/2010

1. **Policy.** Lane Regional Medical Center shall operate a skilled nursing facility in manner and in an environment that promotes maintenance or enhancement of each resident's quality of life in accordance with the federal and state laws, rules and regulations.

2. **Risk Areas**. The following areas have been recognized as risk areas for skilled nursing facilities and are addressed in this plan in order to promote the quality of medical care and the well-being of patients receiving care from the Hospital nursing facility:

a. Resident Eligibility. Medicare patients must meet certain pre-admission requirements for nursing facility services to be covered.

i. 3-Day Inpatient Stay. A nursing facility resident must have been hospitalized in a qualified Hospital or participating CAH, for medically necessary inpatient services, for at least 3 consecutive calendar days, not counting the date of discharge.

ii. Date of Admission Requirement. With certain exceptions, the beneficiary must be in need of post hospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH.

iii. Level of Services. Medicare Part A benefits in skilled nursing facilities are limited to beneficiaries who require skilled services rendered on a daily basis by technical or professional personnel in a skilled nursing setting. Knowingly misrepresenting the nature or level of services provided to a Medicare

beneficiary to circumvent the program's limitation is fraudulent. Required services to be provided can not be achieved at a lower level of care such as home health or in an outpatient setting.

iv. Preadmission Assessment. The pre-admission assessment is to be done with admission criteria met.

b. Patient Assessment. The patient must have a comprehensive assessment completed no later than 14 days after admission (day 1 being the day of admission). The comprehensive assessment instrument used is mandated by HCFA called the Minimum Data Set (MDS). Federal law requires that the patient be assessed accurately using this form. The Registered Nurse signing this form is declaring accuracy of the assessment information. The MDS information is entered into the computer and the RUG level (Resource Utilization Group) is determined. This information is submitted. the RAI (Resident Assessment Instrument) has a specific schedule mandated according to the payor service. The RAI includes: the MDS, triggers, RAPS and care plan. The entire interdisciplinary team contributes to the completion of the MDS and care plan creation. The patient will be encouraged to participate if practical.

c. RUG Creep. RUG Creep occurs when a provider manipulates, or falsely completes the Minimum Data Set (MDS) to fit a patient into a higher RUG category. An inaccurate MDS or inappropriate RUG classification may result in the provision of unnecessary services or improper billing. The MDS is to be completed with accurate information to ensure that the patient receives the appropriate level of services and that the Hospital receives the appropriate payment for claims.

d. Physician Services. Upon the physician signing admission orders he/she is stating that this patient meets Medicare criteria for Skilled Nursing daily. When the therapies are needed, the physician must sign their plan of treatment as approval of that plan.

e. Billing Issues. No items or services are to be billed when they are included in the facility's per diem rate or are the type of item or services that must be billed as a unit and may not be unbundled. The facility may not engage in "bill splitting" wherein the billing procedures are manipulated to create the appearance that the services were rendered over a period of days when, in fact, all treatment occurred during one visit.

f. Billing for Services Not Ordered. No claims shall be submitted for items or services that were not ordered by the treating physician or other authorized person.

g. Documentation. The staff and employees of the Hospital shall maintain sufficient documentation to support the diagnosis, justify treatment, document the course of treatment and results, and promote continuity of care. Documentation must support the MDS Assessment thereby supporting the RUG evaluation assigned.

h. Swapping. Because of the risk of anti-kickback violations, the facility shall not enter into "swapping" agreements with suppliers whereby the supplier gives the facility discounts on Medicare Part A items and services in return for the referrals of Medicare Part B business.

i. Signatures. Only authorized persons may sign documents used to verify that services were ordered and/or provided. Altering or forging a physician's signature on any requests for services or orders will result in discipline or termination.

j. Credit Balances. Any excess payments received made to the facility or Hospital as a result of patient billing or claims processing error should be promptly repaid and reported.

3. **Resident's Rights**. Nursing facility residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Lane Regional Medical Center must protect and promote the rights of each resident, including the following rights:

a. Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility (See Patients' Rights) and as a citizen of the United States, including the right to be free from interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. In the event the resident is adjudged incompetent by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

b. Notice of Rights. The Hospital must inform the patient of his or her rights prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments must be acknowledged in writing.

c. Right to Records. The resident, or his or her legal representative, has the right to access all records, including current clinical records, pertaining to himself or herself within 24 hours of an oral or written request and the right to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

d. Right to Refuse Treatment. Residents have the right to refuse treatment, to refuse to participate in experimental research, and to formulate advance directives (See Patients' Rights).

e. Written Notice of Benefits. The Skilled Nursing Facility must inform patients entitled to Medicaid benefits, in writing, at the time of admission into the nursing facility of the items and services that the facility offers under the State plan and for which they may not be charged. The Skilled Nursing Facility must also inform the residents at the time of admission of those other items and services that the facility offers for which the resident may be charged, and the amount of charges for those services and of any changes regarding such charges.

f. Medicare Residents. The Skilled Nursing Facility must inform each Medicare resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for services not covered by Medicare or by the facility's per diem rate.

g. Legal Rights. The Skilled Nursing Facility must furnish a written description of legal rights which includes:

i. A description of the manner of protecting personal funds;

ii. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to ask for an assessment under Section 1924(c) which determines the extent of a couple's non-exempt resources at the time institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her own process of spending down to Medicaid eligibility levels;

iii. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State Ombudsmen program, the protection and advocacy network, and the Medicaid fraud control unit;

iv. A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and noncompliance with the advance directives requirements.

v. The Hospital must inform each resident of the name, specialty, and the way of contacting the physician responsible for his or her care.

vi. The Hospital must prominently display written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

h. Notification of Changes. The Hospital must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

i. An accident involving the resident which results in injury and has the potential for requiring physician intervention.

ii. A significant change in the resident's physical, mental, or psychosocial status;

iii. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences).

iv. A decision to discharge or transfer the resident from the facility, including the decision to transfer the resident to a bed that is outside of the certified facility, whether the bed is in the same physical plant or not. Such notice must, if possible, be made 30days in advance. The decision to transfer or discharge must be documented. Transfers or discharges may be appropriate if:

(1) Transfer or discharge if necessary for the resident's welfare and the resident's needs cannot be met in the facility. The resident's physician must document the necessity for this type of transfer or discharge.

(2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs services provided by the facility.

(3) The safety of the other residents is endangered.

(4) The resident has failed, after reasonable notice to pay for the stay at the Facility

v. In addition to the employee screening of Lane employees, the nursing assistant's status of certification is checked through the State Nursing Home Registry upon hire.

i. Quality of Care. The Skilled Nursing Facility Committee oversees the functioning of the Skilled Nursing Unit. This committee oversees Policy and Procedures development, Q&I efforts, infection control, and safety issues. This committee is chaired by the Medical Director of Skilled Nursing Facility; other members include the CEO of Lane Regional Medical Center, CNO, CFO, Safety Director, Human Resource Director, QI Director, Infection Control Representative.

i. This committee can make recommendations to other committee of the organization, thus creating a pathway for exchange of information throughout the Lane Organization.

Nursing Home

1. **Policy.** Lane Regional Medical Center shall operate a nursing facility in a manner that provides the care and services necessary to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being. This nursing facility provides residence for Medicaid and private pay residents.

2. **Risk Areas.** The following areas have been recognized as risk areas for nursing facilities and are addressed in this plan in order to promote the quality of medical care and the well-being of patients receiving care from the nursing facility:

a. Eligibility and Admission Waiting List. Any person requesting a place for themselves or a loved one is eligible provided that the nursing home can provide the care needed to the eligible individual. (See admission criteria). A waiting list for admission into the facility is maintained in the executive suite of this organization.

b. Admission Criteria.

i. The facility shall admit a resident only upon request of a physician on the staff of Lane Regional Medical Center.

ii. The nursing facility will only admit residents for whom it can provide adequate care.

iii. The facility shall only admit adults (age 18 or older) for whom it can provide adequate care.

iv. The facility will not discriminate as to race, color, religion, national origin, handicap, or religious preference in admission and care of residents.

v. Persons who request admission will be evaluated individually to determine if the person's needs can be met with the care usually provided at the facility. Those persons with the following conditions generally require a greater level of care than provided at this facility:

(1) Persons who require extensive rehabilitation therapies.

(a) Extensive rehabilitative services are defined as being unable to complete physical therapy program, progress to plateau and be followed by nursing home staff for activities of daily living and routine mobility.

(2) Persons who require extensive respiratory therapies including ventilators, tracheotomies and endotracheal intubation.

(3) Persons requiring complex IV services defined as: IV antibiotics, peripheral or central line hyper alimentation, chemotherapy, blood or blood products.

(4) Persons who are mentally unstable and have a primary diagnosis of mental illness/mental retardation that require ongoing care for that condition.

(5) Persons who require specialized supervisory care.

c. Resident Assessment. The comprehensive assessment mandated by CMS is completed for all admissions, annually, and following a significant change. A quarterly assessment is completed no longer than every 91

days. The comprehensive assessment includes: the Minimum Data Set (MDS), the triggers, the RAPS and care plan.

i. The MDS is completed with input from all disciplines. The care plan is completed using the RAI (Resident Assessment Instrument). The MDS and quarterly assessments are submitted to the State repository via computer link.

(1) The State then compiles information based on submission of quarterly assessments regarding quality indicators defined by CMS. This information is utilized by State Surveyors in their survey process.

d. Physician Services. The resident must be seen by a physician once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter (will be timely if visit is within 10 days of the date visit was required.

i. Residents admitted to the Lane Nursing Home will have an attending physician on staff of Lane Regional Medical Center.

e. Abuse / Neglect. Known or suspected abuse / neglect should be reported to the supervisor at the time of accident, and may require reporting to the Nursing Home Administrator and State agencies according to Hospital and/or State policy.

f. Billing Issues. No items or services are to be billed when they are included in the facility's per diem rate or are the type of item or service that must be billed as a unit. Items or services billed as units may not be unbundled. The facility may not engage in "bill splitting" wherein the billing procedures are manipulated to create the appearance that the services were rendered over a period of days when, in fact, all treatment occurred during one visit.

g. Billing for Services Not Ordered. No claims shall be submitted for items or services that were not ordered by the treating physician or other authorized person.

h. Documentation. The staff and employees of the Hospital shall maintain sufficient documentation to support the diagnosis, justify treatment, document the course of treatment and results, and promote continuity of care. In addition, documentation must support the findings on the MDS and quarterly assessment. Documentation will provide needed information to determine significant changes.

i. Signatures. Only authorized persons may sign documents used to verify those services were ordered and/or provided. Altering or forging a physician's signature on any requests for services or orders will result in discipline or termination.

j. Credit Balances. Any excess payments received made to the facility or Hospital as a result of patient billing or claims processing error should be promptly repaid and reported.

k. Cost Reporting. Cost Reporting is to be completed through the accounting office of the Hospital in accordance with proper cost reporting methodologies.

3. Residents' Rights. Nursing facility residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The Nursing Home must protect and promote the rights of each resident, including the following rights:

a. Exercise of Rights. The resident has the right to exercise his or her right as a resident of the facility (See Patients' Rights) and as a citizen of the United States, including the right to be free from interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. In the event the resident is adjudged incompetent by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

b. Notice of Rights. The Nursing Home must inform the patient of his or her rights prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments must be acknowledged in writing.

c. Right to Records. The resident, or his or her legal representative, has the right access all records, including current clinical records, pertaining to himself or herself within 24 hours of an oral or written request for such access. The resident or his/her legal representative has the right to purchase at a cost not to exceed the community standard upon request and 2 working days advance notice to the facility, photocopies of the records or any portions of them.

d. Right to Refuse Treatment. Residents have the right to refuse treatment, to refuse to participate in experimental research, and to formulate advance directives (See Patients' Rights).

e. Written Notice of Benefits. The Nursing Home must inform patients entitled to Medicaid benefits, in writing, at the time of admission into the nursing facility of the items and services that the facility offers under the State plan and for which they may not be charged. The Hospital must also inform the resident at the time of admission of those other items and services that the facility offers for which the resident may be charged, and the amount of charges for those services and of any changes regarding charges.

f. Use of Restraints. The resident has the right to be free of physical or clinical restraints.

g. Legal Rights. The Nursing Home must furnish a written description of legal rights which include:

i. A description of the manner of protecting personal funds;

ii. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to ask for an assessment under Section 1924(c) which determines the extent of a couple's non-exempt resources at the time institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her own process of spending down to Medicaid eligibility levels;

iii. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State Ombudsmen program, the protection and advocacy network, and the Medicaid fraud control unit;

iv. A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and noncompliance with the advance directives requirements.

v. The Nursing Home must inform each resident of the name, specialty, and the way of contacting the physician responsible for his or her care.

vi. The Nursing Home must prominently display written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

h. Notification of Changes. The Nursing Home must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

i. An accident involving the resident which results in injury and has the potential for requiring physician intervention.

ii. A significant change in the resident's physical, mental, or psychological status.

iii. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences).

i. Discharges. A decision to discharge the resident from the facility may be voluntary or involuntary. A voluntary transfer will be processed by physician's order. Involuntary discharge requires that a letter of intent to discharge be mailed to: resident, responsible party, OFS regional office, welfare worker, ombudsman, medical director and attending physician.

i. The criteria for involuntary discharge include:

(1) Such action is necessary for resident's welfare;

(2) Safety of other residents if endangered;

(3) Non-payment;

(4) Medical reasons.

ii. A discharge planning conference will be called. Either the Director of Nursing, Social Services, patient's physician, family and legal representative, resident/family may ask for a hearing within 30 days after receipt of letter with the Louisiana Department of Health and Hospitals.

j. Quality of Life. The Nursing Home Committee oversees the development of Policies and Procedures, quality improvement efforts, infection control issue, safety and other issues as they arise. Membership includes chairperson, Nursing Home Medical Director, Nursing Home Administration, CEO of Lane, CFO of Lane, CHRO, Quality Improvement Representative, Infection Control Representative, Safety Officer, Nursing Home Director, 3 staff members.

k. Creation of Records. Hard copy of database documentation will be kept;

1) State submission of MDS information,
2) Quality Indicator reports (quarterly)

l. Submission of information. The submission of information to the State repository is to be secured by password.

m. Retention of Medical Records. Medical Records are to be retained through the Hospital medical records department, 1 year's worth of medical records are kept on the unit in accordance with State Regulations.

n. Licensing Surveys. Hard copies of annual state licensing surveys are kept as well as submitted plan of correction.

EMERGENCY TREATMENT POLICY

1. **Policy**. Lane Regional Medical Center is committed to providing immediate care to patients who require emergency medical treatment regardless of the patient's ability to pay. The Hospital is cognizant of its moral, ethical and legal duties to provide such care and has adopted policies and procedures to ensure compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA), as well as any other federal or state rules and regulations pertaining to the treatment of patients presenting to the Hospital with an emergent condition.

2. **Medical Screening Examination**. Any individual who comes to Lane Regional Medical Center Emergency Department requesting an examination or treatment for a medical condition must be given an appropriate medical screening examination within the Hospital's capabilities, including ancillary services which are routinely available to the Emergency Department without regard to whether the patient has the ability to pay for such services. Triage is not considered an appropriate medical screening examination. The Medical Screening Examination will not be delayed in order to inquire about payment status or to complete financial responsibility forms or advanced beneficiary notices (ABNs). The Hospital staff may follow reasonable registration processes for individuals presenting for evaluation and treatment as long as this inquiry does not delay screening or treatment.

a. Emergency Medical Condition Defined. An "emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(2) serious impairment of any bodily organ or part; or
(3) serious dysfunction of any bodily organ or part.

b. Pregnant Woman. An "emergency medical condition" with respect to a pregnant woman who is having contractions exists when (1) there is inadequate time to affect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

3. **Emergency Medical Condition Exists**. If the Hospital determines that an emergency condition exists, the Hospital must provide the following:

a. Stabilizing Treatment. If the Hospital determines that an emergency medical condition exists, the Hospital must provide within the staff and facilities available, for such further medical examination and treatments as may be required to stabilize the patient or to make an appropriate transfer.

b. "Stabilize" Defined. The term "stabilize" with respect to an "emergency medical condition" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a woman in labor, it means that the contractions have stopped, the woman has delivered a child (and placenta), or a physician certifies that the labor is false.

c. Appropriate Transfer. If an emergency medical condition persists even after the best efforts of the Hospital, the Hospital will transfer the patient in accordance with the transfer guidelines of EMTALA. Treatment will be provided to minimize the risks of transfer. Under EMTALA, an "appropriate transfer" is one in which the following occur:

i. The patient has been given medical treatment within the Hospital's capacity which minimizes the risks to the individual patient's health (or, in the case of a woman in labor, the health of the unborn child);

ii. the receiving hospital has available space and qualified personnel for the treatment of the individual; and has agreed to accept transfer of the individual and to provide appropriate medical treatment;

iii. the receiving hospital is given all of the patient's medical records (or copies thereof) related to the emergency condition for which the patient presented, available at the time of the transfer;

iv. the receiving hospital is given the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and

v. the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

d. Restricting Transfer Until Patient Stabilized. If the patient has not been stabilized, the Hospital may not transfer the patient until:

i. The patient (or a legally responsible person acting on the patient's behalf) after being informed of the Hospital's obligations and the risk of transfer, in writing, requests transfer to another medical facility;

ii. A physician has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the patient, and in the case of labor, to the unborn child from effecting the transfer; or if the physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person has signed a certification after a physician, in consultation with the person, has made the determination and subsequently countersigns the certification and the transfer is appropriate in accordance with 3 (b) above.

4. **Non-emergent Condition**. If an appropriate medical screening reveals that the individual presenting to the emergency department does not have an emergent condition, then normal registration procedures or transfer may occur.

Record Maintenance and Retention

1. **Policy.** Lane Regional Medical Center staff and employees shall maintain medical records and other documentation in accordance with federal and state laws, rules and regulations for every individual evaluated or treated by the hospital. All records will be maintained in such a manner as to preserve the confidentiality and privileged nature of any patient information contained within such records.

2. **Medical Record Retention**. Under Louisiana law, hospital medical records are to be maintained in original, microfilmed, or similarly reproduced form for a minimum of ten (10) years.

a. Graphic Materials. Graphic matter, images, x-ray films and like matter that were necessary to produce a diagnostic or therapeutic report should be maintained preserved and properly stored in their original, microfilmed, or similarly reproduced form for a minimum period of five (5) years from the date of discharge in accordance with federal regulations. Upon written request by the attending or consulting physician, the patient (or his or her representative), graphic material may be maintained for a longer period of time.

3. **Privacy and Security**. Lane Regional Medical Center shall preserve the confidentiality of all privileged communications between the patient and Hospital staff and employees. Medical records should be accessed by authorized persons only when necessary. Any information pertaining to a patient's condition should not be discussed in public areas.

a. Privileged Communications. Privileged communications include any information that is acquired, recorded, or transmitted in any manner concerning any facts, opinions, or statements necessary to enable the health care providers to diagnose, treat, prescribe or to act for the patient is privileged and shall not be disclosed to non-authorized persons unless otherwise required by law.

b. Other Privileged Materials. Privileged communications also include all medical records, office records, hospital records, charts, correspondence, memoranda, laboratory tests and results, x-rays, photographs, financial statements, diagnoses and prognoses.

4. **Exceptions to Disclosure**. The Hospital may disclose privileged information to the patient or his or her authorized representatives provided the information unless the health care provider reasonable concludes that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonable be expected to endanger the life or safety of another person.

5. **Access to Patient Records**. The Hospital may provide access to, or copies of, patient records under the following conditions:

a. Patient Request. The Hospital, subject to the above exception, upon a request in writing signed and dated by the patient or his or her authorized representative, may furnish the records as soon as practicable and upon payment of the reasonable cost of so providing.

i. An authorized representative means the parent of a minor patient, tutor, curator, trustee, attorney, succession representative, or other legal agent of the patient.

b. Subpoena Duces Tecum. The Hospital shall disclose records of a patient who is a party to litigation pursuant to a subpoena issued in that litigation only if:

i. The Hospital has been furnished, by the party or the party's attorney at whose request the subpoena has been issued and at the time of service of the subpoena, with an affidavit that attests to the fact that such subpoena is for the records of a party to the litigation and that a copy of the subpoena has been mailed by registered or certified mail to the patient whose records are sought, or, if represented, to his counsel of record, at least seven (7) days prior to the issuance of the subpoena; and

ii. The subpoena is served on the Hospital at least seven (7) days prior to the date on which the records are to be disclosed, and the hospital has not received a copy of a petition or motion indicating that the patient has taken legal action to restrain the release of the records.

iii. If the requesting party is the patient or, if represented, the attorney of the patient, the affidavit shall state that the patient authorizes the release of the records pursuant to the subpoena.

(1) Coroner Requests for Medical Records. When conducting any investigation, the coroner, or any of his authorized agents may review any medical or dental records which he deems relevant to the investigation.

c. Immunization Records. Information and records pertaining to the immunization status of persons against childhood diseases may be disclosed and exchanged with verbal consent of the patient or his or her representative to any of the following:

i. State health care provider;

ii. Private health care provider;

iii. Representatives of a patient;

iv. A patient who is not a minor.

GOVERNMENT INVESTIGATIONS AND SEARCHES RESPONSE

1. **Purpose**. Government investigators may arrive unannounced at Lane Regional Medical Center or the homes of present or former employees and seek interviews and documentation. The purpose of this policy is to establish a mechanism for the orderly response to government investigations to enable the Hospital to protect its interests as well as appropriately cooperate with the investigation. The Hospital will cooperate with any appropriately authorized government investigation or audit; however, the Hospital will assert all protections afforded it by law in any such investigation or audit.

2. **Procedure for Government Request for Interview**. When government investigators request an interview, there is no obligation to consent to an interview, although anyone may volunteer to do so. One may require that the interview be conducted during normal business hours, at the Hospital or another location.

a. The staff member should always be polite and should obtain the following information:

i. The name, agency affiliation, business telephone number, and address of all investigators;

ii. The reason for the visit.

iii. When the investigator arrives, ask if there is a subpoena or warrant to be served, and request a copy of the subpoena or warrant.

b. The interview may be stopped at any time, with a request that the investigator return when counsel can be present. The Hospital will be represented by its corporate counsel; employees have the right to their own individual legal counsel. Local counsel should be present for interviews whenever possible.

c. If an employee chooses not to respond to the investigator's questions, the investigator has the authority to subpoena the employee to appear before a grand jury.

d. Any staff member contacted by an investigator should immediately notify his or her supervisor. Provide this individual with as much information and documentation about the investigation as is known. Ultimately the request should be reported to the Chief Financial Officer and the Corporate Compliance Officer.

3. **Procedure to Search Warrant or Request to Search**. Request an investigator on Hospital premises to wait until either the Corporate Compliance Officer, counsel, the Administrator on-call, or the Chief Financial Officer arrives (each referred to as "the employee in charge").

a. Hospital employees must not alter, remove, or destroy permanent documents or records of the Hospital. All records are subject to state or nationally recognized retention guidelines and may be disposed of only in accordance with these guidelines. Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended.

b. If the investigators present a search warrant or warrant, the investigators have the authority to enter private premises, search for evidence of criminal activity, and seize those documents listed in the warrant. No staff member has to speak to the investigators, but must provide the documents requested in the warrant.

c. Request copies of the warrant and the affidavit providing reasons for the issuance of the warrant.

d. All staff members should request an opportunity to consult with Hospital's counsel before the search commences. Provide counsel with a copy of the warrant immediately. If counsel can be reached by phone, put counsel directly in touch with the lead investigator.

e. Cooperate with the investigators, but do not consent to the search.

f. The employee in charge should instruct the lead investigator that:

i. The Hospital objects to the search;

ii. The search is unjustified because the Hospital is willing to voluntarily cooperate with the government; and

iii. The search will violate the rights of the Hospital and its employees.

iv. Under no circumstances should staff obstruct or interfere with the search. Although they should cooperate, any staff member should clearly state that this does not constitute consent to the search.

v. Whenever possible, keep track of all documents and what information the documents contain given to the investigators.

vi. If local counsel is not available, the employee in charge should contact the prosecutor immediately and request that the search be stopped. One can negotiate alternatives to the search and seizure, including provisions to ensure that all existing evidence will be preserved undisturbed. If the prosecutor refuses to stop the search, request agreement to delay the search to enable Hospital to obtain a hearing on the warrant.

vii. The employee in charge should attempt to negotiate an acceptable methodology with the investigators to minimize disruptions and keep track of the process. Consideration include the sequence of the search; whether investigators are willing to accept copies in place of originals; and if so, who will make the copies and how; whether Hospital will be permitted to make its own set of copies; and arrangements for access to records seized.

viii. The employee in charge should point out limitations on the premises to be searched and on the property to be seized.

ix. Avoid expansion beyond the proper scope of the search from confusion or overreaching.

x. Never consent to an expansion of the search.

xi. Disputes regarding the scope must be brought to the attention of the prosecutor or the court to be settled. The Hospital staff should not prevent the investigators from searching areas they claim to have the right to search.

xii. Investigators generally have the right to seize evidence of crimes that is in their "plain view" during a search regardless of whether such evidence is described in the warrant.

xiii. The employee in charge should take appropriate steps to protect other Hospital staff members.

xiv. The Hospital should send all but essential personnel home or temporarily assign them to other areas when a warrant is served.

xv. Selected employees should remain along with the employee in charge and/or Hospital counsel to monitor the search.

xvi. Investigators should never be left alone on the Hospital's premises, and no employee should be left alone with the investigators.

xvii. Object to any search of privileged documents.

xviii. If there is any possibility that the search will compromise privileged information, the Hospital should object on that basis, and raise the issue with the court if necessary.

xix. Negotiate a methodology to protect the confidentiality of any privileged information pending a resolution of these objections. For example, segregate the privileged documents from other files, and investigators will not read the documents until the court has made a decision or the investigators will seize the document, but place them unread in sealed envelopes until the matter is resolved.

xx. The employee in charge should keep a record regarding the search.

xxi. Ask investigators for proper identification, including their business cards.

xxii. List the names and positions of all the investigators with the date and time. Verify the list with the lead agent and request he or she sign it.

xxiii. Monitor and record the manner in which the search is conducted. Note in detail the precise areas and files searched, the time periods when each of them was searched, the manner in which the search was conducted, the agents who participated, and which files were seized.

xxiv. Several individuals probably will be needed to monitor the different areas being searched simultaneously.

xxv. If the monitor is ordered to leave, contact the lead investigator. A person should only be ordered to move if they are in the way, not to avoid being observed. Never provoke a confrontation with an agent.

xxvi. If possible, do not release a document to the investigators unless it has been reviewed by counsel. This is not possible under a search warrant.

xxvii. Keep all privileged and confidential documents separate and labeled accordingly. If seized, the documents should be protected from disclosure if labeled properly.

xxviii. If possible, the employee in charge should make a record and a copy of all records seized.

xxix. If this is not possible, before the agents leave the Hospital's premises, request an inventory of the documents seized.

xxx. Request the lead agent to note the date and time the search was completed as well as sign the inventory with the agent's full title, address, and telephone number.

xxxi. When documents are seized, the investigators are required to give the occupant a copy of the warrant.

xxxii. Copies of the seized documents should be requested as well, especially medical records, as this is the most efficient way to inventory the documents seized.

xxxiii. Create a parallel inventory of the documents seized.

xxxiv. Download copies of files from hard drives of computers, and copy CDs, especially if the material is essential to the ongoing operations of the Hospital.

xxxv. If possible, videotape the search.

(1) A videotape may provide evidence of undue disruption or misconduct on the part of the investigators.

(2) If the investigators claim the taping interferes with the search, the employee in charge should make a record of the refusal. Do not persist if the agents have warned that they regard the taping as interference.

xxxvi. Warrants Served on Employees. In the event a search warrant is served on any employee or facility, we want to fully comply with the warrant and cooperate with the agents serving the warrant. We also want to exercise and preserve all of our rights afforded by the search warrant process. The policy outlines the procedures to be followed by all employees in the event they are served with a search warrant.

xxxvii. In the event that agents of the federal or state government present any employee with a search warrant seeking access to company material, cooperate with the agents and also immediately contact the Legal Department.

xxxviii. The highest ranking employee within the department should become the contact person for the agents. When possible, nonessential employees should be sent home until the search is completed.

xxxix. Ask for identification from the agent in charge of executing the warrant, and ask for a copy of both the search warrant and the affidavit submitted to the court in order to obtain the warrant. Fax or send this information to the Legal Department as soon as possible.

xl. It is our policy to cooperate fully with the agents. It is absolutely critical that no employees interfere with the agents in any way during their search or prevent them from accessing anything listed in the search warrant. To do so could constitute obstruction of justice.

xli. The contact person should accompany the agents during the search and take notes of what they take, what they look at, to whom they talk, and what questions they ask.

xlii. The agents may ask employees questions during the search. Agents may present themselves at the home of an employee. Employees have the right to either talk to the agents or not talk to them, except to the extent that it is necessary to talk to them to comply with the search warrant. Employees also have the right to consult with counsel when making that decision and to have counsel present if they decide to talk to the agents.

xliii. The search warrant will include an attachment listing things that can be seized and places that may be searched. If the agents try to go into areas that are not listed in the warrant, ask them to wait until legal counsel arrives. If they refuse, do not interfere, but note which agents went into areas not specified in the warrant, when this occurred, and whether they seized anything from the area.

xliv. Agents may take original documents. You should ask for a detailed inventory of the material the agents are taking. They are required to provide a receipt for the articles taken.

xlv. If the agent takes documents (including computer files), ask to make copies of those documents. They are not required to allow copies to be made and may refuse to do so.

xlvi. If the agents are looking for a document housed in a place other than those specific places listed on the warrant, let the agents know we will be happy to comply once their search warrant has been updated. While you should not block access to any area, never give agents permission to search an area whether or not it is listed on the warrant.

g. Definitions.

i. A search warrant is a written document giving legal authorization to specific law enforcement officers to search a specified area and to seize specific materials. To be valid, a search warrant must:

(1) Describe the materials that can be seized and the places that may be searched.

(2) Be signed by, or on behalf of, a judge or magistrate with jurisdiction over the area to be searched.

ACCEPTANCE OF BUSINESS COURTESIES POLICIES AND PROCEDURES

1. **Policy**. Lane Regional Medical Center recognizes that from time to time employees and staff of the Hospital may be in a position to offer or receive business courtesies. No such courtesies are to be extended or accepted if the purpose such a courtesy is to influence the referral of federal health care business. The following policies provide guidance on

the receipt and giving of business courtesies. Employees or staff are to contact the Compliance Officer if there are questions regarding business courtesies that are not addressed in this policy.

2. **Receiving Business Courtesies**

a. Social Events or Entertainment. Invitations to a social event may be accepted from a current or prospective business associate in order to further or develop a business relationship provided the following conditions are met:

i. The cost associated with such an event must be reasonable and appropriate. As a general rule, this will mean that the cost will not exceed $50.00 per person per event. Events or entertainment which may exceed $50.00 should be approved by the Compliance Officer in advance.

ii. The aggregate cost of any events or entertainment received from any current or prospective business associates shall not exceed $300.00 per year. Costs in excess of $300.00 per year per vendor or business associate may be approved by the Compliance Officer.

iii. Social events or entertainment, with respect to any particular individual or entity, should be infrequent, which generally means no more than quarterly, and preferably less often. The Compliance Officer may approve more frequent events with respect to individuals or business entities, as long as the cost and frequency of such entertainment is not intended to result in the referral or generation of federal health care business.

b. Training and Education. Attendance at a vendor sponsored workshop, seminar, or training session is permitted. Arrangements that include travel and overnight accommodations at no cost to the employee or the hospital must be approved in advance by the Compliance Officer.

c. Gifts. Generally, the acceptance of gifts is discouraged; however, employees may accept a gift with a total value of $50.00 or less in any one year from any individual, vendor or organization who has a business relationship with the Hospital. Cash or cash equivalents (gift certificates) may not be accepted as gifts.

i. Perishable or consumable gifts given to a department are acceptable.

ii. Checks received from organizations as a gesture of gratitude for representing the Hospital in a speaking or educational engagement are acceptable as a donation and must be made payable to the Hospital's foundation or endowment fund.

3. **Extending Business Courtesies**.

a. Social Events. Invitations extended to non-referral sources to attend a social event in order to develop a business relationship must be approved in advance by the Compliance Officer or Board of Directors. During such events, topics of a business nature must be discussed and the host must be present.

i. These events normally should not include expenses paid for any travel costs or overnight lodging, unless approved by the Compliance Officer or other individual designated by the Board of Directors.

ii. The cost of such an event should be reasonable (generally, less than $100.00 per person). If the costs are expected to exceed $100.00, advance approval should be obtained from the Compliance Officer, or other individual designated by the Board of Directors.

4. **Business Events**.

a. Meals. Reasonable and appropriate meals may be offered in conjunction with a business event.

b. Transportation and Lodging. Reasonable transportation and lodging are reimbursable by the hospitals for events serving a business purpose.

c. The hospital shall post notices in conspicuous places for employees to view regarding the existence of the procedures to report noncompliance.

5. **Gifts**. It is critical to avoid the appearance of impropriety when giving gifts to individuals who do business or are seeking to do business with the Hospital. Gifts should never be used to influence relationships or business outcomes and must not exceed $50.00 per year per recipient. Such gifts may not be in the form of cash or cash equivalents.

a. The Hospital may not provide any gifts, entertainment, or anything else of value to any employee of the federal or state government. Modes meals and refreshments in connection with business discussions may be provided to government employees.

GLOSSARY OF TERMS

72 Hour Window - In 1990, congress expanded the DRG payment window to 72 hours, and covered any service provided by a hospital or an entity wholly owned or solely operated by a hospital during 72 hours immediately preceding hospital admission for services that are diagnostic (including clinical laboratory tests) or non-diagnostic and related to admission.

Act - General term referring to the Social Security Act enacted in 1965 which created the Medicare and Medicaid Programs.

ABN - Acronym for Advanced Beneficiary Notice. This notice is given to Medicare or Medicaid patients by physicians when services are requested that the physician has reason to believe will not be covered by Medicare or Medicaid. The form advises a beneficiary that the service may not be covered, explains the reasons why the service may not be covered, and states that the beneficiary may be liable for payment of the service.

Advance Directive - Written guidance, or other lawful form of communication, with respect to a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment.

APC - Acronym or Ambulatory Payment Classification. Payment classification of outpatient services and procedures which determines the amount of reimbursement a facility will receive with respect to hospital outpatient services.

Beneficiary - Individual covered under a federally funded healthcare program such as Medicare or Medicaid.

C.F.R. - Acronym for the Code of Federal Regulations. This is an annual accumulation of executive agency regulations published in the daily Federal Register, combined with regulations issued previously that are still in effect.

CAH - Means a facility designated by CMS as meeting the applicable requirements of section 1820 of the social Security Act.

Carrier - Independent contractor that administers Part B claims.

CEO - Acronym for Chief Executive Officer.

CFO - Acronym for Chief Financial Officer.

CHRO - Acronym for Chief Human Resource Officer.

CNO -Acronym for Chief Nursing Officer.

Triage -System implemented in Emergency Department which determines the order in which patients are seen or treated based upon the severity of illness or injury.

Coding - Process of assigning procedure or diagnosis codes for health care services.

Cost reporting - An annual filing required by Hospitals participating in the Medicare in which they identify and claim their costs.

CPT -Acronym for Code of Procedural Terminology. A system of codes for physician services that is published by the American Medical Association and that is part of HCPCS.

DHHS - Acronym for the Department of Health and Human Services which is the parent Department of CMS.

DOJ - Acronym for the Department of Justice which is the parent Department for the federal law enforcement agencies and the U.S. Attorney's Office.

DRG -Acronym for the Diagnosis-Related Group. One of the categories into which patients are classified for purposes of payment under the prospective payment system.

EMTALA - Acronym for the Emergency Medical Treatment and Active Labor Act. Refers to Title 42 U.S.C. 1395dd which was enacted to prevent patient dumping. Requires hospitals to provide emergency medical treatment to individuals presenting to a hospital with an emergent condition regardless of the individual's ability to pay. Requires Hospitals to stabilize patients prior to transferring patients and imposes civil penalties upon finding of a violation.

Excluded Providers - Refers to providers who have been excluded from participating in Federal or State health care programs as a result of the imposition of administrative sanctions imposed by federal or state enforcement agencies or violations of certain civil or criminal statutes relative to health care.

Exclusion - Potential administrative sanction resulting from violation of criminal or civil statute or as a sanction for violation of federal or state health care regulations.

False Claims Act - Refers to Title 31 U.S.C. 3729, which imposes civil fines on any individual who knowingly presents, or causes to be presented, to an officer or employee of the United States, a false or fraudulent claim for payment or approval.

FBI - Acronym for the Federal Bureau of Investigations, which is the Federal Law Enforcement-arm of the Department of Justice which conducts criminal investigations.

CMS - Acronym for the Centers for Medicare Medicaid Services which is the federal agency that administers Medicare and Medicaid.

HCPCS - Acronym for the HCFA Common Procedure Coding System. A uniform coding system used for Medicare Part B and Medicaid.

Hospital-Based Physicians -Includes specialists such as anesthesiologists, pathologists and radiologists. These types of specialties are dependent upon their position at the hospital to obtain referrals from other specialists practicing at their hospital.

ICD-9 -Acronym for the International Classification of Diseases, Ninth Edition. The ICD-9 is a coding system of diagnoses and procedures used in PPS and for identifying diagnoses on Part B bills.

Incident to - Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Inpatient -Refers to patients who are admitted to a hospital to receive health care services from the hospital.

Intermediary - Independent Contractor that administers Part A claims.

Kickback - Any illegal remuneration offered for the purpose of inducing a referral for an item or service which is payable by a federal health care program.

MDS -Acronym for Minimum Data Set. MDS is a comprehensive assessment instrument that CMS requires to be completed. The information is computed according to CMS formulas and results in the Resource Utilization Grouping (RUG) which determines the amount of reimbursement that a skilled nursing facility will receive for providing care to a skilled nursing facility resident.

Medical Screening Examination - Examination required under EMTALA to determine whether an emergent condition exists.

Medicaid - A cooperative state-federal program for medical assistance to the poor.

Medical Assistance Programs -General term referring to federal or state funded health care programs such as Medicare or Medicaid.

Medicare - Federal health insurance program which provides benefits covering certain inpatient hospital, nursing facility, home health, and hospice services under Part A and also provides benefits in the areas of physician services, durable medical equipment, and diagnostic tests under Part B.

OIG - Acronym referring to the Office of Inspector General which is responsible for investigating fraud and abuse and similar activities.

Outliers - Refers to Medicare cases in which HCFA provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary under certain conditions, such as the patient exceeded the mean length-of-stay for the applicable DRG.

Outpatient - Patient receiving hospital services that is not an inpatient.

Part A -Part of the Medicare Health Insurance Program which pays for inpatient hospital, nursing facility, home health and hospice services which is administered by a fiscal Intermediary.

Part B - Part of the Medicare Health Insurance Program which provides benefits for physician services, durable medical equipment, and diagnostic testing, and certain procedures performed in a non-hospital setting.

Plan of Care - The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates care required as well as the individualized modifications in approach necessary to achieve the long- term and short-term goals for the patient or resident.

Profiles (lab) -A combination of biochemical tests usually performed with automated instrumentation upon admission of a patient to a hospital or clinic.

Q&I -Acronym for Quality and improvements.

R.S. - Acronym for Revised Statutes.

RAI - Acronym for Resident Assessment Instrument used to evaluate nursing facility patients.

RUG - Acronym for Resource Utilization Grouping. Refers to a classification system which determines the level of reimbursement that a skilled nursing facility will receive for caring for a particular patient.

SNF - Acronym for Skilled Nursing Facility.

Social Security Act - Act enacted in 1965 which created the Medicare and Medicaid Programs.

Stark -Term referring to legislation passed by Congressmen Stark prohibiting referrals for designated health services by physicians to entities with whom the physician has a financial interest.

Stat -Term for "immediately". Sometimes used to signify an emergency.

Subpoena -Command issued by a court to commanding a person to appear at a designated place and time.

Subpoena Duces Tecum - Command issued by a court to a person to produce and permit inspection and copying of designated books, documents or tangible things in the possession, custody or control of that person, or to permit inspection of premises, at a time and place therein specified.

U.S.C. - Acronym for United States Code. Refers to collection of codified federal statutes.

Warrant - Document signed by a Magistrate or Judge authorizing a search of an identifiable place for evidence. May also refer to an authorization to arrest an individual.

Work Plan - Document produced by the Office of Inspector General details the various projects of the Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), Office of Investigations (OI), and Office of Counsel to the Inspector General (OCIG), that are to be addressed during the fiscal year (FY).