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COMPLIANCE MANUAL

Hutchinson Clinic, P.A.
Compliance Manual

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CODE OF CONDUCT

It is the expectation of Hutchinson Clinic, P.A. (the "Clinic"), that all employees and professional staff will comply fully with all federal, state and local laws and will conduct themselves in accordance with relevant ethical standards when acting on behalf of the Clinic. To achieve that end, the Clinic has created this Compliance Manual (the "Manual") that describes our policies and procedures relating to compliance and the detection and prevention of fraud, waste and abuse with respect to federal and state health care programs. In addition to the policies and procedures, this Manual summarizes the federal and state laws relevant to the prevention of fraud, waste and abuse as well as advises all physicians, employees, contractors, vendors and agents of the Clinic about their rights and obligations as applicable to their individual areas of employment. The Clinic offers this Code of Conduct (the "Code") to ensure that these expectations are understood and met. The basic principles of conduct are as follows:

Be Honest and Ethical. The Clinic expects every employee and agent to adhere to high ethical standards when acting on behalf of the Clinic. Employees and agents should never place consideration for the "bottom line" ahead of ethical conduct. All employees and agents are expected to avoid situations which could be viewed as a conflict of interest in which the individual's position is used for personal gain. An example of a conflict of interest situation is having an ownership interest in a business that is a vendor of, or supplier for, the Clinic.

Obey the Law. There are many laws and regulations that govern the activities of the Clinic, particularly those relating to billing. The Clinic has developed policies set forth in the Manual and elsewhere to help explain these requirements. As a condition of employment or contracting with the Clinic, all employees and agents are expected to comply with applicable laws and regulations. All employees and agents of the Clinic must be committed to full compliance with all federal and state laws, regulations, and requirements related to billing. If you are not certain about what the law requires, you should ask the Compliance Committee for assistance.

Report Information Truthfully. We expect employees and agents to take particular care to ensure that all communications within the Clinic and with outside agencies (including government agencies) are truthful, accurate and complete.

Confidentiality. The Clinic expects all employees and agents to maintain the confidentiality of the Clinic's business information and information relating to the Clinic's vendors and suppliers. Employees and agents should not use any such confidential information except as is appropriate for carrying out business on behalf of the Clinic. It is expected that all patient information (including medical and billing records) will be kept strictly confidential and released only in accordance with applicable law and the terms of the privacy policies and procedures of the Clinic.

Reporting Possible Violations. Every employee and/or agent of the Clinic is required to report any activity he or she reasonably believes to be in violation of the law, or the Clinic's policies, to the Compliance Committee. Reports may be made without fear of retaliation and confidentiality will be protected to the full extent of the law.

Disciplinary Action. The failure to follow any of these principles of conduct may result in disciplinary action, including termination. There is also a range of penalties that can apply to individuals for violations of state and/or federal healthcare program regulations. Such penalties can include monetary fines, civil and criminal legal actions, and program exclusions.

While the Clinic cannot predict or anticipate every situation that might arise with respect to compliance matters, we have developed this Manual to address certain risk areas that have been identified as affecting physician practices such as that of the Clinic and to set forth procedures for monitoring compliance in those risk areas. If you have questions about other topics or issues not addressed in this Manual, please consult with the Compliance Committee for more information.

COMPLIANCE COMMITTEE

The Compliance Committee is responsible for overseeing the development, implementation and daily operation of the compliance program. The Compliance Committee shall report directly to the Board of Directors of the Clinic (the "Board"). Members of the Compliance Committee serve for three-year terms and are appointed by the President of the Clinic and ratified by the Board. The Committee consists of three to six voting physicians and may include employees and administrative personnel as non-voting members. The committee meets a minimum of twice a year.

The primary job duties and responsibilities of the Compliance Committee shall include:

Oversight, coordination, and monitoring of the day-to-day compliance activities of the Clinic as provided for herein.

Distribution of the appropriate compliance manuals, policies and procedures to employees and agents.

Establishing methods, such as periodic audits, to improve the Clinic's efficiency and quality of services, and to reduce the Clinic's vulnerability to fraud and abuse.

Assessing funding needs for the compliance initiatives of the Clinic and reporting those needs to the Board.

Periodically revising the compliance program in light of changes in the needs of the Clinic or changes in the law and in the standards and procedures of government and private payor health plans.

Developing and coordinating training and education programs for employees and agents of the Clinic that focus on the components of the compliance program, including billing and coding issues, and assessing the need for additional training and education.

Developing internal controls to assist in detecting patterns of illegal, unethical or improper conduct by employees and/or agents of the Clinic.

Establishing and monitoring a system to enable employees and agents to report any suspected noncompliance without fear of retribution.

Conducting or arranging for investigations of any report or allegation concerning possible unethical or improper business practices, and monitoring subsequent corrective action and/or compliance.

Reporting significant compliance issues to the Board as necessary.

Ensuring that the Department of Health and Human Services Office of Inspector General's (OIG's) List of Excluded Individuals and Entities, and the General Services Administration's List of Parties Debarred from Federal Programs have been checked with respect to all employees, medical staff and independent contractors.

Reviewing *fraud alerts* that are issued from time to time by the OIG and ensuring that the Clinic ceases and corrects any conduct criticized in such fraud alerts and takes reasonable action to prevent such conduct from occurring in the future.

Monitoring and investigating any exclusions, debarments, suspensions, or removal of any provider from any government or third-party payor program.

Performing other duties as assigned from time to time by the Board.

Employees are urged to contact the Compliance Committee with questions or concerns regarding compliance issues. When an employee contacts the Compliance Committee, the Compliance Committee will treat the employee with dignity and respect, protect the communication to the greatest extent possible, and address and investigate the employee's questions or concerns as appropriate. It is not mandatory that an employee identify him or herself, although it may be helpful for the Compliance Committee to contact the employee with additional questions.

SUPERVISOR' S RESPONSIB ILITY

The medical staff, administrators, and managing supervisors have a responsibility for education regarding the standards, rules and regulations set forth in this Manual that apply to their employees' jobs. Any supervisor or other management personnel who receives a report of known or suspected noncompliant conduct shall forward the information to the Compliance Committee for review and follow-up. They will be held accountable for making sure the employees understand and apply the policies and procedures set forth in this Manual and act if they have concerns.

IMPROPER INDUCEMENTS, KICKBACKS AND SELF-REFERRALS

There are very strict laws and regulations that address referrals by and among health care providers. Two of these laws are the Federal Anti-Kickback Law and the Stark Law.

Federal Anti-Kickback Law

In simple terms, a kickback can be defined as offering anything of value, including money, for referring an individual to a person or place for services paid for in whole or part by a federally funded health plan, i.e. Medicare or Medicaid. An example of a "kickback" in violation of this law would be allowing a physician who refers patients to the Clinic to lease space within the Clinic's building for free. The free rent could be construed as payment for that physician's referral of patients to the Clinic. The law is also violated in the event inappropriate inducements are made to patients, such as waiving coinsurance or deductibles without regard to financial need. Paying for referrals and providing inducements are illegal because it can affect a provider's medical judgment, cause overutilization of services or supplies, and reduce the quality of care provided to patients by encouraging the ordering of services and/or supplies based on profit rather than the patient's best interests.

Violations of the Anti-Kickback Law can result in civil and criminal liability for physicians, non-physicians, and organizations and the penalties can include hefty fines, imprisonment, or both. The Clinic expects its employees and agents to refrain from engaging in illegal kickback or inducement arrangements and to avoid the appearance of such impropriety at all times. In this regard, the following guidelines should be adhered to by all employees and agents of the Clinic:

> It is a violation to accept or solicit anything of value from an individual or entity attempting to do business with the Clinic except items or gifts of a promotional nature and of nominal value. It is difficult to define nominal by a dollar amount. Employees should make a common sense determination as to what would be considered lavish, extravagant or frequent. If questionable, always check with the Compliance Committee. Acceptance of meals, refreshments or entertainment or other items of value must not, in any way, be construed as an attempt by the offering party to secure favorable treatment.

It is a violation to bribe any employee, vendor, supplier, or other individual or entity attempting to do business with the Clinic in return for favors or benefits whether for personal gain or on behalf of the Clinic.

Stark Law

The Stark Law prohibits physicians from referring patients to the Clinic for certain health services if the physician or a physician's family member has a financial relationship with the Clinic. A financial relationship can include an ownership or investment interest or a compensation arrangement. Any relationship involving the transfer of payments or benefits - including payment of salary and benefits, office and or equipment leases, or certain types of loans - constitutes a compensation relationship. If a physician improperly refers a patient to the Clinic in violation of the Stark Law, the Clinic cannot bill for the services provided to such patient. Additionally, the Clinic and/or its physicians could be subject to monetary fines and penalties and exclusion from the Medicare or Medicaid programs.

All "financial relationships" between the Clinic and physicians who refer to the Clinic should be reviewed by legal counsel to ensure that the relationship falls within a stated exception of the Stark Law. No employee or agent should submit claims for improperly referred patients. If any employee or agent suspects that a referral or pattern of referrals is questionable, he or she should report the same to the Compliance Committee.

PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE

The purpose of summaries set forth in this section is to abide by the requirements of Section 6032 of the Deficit Reduction Act of 2005. Accordingly, the summaries discuss the federal and state laws that are relevant to the detection and prevention of fraud, waste and abuse with respect to payments to the Clinic from federal and state health care programs and protection for those who report actual or potential noncompliance. The following summaries should serve to inform all employees, contractors, vendors, and agents of the Clinic about their rights, protections, and obligations under the applicable state and federal laws.

Federal False Claims Laws

Federal False Claims Act

The Federal False Claims Act (the "FCA") was first enacted during the Civil War to address fraudulent activity in supplying goods to the Union Army. Although the FCA was largely ineffective for the first century following its enactment, Congress passed several amendments in 1986 which included expansion to the Medicare and Medicaid programs. The FCA prohibits knowingly making a false claim against the government. Specifically, the FCA sets forth circumstances for which civil liability will be imposed for false claims, including, but not limited to, the following:

> Knowingly filing a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
>
> Knowingly using a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
>
> Conspiring to defraud Medicare, Medicaid, or other federally funded health care program by attempting to have a false or fraudulent claim paid.

According to the FCA, "knowingly" is defined as actual knowledge that the information on the claim is false, acting in deliberate ignorance of whether the claim is true or false, or acting in reckless disregard of

whether the claim is true or false. Additionally, no proof of specific intent to defraud is required by the FCA.

The FCA imposes civil penalties for violations. A person or entity found liable under the FCA is subject to a civil money penalty of between $5,000 and $10,000 plus three (3) times the amount of damages that the government sustained because of the illegal act. In health care, the amount of damages sustained is the amount paid for each false claim that is filed. A court may impose a lesser penalty of not less than two (2) times the amount of damages sustained by the government where the court finds one of the following:

> The person committing the violation furnished governmental officials responsible for investigating false claims with all information known to the person about the violation within thirty (30) days after the date on which the person first obtained the information;
>
> The person fully cooperated with any governmental investigation of the violation; and
>
> At the time the person furnished the government with the information about the violation, no criminal prosecution, civil action, or administrative action had been commenced with respect to the violation and the person did not have actual knowledge of the existence of any investigation into the violation.

The FCA applies to claims submitted under Medicare, Medicaid, other federal health care programs and other state health care programs funded, in whole or in part, by the federal government. Examples of false claims include, but are not limited to the examples listed in the Coding and Billing Policies of this Manual.

Civil Actions under the FCA

Enforcement of the FCA is the responsibility of the United States Attorney General, but to encourage individuals to come forward and report wrongdoing, the FCA includes a qui tam or whistleblower provision. Qui tam actions are brought by private individuals on behalf of the government. More specifically, a qui tam action is defined as a claim brought by a relator or informer under a statute that

establishes a penalty for the commission or omission of a certain act. If a wrongdoing is found, part of the penalty paid by the wrongdoer is paid to the relator with the remainder going to the government.

A qui tam action is initiated by a relator filing his or her lawsuit in a federal district court on behalf of the government for false or fraudulent claims submitted by an individual or an entity doing business with or being reimbursed by the United States government. The lawsuit is filed and shall remain under seal for a period of sixty (60) days in order for the government to investigate and decide whether it will pursue the action. At the end of the sixty (60) day period, the complaint is unsealed and the Department of Justice or a United States Attorney General's office begins prosecuting the claim. If the government decides not to pursue the case, the relator has the right to continue with the case on his or her own. The government may join the action at a later date if it can demonstrate good cause for doing so. Any case must be brought within six (6) years of the filing of the false claim.

Award to Qui Tam Plaintiff under the FCA

If the government proceeds with the lawsuit and is successful, the person who filed the action will receive between fifteen percent (15%) and twenty-five percent (25%) of any proceeds of the action plus attorney fees and costs. The amount of the award depends on the contributions of the individual to the success of the case. If the government declines to pursue the case, the qui tam plaintiff will be entitled to between twenty-five percent (25%) and thirty percent (30%) of the proceeds of the successful case, plus reasonable expenses and attorneys' fees and costs awarded against the defendant. On the other hand, if the qui tam plaintiff is unsuccessful and the court finds that the lawsuit was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment, it may reward the defendant in the action reasonable expenses and attorneys' fees. Whether or not the government proceeds with the lawsuit, if the court finds that the qui tam plaintiff planned and initiated the violation upon which the lawsuit was brought, the court may reduce the share of the proceeds which the person would have otherwise received. If the qui tam plaintiff is convicted of criminal conduct arising from his or her role in the violation, the person will be dismissed from the civil lawsuit and shall not be paid any part of the proceeds.

Anti-Retaliation Protections for Whistleblowers under the FCA

Any individual associated with an organization who observes activities or behavior that may violate the law in some manner and who reports their observations either to management or to governmental

agencies is provided protections under the law. Whistleblowers initiating a qui tam action may not be discriminated or retaliated against in any manner by their employer. Any employee, who is discharged, demoted, suspended, threatened, harassed, or confront discrimination in furtherance of a qui tam action or as a consequence of whistleblowing, are entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, double the amount of back pay, interest on back pay, and compensation for any special damages sustained, plus reasonable expenses and attorneys' fees.

Federal Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801 - 3812

The FCA is not the only federal law that speaks to the issue of detection and prevention of fraud, waste and abuse for federally funded programs. The Program Fraud Civil Remedies Act of 1986 (the "PFCRA") provides administrative remedies for making false claims to certain federal agencies, including the Department of Health and Human Services (the "HHS") separate from and in addition to, the judicial or court remedy for false claims provided by the FCA. The PFCRA may seem quite similar to the FCA in many respects, but they vary in many ways, including differing penalties. The PFCRA addresses the submission of false claims or written statements to a federal agency, which includes the HHS. The PFCRA also addresses fraudulent activity of lesser dollar value, and consequently applies to claims $150,000 or less.

The PFCRA imposes liability on any person (individual or entity) who makes, presents or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know:

is false, fictitious, or fraudulent;

includes or is supported by any written statement that contains false, fictitious, or fraudulent information;

includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the individual or entity submitting the statement has a duty to include the omitted fact; or

> is for payment for the provision of property or services which the individual or entity has not provided as claimed.

The PFCRA also imposes liability on any person (individual or entity) who makes, presents or submits, or causes to be made, presented or submitted, a written statement that:

> the individual or entity knows or has reason to know asserts a material fact which is false, fictitious or fraudulent or is false, fictitious or fraudulent as a result of such omission;
>
> the individual or entity making, presenting, or submitting a written statement which is false fictitious or fraudulent as a result of omission has a duty to include such material fact; and
>
> contains or is accompanied by an express certification or affirmation of the truthfulness or accuracy of the contents of the statement.

The phrase "knows or has reason to know" is defined in the PFCRA as a person (individual or entity) that has actual knowledge that the claim or statement is false, fictitious or fraudulent, acts in deliberate ignorance of the truth or falsity of the claim or statement, or acts in reckless disregard of the truth or falsity of the claim or statement. Like the FCA, no proof of specific intent to defraud is required.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid. Violations are investigated by the HHS Office of the Inspector General and enforcement actions must be approved by the Attorney General. The PFCRA enforcement can begin with a hearing before an administrative law judge. Penalties may be recovered through a civil action brought by the Attorney General or through an administrative offset against clean claims.

State False Claims Laws

Many states have their own laws that are relevant to the detection and prevention of fraud, waste and abuse with respect to payments to the Clinic from state health care programs and protection for those who report actual or potential noncompliance. The following are summaries of such laws in Kansas.

Kansas False Claims Act, K.S.A. §§ 75-7501 - 7511

Many states have enacted statutes like the FCA that provide a civil remedy for the submission of false and fraudulent claims to state health care programs, including Medicaid. Kansas became the 25th state to enact such laws in early 2009. Like its federal counterpart, the Kansas False Claims Act (the "KFCA") allows the Kansas Attorney General to file civil lawsuits to recover funds obtained fraudulently from state and local governments, including Medicaid payments. The KFCA sets out the following actions as fraudulent claims for which individuals and entities can be liable under the statute:

knowingly making a false or fraudulent claim for payment or approval;

knowingly using or submitting false records or statements to get a false or fraudulent claim for payment;

knowingly using or submitting false records or statements to conceal, avoid, or decrease an obligation to pay;

knowingly delivering less property or money than commissioned;

knowingly making or delivering a receipt that falsely certifies property;

knowingly buying or accepting an obligation for public property from a person not authorized to sell or pledge the property;

benefiting from a fraudulent claim and failing to disclose the false claim; and

conspiring to commit any of these actions.

Also similar to the FCA, the KFCA defines "knowingly" as actual knowledge of the information, acting in deliberate ignorance of the trust or falsity of the information, or acting in reckless disregard of the trust or falsity of the information, but proof of specific intent to defraud is not required.

Civil Actions under the KFCA

The Kansas Attorney General's office may bring an action up to three (3) years after the date when material facts are known or should be known to the state, or up to six (6) years after a violation, but in no event more than ten (10) years. Any wrongdoer will be liable for three (3) times the amount of actual damages, a civil penalty of up to $11,000 per violation, and costs and fees associated with the civil litigation. The court may not fine a wrongdoer more than two (2) times the amount of damages in cases where the wrongdoer provides complete information within thirty (30) days of the violation, the wrongdoer fully cooperates in the investigation, and no legal action has already commenced.

Anti-Retaliation Protections for Whistleblowers under the KFCA

The KFCA establishes specific protections for employees or whistleblowers who report a violation of this state law. Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner retaliated against by the employer shall be entitled to all relief necessary to make the employee whole. Although this is yet another similarity with the FCA, the KFCA is distinguished in a significant way; it does not include an equivalent to the qui tam provisions of the FCA.

Kansas Medicaid Fraud Control Act, K.S.A. §§ 21-3844 - 3855

Similar to the federal laws, Kansas does not solely rely on the KFCA for laws addressing the issue of detection and prevention of fraud, waste, and abuse relevant to government-funded programs. Enacted in 1996, the Kansas Medicaid Fraud Control Act (the "KMFC") allows the Kansas Attorney General's office to file lawsuits to recover Medicaid payments under the Kansas criminal code. The KMFC defines making a false claim to the Medicaid program as, knowingly and with intent to defraud, engaging in a pattern of making, presenting, submitting, offering or causing to be made, presented, submitted or offered any false or fraudulent claim, statement, representation, report, book, record, document, data or instrument. The KMFC also defines unlawful acts related to the Medicaid program including knowingly and intentionally soliciting or receiving any remuneration including a kickback, bribe or rebate, directly or indirectly, in cash or in kind for certain acts. Another section of the KMFC addresses the requirement to maintain records which disclose fully the nature of the goods, services, items, facilities or accommodations for which a claim is submitted or payment received, or the income or expenditures upon

which rates of payment were based. Negligence in maintaining records along with intentional destruction or concealment of records can all lead to punishment.

Criminal Actions under the KFCA

Because this act is a part of the Kansas criminal code, wrongdoing can potentially lead to greater punishment than the KFCA. Violations of the KMFC are criminal offenses punishable by imprisonment and payments of full restitution to the State of Kansas plus interest and all reasonable expenses. Recovered funds are remitted to the state treasurer for distribution, as appropriate, to the state Medicaid Fraud Reimbursement Fund, the federal government and affected state agencies. Additionally, the KFCA establishes the Medicaid fraud and abuse division within the Kansas Attorney General's office to receive cases of suspected Medicaid fraud referred by the Department of Social and Rehabilitation Services, or its fiscal agent, for the purposes of investigation, criminal prosecution or referral to the district or county attorney for criminal prosecution.

Perjury and Unsworn Declarations, K.S.A. § 21-3805 and § 53-601

A couple additional Kansas statutes are significant to employees, contractors, vendors, and agents relevant to the issue of false claims and statements. The Kansas statute which discusses the offense of perjury defines it as intentionally, knowingly and falsely swearing, testifying, affirming, declaring or subscribing to any material fact upon any oath legally administered or subscribing as true and correct any material matter in any unsworn declaration, verification, certificate or statement. Kansas law allows the use of unsworn written declaration, verification, certificate or statement dated and subscribed by the person as true, under penalty of perjury, any time Kansas law requires or permits a matter to be established by sworn written declaration, verification, certificate, statement, oath or affidavit, as long as the language is substantially similar to the language set forth in the statute.

CODING AND BILLING POLICIES

It is wrong and illegal to report false information on any request for payment, third-party payor claim form, or cost report and doing so is a serious offense. Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made a false statement or representation of material fact in an application for benefits or payment. Furthermore, federal law states that it is also unlawful to conceal or fail to disclose the occurrence of an event which would affect a health care provider's right to payment with the intent to secure payment that is not due. All of these things are considered to be the submission of a false claim. Some examples of the different types of false claims are:

Billing for items not provided or services not rendered.

Billing for services, supplies and equipment that are not reasonable or necessary based on the patient's documented medical condition.

Double billing resulting in duplicate payment. For example, Dr. X bills for the same exam or item of DME more than once or Dr. X bills for an exam or item of DME that is also billed by Dr. Y.

Billing for non-covered services as if they were covered. For example, billing for an office visit because it is a covered service even though the actual service was an annual physical, which is not a covered service.

Intentional misuse of a provider number issued by a federal health care program. For example, Dr. X has just joined the practice and has not yet received his provider number, so, in order to obtain prompt payment, the services are billed under Dr. Y's provider number as if he performed the services.

Unbundling, which is billing for multiple components of a service that must be included in a single fee. For example, rather than billing for a physical (which may be at a low, comprehensive rate), the physician bills for all of the separate components of the physical (which, when taken together, exceed the comprehensive rate).

Clustering, which is charging one or two middle levels of service codes exclusively (rather than the level of service actually provided) with the thought that some will be higher, some lower, and the charges will average out over an extended period. For example, Dr. X bills all services at a Level 2 service code regardless of what was done with the thinking that some of the services performed are Level 1 and some are Level 3 and that all the charges will average out over time.

Upcoding the level of service provided. For example, billing for a more expensive service than the one actually performed.

The foregoing is not an exhaustive list of all of the types of false claims that can be submitted – a false claim is submitted any time false information is contained in a claim or report. It has been included to alert those individuals who prepare or submit claims on behalf of the Clinic to the types of errors for which they should be looking. There is a distinction between an erroneous claim, in which case someone made an innocent mistake, and a false claim, which involves reckless or intentional conduct. Both erroneous claims and false claims should be reported to the Compliance Committee, but the actions taken in response to the claims may be different. Individuals who submit false claims can be subjected to civil and criminal liability and the penalties may include hefty fines, imprisonment, or both.

Additionally, the Compliance Committee shall periodically examine the claims denial history of the Clinic and/or claims that have resulted in repeated overpayments and identify and correct the most frequent sources of those denials or overpayments.

Billing Policies

Physicians, physician assistants, and physical therapists within the Clinic, as well as personnel within the Clinic's billing department, have responsibility for entering charges, diagnoses and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules and established coding guidelines and to comply with the following policies and standards:

Bill only for items or services actually rendered. Employees and agents shall never submit a claim for reimbursement without adequate information to indicate that the service billed for was actually rendered or the item billed for was actually provided to the

patient. Such information should include: the date and time the service was rendered or item was provided; the identity of the patient; a description of the services rendered or item provided; and the identity of the person providing the service or item for which reimbursement is sought.

Bill only for medically necessary services. Employees and agents shall only submit claims for items and/or services that the Clinic has reason to believe are medically necessary and that were ordered by a physician or other licensed provider. If any employee or agent has any question about the medical necessity of a service, he or she should review all documentation relating to the claim and consult with the Compliance Committee, if necessary.

Double-check all billing codes. Employees and agents shall take steps to ensure that the code being billed for is consistent with the item and/or service provided and is the code that most accurately describes the item and/or service provided. This can be done by checking the medical chart and/or consulting with the provider of the item and/or service.

Check for duplicate billing. Employees and agents shall check claims to ensure that no more than one claim is submitted for the service and/or item for which reimbursement is being sought.

Assign comprehensive codes. Employees and agents shall use every reasonable attempt to assign a comprehensive CPT code to an item or service to avoid fragmented or "unbundled" billing. The National Correct Coding Initiative Coding Policy Manual for Medicare Services should be referenced for comprehensive CPT codes.

Timely refund credit balances. A credit balance report, including amount of credit, patient name or responsible party, and date the credit is established shall be prepared on a quarterly basis. Credit balances should be repaid in a timely manner.

Waive copays or deductibles only in accordance with policies. Coinsurance and/or deductibles should only be waived in accordance with the indigency policy of the Clinic,

a copy of which is attached hereto as Exhibit A, and/or the Clinic's policy on professional courtesy, a copy of which is attached hereto as Exhibit B.

The Clinic will provide resources within its budget to keep physicians, physician assistants, and physical therapists within the Clinic, as well as personnel within the Clinic's billing department, updated with a continuing education process at the expense of the Clinic.

It is a violation to alter or change a CPT and/or ICD-9 code that has been originally assigned without the approval of the treating physician. It is also a violation to submit a bill at the instruction of a supervisor or physician if doing so would result in an inaccurate or false representation of services. In the event that you are instructed or asked by someone to submit a bill with inaccurate or false information, or if you suspect a violation of any of the foregoing policies and standards, you should report this to your office manager, administrator, or the Compliance Committee immediately. The officer managers and administrator should, on a quarterly basis, report any trends or substantial variances noted during that period to the Compliance Committee.

Recording Billing Information

The physicians and other licensed providers acting on behalf of the Clinic play an important role in ensuring that accurate claims are submitted. In this regard, the Clinic expects physicians and other licensed providers performing services on behalf of the Clinic to maintain complete and legible medical records which, at a minimum:

Document each patient encounter by including the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the person that provided the services being billed for and/or, where appropriate, the observer(s).

If not documented, presents the rationale for ordering diagnostic and other ancillary services that can be easily inferred by an independent reviewer or third party who has appropriate medical training.

Includes CPT and ICD-9-CM codes used for claims submission that are supported by documentation and the medical record.

Identifies the appropriate health risk factors, including, but not limited to, the patient's progress, his or her response to, and any changes in, treatment, and any revisions in diagnosis.

Adequately supports the finding that each service was reasonable and necessary for the particular patient.

Every attempt will be made to obtain an "Advanced Beneficiary Notification" waiver for services that may be considered medically unnecessary under Medicare and Medicaid programs or the guidelines of any other third party payor.

CONFLICTS OF INTEREST

A conflict of interest occurs when a representative of the Clinic allows personal gain to interfere or influence the performance of his or her work duties. Avoid situations which may be called into question. When in doubt about any activity or relationship, contact the Compliance Committee for clarification. New employees are advised to disclose any possible conflicts of interest to the Compliance Committee at the earliest possible opportunity.

Situations which could be perceived as a conflict of interest include:

Receiving gifts, payments or services from suppliers or vendors seeking to do business with the Clinic.

An employee or employee's immediate family having significant financial interest in a supplier or vendor that conducts business with the Clinic.

Disclosing the Clinic's confidential business information, such as financial data, fee schedule and billing practices.

To avoid the appearance of impropriety, personnel within the billing department will not work on any bills or other matters involving themselves or a member of their immediate family.

TRAINING AND EDUCATION

The Clinic is committed to providing employees with training and education on billing matters, the Clinic's standards of conduct and each person's ethical and legal responsibilities related to their day-to-day work. The Compliance Committee will be responsible for developing and/or monitoring ongoing education relating to foregoing corporate ethics and compliance issues. Each physician and employee at the Clinic will receive training annually pertaining to the compliance plan and related issues. New physicians and employees will receive compliance education as a part of their initial orientation. Medical staff and employees may receive additional specialized training or education tailored for their respective responsibilities. Education may be provided through a variety of means including orientation, written materials, newsletters, staff meetings and formal internal and external corporate education. The specialized training may focus on complex areas or in areas which the Compliance Committee has deemed high risk. The Compliance Committee will monitor continuing education specific to the individual medical staff and employee positions and responsibilities.

MONITORING COMPLIANCE

In order for the Clinic's compliance program to be effective, it is necessary to periodically audit the compliance standards and procedures of the Clinic to ensure that they adequately identify and address compliance problems. To this end, the Compliance Committee shall be responsible for overseeing and monitoring the various compliance activities and operations of the Clinic, assessing the effectiveness of the compliance program, and identifying areas in which the program may need revision or improvement.

The Compliance Committee shall employ various techniques for monitoring the effectiveness of the compliance program, which shall include, but not be limited to, periodic interviews with employees and agents regarding their perceived levels of compliance and that of the Clinic, audits performed by internal and/or external auditors, investigations of alleged noncompliance, and exit interviews for departing employees. Audits will be conducted at least annually to ensure that the compliance program is being followed. If problems are identified, the Compliance Committee may determine that a more focused review should be conducted or that audits should be performed on a more frequent basis. If audit results reveal that additional information or education of physicians and employees is needed, the Compliance Committee will determine whether these areas should be incorporated into the training system. The Compliance Committee will establish protocols for appropriate responses when a problem is identified. A system to respond to and report potential problems will be part of the protocol.

The Compliance Committee shall maintain written reports of its monitoring activities as appropriate and shall provide an overview of the auditing process being used and the results of such monitored activities to the Board periodically or as requested. Additionally, no less often than annually, the Compliance Committee shall evaluate the effectiveness of the compliance program, including all manuals, policies and procedures, and provide the results of such evaluation to the Board.

All medical staff and employees are expected to cooperate fully with all internal and external audits done as part of the compliance program, all legitimate government investigations, and all accrediting bodies.

REPORTING NONCOMPLIANCE

All employees, contractors, vendors and agents of the Clinic are expected to not only comply with the policies and procedures contained in this Manual, but are also required to report any conduct that they believe to be erroneous or fraudulent to their business office manager, the administrator, or the Compliance Committee. It is important that conduct which is simply erroneous (*i.e.* not intentional) be reported, as well as fraudulent conduct, so that the Clinic can conduct an analysis of its procedures and determine if changes are necessary to prevent such errors from occurring in the future. The Compliance Committee shall be notified of all reports made to the office manager and/or administrator and, if the issue was handled by the office manager or administrator, the manner in which the same was resolved. The Compliance Committee shall assess all reports and shall determine if there is a basis for believing that the conduct being reported is not in compliance with this Manual and whether disciplinary action is recommended. Additionally, the Compliance Committee shall, based on its review of such reports, inform the Board of any trends and/or recommendation for changes.

Reports may be made verbally or in writing and mailed to the attention of the Compliance Committee at the Clinic's address. Any mail addressed to "Compliance Committee" shall not be opened and shall be delivered immediately to the Compliance Committee. Employees may also report concerns anonymously by submitting a report by mail as addressed above, or to the Employee Comment box in the Employee Lounge at the Clinic's main facility or at the 1100 North Main facility. The Compliance Committee will document the question and/or concern brought to his/her attention by the employee. To the extent allowed by law, the Clinic will maintain the confidentiality of the reporter.

The failure to report conduct that a reasonable person, in good faith, would believe to be erroneous, fraudulent, or in violation of the policies and procedures contained herein is a violation of the compliance program and can result in disciplinary action being taken against the person who knew about such conduct and failed to report the same. Employees and agents should rest assured that the Clinic will not retaliate against any person reporting suspected noncompliance in accordance with the policies and procedures set forth herein. Anyone discouraging an employee or trying to stop them from contacting the Compliance Committee regarding an issue of concern is subject to disciplinary action up to and including dismissal.

INVESTIGATING NONCOMPLIANCE

Investigation and Corrective Action

If, after the initial assessment of a report of noncompliance, the Compliance Committee believes the conduct in question is in violation of the Manual or if, as a result of the monitoring mechanisms employed by the Compliance Committee, it has reason to believe that there has been conduct which violates the Manual, it shall report the same to the Board. The Compliance Committee shall then conduct, or oversee the conduct of, an investigation, which investigation may involve the review of relevant documents, interviewing person(s) involved in the conduct at issue, reviewing and researching the law and policies and procedures of the Clinic, and soliciting the support of internal and external resources, as necessary. If, during an investigation, the Compliance Committee believes that the integrity of the investigation may be compromised because of the presence of individuals under investigation, these individuals may be removed from their current work activity until the investigation is completed.

Once the investigation is complete, the Compliance Committee shall prepare a report which includes: (i) a summary of the proposed misconduct; (ii) a summary of the investigation, including copies of all relevant documents (reports from interviews, relevant billings, etc); (iii) a summary of the findings; (iv) a plan of corrective action (if a violation was found to have occurred); and (v) recommended disciplinary measures to be taken against the person or persons whose activities or conduct are the subject of the investigation (if a violation was found to have occurred).

Any plan of corrective action shall include: (i) an analysis of the Clinic's policies and procedures and/or billing practices to determine if any changes are necessary and implementation of any changes deemed necessary; (ii) additional education and training, if necessary, to reduce the likelihood that the errors will occur again in the future; (iii) repayment of overpayments discovered in the investigation (including interest, if appropriate); (iv) compliance with any mandatory disclosure obligations; and (v) scheduled follow-up reviews to ensure that the errors have been corrected. Additionally, in the event the Compliance Committee believes that disciplinary action is appropriate based on the circumstances, it will make a recommendation to the Board regarding the form of discipline being recommended and the Board shall make the final determination regarding the level of discipline to be imposed.

DISCIPLINARY ACTION

If the Clinic determines that any physician, employee, or agent has violated the procedures contained in this Manual, including, but not limited to, the failure to report suspected violations, negligently providing incorrect information to a payor, provider or other third party, or willfully providing false information, he or she shall be subject to disciplinary action. The scope and severity of the disciplinary action shall be based on the nature of the violation (*i.e.* whether willful or unintentional), the damage caused by the violation, and the individual's disciplinary record and may include, but not be limited to, any or all of the following: a verbal warning, written reprimand, demotion, suspension without pay, termination, and/or restitution of damages. If applicable, the incident shall be reported to the appropriate licensing board(s) and/or governmental authorities.

The President and the Board will be made aware of any disciplinary procedures recommended against any Clinic physicians, employees, or agent for violations of laws, rules, or regulations. The physician, employee, or agent will have available to them the existing appeals and grievances process as addressed in the Physicians' Governing Policies Manual and the Personnel Policy Manual.

RECORD RETENTION AND COMMUNICATION WITH GOVERNMENT & PAYORS

Documents generated pursuant to this Manual and the overall compliance program of the Clinic, including investigatory documents, review reports, corrective action plans and educational materials shall be maintained by the Compliance Committee for a minimum of five (5) years; provided, however, that if there is any ongoing internal or external investigation, lawsuit or similar action, the records relevant to the action shall be retained until the action is concluded. The Compliance Committee shall take steps to include that the documents are secured and confidentiality of such documents is maintained. Additionally, the Compliance Committee shall provide for the maintenance and retention of records as required by all state and federal laws.

The Clinic and its physicians and employees should accurately respond to all governmental, payor or patient inquiries as required by law and maintain any instructions received from the government or payors.

HUTCHINSON CLINIC, P.A.

EMPLOYEE ACKNOWLEDGMENT AND CERTIFICATION

OF COMPLIANCE TRAINING

I have read and understand the Compliance Manual of Hutchinson Clinic, P.A. (the "Clinic"). If I have questions about any of the information contained in such manual, I understand that I may discuss such questions with the Clinic's Compliance Committee at any time. I understand that the Compliance Manual is available for my review, and I am aware of the location of such manual within the Clinic. I understand that I am responsible for complying with the policies and procedures set forth in the manual and may be subjected to disciplinary action for violations of such policies and procedures.

I certify that on _____ I received training by the Clinic on its compliance policies and procedures.

_____

Employee Signature

_____

Print Name

_____

Date

_____

Compliance Committee Member Signature

HUTCHINSON CLINIC, P.A.

INCIDENT REPORTING FORM

Please document the situation or action you believe may violate the Clinic's standard(s) of conduct described in the Compliance Manual. You may return this form to the Compliance Committee direct by mail addressed to Hutchinson Clinic, Attn: Compliance Committee, 2101 N. Waldron, Hutchinson, KS 67502; or by placing the form in the Employee Comment Box in the Employee Lounge at the Clinic's Main building or 1100 N. Main location in Hutchinson.

_____
_____
_____
_____
_____
_____
_____
_____

You May Remain Anonymous

_____ _____

Date Name (Not Required)

EXHIBIT A

HUTCHINSON CLINIC, PA
Business Office Standard Operating Procedure (SOP)

FINANCIAL ASSISTANCE PROGRAM (FAP)

Approved by: CBO TASK FORCE **Effective Date: 03/01/2011**
Revised: 01-31-12
(Any revisions must be reported to Compliance Dept.)

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Responsible Area: Central Business Office, Front End and Oncology

Purpose:

To provide administrative and financial assistance for patients experiencing financial hardship that either fall within the Federal Poverty Level Guidelines to qualify for a FAP Discount Program or to provide assistance in initiating the application process for supplemental coverage or applicable state and federal healthcare programs, such as the Kansas Medical Assistance Program (KMAP/MCAID).

Policy:

It is the goal of the FAP Discount Program to assistance with deductibles and co-insurance for existing health insurance coverage to exclude FAP qualifying charges from the Collection Process with the following criteria:

a. Yearly limit of $5,000.00
b. Co-pays to be paid by patient and collected at date of service

Requirements:

1. Legal resident of the U.S.
2. Carry current health insurance coverage
3. Only applicable to charges set to Self-Pay within the last 6 months
4. Submit a completed prior year tax return showing number of dependents claimed and annual income
5. Meet the Federal Poverty Guidelines
   (link found at http://aspe.hhs.gov/poverty/12poverty.shtml)
~~~~~~

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

6. If they currently do not have Medicaid and fall within the guidelines they will need to apply for Medicaid.

Medical Programs Standards and Limits

Poverty Level Standards (5-1-11)

Standard for	# Persons	100%	120%	133%	135%	150%	185%	200%	238%	300%
MP N4 100%										
MP N3 133%	1	$908	1089	1207	1226	1362	1679	1815	2160	2723
MP N2 150%	2	1226	1471	1631	1655	1839	2268	2452	2918	3678
MP PW 150%	3	1545	1853	2054	2085	2317	2857	3089	3676	4633
MP T6 > 100-150%	4	1863	2235	2478	2515	2794	3446	3725	4433	5588
MP T5 > 133-150%	5	2181	2617	2901	2945	3272	4035	4362	5191	6543
MP T7 > 150-200%	6	2500	2999	3324	3374	3749	4624	4999	5949	7498
	Each add	319	382	424	430	478	589	637	758	955

Independent Living Protected Income Limits

# of Months	1	2	3	4	5	6	7	8
1 mo.	475	475	480	497	558	619	680	741
2 mos.	950	950	960	994	1116	1238	1360	1482
3 mos.	1425	1425	1440	1491	1674	1857	2040	2223
4 mos.	1900	1900	1920	1988	2232	2476	2720	2964
5 mos.	2375	2375	2400	2485	2790	3095	3400	3705

6 mos.	2850	2850	2880	2982	3348	3714	4080	4446

For 9 or more persons, use the Shelter Group V standard from Table I, KEESM Standard Table.

HCBS Protected Income = $727 (eff 7-08)
Spousal Impoverishment Resource Minimum = $21,912
Minimum Income Allowance = $1,839

Dependent Family Member Allowance = $613

Institutional Protected Income = $62 (eff 1-09)
Resource Maximum = $109,560
Maximum Income Allowance = $2,739
Standard Part B Medicare Premium = $115.40 (eff 1-1-11)
= $110.50 (eff 1-1-10)
= $96.40 (eff 1-1-08)

GUIDELINES

Financial assistance needed will be determined by utilizing the following methods:

1. Patients with healthcare coverage who are under-insured (high deductibles and co-insurance) with household income within the Federal Poverty Guidelines will be eligible for a FAP Discount in the following categories:

1-125% of Federal Poverty Level	100% Discount
126-150% of Federal Poverty Level	75% Discount
151-175% of Federal Poverty Level	50% Discount
176-200% of Federal Poverty Level	25% Discount

2. Patients with Medicare and no supplemental coverage will be provided information in obtaining supplemental insurance.
    a. Generally, Medicare beneficiaries with income below 100% of the Federal Poverty Guidelines are eligible for Medicaid's QMB status which pays the Medicare co-insurance and deductibles.

3. Patients who were previously insured and now find themselves without insurance due to disability, will obtain assistance in acquiring disability coverage or enrollment in other State Assistance Programs.

4. Patients who qualify for Medicaid will need to apply. They will retain a "FAP Pending" status until they either have been approved or denied by Medicaid.

FAP Discount Process:

After patient has been identified as having a need for Financial Assistance, patient will be referred to either:

i. **Hematology/Oncology Patient:** Social Services Coordinator
ii. **Non-Oncology Patient:** Central Business Office FAP Representative

FAP Representative or Social Service Coordinator

1. Conduct a pre-screening interview with patient to see if they meet the Requirements listed above for the FAP Discount Program, Kansas Medical Assistance Program (KMAP/MCAID), Medicare Supplemental Insurance or COBRA for loss of insurance coverage due to loss of employment.

2. Assist with the application process for the applicable programs
    a. FAP Discount Program
        i. Provide patient with FAP application from Quick Docs in Allscripts PM
        ii. Make FAP Application note in Allscripts PM to expire in 30 days if patient doesn't return the application
    b. Medicaid
    c. Medicare Supplemental Insurance
    d. COBRA

3. When FAP Discount Program has been returned by the patient
    a. Verify patient portion of application is complete, return any incomplete applications to the patients to be completed and resubmitted with letter from Quick Docs to let patient knowing what items are needed to be completed
    b. If application is complete, make FAP Application note type in Allscripts PM stating that the application was received then print a FAP Application Checklist and attach to patient application and follow the steps as directed to complete application process. They also will note if they are applying for Medicaid. If they do not qualify for Medicaid then the packet can be forwarded.
    c. Forward completed FAP Discount Application packets to the Financial Services Team Leader and add note in Allscripts PM using a FAP Pending note type

FAP Committee

Comprised of the CBO Director, CBO Manager and the Financial Services Team Leader will:

1. Review all packets and patients accounts to ensure all requirements are meet.
2. Approve/Disapprove packets with the appropriate information.
3. Print Quick Doc Approval or Denial letter from Allscripts PM to mail to the patient
4. If approved, change account type in Allscripts PM to appropriate FAP status (FAP100, FAP75, FAP50 or FAP25), enter FAP Approval Note with expiration as December 31st of the current year and alert Financial Services Representative to contact patient to set up payment plan;

5. If denied, alert Collection Representative to contact payment to contact patient to set up payment plan
6. Send completed packets to DMS Scanning to be archived in Patient Account folder
7. Generate Crystal Report - open “The Report Viewer” from your desktop or programs from Start menu (Connection List = Ntier_HCPA) Select Initial FAP Courtesy Adjustment by Patient report. (If there isn’t a report on the screen, select the open folder icon at the top left and use the following path - \\Hcfp10\dprtmnts$\Public\Crystal Reports\Business Office\FAP). Click the Refresh button on the right side of the screen. (If the system prompts for a login ID use “TWReporting”, the password is “REPORTS”.) Using the drop-down calendar, select the appropriate date range and patient number, click OK. Click “Finish”. Place report in Transaction Processing In-Tray to have initial FAP adjustments taken.

EXHIBIT B

Hutchinson Clinic, P.A.

Professional Courtesy Policy

SUBJECT: PROFESSIONAL COURTESY ARRANGEMENTS

PURPOSE: The Clinic desires to permit discounts on medical services to its staff members, physicians, or their immediate family members, in accordance with applicable law.

POLICY: The Clinic will establish a policy to ensure that any professional courtesy arrangements entered into by the physicians of the Clinic comply with all applicable laws relating to how the professional courtesy is extended and how the recipients of such courtesy are selected.

1. For purposes of this policy, the term "professional courtesy" shall be defined as:

   a. The practice by a physician of waiving all or a part of the fee for services provided to patients, including the physician's office staff, other physicians, and/or their immediate family members; and

   b. The waiver of coinsurance obligations or other out-of-pocket expenses for patients (i.e., "insurance only" billing) and similar payment arrangements.

2. Waiver of Fees, Discounts, Co-payments and Deductibles

   a. Waiver of Fees and Discounts – The physicians of the Clinic may engage in a regular and consistent practice of extending professional courtesy by waiving the entire fee for services or discounting services rendered to an individual or group of persons as long as it does not violate the anti-kickback statute or any billing or claims submission laws or regulation, and so long as the individual and/or membership in the group is determined in a manner that does not take into account directly or indirectly the ability of such individual and/or any member in the group to refer to, or otherwise generate Federal health care program business for, that particular physician.

   b. Waiver of Co-payments and/or Deductibles

      - The physicians of the Clinic may engage in a regular and consistent practice of extending professional courtesy by waiving otherwise applicable co-payments and/or deductibles for services rendered to an individual or group of persons as long as it does not violate the anti-kickback statute or any billing or claims submission laws or regulation, and so long as the individual and/or membership in the group is determined in a manner that does not take into account directly or indirectly the ability to refer to, or otherwise generate Federal health care program business for, that particular physician.

- In the event a patient is a beneficiary of a Federal health care program, a co-payment or deductible can only be waived for such patient in the event he or she is determined to be "financially needy" in accordance with the guidelines set forth in the policy entitled "Financial Assistance Program" or any other conditions have been satisfied per current laws and regulations.

3. The Clinic shall comply with the notification provisions of any provider contracts entered into with third party payors with respect to its offering of discounts and/or waivers of co-payments and deductibles.

4. The professional courtesy must be offered equally to individuals or groups of persons without regard to the volume or value of referrals or other business generated by the physicians.

5. The medical services provided/discounted must be of a type routinely provided by the Clinic.