CORPORATE COMPLIANCE PROGRAM HANDBOOK

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Corporate Compliance Handbook

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a. Introduction

Crouse Health Hospital, Inc., d/b/a Crouse Hospital (the "Hospital") is committed to conducting its operations in an ethical and lawful manner. Accordingly, the Hospital has developed and implemented a Corporate Compliance Program that applies to all Hospital Employees and others who provide services on behalf of Crouse Hospital (collectively, “Employees”). The Hospital’s Compliance Program is intended to prevent, detect, and correct violations of applicable law, regulations, third-party payer requirements, Hospital’s policies/procedures, the Code of Conduct and other applicable standards.

The Compliance Program consists primarily of the key elements described in the Compliance Plan, Crouse Hospital’s Code of Conduct and various policies and procedures designed to implement the Compliance Program, all which are contained in this Corporate Compliance Program Handbook (the “Handbook”). The Handbook also contains a summary of the relevant health care fraud and abuse laws, including whistleblower protection laws. As described in greater detail in the Handbook, the Hospital has adopted a strict non-retaliation policy to protect its Employees for their good faith reporting of compliance-related concerns or issues.

b. Board of Directors’ Authorization

Crouse Hospital’s Board of Directors authorized the creation of a corporate compliance program. The purpose of the program to promote and support the highest standards of conduct-- legally, ethically and morally, on the part of the Hospital, its personnel and vendors, regarding all laws that regulate the Hospital, including, but not limited to, the applicable fraud and abuse laws.

The Board of Directors authorized the Hospital’s President to appoint a Corporate Compliance Officer. The Chief Quality Officer serves as the Hospital’s Corporate Compliance Officer (“CCO”). He/she works with the Corporate Compliance Performance Improvement Council (“CCPIC”), which serves as Crouse Hospital’s compliance committee.

Any questions concerning the Hospital’s Corporate Compliance Program should be directed to the CCO, or his/her designee.
Part II Compliance Plan: Summary of Key Elements

The key elements of the Hospital’s Compliance Plan are designed to help prevent, detect, and correct violations of applicable law, regulations, third-party payer requirements, Hospital’s policies/procedures, the Code of Conduct and other applicable standards. These key elements of Crouse Hospital’s Corporate Compliance Plan incorporate the applicable state and federal regulations and guidance. In addition, the Hospital has developed certain compliance policies and procedures designed to implement the key elements, which are also set forth in this Handbook.

Key Elements:


Crouse Hospital shall operate in accordance with applicable federal, state and local laws, standards pertaining to the delivery of patient care and the billing for such care. To this end, the Hospital has developed policies and procedures to foster compliance with such laws and standards and to promote conduct by the Hospital and its employees that is ethical and upholds our mission and values.

The Chief Compliance Office (“CCO”), or his/her designee, with input from the Corporate Compliance Performance Improvement Committee (“CCPIC”), shall oversee the development and implementation of policies pertaining to the Corporate Compliance Program and/or the Code of Conduct. Corporate Compliance Policies are reviewed periodically and in accordance with Hospital procedures. The Hospital shall update its standards, policies and procedures as necessary to remain current with applicable law and regulations, the needs of the Hospital and its Compliance Program and to reflect current ethical and legal business practices.

Employees who have questions, suggestions and/or concerns about current Hospital standards, policies, procedures, business, patient care or other practices should notify their supervisor or the CCO, or Compliance Hotline (315-470-7770) or by submitting a Compliance Form on the Hospital’s Intranet.

b. Delegation of Authority to the Compliance Officer and Committee.

Crouse Hospital has designated a Chief Compliance Officer (“CCO”), who reports directly to the Hospital’s President/CEO, and to the Board of Directors, including the Board Quality Improvement Committee. The CCO may delegate as appropriate certain duties of his/her office to other compliance professionals such as the Assistant Director of Compliance and the Compliance Manager. The CCO’s compliance authority and obligations are more fully explained in the Hospital’s CCO policy.

Crouse Hospital has also formed the Corporate Compliance Performance Improvement Committee (CCPIC”) to function as the compliance committee. The CCPIC meets monthly and is comprised of those individuals whose input is necessary for the proper oversight and implementation of the Hospital’s Compliance Program. The CCO is an active member of the CCPIC, as well as those individuals listed in the Policy on the Compliance Committee.

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1 18 NYCRR Part 521 (New York State Office of Medicaid Inspector General’s Provider Compliance Program regulations).

c. Provision of Compliance Education and Training.

Crouse Hospital conducts compliance training and education to help ensure that each employee, contractor or any individual who performs a function on behalf of Crouse Hospital is fully capable of executing his or her duties in conformity with applicable laws, rules, regulations, and other standards. It is an expectation of performance that employees meet their compliance education and training requirements. Failure to undergo compliance education and training may result in discipline, up to and including termination.

In general, employees shall undergo appropriate levels of compliance training during New Employee Orientation (NEO). Certain employees may also receive additional targeted compliance training depending upon the person’s job-related obligations and responsibilities.

Vendors and other contractors shall be provided access to Crouse Hospital’s policies and procedures to detect, prevent and avoid fraud and abuse and to information on the Hospital’s Compliance Program efforts as well.

d. Reporting Concerns and Complaints Through Open Communication and Compliance Hotline

Every employee has an individual responsibility to immediately report any activity involving or concerning the Hospital that appears to violate the Compliance Program, the Code of Conduct or any Hospital policy, as well as applicable laws, rules or regulations. Therefore, the Hospital has established a means for concerns or complaints to be reported in a safe and private manner. There is absolutely no retaliation permitted for the good faith reporting of actual or suspected compliance problems. Failure to report may, by itself, be a violation of the Hospital’s Compliance Program, which may subject the person to discipline, up to and including termination of employment of affiliation with the Hospital.

The Hospital shall publish phone numbers and other contact information for employees and others to report compliance-related concerns or issues and/or to ask questions or make suggestions about the Compliance Program.

e. Requiring Employee Participation in the Compliance Program and Discipline

It is the responsibility of every Crouse Hospital Employee to abide by applicable laws, regulations, support the Hospital’s compliance efforts, and to participate in the Corporate Compliance Program. Accordingly, each Employee must report his/her good faith belief of any suspected or actual violation of applicable local, state or federal law or Hospital policies and procedures, including, without limitation, the Hospital’s Compliance Program and Code of Conduct. There are many activities that could be considered a violation. A violation could be fraudulent billing suspicion, incorrect patterned claim activity, misrepresentation, stealing, breach of rules both internal and external, etc. In support of this principle, the Hospital has also adopted a strict non-retaliation policy prohibiting any retaliation against any Employee who in good faith reports a suspected or actual violation. The Hospital shall take reasonable and appropriate efforts to maximize a reporting Employee’s confidentiality and will honor all requests for confidentiality to the limit allowed by law.

f. Conducting Audits and Routine Identification of Compliance Risk Areas

Crouse Hospital shall assess its risk for noncompliance and shall take the steps necessary to reduce any identified compliance issues. The CCO, or his/her designee, in conjunction with the CCPIC and the necessary Hospital departments (for example, billing and coding) shall conduct ongoing and periodic reviews of the Compliance Program, its operations and systems.
g. Responding to and Investigating Potential Compliance Problems

Crouse Hospital takes potential compliance issues seriously and investigates compliance issues promptly, regardless of the source of the complaint or concern. The purpose of an investigation is to identify those situations in which applicable laws and regulations may not have been followed; to facilitate corrective action as necessary; and to implement procedures to ensure future compliance. The CCO, or his/her designee, has primary responsibility for conducting and/or overseeing investigations.

h. Non-Retaliation for Good Faith Reporting of Compliance-Related Concerns

The Hospital is committed to maintaining a workplace where Employees are free to raise good faith concerns regarding the Hospital’s business practices and the care of its patients. It is the responsibility of every Hospital Employee to abide by applicable laws and regulations and support the Hospital’s compliance efforts, including reporting their good faith belief of any violation of applicable local, state or federal law or Hospital policies and procedures, including, without limitation, the Hospital’s Corporate Compliance Program and Code of Conduct. The Hospital is committed to fostering a workplace that is conducive to open discussions by its Employees of its business and clinical practices. To promote an open culture, the Hospital has adopted a strict non-retaliation policy. The Hospital, in accordance with applicable local, state or federal law, and Hospital policies and procedures, including, without limitation, the Hospital’s Corporate Compliance Program and Code of Conduct, fully complies with all applicable whistleblower protections.
Part III

Code of Conduct

(Revised December 2010)
Code of Conduct

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A. Introduction

Why Have a Code of Conduct? To promote conduct that is honest, ethical and legal.

Crouse Hospital has adopted this Code of Conduct (also referred to as the “Code”) to provide standards and guidance by which employees, members of the medical staff, vendors and other individuals affiliated with Crouse Hospital will conduct themselves (Collectively referred to as “Employees”).

All Employees should strive to protect and promote patient’s rights, quality of care, Hospital-wide integrity, ethical business practices and fulfillment of our Mission, Vision and Values.

This Code of Conduct is a fundamental part of Crouse Hospital’s Corporate Compliance Program, and works together with our Mission, Vision and Value statements and our Corporate Compliance Policies and Procedures.

It is important for all Employees to understand personal obligations under this Code of Conduct. The Code does not cover every situation one may encounter. Instead, the Code contains principles that are intended to guide Employees in making ethical decisions in carrying out duties for or on behalf of Crouse Hospital.

All Employees share in the responsibility to uphold the principles of caring, honesty and integrity that are fundamental to this Code of Conduct.

If, at any time, you have questions, comments or suggestions regarding the Code of Conduct or your responsibilities under the Code, please call the Chief Corporate Compliance Officer at (315) 470-5776, or contact the Compliance Office at (315) 470-7477 and someone there will help you.
B. Crouse Hospital’s Mission, Vision and Values

Our Mission

To provide the best in patient care and to promote community health.

Our Vision

To be a leading healthcare provider in Central New York by:

1. Being committed to excellence in all areas of our organization by anticipating and exceeding the expectations of those we serve: our patients and their families, physicians, employees, volunteers and other partners;
2. Building a dynamic work environment where all are valued, respected and are provided the opportunity for personal and professional growth;
3. Developing and building on centers of excellence that support our mission;
4. Strengthening our relationships with other healthcare community providers to enhance our continuum of care for those we serve;
5. Operating in a fiscally responsible manner that allows us to provide the best in patient care and technology.

Our Values

C – Community – working together
R – Respect – honor, dignity, and trust
O – Open and honest communication
U – Undivided commitment to quality
S – Service to our patients, physicians and employees
E – Excellence through innovation and creativity
C. Code of Conduct Principles

1. Quality Patient Care

Our Mission, “To provide the best in patient care and to promote community health” requires the efforts and commitment of all Crouse Hospital Employees. It is an expectation that Crouse Hospital will provide high quality patient care, in a compassionate manner and in a safe environment. Each Crouse Hospital Employee should be committed to this expectation, even if such Employee does not provide direct patient care.

Reporting Concerns. Employees should report any incident of patient care or safety that does not appear to meet Crouse Hospital’s standards of care. Reports can be made to the Employee’s supervisor, the Compliance Office (315) 470-7477 and/or the Compliance Hotline (315) 470-7770 or compliance reporting form on the Crouse Intranet page. If an Employee is not satisfied with the response from the Hospital or believes a patient’s immediate health and safety is in jeopardy the Employee may contact the New York State Department of Health (“DOH”) at 1-800-804-5447.

In the event a patient approaches an Employee with an issue pertaining to patient care or other standards, he/she should also assist such patient in communicating such concerns to Crouse Hospital’s Guest Relations Department (470-7087). If a patient is not satisfied with the Hospital’s response, the patient/family will be given the proper contact information for the DOH.

Direct Care Providers. Employees who are directly involved in patient care must have the proper credentials, skill, expertise and competency to care for such patients. Each Employee should promptly and efficiently fulfill any personal responsibility he/she may have concerning the delivery of patient care and compliance with applicable standards of care. Care must be medically necessary, appropriate to the situation, safe and in conformity with applicable standards of care. As appropriate, the patient’s family should be kept informed of important aspects of the patient’s care.

Patient Rights. Every patient is entitled to receive a copy of the booklet Your Rights as a Hospital Patient in New York State. Employees should become familiar with patient rights and, as appropriate, are encouraged to help patients and their families understand their rights as well. Examples of patient rights include, but are certainly not limited to, informed consent to treatment, participation in decision-making, non-discrimination and confidentiality.

Emergency Care. Crouse Hospital provides emergency care to patients in accordance with state and federal law, including The Emergency Medical Treatment and Labor Act (EMTALA) and the relevant regulations published by the Centers for Medicare and Medicaid Services (“CMS”) to implement EMTALA. Crouse Hospital provides emergency care to patients regardless of the patient’s ability to pay and without delay.
**Patient Care Standards/Policies.** Crouse Hospital maintains extensive policies and procedures concerning patient care and rights. All Employees are encouraged to refer to the policies and procedures that relate to their Crouse Hospital work-related obligations, which are available from their department supervisor and on Crouse Hospital’s Intranet.

2. **Workplace Conduct**

Crouse Hospital works diligently to foster a safe, professional, cooperative and creative workplace for all Employees, and to comply with all health and safety laws and regulations governing the workplace.

Employees will strive to work collaboratively with colleagues and communicate respectfully to and about others, and in a positive manner.

Employees are expected to become familiar with and understand Crouse Hospital’s policies and procedures developed to promote the protection of the workplace and to observe all posted notices, warnings and regulations.

Employees shall comply with Crouse Hospital’s policy of a smoke and drug/alcohol free workplace. Employees must report to work free from the influences of illegal drugs and alcohol.

3. **Non-Discrimination**

Crouse Hospital believes that the fair treatment of Employees, patients and others is vital to the fulfillment of its Mission, Vision and Values.

Employees shall treat all persons with respect and shall not discriminate or harass in any manner any person on the basis of race, color, religion, sex, sexual orientation, gender and/or gender identity expression, marital or parental status, national origin, ethnicity, citizenship status, veteran or military status, age, disability or source of payment with respect to patients.

Crouse Hospital recruits, hires, trains, promotes, assigns, transfers, lays off/recalls and terminates all members of its workforce based on the individual’s ability, achievement, experience and conduct without regard to race, color, religion, sex, sexual orientation, gender and/or gender identity expression, marital or parental status, national origin, ethnicity, citizenship status, veteran or military status, age, disability, or any other classification protected by law. All allegations of discrimination and/or harassment shall be promptly investigated in accordance with human resources, corporate compliance or other applicable policies and procedures.
4. Compliance with Federal, State and Local Laws and Regulations

Crouse Hospital strives to ensure that all activity by or on its behalf complies with applicable laws and regulations. To foster this compliance, all Employees should familiarize themselves with the laws and regulations relating to the Employee’s position. Employees who have management or supervisory positions should also seek out professional development opportunities that will help them carryout responsibilities.

Employees who are licensed professionals should become familiar with the legal requirements associated with their licenses and should have an understanding of what actions constitute professional misconduct and should avoid such actions. The New York State Education Department provides detailed information on professional licensure requirements as well as information on professional misconduct: http://www.op.nysed.gov/prof/

The Compliance Office will develop educational programs to help Employees understand such applicable laws and regulations. If at any time, an Employee has questions regarding a law, regulation or related Crouse Hospital Policy, the Compliance Officer and/or Compliance Officer Staff can serve as a resource.

5. Health Care Fraud and Abuse Prevention

One of the primary goals of Crouse Hospital’s Corporate Compliance Program is to prevent and detect fraud and abuse. Health care decision-making must be based upon the patient’s medical needs, and must not be based upon financial benefits to Crouse Hospital, Employees (including medical staff), or that of any other entity or individual. Crouse Hospital is committed to this principle.

Crouse Hospital and its Employees may not give, receive, offer or ask for anything of value in exchange for referring patients, products, or services. This includes accepting anything of value for purchasing, leasing, ordering, arranging for, or recommending a particular product or service.

Crouse Hospital shall ensure that its relationships with Physicians satisfy the rules concerning the prohibition against physician self-referral (both the Federal Stark law and applicable state law). In addition, Crouse Hospital shall routinely screen employees, clinicians and vendor’s for their eligibility or exclusion with Medicare and Medicaid programs.

Crouse Hospital and its Employees must not submit false or fraudulent or misleading claims to any payer, including Medicare, Medicaid, or other government or commercial third party payers. Such prohibited claims include claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not comply with payer requirements. Furthermore, no one may make false representations to any person or entity for purposes of participation in a health care benefits program or to get a claim paid. Crouse Hospital shall report, repay and address the system/process issues in regards to overpayments submitted to these programs.

Employees must report suspected or actual fraud and/or abuse activities by calling the Compliance Office (315)-470-7477, the Compliance Officer (315)-470-5776 or the Compliance Hotline (315)-470-7770 or by submitting the compliance reporting form on the Crouse Intranet page. See the “Responsibility for Reporting” Section of this Code of Conduct for more details. Crouse Hospital does not retaliate against anyone who reports in good faith suspected or actual fraud and abuse or other concerns.
6. **Coding and Reimbursement**

Crouse Hospital promotes full compliance with all relevant billing and claims reimbursement requirements.

All persons who are involved in any aspect of the Hospital’s coding, billing and claims submission processes must be appropriately trained, credentialed and prepared for their responsibilities, including without limitation appropriate training with respect to the requirements of the Medicare and Medicaid programs.

The Hospital only bills for services actually rendered as reflected in the medical documentation. All clinical staff are required to document health care services in an accurate, organized, legible and timely manner and in accordance with applicable Medical Staff and Hospital policy.

7. **Accurate and Truthful Documentation**

Employees who are responsible for documenting in patient records, financial records or other Crouse Hospital business records must perform their duties accurately, truthfully, completely and in a timely manner. All patient records, financial and accounting reports, research reports, expense accounts, time sheets and any other documentation must accurately and clearly represent the relevant facts and the true nature of a transaction. No one may alter or falsify information on any Hospital record or document. Employees who suspect inaccurate documentation and/or record keeping must notify their supervisor and/or the Compliance Office, Compliance Officer or Hotline.

All records, both medical and business, shall be retained and disposed of in accordance with applicable law and Crouse Hospital’s specific record retention policies.

8. **Record Retention and Destruction**

All Employees must protect the integrity of the Hospital’s documents and records to ensure that records are maintained in accordance with regulatory and legal requirements, and for the required length of time. All records, both medical and business, shall be retained in accordance with the law and the Hospital’s specific record retention policies. Records and documents, which include both written and computer-based information, such as e-mail or computer files on disk or tape, shall be retained and destroyed in accordance with Hospital policy and procedures.
9. **Confidentiality**

Crouse Hospital has in its possession a broad variety of confidential, sensitive and proprietary information, which if inappropriately released, could be harmful to individuals, our business partners and to Crouse Hospital itself. Therefore, Employees should always safeguard confidential information concerning patients, employees, and business matters in accordance with Crouse Hospital’s policies and procedures and relevant state and federal law. Each Employee must always respect and maintain the privacy of confidential information, even after the Employee is no longer affiliated with Crouse Hospital.

Employees should become familiar with their department’s specific policies and procedures in addition to hospital-wide policies, such as the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Employees must also treat as confidential, salary, benefits, and other personal information pertaining to Employees. Personnel files, payroll information, disciplinary matters and similar information will be maintained in a confidential manner.

In addition to safeguarding patient and personnel information, Employees must also protect Crouse Hospital’s proprietary information. This means that Employees should not disclose the Hospital’s confidential business information, such as contractual arrangements, strategic plans, future marketing efforts, and financial information.

Generally, an Employee should only access and use the information necessary to perform the Employee’s work-related responsibilities and should only disclose information as authorized to others having an official need to know. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, Employees should seek guidance from their supervisor. Supervisors in turn should seek guidance from an appropriate Crouse Hospital administrator or the Compliance Office.

10. **Conflict of Interest**

A conflict of interest may occur if an Employee’s outside activities or personal financial interests influence or appear to influence the Employee’s ability to make objective decisions in the course of the Employee carrying out his/her Crouse Hospital responsibilities and obligations. Employees should always avoid such conflicts of interest.

An Employee should never use his/her position to profit personally or to assist others in profiting at the expense of Crouse Hospital.

Crouse Hospital requires certain Employees to disclose financial interest that the Employee (or the Employee’s immediate family member) may have that would interfere or affect the Employee’s responsibilities for on behalf of Crouse Hospital. Employees should refer to Crouse Hospital’s Conflict of Interest Policy for more details concerning conflicts.
11. Provider/Hospital Business Relationships and Referrals

Any business relationship or arrangement between the Hospital and a physician, physician entity or other healthcare provider must be structured to ensure compliance with all legal requirements, including, but not limited to, the fraud and abuse laws and regulations, and to avoid jeopardizing the Hospital’s tax-exempt status as a not-for-profit entity. Such relationships and arrangements must be documented in writing, signed by the parties and subject to review and approval by the Hospital’s counsel.

The Hospital does not pay for patient referrals. The Hospital’s acceptance of patient referrals and admissions is based on the medical needs of the patient and its ability to provide needed services. All Hospital Directors, officers and Employees are prohibited from paying or offering to pay, directly or indirectly, for referral of patients. In addition, the Hospital will not accept payments for the referrals it makes to a provider, nor take into account the volume or value of referrals that the provider has or may make to the Hospital. No Hospital Director, officer or Employee shall accept or solicit any payment or item of value, directly or indirectly, for referrals of patients to the Hospital.

12. Protection of Crouse Hospital Assets

Employees must strive to preserve Crouse Hospital’s assets, including equipment, materials, supplies, time and information, and to protect assets from loss, damage, theft, misuse, and waste.

Employees must not remove Crouse Hospital’s equipment, materials and supplies from the premises for personal use and must only use such assets as authorized under Crouse Hospital policy.

Employees whose responsibilities include the management of departmental funds shall maintain internal controls and record keeping and shall exercise appropriate oversight. Any use of Crouse Hospital’s resources for personal financial gain unrelated to Hospital business is not permitted.

Employee’s use of travel expenses must be consistent with the Employee’s job responsibility and Crouse Hospital’s needs and resources. Employees are expected to exercise reasonable judgment in incurring travel expenses and shall provide sufficient documentation for purposes of reimbursement.

As mentioned, time is also an asset. Employees shall report time and attendance accurately and shall use their work time productively.
13. **Gifts and Gratuities**

Gifts that influence decision-making by or on behalf of Crouse Hospital are not permitted. Employees are prohibited from soliciting tips, personal gratuities or any gifts from patients or their family members and from accepting any monetary tips or gratuities. Employees may accept (if offered), gifts of appreciation of no more than a nominal value from patients/families such as flowers, food or candy. Monetary gifts of any value may not be accepted. If a patient or another individual wishes to present a monetary gift, he/she should be referred to the appropriate department director or vice president or Hospital Foundation.

Employees may not accept or solicit from the Hospital’s business associates or vendors, individually or on behalf of Crouse Hospital, gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting the Hospital might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, customer, government official or other person is absolutely prohibited. Employees must report any such conduct to the Employee’s supervisor and/or the Corporate Compliance Office.

14. **Tax Exempt Status**

Crouse Hospital is a not-for-profit, tax exempt organization and has certain legal and ethical responsibilities. Importantly, Crouse Hospital is obligated to engage in activities that support its charitable purposes and to ensure that its resources are used in a manner that furthers the public good rather than the private or personal interests of any individual. As a result, Crouse Hospital and its Employees will only enter into compensation arrangements that reflect fair market value for the service or item. In addition, Crouse Hospital will accurately report tax payments and will file all tax information and returns in a lawful manner.

15. **Political/Lobbying Activity**

Participation by Crouse Hospital in a political campaign or lobbying could jeopardize the Hospital’s tax-exempt status. Therefore, Employees may not use Crouse Hospital’s funds, time, equipment or other assets to campaign for or against any political candidate, or to engage in a lobbying activity. This includes contributing t-shirts, hats or any other tangible item that includes the Crouse logo.

Employees may participate in or contribute to, a political/lobbying activity of their choosing as a private citizen, but not as a Crouse Hospital representative.

Crouse Hospital, where its experience may be helpful, may publically offer recommendations concerning legislation or regulations being considered. In addition, Crouse Hospital may analyze and take public positions on issues that have a relationship to the operations of the Hospital when our experience contributes to the understanding of such issues.

Crouse Hospital has many contacts and dealings with governmental agencies and officials. Crouse Hospital and its Employees shall conduct all such contacts and transactions in an honest and ethical manner. No one shall attempt to influence the decision-making process of government agencies or officials by an improper offer of any benefit. Employees should immediately report any suspected or actual improper requests or demands by a government agency or official to the Corporate Compliance Officer.
16. **Fair Competition**

Crouse Hospital strives to ensure that all activity by or on its behalf complies with laws governing fair competition (these laws are also known as “antitrust laws”). These laws prohibit certain activity that could give an organization an unfair business advantage over a competitor. Examples of prohibited unfair competition activities include: agreements to fix prices, bid rigging, collusion with competitors, boycotts, certain exclusive dealing and price discrimination agreements, unfair trade practices, including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. Employees must not engage in prohibited unfair competition activities and must seek advice from the Corporate Compliance Officer when confronted with business decisions which might violate these laws.

17. **Marketing**

Crouse Hospital may use marketing and advertising activities to educate the public, provide information to the community and increase awareness of Hospital services. The Hospital will present only truthful, fully informative and non-deceptive information in these materials and announcements.

18. **Prescription Drugs and Controlled Substances**

Crouse Hospital is committed to the safe and legal handling of all drugs and controlled substances. Employees having responsibility for, or access to, prescription drugs, controlled substances, over-the-counter drugs, or any street-valued medical supply (hypodermic needles for example) shall maintain the highest possible professional and ethical standards with regards to such drugs and supplies. Employees should become familiar with the laws, internal policies, and patient care standards that govern their work with these substances and supplies. Drugs must only be provided upon an order of a licensed provider who is authorized by New York State to write prescriptions. Employees shall take care to keep drugs secured at all times and not available to individuals who do not have a prescription. Employee must follow Hospital policy and procedures for handling outdated or unused drugs. Employees must immediately report any inappropriate distribution or diversion of drugs or supplies, or theft/loss of prescriptions, to their supervisor or the Compliance Officer.

The New York State Bureau of Narcotic Enforcement provides many references for providers concerning drug diversion and other controlled substances issues on its website: [http://www.health.state.ny.us/professionals/narcotic/practitioners/](http://www.health.state.ny.us/professionals/narcotic/practitioners/)

19. **Environmental Health and Safety**

Crouse Hospital shall manage and operate its business in a manner that respects our environment and conserves natural resources. Employees shall comply with the Hospital’s safety and health policies to help ensure that patients, visitors, the workforce and others are protected from unnecessary risks and unsafe conditions.

For example, Employees shall dispose of all waste in accordance with applicable laws and regulations and shall strive to utilize resources appropriately and efficiently, including recycling where possible. Employees shall immediately report suspected violations of an environmental or occupational health and safety law and shall work cooperatively with the appropriate authorities to remedy any environmental contamination that may occur in the workplace.
20. **Scientific and Clinical Research**

Crouse Hospital encourages the conduct of research in each of its departments, and in collaboration with other educational institutions, agencies, and organizations. In this regard, the Hospital is firmly committed to adhering to the basic ethical principles underlying the acceptable conduct of research involving human subjects, as set forth in The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. These three principles, respect for persons, beneficence, and justice are particularly relevant to the protection of human subjects in biomedical and behavioral research, and are the accepted requirements for the ethical conduct of such research.

- **Respect for persons** involves recognition of the personal dignity and autonomy (self-rule) of individuals, and special protection of those persons with diminished autonomy.

- **Beneficence** entails an obligation to protect persons from harm by maximizing anticipated results and minimizing possible risks of harm.

- **Justice** requires that the benefits and burdens of research be distributed fairly.

Employees who are involved in proposing and/or conducting research activities will ensure that their work is conducted with the highest ethical standards in accordance with federal, New York state and local laws and regulations, and applicable Hospital policy and procedures, including those from the Hospital’s Institutional Review Board (“IRB”). Employees must always document accurately, truthfully and completely and must never make up and/or falsify research data or results. Employees who have concerns or questions regarding a research activity should contact their supervisor, the Corporate Compliance Officer or the Hospital’s IRB Administrator at (315) 470-8836.

21. **Government Investigations, Accreditations and Surveys**

Crouse Hospital and Employees shall cooperate fully and promptly with appropriate government investigations into potential violations of the law and to the efforts of our accrediting and surveying agencies. Governmental and/or agency inquiries or requests should be promptly referred to the Corporate Compliance Officer or Hospital Administration.

Crouse Hospital promptly and thoroughly investigates reports of suspected illegal activities or violations of the Corporate Compliance Program or this Code of Conduct. Employees must cooperate with such investigations and may not take actions to prevent, hinder or delay discovery and full investigation. For example, Employees must never alter or destroy records or documents requested in the course of an investigation, nor shall Employees make a false or misleading statement on such documents or to an investigator. Also, Employees must never pressure any person to provide false information to, or to hide information from, an investigator.
22. Responsibility for Reporting

Corporate Compliance is everyone’s responsibility. Therefore, all Employees are required to report their good faith belief of any suspected or actual violation of the Code of Conduct, the Corporate Compliance Program, other Hospital policies or applicable law. Sometimes it is unclear whether a particular activity or situation may be a violation of the Code or the Compliance Program. When this happens, Employees should contact their supervisors or the Compliance Officer/Officer.

Reports of suspected or actual violations can be made in a number of ways as described below:

- Orally or in writing to the Employee’s director/supervisor;
- By calling the Corporate Compliance Officer at 315-470-5776; the Compliance Office at 315-470-7477, or the Compliance Hotline at 315-470-7770;
- By mailing a written concern or complaint to the Corporate Compliance Officer; and/or
- By submitting the compliance reporting form on the Crouse Intranet page.

Crouse Hospital, at the request of the Employee, will maintain the confidentiality of the reporting Employee to the extent possible, consistent with its obligations to investigate the Employee’s concerns and take necessary corrective action. Anonymous reporting is available. However, the Hospital will be unable to provide feedback if anonymous reports are made.

Employees who fail to report suspected or actual violations are themselves violating this Code and our Corporate Compliance Program and may be subject to discipline, which could result in termination from employment or affiliation with the Hospital.

23. Non-Retaliation

Crouse Hospital is committed to fostering a workplace that is conducive to open discussion by its Employees of its business and clinical practices. To promote an open culture, the Hospital has adopted a strict non-retaliation policy to protect its Employees. Accordingly, there will be no retaliation in the terms and conditions of employment or affiliation as a result of an Employee’s good faith reporting of a violation or suspected violation. Any manager, supervisor or other Employee who commits or condones any form of retaliation will be subject to discipline up to, and possibly including, termination. For more information regarding applicable non-retaliation and whistleblower protection laws, please refer to Appendix B of Crouse Hospital’s Corporate Compliance Program Handbook and to the Non Retaliation Corporate Compliance Policy.
24. Enforcement of the Code of Conduct

Employees must understand that they will be subject to discipline for violations of the Code of Conduct, up to and including termination of employment or affiliation with Crouse Hospital. The specific disciplinary action depends upon the nature and severity of the violation. Crouse Hospital imposes sanctions in a consistent manner in accordance with Hospital policy and procedures.

Examples of violations of the Code which could result in disciplinary action include:

- Participating in activities that violate the Code;
- Encouraging others to violate the Code;
- Failing to report suspected violations of the Code; and
- For employees who are supervisors or managers, failing to detect violations of the Code, if such violation should have been discovered in the reasonable course of the Employee’s job responsibilities.
Part IV

Selected Policies and Procedures
I. Policy

It is the policy of Crouse Hospital to have policies and procedures in place to address issues related to the compliance with laws and regulations pertaining to its corporate business practices, including those pertaining to the development, implementation and evaluation of Crouse Hospital’s Corporate Compliance Program’s policies and procedures. This Policy is subject to the requirements, as applicable, of Crouse Hospital’s policy entitled “Policy and Procedure Development” which provides a mechanism for the development/management, distribution, communication and documentation process of Hospital policies and procedures in general.

II. Purpose

The Purposes of this Policy is to establish the mechanism for development, implementation, evaluation and revision as necessary of policies and procedures for matters that pose a risk of noncompliance with laws, regulations and standards of business and ethical practice embodied in Crouse Hospital’s Code of Conduct and Corporate Compliance Program.

III. Scope

This Policy applies to all Corporate Compliance Program Handbook Policies and Procedures.

IV. Procedures

In addition to the applicable requirements set forth in the policy entitled “Policy and Procedure Development” referenced above, the following applies:

a. The Corporate Compliance Performance Improvement Council (“CCPIC”) shall receive for approval, policies and procedures relating to Corporate Compliance and the Code of Conduct. The CCPIC shall discuss and shall hear presentations on an as needed basis on those policies and procedures relevant to the Corporate Compliance Program and the Code of Conduct.

b. The CCPIC is authorized to make technical changes to the Corporate Compliance Program Handbook and policies and procedures.

c. To the extent a new Corporate Compliance policy or an amendment to an existing policy is deemed by the CCPIC to materially modify the Corporate Compliance Program, the CCPIC shall submit such amended policy to the Crouse Hospital Board of Directors for review and approval.
V. Policy

It is the policy of Crouse Hospital to identify the accuracy in billing of services with regards to patients following their date of expiration according to state records. It is the responsibility of Crouse hospital to maintain procedures in which the accuracy of expired patient claims submitted is consistently monitored and upheld. The proper management of such claims will assist in avoiding activities which may be considered fraudulent, abusive or wasteful.

VI. Purpose

The purpose of this Policy is to identify expired patients and properly review and/or correct any charges which are posted after a discharge date (and/or prior to admission). This policy shall assist in fostering appropriate billing practices and in the prevention of fraudulent, wasteful billing in order to avoid a potential false claim.

VII. Scope

This Policy applies to the Business Office, Patient Access, Health Information Management, Finance, Corporate Compliance departments and any individuals involved in the processing of handling deceased patient accounts (i.e. Billers, Patient Access Reps, Coders, etc).

VIII. Procedures

a. The billing staff receives daily report number *$PXICHG Inpatient prior to admission date or after discharge date. The discharge date on a patient account is when the patient is discharged to home, transferred to another facility or expired. Discharge dates are entered by Admitting staff who receive notification from Premise. Premise is maintained by the nurses on the floors.

b. Expired patients will show in Patient Accounting with an asterisk (*) next to EXP IND. The discharge status on a UB or 837 I will show as 20.

c. When charges are posted after the discharge date, billers receive a daily report as noted above next to SPECIAL INFORMATION. Any charges posted prior to admission date or after discharge date need to be reviewed for correct location and service dates.
Billing and Charges for Expired Patients (Continued)

d. Billers may also look up orders and when the patient received tests in HPF (Document Imaging). They can also call the department who posted the charge for any clarification needed. No orders or documentation test need to be credited off the account.

e. If orders are located and documented test given, but the charge date is incorrect on the patient account, remove the incorrect charge and add the charge with the correct service date.

f. Remember to enter/include notes on the patient account.

g. The TCE report should also be checked. The TCE report is maintained by the System Maintenance staff. The charges do not post to the patient account with a service date after the discharge date and these are noted on the report. The System Maintenance staff would research where the charge belongs, make the correction and note the account.
I. Policy

The Hospital has designated a compliance officer and committee to oversee and implement the Hospital’s Code of Conduct and Compliance Program (“Compliance Program”) and to ensure compliance with the relevant laws, rules and regulations, and government (including Medicare, Medicaid) and private payer requirements.

II. Purpose

The purpose of this Policy is to set forth the structure of the Hospital’s corporate compliance committee, which is known as the Corporate Compliance Performance Improvement Council (“CCPIC”); describe the composition of the CCPIC and its responsibilities, and those of the Chief Compliance Officer (“CCO”).

III. Scope

This Policy applies to all individuals who will comprise the CCPIC and serve as the CCO, and his/her designees.

IV. Procedures

a. Responsibilities of the CCPIC.

The CCPIC will provide strategic direction and oversight of the operation of the Compliance Program. The CCPIC will assist in the operation, evaluation and amendment of the Compliance Program which includes, but is not limited to, the following:

i. Receiving and acting upon reports and recommendation of the CCO, or his/her designee;

ii. Conducting periodic analysis of the current health care environment, the legal requirements to which the Hospital is subject, and identification of specific risk areas;

iii. Reviewing and assessing the Compliance Plan policies and procedures as well as other existing policies and procedures that address risk areas, and making recommendations accordingly;
Compliance Officer and Committee (Continued)

iv. Working with Hospital departments to develop standards of conduct and policies and procedures to ensure effective implementation of the Compliance Program;

v. Monitoring internal systems and controls implementing Compliance Program’s standards, policies and procedures which incorporate them into daily Hospital operations;

vi. Maintaining appropriate strategies to promote compliance and the detection of potential violations, including the hotline or other fraud reporting mechanisms;

vii. Monitoring the status of internal and external audits conducted pursuant to the Compliance Program and implementing corrective and preventive action;

viii. Submitting an annual formal report to the Board of Directors regarding the status of the Compliance Program and any recommended changes or amendments; and

ix. Making additional reports to the Board of Directors as necessary.

b. Composition of the CCPIC.

The composition of the CCPIC includes the following:

i. Director of Risk Management/Assistant Compliance Officer (co-chair);

ii. Physician (co-chair);

iii. CCO;

iv. Corporate Compliance Manager;

v. Director of Quality Improvement;

vi. Director- School of Nursing;

vii. Director- Opiate Treatment Services/Commonwealth Place;

viii. Director- Health Information Management (Privacy Officer);

ix. Director- Business Office;

x. Manager- Coding;

xi. Director- Education;

xii. Director- Finance (Reimbursement);

xiii. Director- Human Resources;

xiv. Information Technology Security Officer;

xv. Director- Business Development and Strategic Planning;

xvi. Manager- Business Development (Physician Relations); and

xvii. Ad Hoc membership based upon projects or issues.

c. Meetings of the CCPIC

The CCPIC generally meets on a monthly basis and reports to the Quality Improvement Committee of the Board of Directors. The CCO or his/her designee shall document a summary of items addressed and action taken at each CCPIC meeting. CCPIC meeting documentation shall be retained in accordance with the Hospital’s record retention policies.
Compliance Officer and Committee (Continued)

d. Compliance Officer’s Responsibilities

The CCO, who reports directly to the Hospital’s President/CEO, shall be responsible for the day-to-day operation and oversight of the Compliance Program. The CCO may designate as he/she deems appropriate, an individual, such as the Director of Risk Management/Assistant Compliance Officer and/or the Compliance Manager, to assist in the day to day operation and duties of the CCO which may include, without limitation, the following:

i. Reporting on a regular basis to the Board of Directors, the President/CEO, and the CCPIC;

ii. Administering the Compliance Program;

iii. Developing policies and procedures to implement and improve the Compliance Program;

iv. Revising the Compliance Program as necessary to address changes in the Hospital and in the applicable laws, policies and procedures of government and private payer health plans;

v. Developing and participating in a multifaceted educational and training program focusing on the elements of the Compliance Program and ensuring all employees and management are knowledgeable of and comply with pertinent federal, state and local laws;

vi. Ensuring that employees, independent contractors and agents who furnish medical, billing and coding services to the Hospital are aware of the requirements of the Hospital’s Compliance Program;

vii. Coordinating efforts by Hospital departments to implement the Compliance Program;

viii. Coordinating personnel issues with the Hospital’s Human Resources Department and Medical Staff Office to ensure that the National Practitioner Data Bank and the excluded provider lists are regularly reviewed with respect to all employees, medical staff, and independent contractors;

ix. Supervising, coordinating and/or conducting internal compliance review, audit and monitoring activities, including annual or periodic review of Hospital departments to determine compliance and coordinating any resulting corrective action;

x. Independently investigating matters related to compliance, including the design and coordination of investigations, the initiation of a response to reports of problems or suspected violations, and the application of necessary corrective action with all Hospital departments, providers, agents and independent contractors;

xi. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation;

xii. Recommending disciplinary action for those employees found to be in violation of the Compliance Program; and

xiii. Meeting with the Hospital’s legal counsel to help ensure that the Hospital remains in compliance with all applicable Federal and state laws and regulations with respect to its business arrangements and relationships.
Compliance Officer and Committee (Continued)

e. Compliance Officer’s Authority
   i. The CCO shall have the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, marketing records, and contracts with other parties, including employees, staff professionals, independent contractors, suppliers, agents, and Hospital-based physicians.

   ii. The CCO shall have the authority to review all contracts and obligations of the Hospital, seek the advice of legal counsel where appropriate, with a particular concern for referral and payment issues that may violate the anti-kickback statute, as well as the physician self-referral prohibition and other legal or regulatory requirements.

   iii. The CCO should be an employee of the Hospital who is familiar with the operation of the Hospital, has the authority to recommend and implement operational changes within the Hospital and is someone who is regarded as being approachable by all employees of the Hospital.

   iv. The CCO shall have authority to stop the processing of claims for services that he or she believes are problematic until such time as the issue in question has been resolved.
I. Policy

It is the policy of Crouse Hospital to conduct an effective compliance training and education program to help ensure that each employee, contractor or any other individual who performs a function on behalf of Crouse Hospital is fully capable of executing his or her duties in conformity with applicable laws, rules, regulations, and other standards.

II. Purpose

The purpose of this Policy is to set forth the general education and training guidelines and goals of Crouse Hospital’s Corporate Compliance Program.

III. Scope

This Policy applies throughout Crouse Hospital. Individuals required to undergo compliance education may include, but are not necessarily limited to, employees, staff, officers, volunteers, and other individuals (collectively referred to as “Employees” for purposes of this Policy) as well as Members of the Hospital’s Board of Directors.

IV. Procedures

   i. The Chief Corporate Compliance Officer (“CCO”), in collaboration with the Corporate Compliance Performance Improvement Council (“CCPIC”), is responsible for general oversight of Employee compliance education and training. The CCPIC serves as the Hospital’s Corporate Compliance Committee.
   ii. The Corporate Compliance Manager, or his/her designee, shall conduct the Employee compliance educational sessions required by this Policy, and/or shall ensure that such sessions occur. The Corporate Compliance Manager may carry out this responsibility in cooperation with Educational Services, and other Crouse Hospital departments as appropriate.
Compliance Education and Training (Continued)

b. Board of Directors.
Each Member of the Board of Directors shall receive initial compliance training soon after appointment to the Board and on a regular basis thereafter, during such Member’s term. Generally, the CCO shall provide such instruction to Board Members. Each Board Member shall receive a copy of the Code of Conduct, and shall be given access to the current Corporate Compliance Program Handbook (which contains Crouse Hospital’s compliance policies and procedures). The CCO shall document the distribution of the Code of Conduct to Board Members.

   i. Distribution to Employees. All new Employees are directed on where to find the Code of Conduct and Corporate Compliance Handbook at New Employee Orientation (“NEO”). The Code of Conduct and Crouse Hospital’s Corporate Compliance Program Handbook shall be available as amended on the Hospital’s web site; Crouse.org and the Crouse Hospital Intranet CNN web page. Employees may also access a hard copy of the Code of Conduct and the Corporate Compliance Program Handbook by calling the Compliance Office at (315) 470-7477.
   ii. Website. The Code of Conduct and Crouse Hospital’s Corporate Compliance Program Handbook available on the website shall be maintained and periodically updated by the Corporate Compliance Manager or his/her designee, in cooperation with Information Technology.

d. New Employee Orientation.
   i. Scope of General Orientation. All new employees shall undergo appropriate levels of compliance training during New Employee Orientation (NEO) and annually thereafter.
   ii. Content of NEO. Compliance-related matters covered in NEO may include, but are not limited to, the following areas:
      1. General overview of Crouse Hospital’s Code of Conduct and Corporate Compliance Program;
      2. Relevant health care fraud and abuse laws;
      3. How to contact the Compliance Office/CCO;
      4. Crouse Hospital’s non-retaliation policy;
      5. Other compliance topics as deemed appropriate by the CCPIC, CCO, and/or Compliance Manager.

e. Annual Compliance Update.
   Computer-Based Training. For purposes of completing annual compliance training, Employees shall participate in computer-based compliance education and training modules. The CCO, or his/her designee in consultation with the CCPIC, shall determine the content and duration of annual compliance training materials.
Compliance Education and Training (Continued)

f. Job Specific/Targeted Compliance Education and Training.
   i. **Targeted Education.** Crouse Hospital recognizes that the duties of certain Employees affect the accuracy of claims for reimbursement submitted to Government payers, such as Medicare and Medicaid, and to private payers. Consequently, it is important for certain Employees to receive targeted compliance education and training, including periodic updates.

   ii. **Employees Identified for Targeted Education.** The CCO or his/her designee in consultation with the CCPIC and various departments (for example, Coding) shall identify those Employees who require targeted education. Examples of such Employees include, but are not limited to, billing and coding staff, patient accounting, finance, and marketing.

   iii. The CCO or his/her designee in consultation with the CCPIC and various departments shall develop and implement targeted compliance education and training.

g. Other venues for education.
   i. **College of Nursing Orientation.** The Corporate Compliance Office shall be included in either the first or second day of the College of Nursing Orientation program. The compliance office will speak no less than 30 minutes to new students about what compliance is, what role compliance plays at Crouse and at the School, elements of a compliance program (ie- Compliance Officer and hotline number, fraud and abuse) and privacy and confidentiality of patient information.

   ii. **GOLD Program.** The Corporate Compliance Office shall be included in the GOLD (Growth Opportunity in Leadership Development) Program during the first or second week’s schedule. The Corporate Compliance Office will educate newly hired and promoted leaders about compliance, the role of compliance at Crouse, elements of a compliance program (ie- Compliance Officer and hotline number, fraud and abuse). The Compliance Office shall speak no less than 1 hour.

   iii. **Management Meetings.** The Corporate Compliance Office shall educate Senior Leadership and the Crouse Management staff on Compliance topics once a quarter during monthly Management meetings. Topics for education will be relevant to current trends, occurrences within the organization, and/or changes or updates in legislation.

   iv. **Other programs/meetings.** The Corporate Compliance Office shall make themselves available for any other department meetings or ad-hoc education sessions. For example, the Corporate Compliance Office will attend Nursing Practice Council when invited, to discuss various compliance issues that affect the nursing staff.

h. Other Forms of Communication.
   i. **Hospital-Wide Email.** The Corporate Compliance Office shall develop and maintain compliance-related email announcements and messages designed to further the values and goals of Crouse Hospital’s Corporate Compliance Program.

   ii. **Pink Sheet.** The Pink Sheet is a Crouse Hospital publication that informs Employees of Crouse Hospital's current events. The Corporate Compliance Manager, or his/her designee, shall periodically submit for inclusion in the Pink Sheet short articles with compliance-related topics and information.
Compliance Education and Training (Continued)

iii. CNN Intranet. Beginning in 2010, ‘Fact Sheets’ will be housed on the CNN intranet for multiple access and hospital-wide use. These compliance related ‘fact sheets’ will discuss such topics as: Compliance 101, Breaches, Red Flags, RHIO’s (Regional Health Information Organizations), RAC (Recovery Audit Contractors), FHCDATA (Family Health Care Decision Act), Fraud-Waste-Abuse, etc. The ‘fact sheets’ will help facilitate departments, Managers or Directors answer questions they may have on any given compliance topic. The ‘fact sheets’ will encourage the reader to contact the Corporate Compliance team for further questions or clarification. The ‘fact sheets’ will be updated as rules, regulations, updates/changes and need dictates. They will be found on the left side column near the Corporate Compliance Reporting form.

iv. Hospital-wide ‘Fairs’. The Compliance Office will participate in any and all hospital Fairs where compliance is applicable. For Example; the annual National Compliance and Ethics week (spring) will be celebrated by organizational wide education (including off-sites). Compliance will participate in the hospital’s annual Safety Fair (fall).

i. Deficit Reduction Act of 2005 Compliance.
   i. Crouse Hospital must establish/maintain detailed written policies regarding:
      1. The federal False Claims Act;
      2. The New York State False Claims Act;
      3. Any other applicable state civil or criminal laws and state and federal whistleblower/non-retaliation protections; and
      4. Crouse Hospital’s policies and procedures for detecting and preventing waste, fraud and abuse.

   ii. Crouse Hospital, under the direction of the CCO, or his/her designee, must disseminate the policies and information referenced above in section (h)(i) of this Policy to all:
      1. Employees; and
      2. Contractors, subcontractors and agents who, on behalf of Crouse Hospital, furnishes, or authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by Crouse Hospital.

j. Professional Educational Courses.
   Periodic professional continuing education courses required by applicable state and/or federal law and regulation for certain Crouse Hospital personnel shall be administered by Human Resources and/or Educational Services.
Compliance Education and Training (Continued)


i. **Attendance Required.** Attendance at NEO and participation in annual/periodic compliance education and training (including targeted sessions for certain Employees, as applicable) is an expectation of performance for all Employees, which shall be reflected in Employee evaluations. A log for all various types of compliance education activity will also be kept in the Corporate Compliance share drive. This log (‘Compliance Record of Education’) will also keep a running tally of the time in minutes and hours that have been spent on compliance education.

ii. **Sanctions.** Failure to attend and/or participate in required compliance education and training sessions may result in discipline, up to and including termination of employment or affiliation with Crouse Hospital.

l. Documentation and Retention of Attendance Logs and Other Materials.

i. Educational Services, in collaboration with the Corporate Compliance Office, shall maintain attendance logs for all compliance education and training sessions conducted. Attendance logs should include, but are not necessarily limited to, the following information:
   1. Employee name and title;
   2. Employee’s department;
   3. Date and time of attendance;
   4. General description of the educational session (attach program information/handouts to logs).

ii. Attendance logs plus program attachments and other documentation required by this Policy shall be retained for a minimum of six years, or in accordance with the Hospital’s record retention policies and procedures, whichever is longest.

m. Yearly Reevaluation of Compliance Education and Training Program.

i. At least annually, the CCPIC shall evaluate the effectiveness of Crouse Hospital’s corporate compliance education and training efforts.

ii. The CCPIC shall take into consideration the OIG’s and OMIG’s annual work plans and other compliance initiatives in developing the content of future compliance education and training programs.

V. References

a. US DHHS, OIG Hospital Compliance Guidance, 1998; Supplemental Hospital Compliance Guidance, 2005; The OIG’s website is: [http://oig.hhs.gov/](http://oig.hhs.gov/)

b. NYS OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521. OMIG’s website is: [http://www.omig.state.ny.us/data/](http://www.omig.state.ny.us/data/)
I. Policy

Every Employee has an individual responsibility to immediately report any activity within the Hospital that appears to violate the Compliance Program, the Code of Conduct or any Hospital Policy, as well any applicable laws, rules or regulations. Accordingly, the Hospital has established a compliance reporting system for Employees to report their good faith belief of violations or for any questions about the Compliance Program. Within the limitations of the law and particular circumstances, communications with the Chief Compliance Officer (“CCO”), or his/her designee will be kept confidential.

The Hospital shall publicize the Compliance Hotline Number (315-470-7770) to Employees and affiliates, including during New Employee Orientation and periodically through other Hospital publications.

II. Purpose

The purpose of this Policy is to establish a system for Employees and others to ask questions or raise concerns about the Compliance Program, Code of Conduct and other policies; and to foster an open means of communicating reports of suspected or actual violations or concerns of the Hospital’s business and patient care practices.

III. Scope

This Policy applies Hospital-wide.

IV. Procedures

a. Required Reporting. Employees are required to report their good faith belief of a violation, or suspected violation, of applicable local, state or federal law and/or regulations, Hospital policies and procedures, the Corporate Compliance Program and the Code of Conduct.

b. Non-Retaliation. There is no retaliation in the terms and conditions of employment or affiliation as a result of an Employee’s good faith reporting of a violation or suspected violation. (Refer to Hospital’s Non-Retaliation Policy for more detail).
Communication, Compliance Hotline and Reporting (Continued)

c. **Methods to Submit Reports.** Concerns or reports of suspected or actual violations may be made to the Hospital in a number of ways as described below.

1. Orally or in writing to the Employee’s director/supervisor (unless the Employee is not comfortable calling his/her supervisor, in which case the other means listed are available);
2. By calling the CCO at 315-470-5776; the Compliance Office at 315-470-7477, or the Compliance Hotline at 315-470-7770;
3. By mailing a written concern or complaint to the CCO; and/or
4. By submitting the Compliance Reporting Form on the Crouse Intranet page.

d. **Anonymous Reporting.** Anonymous reports are permissible but the Hospital will be unable to provide feedback to the reporting party if anonymous reports are made.

e. **Requests for Confidentially.** The Hospital will honor all requests for confidentiality to the limit allowed by law. If it becomes necessary to take steps that might reveal a reporting party’s identity, if possible the Hospital will make a good faith effort to alert the party in advance.

f. **Detailed Information.**

1. Whether reporting orally or in writing, reporting parties should provide detailed and accurate information, including names, dates, times, places and the specific conduct in question or believed to be in violation.
2. Reporting parties wishing or agreeing to be contacted must provide the appropriate contact numbers/addresses.

g. **Compliance Log.** The CCO, or his/her designee, shall document compliance reports and concerns in the Compliance Reporting Log (See the Appendix to the Corporate Compliance Program Handbook).
I. Policy

Consistent with the Hospital’s Code of Conduct, the Hospital Bylaws and this Policy, Covered Persons, as defined below, owe a duty of undivided and unqualified loyalty to the Hospital. Covered Persons may not use their positions to profit personally or to assist others in profiting in any way at the expense of the Hospital. All Covered Persons are expected to regulate their activities so as to avoid actual impropriety and/or the appearance of impropriety which might arise from the influence of those activities on business decisions of the Hospital, or from disclosure or private use of the Hospital's business affairs or plans.

II. Purpose

The purpose of this Policy is to enable Covered Persons to identify, understand, manage and appropriately disclose actual, potential or perceived conflicts of interest.

III. Scope

This Policy applies to the Hospital’s Board of Directors, officers and key employees (“Covered Persons”). Key employees shall include, but is not limited to, those employees falling within the definition of “key employee” as set forth in applicable IRS instructions.

IV. Procedure

a. General Requirements

i. The Hospital recognizes that the potential for conflicts of interest exists in the decision-making process in both subtle and obvious circumstances. Such conflicts may exist for decision makers at all organizational levels. All Covered Persons are expected to recognize situations where conflicts may occur including, but not limited to, deriving unethical personal and/or financial benefit from the exercise of one’s authority. All Covered Persons shall fully disclose any potential or actual conflict of interest he or she may have.

ii. As further defined in this Policy, a conflict of interest may arise when a Covered Person, who is in a position of authority within the Hospital, may benefit personally, directly or indirectly, from a decision he or she could make. Examples of such conflicts include any direct personal or financial interest or outside activity that may interfere with the execution of a Covered Person’s professional Hospital responsibilities or duties, or activities which may jeopardize the Hospital’s tax-exempt status.
CORPORATE COMPLIANCE: CONFLICT OF INTEREST (Continued)

iii. Covered Persons have a responsibility to obtain clarification from their supervisors, board chair, Chief Compliance Officer (“CCO”) or hospital legal counsel on any doubt or concern that may arise as to whether specific conduct or activities constitute a conflict of interest.

b. Outside Financial Interests

While not all inclusive, the following serves as a guide to the types of activities by a Covered Person, or family member of a Covered Person, which might cause conflicts of interest:

i. Ownership in or employment by, or engagement in another business relationship with any outside concern which does business with the Hospital. This does not apply to stock or other investments held in a publicly held corporation, provided the value of the stock or other investments does not exceed 5% of the corporation's stock. The Hospital may, following a review of the relevant facts, permit ownership interests which exceed this amount if Hospital management concludes such ownership interests will not adversely impact the Hospital's business interest or the judgment of the Covered Person.

ii. Use of a Covered Person's position at the Hospital to obtain favorable treatment when conducting any business not on behalf of the Hospital, with any vendor, supplier, contractor, or agency, or any of their officers or employees.

iii. Representation of the Hospital by a Covered Person in any transaction in which he or she or a family member has a substantial personal interest.

iv. Disclosure or use of confidential, special or inside information of or about the Hospital, particularly for personal profit or advantage of the Covered Person or his/her family member.

v. Competition with the Hospital by a Covered Person, directly or indirectly, in the purchase, sale or ownership of property or property rights or interests, or business investment opportunities.

vi. Involvement in the management or oversight of a business or charity (even without compensation), whether or not competitive to the Hospital, which divides the Covered Person’s loyalty to the Hospital.

c. Gifts and Gratuities

i. Gifts Influencing Decision-making: Covered Persons will not accept gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting the Hospital might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, customer, government official or other person by the Hospital is absolutely prohibited. Any such conduct must be reported immediately to the Covered Person’s supervisor and/or CCO.
CORPORATE COMPLIANCE: CONFLICT OF INTEREST (Continued)

ii. Gifts from Vendors. Covered Persons may not accept personal gifts from vendors which have more than a nominal value ($30.00) without approval of the appropriate supervisor or CCO, nor may they solicit personal gifts from vendors, suppliers, contractors or other persons. To the extent possible, these gifts should be shared with the Covered Person’s co-workers.

d. Business Inducements

i. Covered Persons will not seek to gain any advantage through the improper use of payments, business courtesies or other inducements. Offering, giving, soliciting or receiving any form of bribe, kickback or other improper payment is prohibited.

ii. Appropriate commissions, rebates, discounts and allowances are customary and acceptable business practices provided that they are approved by the Hospital’s chief financial officer and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to which the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

e. Services for Competitors/Vendors

No Covered Person will perform work or render services for any competitor of the Hospital or for any organization with which the Hospital does business or which seeks to do business with the Hospital outside of the normal course of his/her employment with the Hospital without the approval of the President of the Hospital or the Covered Person’s supervisor. Without such approval, no Covered Person shall be a director, officer, or consultant of such an organization, nor permit his/her name to be used in any fashion that would tend to indicate a business connection with such organization.

f. Participation on Boards of Directors

i. A Covered Person must obtain approval from his/her supervisor or, if a Director from the Chairperson of the Board of Directors, prior to serving as a member of the Board of Directors/Trustees of any organization whose interest may conflict with those of the Hospital.

ii. A Covered Person who is asked, or seeks to serve on the Board of Directors/Trustees of any organization whose interest would not impact the Hospital (for example, civic [non-governmental], charitable, fraternal, and so forth) will not be required to obtain such approval.

iii. A Covered Person must disclose all Board of Directors/Trustees activities in the annual Conflicts of Interest Disclosure Form. Questions regarding whether or not Board participation might present a conflict of interest should be discussed with a Covered Person’s supervisor or, if a Director, with the Chairperson of the Board of Directors.
CORPORATE COMPLIANCE: CONFLICT OF INTEREST (Continued)

g. Honoraria

Covered Persons are encouraged to participate as faculty and speakers at educational programs and functions consistent with such Covered Person’s Hospital duties and responsibilities. Honoraria provided to Covered Persons shall be consistent with this Conflicts of Interest Policy. Any honoraria received by Covered Persons for participation in programs during paid Hospital work time may be required to be turned over to the Hospital subject to review of the CCO and/or the Covered Person’s supervisor or manager.

h. Acknowledgment, Disclosure and Reporting Procedures

i. Each Covered Person shall review this Policy and the Conflicts of Interest Disclosure Form upon orientation to his or her position.

ii. At least annually thereafter, each Covered Person shall review this Policy and any amendments thereto, and must submit to his/her supervisor or administrator a completed Conflicts of Interest Disclosure Form. The form will be dispersed in February, the results will be analyzed in March, and final results will be reported in April.

iii. The Covered Person’s supervisor or administrator or, in the case of Directors, the Board Chairperson, shall review the Covered Person’s completed Conflicts of Interest Disclosure Form and shall determine if further action is required.

iv. Each Covered Person shall at all times have an affirmative obligation to report any changes in his or her responses to the Conflicts of Interest Disclosure Form that may result from changes in circumstances prior to the Covered Person’s next annual disclosure due date.

i. Management of Conflicts of Interest

In the case of pending transactions, once a conflict of interest has been identified, if the transaction in question is to be considered and/or approved by the Board of Directors, the procedure set forth in the Conflicts of Interest Policy referred to in the Hospital Bylaws shall be followed. In all other cases, the CCO, with input from the appropriate supervisor or manager, shall first determine whether the Hospital may enter into a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest. If it is determined that a more advantageous transaction or arrangement may not be possible, the CCO shall then assess whether the transaction or arrangement is in the Hospital’s best interest and for its own benefit and whether it is fair and reasonable to the Hospital. He/she shall then advise the appropriate authorized Hospital administrator/manager of this assessment for purposes of determining whether to enter into the proposed transaction. A written record of this process, including the determinations made, shall be maintained in the appropriate files of the Hospital.
December 20, 2010

CROUSE HOSPITAL
Corporate Compliance Manual
POLICY/PROCEDURE/STANDARDS

SUBJECT: Employee Participation and Discipline
(overlay/CorpComp-emp part.doc)

ORIGINAL DATE: January 2010
REVIEW/REVISE: December 2010 (REV)

CORPORATE COMPLIANCE OFFICER: ________________________________
CHIEF EXECUTIVE OFFICER: ________________________________

I. Policy

It is the responsibility of every Crouse Hospital Employee to abide by applicable laws and regulations, support the Hospital’s compliance efforts, and to participate in the Corporate Compliance Program. Accordingly, each Employee must report his/her good faith belief of any suspected or actual violation of applicable local, state or federal law or Hospital policies and procedures, including, without limitation, the Hospital’s Compliance Program and Code of Conduct. A violation could be fraudulent billing suspicion, incorrect patterned claim activity, misrepresentation, stealing, breach of rules both internal and external, etc. In support of this principle, the Hospital has also adopted a strict non-retaliation policy prohibiting any retaliation against any Employee who in good faith reports a suspected or actual violation.

II. Purpose

The purpose of this Policy is to ensure all Employees are aware of their obligations and responsibilities to adhere to the Compliance Program and policies, Code of Conduct and any applicable laws, rules and regulations as well as their responsibility to report any potential violations.

III. Scope

This Policy applies Hospital-wide.

IV. Procedures

a. Employee Obligations to Participate in Compliance Program.

1. All Hospital Employees are required to abide by applicable state and federal laws and regulations, and all policies and procedures of the Hospital, including without limitation the Compliance Program and the Code of Conduct.

2. Employees shall report suspected, potential or actual violations of applicable law and regulations, the Compliance Program and/or Code of Conduct (Refer to Communication and Hotline Compliance Policy).
Employee Participation and Discipline (Continued)

3. Failure by an Employee to report possible improper conduct is itself a violation of Hospital policy, the Corporate Compliance Program and the Code of Conduct and may subject the Employee to discipline, up to and including termination.

4. Employees shall participate in Compliance Education and Training during New Employee Orientation and at least annually thereafter, and shall participate in compliance activities and additional training as required by their respective departments.

b. **Confidentiality.**

The Hospital shall take reasonable and appropriate efforts to maximize a reporting Employee’s confidentiality and will honor all requests for confidentiality to the limit allowed by law. In the event the Hospital must take a course of action that could reveal the identity of a reporting Employee, the Hospital shall, to the extent reasonably feasible, notify the Employee of such intended course of action.

c. **Disciplinary Action.**

Employee actions (or inaction) that may result in discipline, include, but are not limited to the following:

1. Authorizing or participating directly in actions that are in violation of any applicable local, state or federal law/regulation or the Compliance Program, the Code of Conduct or other Hospital policies and procedures;
2. Deliberately failing to report a violation or deliberately withholding relevant and material information concerning a violation;
3. Retaliating, directly or indirectly, or encouraging others to do so, against any Employee who reports a violation; or
4. Fabricating or knowingly misrepresenting facts concerning a compliance investigation.

d. **Fair Enforcement of Discipline**

The Hospital shall enforce sanctions and discipline resulting from a violation of this Policy in a fair and consistent manner, in accordance with applicable Human Resources policies and procedures and collective bargaining agreements.
It is the policy of Crouse Hospital to respond to compliance-related concerns and complaints and to investigate possible violations of applicable laws, regulations, Hospital policies, procedures and standards, including the Hospital’s Code of Conduct and Corporate Compliance Program.

The purpose of this Policy is to set forth the procedures to be followed for investigating reports of compliance concerns and possible violations. Sources of potential compliance issues include calls from Employees and others to the Compliance Hotline, telephone or written reports to the Chief Corporate Compliance Officer (“CCO”), the Compliance Intranet Form, or through internal or external auditing activities.

Regardless of the source of the complaint or concern, the Hospital takes potential compliance issues seriously and investigates compliance issues promptly. The purpose of an investigation is to identify those situations in which applicable laws and regulations may not have been followed; to facilitate corrective action as necessary; and to implement procedures to ensure future compliance.

This Policy applies Hospital-wide.

a. Receipt of Complaints and Investigation.
   i. The CCO, or his/her designee, has primary responsibility for conducting and/or overseeing investigations of potential compliance concerns and/or complaints.
   ii. All Employees are required to promptly report issues of suspected or actual noncompliance, and may be subject to discipline for failing to report. The Hospital has a strict non-retaliation policy for good faith reporting of suspected or actual compliance problems. (See Hospital’s Non-Retaliation and Participation and Discipline Compliance Policies).
Responding to and Investigating Potential Compliance Issues (Continued)

iii. The CCO or his/her designee shall commence an investigation as soon as reasonably possible following receipt of a complaint or the detection of a potential compliance issue. Depending on the issue being investigated, the CCO shall report the investigation to the Hospital’s CEO/President.

iv. The CCO, or his/her designee, shall log all complaints in a form and manner as determined by the CCO. The ‘intake reporting form’ (see sample in Appendix E of the Corporate Compliance Program Handbook) and Compliance ‘issues reporting log’ spreadsheet (see sample Appendix C) on the share drive should be utilized for documentation.

v. The CCO may conduct the investigation under the guidance of the Hospital’s legal counsel as deemed necessary by the CCO.

vi. In the course of the investigation, the CCO, or his/her designee, is authorized to perform the following:
   1. Conduct interviews with any Crouse Hospital Employee or other person whose activities or work obligations pertain to the potential compliance matter;
   2. Identify and review relevant documents and materials, including without limitation, bills and claims for services, patient records, business records, email and other forms of communications, and any other document or record necessary for the investigation;
   3. Seek out individuals, internal or external to the Hospital, whose expertise may assist the investigation; and
   4. Undertake other processes as deemed necessary by the CCO to fully investigate the compliance issue raised.

b. Documentation/Reports.
   i. In addition to documenting on the ‘intake reporting form’ and ‘issues reporting log’ spreadsheet, the CCO or their designee may prepare a report which summarizes the nature of the problem, concern or complaint may be necessary. At the discretion of the CCO or their designee, such report may be developed under the guidance of the Hospital’s legal counsel. To the extent relevant, the CCO or designee’s report shall include the following:
      1. A summary of the investigation process;
      2. The relevant facts and identification of involved persons;
      3. Whether a systems error was involved;
      4. Whether there is evidence of intentional wrongdoing;
      5. An estimate of potential overpayments, if any;
      6. Any other information relevant to the investigation.

   ii. Depending on the nature of the findings, the CCO or designee may report the results of the investigation to the Corporate Compliance Performance Improvement Council (“CCPIC”), Hospital Administration, the Board of Directors or other departments or individuals as necessary to ensure proper mitigation and prevention of future compliance issues.
Responding to and Investigating Potential Compliance Issues (Continued)

iii. On a periodic basis, the CCO shall report a summary of compliance investigations to the CCPIC and the Board of Directors.

iv. Documents generated under this Policy shall be maintained in accordance with the Hospital's document retention policies and procedures.

c. Response to Investigations.

i. The Hospital’s response to an investigation will be determined by the type of noncompliant activity that is suspected and/or verified.

ii. The Hospital’s response shall be designed to correct the problem promptly and thoroughly, and to implement procedures and systems to prevent recurrence of the problem. To the extent feasible for complaints and concerns that are not made on an anonymous basis, the CCO or his/her designee shall respond to the individual who initially raised the compliance issue, within the limits of applicable confidentiality laws and regulations.

iii. The following are examples of responses to specific compliance issues (this is not a complete list, but is intended to provide an idea of the variety of possible considerations).

1. Billing Issues. Once a billing problem is identified, all billing involved in the compliance situation, if any, with be discontinued until such time as appropriate corrections are made.

2. Potential Duplicate/Incorrect Payments by Payer. If duplicate or incorrect payments have been made, or could have been made, by a payer, including Medicare, Medicaid and commercial insurers, because of a coding or systems error i) the defective practice or procedure will be corrected as quickly as possible; ii) overpayments, if any, will be calculated and promptly repaid to the appropriate payer; and iii) an education program will be undertaken with the appropriate Employees or affiliated persons to prevent future similar events.

3. Possible Criminal Behavior. If criminal behavior is suspected by an Employee or other Crouse Hospital affiliate, the CCO shall immediately inform the Hospital’s CEO/President, and shall proceed under the guidance of legal counsel. The Hospital shall initiate appropriate disciplinary procedures, which may result in termination. If deemed necessary and appropriate to the situation, under the guidance of legal counsel the Hospital shall inform the appropriate law enforcement or government agency.

iv. In the spirit of the Crouse values, Crouse shall self-disclose to any necessary agencies, individuals, companies, any findings of investigations as appropriate. Crouse Hospital shall report, repay and address the system/process issues in regards to the appropriate payors or parties during routine internal and external audits.

v. Crouse also will investigate and respond to any action or suspected action of retaliation due to the outcome of the investigation.
Responding to and Investigating Potential Compliance Issues (Continued)

References

d. US DHHS, OIG Hospital Compliance Guidance, 1998; Supplemental Hospital Compliance Guidance, 2005;
e. NYS OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521.
I. Policy

The Hospital is committed to maintaining a workplace where Employees are free to raise good faith concerns regarding the Hospital’s business practices and the care of its patients. It is the responsibility of every Hospital Employee to abide by applicable laws and regulations and support the Hospital’s compliance efforts, including reporting their good faith belief of any violation of applicable local, state or federal law or Hospital policies and procedures, including, without limitation, the Hospital’s Corporate Compliance Program and Code of Conduct. The Hospital is committed to fostering a workplace that is conducive to open discussions by its Employees of its business and clinical practices. To promote an open culture, the Hospital has adopted a strict non-retaliation policy.

II. Purpose

To ensure Hospital Employees who raise and identify good faith concerns regarding violations, or suspected violations, of applicable law or Hospital policy and/or cooperate in investigations by the Hospital, government agencies, or law enforcement, concerning violations or suspected violations are protected from retaliation when taking such actions.

III. Scope

This Policy applies Hospital-wide.

IV. Procedures

   a. The Hospital expressly prohibits retaliation in the terms and conditions of employment as a result of an Employee’s good faith reporting of a violation or suspected violation.

   b. Any Employee or Hospital affiliate who commits or condones any form of retaliation will be subject to discipline up to, and possibly including, termination of employment or affiliation.
Non-Retaliation (Continued)

a. Any Employee who believes that he or she has been retaliated against as a result of reporting a violation or suspected violation should contact the Chief Corporate Compliance Officer (“CCO”), or his/her designee. Employees can call/contact:

1. Compliance Office/Compliance Manager at (315) 470-7477;
2. Director of Risk Management/Assistant Compliance Officer at (315) 470-7666;
3. CCO at (315) 470-5776;
4. Compliance Hotline at (315) 470-7770; or
5. Via the Compliance Reporting Form on the Crouse Hospital Intranet.

d. The Hospital, in accordance with applicable local, state or federal law, and Hospital policies and procedures, including, without limitation, the Hospital’s Corporate Compliance Program and Code of Conduct, fully complies with all applicable whistleblower protections. For more information regarding applicable non-retaliation and whistleblower protection laws, refer to the Appendix of Crouse Hospital’s Corporate Compliance Program Handbook.
CROUSE HOSPITAL
Corporate Compliance Manual
POLICY/PROCEDURE/STANDARDS

SUBJECT: Excluded Providers/Employee and Vendor Screening
(admin/CorpComp-Exc providers.doc)

ORIGINAL DATE: January 2010

REVIEW/REVISE: August 2010 (REV), August 2011, September 2012

CORPORATE COMPLIANCE OFFICER: ________________________________

CHIEF EXECUTIVE OFFICER: ________________________________

POLICY:

Crouse Hospital does not hire, employ or enter into any business arrangement with any entity or person who is excluded from participating in any government health care benefits program, including without limitation, Medicare or Medicaid. The Hospital screens all applicants and employees, candidates for, and current Members of, the Medical Staff, independent contractors, and vendors for exclusion from government health care programs and monitors the exclusion lists on an ongoing basis. An “Excluded Provider” is anyone who appears on the screening database lists, found under the Procedures, Section B.

PURPOSE:

The purpose of this Policy is to ensure that the Hospital does not conduct business or have relationships with companies or individuals who are Excluded Providers, and to ensure that the Hospital remains in compliance with applicable laws and regulations and provides safe and quality care to its patients.

SCOPE:

This policy applies to all Hospital business arrangements, including, but not limited to, employment relationships, physician and provider credentialing activities, and contractual arrangements with third parties. This Policy does not override or replace other Hospital screening procedures such those pertaining to criminal background checks.

PROCEDURE:

a. General Requirement. The Hospital (through Human Resources, the Medical Staff Office, and Purchasing, the Business Office or other department) shall screen all individuals and companies with whom the Hospital has business relationships and/or employment relationships. Screenings shall be conducted prior to the start of the business/employment relationship and periodically thereafter as determined necessary by the Chief Compliance Officer (“CCO”), or his/her designee, and in accordance with applicable federal and state guidelines. For example, the New York State Office of Medicaid Inspector General (OMIG) currently recommends providers screen the updated state and federal exclusion lists (described below) every thirty (30) days.
b. Various Screening Data Bases. The CCO, or his/her designee, shall ensure that one or more of the following or other websites as applicable are queried in accordance with this Policy:

1. **United States Department of Health and Human Services, Office of Inspector General (OIG) website** – List of Excluded Individuals/Entities (LEIE)- This database provides information regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all Federal health care programs.;

2. **New York State Office of the Medicaid Inspector General (OMIG) website** – OMIG’s website provides access to the list of individuals or entities whose participation in the Medicaid program has been restricted, terminated or excluded;

3. **New York State Department of Health, Office of Professional Medical Conduct and Physician Discipline (OPMC) website** – Verification of practitioners who have been disciplined by OPMC;

4. **National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank**; Flagging systems intended to facilitate a comprehensive review of health care practitioners’ professional credentials or past actions;

5. **System for Award Management (SAM) website** – replaced the Excluded Parties List System (EPLS) in August 2012. Verification of practitioners excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non financial assistance and benefits.

**Purchasing Department verification.**

1. Individual sales representatives are the responsibility of the companies they are employed by. Upon Crouse’s request, these companies will be required provide verification that exclusion checks of their sales reps are performed.

2. VeriRep, the hospital vendor credentialing service, performs all checks per OIG and OMIG stated guidelines as of September 2010. Those companies who are not registered with VeriRep will be verified by Crouse staff.

3. All new companies to Crouse are checked against the above mentioned websites prior to doing business with the organization and/or being added to the Lawson vendor (company) file. The complete hospital vendor (company) file will be checked quarterly against the three websites (OIG, OMIG, SAM) as per current practice.

C. **Ongoing Obligation to Report.** All Members of the Medical Staff are required to disclose if they become Excluded Providers subsequent to appointment/reappointment. All current employees, independent contractors and vendors of the Hospital have an obligation to notify the CCO immediately upon receipt of any information indicating that they have been charged with a crime relating to health care or are facing debarment, exclusion or other ineligibility from participation in any state or federal health care program. Failure to notify the CCO may result in disciplinary action.
D. Notification to CCO. If it is determined that an individual or company is listed as excluded or disqualified, the department conducting the query shall immediately notify the CCO. The CCO, or his/her designee shall ensure that appropriate action is taken immediately to ensure the excluded or disqualified individual/company no longer conducts business with the Hospital, including but not limited to the ordering, furnishing or prescribing of medical care or treatments for Hospital patients. Crouse shall give the individual the opportunity to further identify themselves in order to verify that the name on the list is in fact that person.

DOCUMENTATION:

The CCO, or his/her designee, shall ensure that a record of each screening query made under this Policy will be maintained in accordance with the Hospital’s record retention policies and procedures.

REFERENCES:

1. US Department of Health and Human Services, Office of Inspector General, LEIE Website: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp

2. New York State Office of Medicaid Inspector General; Restricted, Terminated or Excluded Individuals or Entities Website: http://www.omig.ny.gov/data/content/view/?2/52/

3. New York State Department of Health, Links to the OPMC and Physician Profile Websites: http://www.health.state.ny.us/professionals/doctors/conduct/


5. System for Award Management: http://www.sam.gov
I. POLICY

It is the policy of Crouse Hospital to establish and maintain an Identity Theft Prevention & Detection Program (the “Program”) to monitor and help prevent identity theft in connection with any new or existing patient accounts, and to mitigate to the extent feasible the effects of identity theft activities. This Program has been developed in accordance with the Federal Trade Commission’s Identity Theft Prevention Red Flags Rule (16 CFR § 681.2), and has been duly approved by the Crouse Hospital Board of Directors.

This Program has been created in consultation with the Corporate Compliance Performance Improvement Council, The Business Office, Information Technology (IT), Health Information Management (HIM), and legal counsel, after conducting an assessment of risk of Identity Theft associated with certain Covered Accounts (as defined below) offered by Crouse Hospital. Nothing in this Program should be construed to limit patient access to care provided by Crouse Hospital.

II. PURPOSE

The Purposes of the Program are to:

a. Identify the relevant Red Flags based on the risk factors associated with the Hospital’s covered accounts;
b. Institute policies and procedures for detecting Red Flags;
c. Identify steps the Hospital will take to prevent and mitigate Identity Theft; and
d. Create a system for regular updates and administrative oversight to the Program.

III. SCOPE

This Policy applies throughout Crouse Hospital.
IDENTITY THEFT PREVENTION AND DETECTION PROGRAM
(Continued)

IV. DEFINITIONS

For purposes of this Policy and the Program, the following terms are defined:

“Covered Account” means (i) any account the Hospital offers or maintains primarily for patients/individuals, that involves multiple payments or transactions, including one or more deferred payments; and (ii) any other account the Hospital identifies as having a reasonably foreseeable risk to patients/individuals or to the safety and soundness of the Hospital from Identity Theft. As of October 2009 the Hospital has identified the following types of accounts as Covered Accounts:

- Patient billing
- Patient payment arrangements
- Bad debt collections

“Identity Theft” means fraud committed using the identifying information of another person.

“Red Flag” means a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

V. PROCEDURES

A. Identification of Red Flags

1. The Identity Theft, Mitigation and Resolution Procedures (Appendix A) identifies the Red Flags that would be most relevant to the Hospital.

2. Red Flags generally fall within one of the following four categories:
   a. Suspicious documents associated with a Covered Account;
   b. Patient has presented suspicious personal identifying information;
   c. Suspicious or unusual activity related to a Covered Account; and
   d. Alerts from a third party indicate suspicious activity.

B. Detection of Red Flags

In order to facilitate detection of the Red Flags identified in Appendix A, the Hospital will take the following steps to obtain and verify the identity of the person:

1. New Patients/Accounts
   a. Require identifying information (e.g., full name, date of birth, address, government-issued ID, insurance card, etc.); and
   b. When available, verify information with insurance company’s information.

2. Existing Accounts
   a. Verify validity of requests for changes of billing address; and
   b. Verify identification of customers before giving out any personal information.

C. Preventing and Mitigating Identity Theft

1. Upon registration, staff will flag accounts that appear to be suspicious in the system. These flags, indicated by entering a “Y” in the Red Flag field, will produce a daily report. This report will be reviewed by the Corporate Compliance Manager, Patient Access Manager, and Business Office staff members.

2. The Corporate Compliance Manager will work with the appropriate Directors/Managers of departments where the red flag was identified.

3. In order to prevent and mitigate the effects of Identity Theft, the Hospital will follow the appropriate steps identified in the attached Identity Theft Red Flags Mitigation and Resolution Procedures (Appendix A).
IDENTITY THEFT PREVENTION AND DETECTION PROGRAM
(Continued)

4. In the event personnel have concerns or other questions regarding potential red flags not covered by the above steps or Appendix A, or for any other reason, they should notify their department supervisor.

D. Program Administration/Updating of Program
1. The Corporate Compliance Performance Improvement Council is responsible for developing, implementing, administering and updating the Program. Accordingly, the Corporate Compliance Performance Improvement Council will annually (or more frequently as necessary) review the effectiveness of the Program and update the Program to reflect the addition or removal of Covered Accounts, and changes in risks to patients/individuals from Identity Theft.

2. The Hospital will update the Program to address the following factors:
   • The Hospital’s experiences with identity theft;
   • Changes in the methods of identity theft;
   • Changes in the method to detect, prevent and mitigate identity theft;
   • Changes in the types of accounts that the Hospital offers or maintains;
   • Changes in the Hospital’s business arrangements, including mergers, acquisitions, alliances, joint ventures and service provider arrangements.

3. The Corporate Compliance Manager, or his/her designee, will be responsible for developing and overseeing a training program for staff who are responsible for, or have a role in, the Program.

E. Service Provider Arrangements

The Hospital will require service providers performing activities in connection with Covered Accounts to have policies and procedures in place designed to detect, prevent and mitigate the risk of Identity Theft with regard to the Covered Accounts.
# APPENDIX A
## RELEVANT IDENTITY THEFT, MITIGATION AND RESOLUTION PROCEDURES

<table>
<thead>
<tr>
<th>IDENTITY THEFT RED FLAG</th>
<th>PREVENTION/MITIGATION PROCEDURE</th>
<th>RESOLUTION OF RED FLAG</th>
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<tbody>
<tr>
<td>DOCUMENTS ASSOCIATED WITH A COVERED ACCOUNT ARE SUSPICIOUS</td>
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</tr>
<tr>
<td>Documents provided for identification appear to have been altered or forged.</td>
<td>Ask the individual to provide additional identification to verify identity. If unable to do so, the account must be flagged in the SMS/NetAccess system with a “Y”.</td>
<td>If additional documentation has been provided and is consistent, proceed with the admission/billing process. If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up.</td>
</tr>
<tr>
<td>Patient’s photograph or physical description on their identification documents (e.g. driver’s license) is inconsistent with the person presenting the document</td>
<td>Ask the individual to provide an additional form of identification to verify identity. If unable to do so, the account must be flagged in the SMS/Net Access system with a “Y”.</td>
<td>If additional documentation has been provided and is consistent, proceed with the admission/billing process. If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up.</td>
</tr>
<tr>
<td>Patient has an insurance number but never produces an insurance card or other physical documentation of insurance. (Unless Hospital can confirm that there is a reason for the absence of such documentation.)</td>
<td>If the patient continues to be unable to provide an insurance card or other documentation, the account must be flagged in the SMS/Net Access system with a “Y”</td>
<td>If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>IDENTITY THEFT RED FLAG</td>
<td>PREVENTION/MITIGATION PROCEDURE</td>
<td>RESOLUTION OF RED FLAG</td>
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<tr>
<td><strong>PATIENT HAS PRESENTED SUSPICIOUS PERSONAL IDENTIFYING INFORMATION</strong></td>
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</tr>
<tr>
<td>The Social Security Number (SSN) provided is the same as that submitted by other persons opening an account or other patients.</td>
<td>Confirm the SSN with the patient. Ask the individual to provide an additional form of identification to verify identity. If unable to do so, the account must be flagged in the SMS/Net Access system with a “Y”</td>
<td>If additional documentation has been provided and is consistent, proceed with the admission/billing process. If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up.</td>
</tr>
<tr>
<td>Personal identifying information provided by the customer is not consistent with other personal identifying information provided by the patient. For example, there is a lack of correlation between the SSN range and date of birth.</td>
<td>Ask the individual to provide an additional form of identification to verify identity. If unable to do so, the account must be flagged in the SMS/Net Access system with a “Y”</td>
<td>If additional documentation has been provided and is consistent, proceed with the admission/billing process. If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up.</td>
</tr>
<tr>
<td>The insurance number provided is the same as that submitted by another patient.</td>
<td>If the patient is unable to verify insurance information, the account must be flagged in the SMS/Net Access system with a “Y”</td>
<td>If additional documentation has been provided and is consistent, proceed with the admission/billing process. If the red flag field has been filled in, a report will go to the Corporate Compliance Manager, Patient Access Manager, and Business Office staff for follow up. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>Personal identifying information provided by the patient is associated with known fraudulent activity as indicated by internal or third-party sources used by the Hospital. For example: - The address on a document is the same as the address provided on a fraudulent document; or - The phone number on a document is the same as the number provided on a fraudulent document.</td>
<td>The account must be flagged in the SMS/Net Access system with a “Y” Investigate complaint, interview individuals as appropriate</td>
<td>Put the billing process on hold until identity can be resolved. After consultation with legal counsel, notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>IDENTITY THEFT RED FLAG</td>
<td>PREVENTION/MITIGATION PROCEDURE</td>
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<tr>
<td>UNUSUAL OR SUSPICIOUS ACTIVITY RELATED TO A COVERED ACCOUNT</td>
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<tr>
<td>Mail sent to the patient is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the patient’s covered account.</td>
<td>Skip-tracing procedures are used to find the patient’s current mailing address.</td>
<td>Patient is found and contact information is updated.</td>
</tr>
<tr>
<td>Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient (e.g., inconsistent blood type).</td>
<td>Investigate complaint, interview individuals as appropriate, review previous files for potential inaccurate records. Items to consider include: blood type, age, race, and other physical descriptions may be evidence of medical identity theft.</td>
<td>Put the billing process on hold until identity has been resolved. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>ALERTS BY THIRD PARTY INDICATE SUSPICIOUS ACTIVITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint/inquiry from an individual based on receipt of: -a bill for another individual -a bill for a product or service that the patient denies receiving -a bill from a health care provider that the patient never patronized - a notice of insurance benefits (or Explanation of Benefits) for health services never received.</td>
<td>Investigate complaint, interview individuals as appropriate.</td>
<td>Put the billing process on hold until identity has been resolved. After consultation with legal counsel, notify law enforcement as appropriate. If the results of investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>Complaint/inquiry from a patient about information added to a credit report by a health care provider or insurer</td>
<td>Investigate complaint, interview individuals as appropriate.</td>
<td>Put the billing process on hold until identity has been resolved. After consultation with legal counsel, notify law enforcement as appropriate. If the results of investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>IDENTITY THEFT RED FLAG</td>
<td>PREVENTION/MITIGATION PROCEDURE</td>
<td>RESOLUTION OF RED FLAG</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>ALERTS BY THIRD PARTY INDICATE SUSPICIOUS ACTIVITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint or question from a patient about the receipt of a collection notice from a bill collector.</td>
<td>Investigate complaint, interview individuals as appropriate.</td>
<td>Discontinue attempting to collect on the account until identity has been resolved. After consultation with legal counsel, notify law enforcement as appropriate. If the results of investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
<tr>
<td>Hospital is notified by a patient, a victim of identity theft, a law enforcement authority, or any other person that it has opened a fraudulent account for a person engaged in identity theft.</td>
<td>Investigate complaint, interview individuals as appropriate.</td>
<td>If applicable, put the billing process on hold until identity has been resolved. Contact insurance company as necessary. After consultation with legal counsel, notify law enforcement as appropriate. If the results of investigation do not indicate fraud, all contact and identifying information is re-verified with patient.</td>
</tr>
</tbody>
</table>
October 7, 2011

CROUSE HOSPITAL
Corporate Compliance Manual
POLICY/PROCEDURE/STANDARDS

SUBJECT: Internal Quality Audit Program; including Routine Identification of Compliance Risk Areas and HIPAA Department Monitoring
(admin/CorpComp-audit.doc)

ORIGINAL DATE: October 2011

REVIEW/REVISE:

CORPORATE COMPLIANCE OFFICER: _______________________________

CHIEF EXECUTIVE OFFICER: _______________________________

5. Policy

It is the policy of Crouse Hospital to ensure that all departments are audited at least annually for compliance with ISO 9001:2000 standards. As well as ISO 9001:2000 auditing, the Compliance Department, in collaboration with the Corporate Compliance Performance Improvement Council (“CCPIC”) and relevant Hospital departments will conduct ongoing and periodic reviews of the Compliance Program’s operations and systems. This process will be used to determine whether the elements of the Compliance Program are consistently being addressed and satisfied. In conjunction with the above mentioned auditing and monitoring processes, all departments will be audited at least annually for compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and New York State laws pertaining to privacy and confidentiality.

6. Purpose

The purpose of this Policy is to provide a procedure that outlines the measurement, analysis, and reporting system used to audit Crouse’s compliance with ISO 9001:2000 standards. It also serves to describe the Hospital’s approach and commitment to periodic review, audit and monitoring of the compliance program’s effectiveness in identifying risks and removal of identified problems. This policy also assists in maintaining HIPAA and New York State privacy and confidentiality compliance throughout the organization.

7. Scope

This Policy applies Hospital-wide.

8. Procedures

   a. The Director of Quality Improvement will develop and communicate a schedule that ensures all hospital service functions are audited. Audits should be scheduled based on the status and importance of the activities being audited. For example; previous audit non-conformances, department volume, department complexity or newly implemented systems. Audits may be adjusted and/or rescheduled, but must be communicated to and approved by the ISO Management representative.
b. Individuals conducting the ISO 9001:2000 audits will be pre-approved and trained as internal auditors. An auditor may not conduct an audit in their respective department and therefore, must be independent of the department they are auditing.

c. Auditors will address all unresolved previous audit findings, complete the internal audit summary, summarize the audit and communicate the findings to the ISO Management representative.

d. It is the responsibility of the department manager to follow up on all non-conformities identified for their respective area. They should set a completion date for the corrective action and return the non-conformance report to the ISO Management representative.

e. Internal audits will be reviewed at the DNV Oversight Committee meetings. The Director of Quality Improvement will maintain internal audit records for review.

2. Identification of Compliance Risk Areas

a. The Corporate Compliance department, in collaboration with the CCPIC shall identify those risk areas that require review on a periodic basis or in response to a specific issue raised.

b. The Corporate Compliance department shall be responsible for conducting and/or ensuring the performance of, ongoing and periodic reviews of all aspects of the Compliance Program to monitor its effectiveness and to take appropriate steps as necessary to assure adherence to the Compliance Program.

c. Results will be documented and reported to the CCPIC, the Board of Directors and the relevant managers and other corporate officers. Prompt action shall be taken to correct any improper practices or deviation from the Compliance Program, Code of Conduct, other Hospital policies and procedures, applicable laws and regulations and third-party payer requirements. Documentation shall be retained in accordance with the Hospital’s record retention policies and procedures.

d. The Corporate Compliance department and CCPIC shall meet regularly to monitor and review developments in applicable laws influencing the Hospital’s legal duties under the Compliance Program and to revise and update the Compliance Program as necessary.

e. In collaboration with the CCPIC and any relevant Hospital department the Corporate Compliance department, shall conduct and/or ensure the performance of reviews and audits, which may include, but is not limited to, the following:

   i. Periodic review of the coding and claims processing systems, including but not limited to audits of claims to be submitted to federal healthcare programs, including Medicare and Medicaid;

   ii. Review of documentation generated by providers and other personnel who have a direct impact on claim development and submission, including claims prepared by new employees to ensure proper training and knowledge of the claims processing system;

   iii. Follow up audits in response to complaints and/or concerns raised related to the claims processing and other Compliance Program processes;

   iv. Review of physician and allied health professional licensing and credentialing requirements;

   v. Review of government disqualified/excluded provider lists;
vi. Review of adherence to the Hospital’s Compliance Program/Code of Conduct: for example, assess compliance with education and training requirements for Employees;

vii. Review of the Hospital’s complaint and reporting logs to determine if complaints or reports were handled appropriately and whether there have been repeated inquiries regarding the same topic or issue of concern.

viii. Review of compliance with the Hospital’s various mandatory reporting obligations;

ix. Review of compliance with standards applicable to governance;

x. Review of patient quality of care for services rendered to Medicare, Medicaid and other patients; and

xi. Other reviews and risk areas identified by the Corporate Compliance department, CCPIC and/or individual departments.

f. Reviews/audits shall be periodically updated to reflect changes in applicable laws, regulations, coding guidelines and third-party payer requirements.

g. Reviews/audits shall include both internal audits conducted by the Hospital and external audits conducted by an outside auditor engaged by the Hospital or through its legal counsel.

h. The Hospital shall devote resources that are reasonably necessary to ensure audits are adequately staffed by persons with appropriate knowledge and experience.

3. Department Monitoring of HIPAA

a. The Privacy Officer, Director of Risk Management, Corporate Compliance Manager and/or their designated representative will conduct monthly audits of each department/unit to determine their compliance with privacy standards.

b. A predetermined set of criteria, formatted on an audit tool will be utilized for each audit.

c. Once the department/unit has been evaluated, a summary spreadsheet and list of recommendations will be forwarded to the director/manager of that area. A copy will also be kept on file in Corporate Compliance.

d. If any recommendations are given, a follow up visit will be performed within the next month of receiving the information. The follow up ensures that the recommendations have been implemented.

e. All audits and follow up visits will be scheduled utilizing Microsoft Outlook Calendar.
POLICY:

It is the policy of Crouse Hospital to adhere to all applicable state and federal laws and regulations concerning the delivery of patient care, billing and reimbursement for such care, and our business practices in general. Crouse Hospital is committed to conducting its operations in an ethical and lawful manner and has therefore developed and implemented a Corporate Compliance Program. The Compliance Program is intended to prevent and detect health care fraud, abuse and waste, and to detect and correct violations of applicable law, regulations, third-party payer requirements, Crouse Hospital's policies and procedures, the Code of Conduct and other applicable standards.

PURPOSE:

The purpose of this Policy is to: i) ensure that employees, staff and other persons covered by this Policy are familiar with Crouse Hospital’s efforts to prevent and detect health care fraud, abuse and waste as required by Crouse Hospital’s Code of Conduct, Corporate Compliance Program and the Deficit Reduction Act of 2005; ii) assist employees, staff and other persons covered by this Policy in recognizing instances of potential fraud, abuse and waste; and iii) encourage the good faith reporting of potential fraud, abuse and waste involving Crouse Hospital.

SCOPE:

This Policy applies to all Crouse Hospital employees and staff and to contractors, subcontractors and agents who, on behalf of Crouse Hospital, furnish, or authorize the furnishing of, Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by Crouse Hospital.

Definitions and Examples of Fraud, Abuse and Waste

1. Fraud is intentional deception or misrepresentation that a person knows to be false or does not believe to be true, when it is known that the deception could result in an unauthorized benefit to such person or another party. In addition, fraud may occur from a false statement or misrepresentation that is material to entitlement or payment under a government health care program, such as Medicare or Medicaid, or to another payer.
Preventing and Protecting Fraud, Abuse and Waste (Continued)

2. Abuse and waste include incidents or practices of providers that are inconsistent with accepted and sound medical, business, or fiscal practices; or the careless expenditure, consumption, mismanagement or use of health care resources. Such abusive practices may directly or indirectly result in unnecessary costs to Medicare, Medicaid, or another payer; improper payment; or payment for services that fail to meet professionally recognized standards of care, or that are not medically necessary. Abuse may include situations involving payment for items or services when there is no legal entitlement to that payment but the provider has not knowingly misrepresented the facts to obtain payment.

3. The following are a few examples of fraud, abuse and waste in a health care setting. This list is for purposes of illustration and is not intended to be a complete list of fraud, waste and abuse situations. Examples include:

a. Billing for services or items not provided;
b. Billing for care already reimbursed by another payer;
c. Assigning incorrect codes to secure higher reimbursement;
d. Falsifying claim forms;
e. Characterizing non-covered services or costs in a way that secures reimbursement;
f. Offering or receiving kickbacks, bribes, or illegal rebates;
g. Using another person’s Medicare number to obtain services or payment;
h. Not seeking payment from beneficiaries who may have other primary payment sources;
i. Excessive charges for services or supplies;
j. Claims for services that are not medically necessary;
k. Breach of the Medicare participation or assignment agreements;
l. Improper documentation and/or billing practices.

PROCEDURE:

1. The Chief Compliance Officer (“CCO”) or his/her designee, shall ensure that employees and staff are provided detailed information concerning Crouse Hospital’s efforts to prevent and detect health care fraud, abuse or waste, in accordance with Crouse Hospital’s Compliance Education Policy.

2. The CCO, or his/her designee, shall ensure that Crouse Hospital’s contractors, subcontractors and agents who are covered by this Policy are provided access to this Policy and other information concerning Crouse Hospital’s efforts to prevent and detect health care fraud, abuse or waste. This includes access to Crouse Hospital’s Corporate Compliance Program Handbook, the Code of Conduct and compliance-related policies. Access to such information may be via the Internet.

3. The CCO, or his/her designee, shall ensure that internal and/or external audits are conducted on a periodic, regular basis, to verify the accuracy of Crouse Hospital’s claims submission processes and reimbursement practices and for the purposes of preventing and detecting potential instances of fraud, abuse and waste. Such audits will be conducted in accordance with Crouse Hospital’s Corporate Compliance Program and the results shared with appropriate Crouse Hospital departments and committees, including without limitation, the Corporate Compliance Performance Improvement Council. Refer to Crouse Hospital’s Corporate Compliance policy on Audits and Routine Identification of Compliance Risk Areas.
Preventing and Protecting Fraud, Abuse and Waste (Continued)

4. Employees, staff and other persons covered by this Policy should report questions, concerns, and/or suspected violations of Crouse Hospital’s policies and procedures and applicable law, and/or instances of potential fraud, abuse and waste to the CCO (315-470-7770) or to the applicable department’s supervisor or manager. Crouse Hospital has adopted a strict non-retaliation policy for good faith reporting of compliance issues or concerns. For further information, refer to Crouse Hospital’s Corporate Compliance policies on Communication, Compliance Hotline and Reporting; and Non-Retaliation.

REFERENCES:

f. New York State Office of Medicaid Inspector General Provider Compliance: http://www.omig.state.ny.us/data/content/view/81/206/

g. Crouse Hospital Code of Conduct; and Corporate Compliance Program Handbook, including Appendix A: Description of Fraud and Abuse/Non-Retaliation Laws.

h. Department of Health and Human Services, Office of Inspector General’s Fraud and Abuse Prevention Website: http://oig.hhs.gov/fraud.asp

i. Centers for Medicare and Medicaid Services, Fraud Overview Website for Beneficiaries: http://www.medicare.gov/FraudAbuse/Overview.asp

August 24, 2011

CROUSE HOSPITAL
Corporate Compliance Manual
POLICY/PROCEDURE/STANDARDS

SUBJECT: Compliance with Federal and State False Claims Acts
(admin/CorpComp-Fed State False Claims.doc)

ORIGINAL DATE: July 2010

REVIEW/REVISE: August 2011

CORPORATE COMPLIANCE OFFICER: ________________________________

CHIEF EXECUTIVE OFFICER: ________________________________

POLICY:

It is the policy of Crouse Hospital to adhere to all applicable state and federal laws and regulations concerning the submission of claims to state and federal health care programs. Such laws include, without limitation, the Federal False Claims Act and the New York State False Claims Act.

PURPOSE:

The purpose of this Policy is to i) ensure that Crouse Hospital’s employees, staff and other persons covered by this Policy are provided with sufficient information concerning New York State and federal false claims acts as required by Crouse Hospital’s Corporate Compliance Program and the Deficit Reduction Act of 2005; ii) ensure that employees, staff and other persons covered by this Policy are made aware of the importance of complying with state and federal false claims acts and the penalties for non-compliance with such laws; and iii) to encourage the good faith reporting of instances of non-compliance and/or violations of the law without fear or concerns of retaliation.

SCOPE

This Policy applies to all Crouse Hospital employees and staff and to contractors, subcontractors and agents who, on behalf of Crouse Hospital, furnish, or authorize the furnishing of, Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by Crouse Hospital.

Description of the Federal and State False Claims Acts; Penalties and Remedies

A. A person (or entity) may be in violation of the Federal False Claims Act if such person:

1. Knowingly presents, or causes to be presented, to the United States Government, a false or fraudulent claim for payment or approval;
2. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
3. Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
Compliance with Federal and State False Claims Acts (Continued)

4. Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

5. Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

6. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

7. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

B. The New York State False Claims Act is very similar to the Federal False Claims Act. It prohibits the filing of a false claim which means that a person:

1. Knowingly presents, or causes to be presented, to any employee, office or agent of the state or a local government, a false or fraudulent claim for payment or approval;

2. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;

3. Conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid;

4. Has possession, custody, or control of property or money used, or to be used, by the State or a local government and, intending to defraud the state or a local government or willfully to conceal the property or money, delivers, or causes to be delivered, less property or money than the amount for which the person receives a certificate or receipt;

5. Is authorized to make or deliver a document certifying receipt of property used or to be used by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

6. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee lawfully may not sell or pledge the property; or

7. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a local government.

C. Any person who engages in any of the above conduct may have violated the Federal and/or New York State false claims acts and may be liable for monetary penalties and damages, depending on the circumstances surrounding the false claim(s).
Compliance with Federal and State False Claims Acts (Continued)

D. Qui Tam Lawsuits. The Federal False Claims Act and the New York State False Claims Act also provide for *qui tam* lawsuits through which any person (the “qui tam relator”) may bring a civil action for himself/herself and on behalf of the government for any violation of the False Claims Act. If the qui tam relator ultimately wins the lawsuit or if there is a settlement of the lawsuit, he or she may share in a portion of any money recovered with the government and receive reimbursement for reasonable expenses, reasonable attorneys’ fees and costs. Please note recovery by the qui tam relator is uncertain and dependent upon the facts and circumstances of the case.


1. State and Federal false claims acts forbid retaliation by an employer against an employee who cooperates with investigators regarding potential false claims act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program, Crouse Hospital fully complies with all applicable “whistle-blower” protections.

2. The Federal False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. The New York State False Claims Act has similar non-retaliation protections.

F. Program Fraud Civil Remedies Act, 31 USC §§ 3801-3812 (PFCRA). PFCRA provides for administrative remedies against any person who knowingly makes a claim or statement that the person knows or has reason to know is false, fictitious or fraudulent. The presence of a false claim is not required: a false statement is enough to trigger remedies under PFCRA.

PROCEDURES:

A. The Chief Compliance Officer (“CCO”) or his/her designee, shall ensure that employees and staff are provided detailed information concerning relevant fraud and abuse laws, including the state and federal false claims acts described above, in accordance with Crouse Hospital’s Compliance Education Policy.

B. The CCO, or his/her designee, shall ensure that Crouse Hospital’s contractors, subcontractors and agents who are covered by this Policy are provided access to detailed information concerning relevant fraud and abuse laws, including the state and federal false claims acts described above (such access may be via the Internet).
Compliance with Federal and State False Claims Acts (Continued)

C. The CCO, or his/her designee, shall ensure that audits are conducted on a periodic, regular basis, to verify the accuracy of Crouse Hospital’s claims submission processes and reimbursement practices.

1. Such audits will be conducted in accordance with Crouse Hospital’s Corporate Compliance Program. Refer to Crouse Hospital’s Corporate Compliance policy on Audits and Routine Identification of Compliance Risk Areas.

2. The results of such audits will be posted on a “Share Drive” and reported quarterly to the QI Finance Committee and the Corporate Compliance Performance Improvement Council.

D. Employees, staff and other persons covered by this Policy should report questions, concerns, and/or suspected violations of Crouse Hospital’s policies and procedures and applicable law to the CCO or to the applicable department’s supervisor or manager. For further information, refer to Crouse Hospital’s Corporate Compliance policy on Non-Retaliation.

References:

1. New York State Office of Medicaid Inspector General Provider Compliance: http://www.omig.state.ny.us/data/content/view/81/206/
2. 31 USC Sections 3729-3733.
CROUSE HOSPITAL
Corporate Compliance Manual
POLICY/PROCEDURE/STANDARDS

SUBJECT: Payer/Patient Refund Policy
(admin/CorpComp-refund policy.doc)

ORIGINAL DATE: August 2011

REVIEW/REVISE:

CHIEF FINANCIAL OFFICER: ________________________________
DIRECTOR OF REVENUE CYCLE AND FINANCIAL ANALYSIS: ________________________________

I. Purpose: To provide for timely and appropriate refunds for documented overpayments in compliance with the Patient Protection and Affordable Care Act (ACA) section 6402, program integrity provisions.

II. Policy: Overpayments are any funds that Crouse Hospital receives or retains to which after applicable reconciliation, they are not entitled to. Overpayments occur when the amount of money the Hospital receives for services or supplies is in excess of the amount due and payable under a particular health care program, by a third party payer, including Medicare and Medicaid, or by a paying patient. Events leading to overpayments may include, but are not limited to, duplicate payments or payment for non-covered services. Once verified, overpayments must be refunded to the appropriate payer or client and/or processed according to the payer contracts. Retention of a Medicare or Medicaid overpayment beyond 60 days can be considered a false claim.

Patient Account Reps (PAR), government or private payers, as well as patients, can initiate requests for refunds. Audits will also be conducted on a periodic basis, to verify the accuracy of Crouse’s claims submission process and reimbursement practices (see Corporate Compliance policy ‘Compliance with Federal and State False Claims Acts).

The Payment Rep staff will evaluate and process refunds, as appropriate, after a thorough review. The review will incorporate an evaluation of billing, remittance notices and Explanations of Benefits (EOBs), payer and patient correspondence documentation, or other documentation as necessary. Corporate Compliance may get involved and work with the PARs and Business Office Management in the event that an overpayment is identified through a compliance-related activity.

III. Procedure:

A. Third Party Payer or Patient Request Refund of Overpayment

1. The Payment Rep(PAR) receives request for a refund for a potential overpayment(s) from either a third party payer (government or private), or patient.

2. The Payment Rep will review the request and will verify the overpayment for refund after thorough review of the documentation.

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3. The Payment Rep will promptly process for refund if appropriate to the payer or patient, or will follow guidelines for overpayment processes per payer contract. For Medicaid and Medicare overpayments, voids and adjustments will be done to those payers as soon as the overpayment is verified so that they can retract the overpayment on a future remit.

4. All refund paperwork will be completed with supporting documentation and will be given to the Patient Account Rep Float to process.
   
   i) The PAR Float will review the paperwork for accuracy. She will note the account that the refund is in process.
   
   ii) Any refund under $1000.00 can be sent to Finance for refund check processing. Any refund over $1000.00 has to follow an authorized signature process. All refunds over $1000.00 will be reviewed in detail by the Patient Account Manager for approval and signature. If the refund is approved, it is signed and the paperwork goes back to the PAR Float. The PAR Float then checks for refunds over $5000.00 and refunds over $10,000.00. If there are refunds over $5000.00, the Director also needs to approve and sign and if over $10,000.00, the CFO also has to approve and sign. If the Patient Account Manager cannot verify the overpayment, the paperwork will go back to the Payment Rep for further review and clarification.
   
   iii) Once all applicable signatures are obtained by the PAR Float, the PAR Float will bring the refund paperwork to Finance for refund check processing. Finance cuts refund checks bi-weekly.

5. New York State Medicaid, Medicare and other payers, pursuant to their contracts with the Company, may request the refund for an overpayment through future deductions in payments to accommodate the overpayment.

B. Payment Rep or other Patient Account Rep Request Refund of Overpayments

1. Through the usual Account Review process which includes credit balance reports, a PAR may identify a potential overpayment(s) made by a third party payer (government or private), or patient.

2. The PAR will promptly forward to the Payment Rep to request to review the account for potential overpayment. The Payment Rep will verify the overpayment after thorough review of the documentation.

3. The Refund process will then follow steps 3-5 in the above procedure.

C. Non-Routine Processing Errors

In the event that a review of a potential overpayment(s) reveals more than a routine processing error, warranting further auditing or review, the Payment Rep will promptly inform the Supervisor, Manager and/or Director for appropriate resolution.
**Payer/Patient Refund Policy**  
(Continued)

D. **Medicare Credit Balance Reporting**

Under Medicare guidelines, the hospital is responsible to report any Medicare credit balances quarterly to their fiscal intermediary. The hospital runs reports of all Medicare payer codes for credit balances quarterly. Any credit balance outstanding is submitted electronically to Medicare on their omnipro system. A certification page signed by the CFO is also faxed to the fiscal intermediary.

F. **Unclaimed or Abandoned Property**

i) For some verified overpayments it may be impossible after reasonable attempts for the Company to locate or identify the intended recipient of the overpayment.

ii) If it is not possible to locate or identify the payer or patient to whom a refund is owed, the Company will follow the relevant New York laws pertaining to unclaimed property and/or abandoned property, for resolution of the matter. The Company will maintain appropriate records of unclaimed and/or abandoned property.
Part V

Appendixes
Appendix A: Description of Fraud and Abuse/Non-Retaliation Laws

I. Federal and New York State Health Care Fraud and Abuse Laws.
Both the federal and New York state governments fund health care programs that provide medical and mental health care benefits to qualified patients. Examples of such government health care programs include, but are not limited to, Medicare and Medicaid. To avoid waste, fraud and abuse in Medicare, Medicaid and other programs, there are Federal and State laws designed to deter fraud and abuse, some of which are described below.

a. Federal False Claims Act, 31 USC §§ 3729-3733. This law applies to any person (or entity) who:
   i. Knowingly presents, or causes to be presented, to the United States Government, a false or fraudulent claim for payment or approval;
   ii. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
   iii. Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
   iv. Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
   v. Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
   vi. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
   vii. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
   viii. Any person who engages in any of the above conduct may have violated the False Claims Act and may be liable for monetary penalties and damages, depending on the circumstances surrounding the false claim(s).

b. Program Fraud Civil Remedies Act, 31 USC §§ 3801-3812 (PFCRA). PFCRA provides for administrative remedies against any person who knowingly makes a claim or statement that the person knows or has reason to know is false, fictitious or fraudulent. The presence of a false claim is not required: a false statement is enough to trigger remedies under PFCRA.
c. **New York State False Claims Act, State Finance Law, Article 13.** The New York State false claims act is very similar to the Federal False Claims Act. It prohibits the filing of a false claim which means that a person:

i. Knowingly presents, or causes to be presented, to any employee, office or agent of the state or a local government, a false or fraudulent claim for payment or approval;

ii. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;

iii. Conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid;

iv. Has possession, custody, or control of property or money used, or to be used, by the State or a local government and, intending to defraud the state or a local government or willfully to conceal the property or money, delivers, or causes to be delivered, less property or money than the amount for which the person receives a certificate or receipt;

v. Is authorized to make or deliver a document certifying receipt of property used or to be used by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

vi. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee lawfully may not sell or pledge the property; or

vii. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a local government.

viii. A person who does any of the above acts will be liable for a civil penalty of between $6,000.00 and $12,000.00 plus three times the amount of damages sustained by the state or local government. The amount of damages may be reduced if the violator self-discloses the violation.

d. **Qui Tam Lawsuits.** The Federal False Claims Act and the New York State False Claims Act also provide for *qui tam* lawsuits through which any person (the “qui tam relator”) may bring a civil action for himself or herself and on behalf of the US Government for any violation of the False Claims Act. If the qui tam relator ultimately wins the lawsuit or if there is a settlement of the lawsuit, he or she may share in a portion of any money recovered with the government and receive reimbursement for reasonable expenses, reasonable attorneys’ fees and costs. Please note recovery by the qui tam relator is uncertain and dependent upon the facts and circumstances of the case.
e. **Non-Retaliation Policy.**
   
i. The False Claims Act forbids retaliation by an employer against an employee who cooperates with investigators regarding potential False Claims Act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program, Crouse Hospital fully complies with all applicable “whistle-blower” protections.

   ii. The False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. The New York State False Claims Act has similar non-retaliation protections.

f. **New York State Social Services Law § 145-b: False Statements.**

   i. Under New York Social Services Law § 145-b, it is unlawful for any person, firm or corporation to knowingly by means of a false statement or representation (defined below), or by deliberate concealment of any material fact, or other fraudulent scheme or device, on behalf of himself/herself or others, to attempt to obtain or to obtain payment from public funds for services or supplies furnished or purportedly furnished under the Social Services Law, including Medicaid.

   ii. "Statement or representation" includes, but is not limited to: a claim for payment made to the state, a political subdivision of the state, or an entity performing services under contract to the state or a political subdivision of the state; an acknowledgment, certification, claim, ratification or report of data which serves as the basis for a claim or a rate of payment, financial information whether in a cost report or otherwise, health care services available or rendered, and the qualifications of a person that is or has rendered health care services.
iii. For the violations described in section i above, the government may recover civil damages (plus interest) equal to three times the amount of the false claim or in the case of non-monetary false statements, three times the amount of actual damages or five thousand dollars, whichever is greater.

iv. **DOH Penalties.**

The Department of Health may require the payment of a monetary penalty by any person who fails to comply with the standards of Medicaid or of generally accepted medical practice in a substantial number of cases or grossly and flagrantly violated such standards and receives, or causes to be received by another person, Medicaid payment when such person knew, or had reason to know, that:

1. the payment involved the providing or ordering of care, services or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
2. the care, services or supplies were not provided as claimed;
3. the person who ordered or prescribed care, services or supplies which was medically improper, unnecessary or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from Medicaid at the time the care, services or supplies were furnished; or
4. the services or supplies for which payment was received were not, in fact, provided.

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g. **New York State Social Services Law § 145-c: Sanctions.** It is a violation of the law for any person to apply for or receive public assistance, including Medicaid, by intentionally making (or intending to make) a false or misleading statement. Social Services Law §145-c sets forth certain sanctions which may be imposed against a person for such illegal actions.

h. **Social Services Law § 145: Penalties.** Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

i. **New York Social Services Law § 366-b.** Any person who obtains or attempts to obtain, for himself or others, Medicaid benefits by false means is guilty of a Class A misdemeanor. In addition, any person who, with the intent to defraud, presents for payment any false or fraudulent claim, knowingly gives false information to obtain more money than he is legally entitled to, or knowingly gives false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.
j. **New York Penal Law Article 155, Larceny.** A person steals property and commits larceny when, with the intent to deprive another of his property, wrongfully takes, obtains, or withholds such property by means of trick, embezzlement, false pretense or fraud. There are four levels of offenses, depending on the value of the property involved.

k. **New York Penal Law Article 175, False Written Statements.** The crimes under Article 175 involve false written statements, including for example, filing false information, the falsification of business records and tampering with public records.

l. **Insurance Fraud Under Article 176 of the New York Penal Law.** Under Penal Law § 176.05, a fraudulent health care insurance act is committed by any person who, knowingly and with intent to defraud, presents (or causes to be presented) to an insurer, including Medicaid, a claim for health benefits which such person knows to contain materially false or misleading information. There are six levels of offenses, generally depending on the value of the false claim. A person is guilty of aggravated insurance fraud when he commits a fraudulent insurance act, and has been previously convicted within the preceding five years of any offense also involving a fraudulent insurance act.

m. **Health Care Fraud Under Article 177 of the New York Penal Law**

   i. Penal Law Article 177 also involves offenses of health care fraud. Under Article 177, a person is guilty of health care fraud when, with the intent to defraud a health plan (including Medicaid), he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for items or services and, as a result of such information or omission, payment is received for which he/she or another person is not entitled. There are five levels of offenses, depending on the value of the fraudulent claims.

   ii. It is a defense for crimes under Article 177 that the defendant was a clerk, bookkeeper or other employee (other than an employee charged with active management and control, in an executive capacity, of the affairs of the corporation) who, without personal benefit, merely executed the orders of his or her employer/supervisor.

n. **Insurance Frauds Prevention.** Section 403 of the New York Insurance Law prohibits an individual, firm, association or corporation from committing a fraudulent insurance act as defined in Penal Law § 176.05. Violators may be subject to both criminal liability and money penalties.
II. **Employee Whistleblower Protection Rights/Non-Retaliation.**

a. **Crouse Hospital’s Non-Retaliation Policy.** As set forth in greater detail below, the False Claims Act forbids retaliation by an employer against an employee who cooperates with investigators regarding potential False Claims Act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program, Crouse Hospital fully complies with all applicable “whistle-blower” protections.

b. **Specific False Claims Act Protection.** The False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.

c. **New York Labor Laws Prohibiting Retaliatory Personnel Actions.**

Two Laws prohibiting employer retaliation against employees are addressed below. The first is Labor Law § 740 and applies to employers in general. The second is Labor Law § 741, and is specific to health care providers.

i. **Labor Law § 740.** This law prohibits retaliatory personnel action by an employer against an employee who discloses or who threatens to disclose, to a supervisor or to a public body, an activity, policy or practice of the employer that the employee believes in good faith to be in violation of law, rule or regulation which creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud.

1. The protection against retaliatory personnel action provided above pertaining to disclosure to a public body only applies where the employee has first brought the activity, policy or practice believed to be in violation of law, rule or regulation to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice.
2. Labor Law § 740 also prohibits an employer from taking retaliatory personnel action against an employee who provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into a violation of law, rule or regulation by such employer. In addition, an employer may not take retaliatory personnel action against an employee who objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

3. For purposes of Labor Law §740, “retaliatory personnel action” means the discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

4. An employee who has been the subject of a retaliatory personnel action in violation of Labor Law § 740 may commence a civil court action within one year after the alleged retaliatory personnel action was taken. The employee may seek the following relief:
   a. an injunction to restrain the employer’s continued violation;
   b. the reinstatement of the employee to the same position held before the retaliatory personnel action, or to an equivalent position;
   c. the reinstatement of full fringe benefits and seniority rights;
   d. compensation for lost wages and benefits; and
   e. payment by the employer of reasonable costs, disbursements, and attorney’s fees.

5. Labor Law § 740 does not diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract. However, an action brought under § 740 is deemed a waiver of the rights and remedies otherwise available to the employee under any other contract, collective bargaining agreement, law, rule or regulation or under the common law.
ii. **Labor Law § 741.** This law prohibits retaliatory action by *certain health care* employers against a health care employee who discloses or who threatens to disclose, to a supervisor or to a public body, an activity, policy or practice of the employer or employer’s agent that the employee, in good faith reasonably believes constitutes improper quality of patient care. Labor Law § 741 also prohibits retaliatory action by such employer if the employee objects to, or refuses to participate in any activity, policy or practice of the employer that the employee, in good faith, reasonably believes constitutes improper quality of patient care.

1. Protection against retaliatory action does not apply unless the employee has first notified the employer of the improper quality of patient care and has afforded the employer a reasonable opportunity to correct such activity, policy or practice. However, such notice is not required if there is an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

2. For purposes of Labor Law § 741, "retaliatory action" means the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

3. Under Labor Law § 741, an employee has two years from the date of the alleged retaliatory action to commence a lawsuit. In addition to the remedies that may be available to the employee a court may assess a fine up to $10,000 against the employer if the court finds that the employer acted in bad faith. These fines are not paid to the employee, but will be deposited into a state-wide fund to improve patient care.
### Staff Development Report Form

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Attendance Record

Payroll or ID number must be entered. Report CLEARLY and CORRECTLY to receive credit for this course.

Complete and forward this staff development form to Educational Services, 2nd Floor, Marley Education Center.

Completion Date ____________________________

(Month, Day, Year)

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Appendix C: Issue Reporting Log

Year: 20___

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<tr>
<th>Date</th>
<th>Form of Intake (e.g. anonymous call, written complaint, audit finding)</th>
<th>Type of Issue</th>
<th>Investigation Summary</th>
<th>Resolution</th>
<th>Additional Comments</th>
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Corporate Compliance Form

Dear Employee,

Crouse Hospital encourages the reporting of concerns and/or suspicious activity. Non-retaliation and a safe reporting environment are components of our Corporate Compliance program. Please note that using this form allows you to remain anonymous, however, we invite you to include your information. Supplying your contact information allows us to gain more specific information to address the investigation or to directly provide you with follow up. Again, we will always keep the matter in the most strict confidence.

You may also call the Corporate Compliance hotline at anytime 470-7770.

My concern:

Optional
Name: ____________________________________________

Dept/Unit: _________________________________________

Phone: ___________________________________________ e-mail: ____________________________
Appendix E: Compliance Intake Report Form

Date: _______________________________ Time: _______________________________

Person Taking Call: _______________________________

Answering Machine: _____Yes _____No Spoke with caller: _____Yes _____No

Did the caller wish to remain anonymous? _____Yes _____No

Discussed limitations of the ability to protect identity if disclosed: _____Yes _____No

Identity of individual, if disclosed:

Name: __________________________________________

Department: _______________________________________

Phone Number: ___________________________________

Type of Call (Circle all that apply):

- **Informational**- Information was given on the policy and/or procedure of the Compliance Program or guidance was requested.

- **Consultative**- No complaint of misconduct, but further consultation is required.

- **Complaint or Report**- Alleged misconduct was reported.

Description of allegations or concerns:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Action Initiated:

- _____No Action

- _____Caller referred to policy(ies) and/or procedure(s) – Note policy(ies) and/or procedure:

________________________________________________________________________________________

________________________________________________________________________________________

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________________________________________________________________________________________
Referred to other department or individual – Note department or individual:

__________________________________________________________________________

__________________________________________________________________________

Action Taken:

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Contact Legal Counsel: ________Yes ________No

Further Caller Contact:
______No Contact Necessary
______Caller to be contacted on: _____________________________ (mm/dd/yy)
______Caller Contacted on: _____________________________ (mm/dd/yy)

File Closed: _____________________________ (mm/dd/yy)

Signature of Chief Compliance Officer or designee

***Attach all relevant documents, paperwork, interviews to this form.*

Page 2 of 2