I. EXECUTIVE VICE PRESIDENT FOR HEALTH AFFAIRS' POLICY STATEMENT

UK HealthCare (UKHC) and its affiliated clinics and health care facilities requires all employees, agents and medical staff members (collectively, "UKHC Employees") to act, at all times, in an ethical and legal manner, consistent with all applicable legal, governmental, and professional standards and requirements. For all purposes of the Corporate Compliance Program ("CCP"), UK HealthCare is defined as all health care delivery and clinical enterprises, including but not limited to the College of Medicine, College of Dentistry, College of Nursing, College of Pharmacy, College of Health Sciences, University of Kentucky Chandler Hospital, Good Samaritan Hospital, Kentucky Clinics, Centers for Rural Health, Sanders Brown Center on Aging, Markey Cancer Center, and the Gill Heart Institute. In order to avoid even the appearance of impropriety or conflict of interest, this CCP applies to all faculty, staff, and students within UKHC, without regard to an individual's specific job duties or function. It is the policy of UKHC that all services and business transactions rendered by UKHC shall be carried out and documented in accordance with federal, state, and local laws, regulations, and interpretations.

This Corporate Compliance Program is intended to enhance and further demonstrate UKHC's commitment to honest and fair dealing by providing an effective means by which to prevent and detect illegal, unethical conduct or abusive conduct. The CCP: (1) sets forth operating protocol and standards of conduct; (2) designates oversight responsibilities; (3) provides for employee compliance training; (4) implements monitoring, auditing, enforcement and disciplinary procedures; and (5) establishes response and prevention plans. UKHC will exercise due diligence in its efforts to ensure that the CCP is effective in its design, implementation and enforcement.

UKHC employees are expected to deal fairly and honestly with patients and their families, suppliers, third-party payors, and their professional associates. Adherence to the CCP is a condition of employment at UKHC. Likewise, the granting of medical staff privileges and the offer of employment at UKHC is contingent upon acceptance of and compliance with the CCP.

The Corporate Compliance Manual ("Manual"), among other things, sets out the CCP's Purposes and Objectives, Standards of Conduct and Standard Operating Policies and Procedures. The CCP described in this Manual has been designed to establish a framework for legal and ethical compliance by UKHC employees. These standards are not intended to be exhaustive, thus conduct not specifically addressed in the CCP should be judged in light of the overall theme and intent of the CCP. The CCP is not intended to replace all of the substantive programs and practices of the UKHC which are designed to achieve compliance. Rather, the purpose of the CCP is to provide UKHC with a codified program that provides for an effective means of detecting ongoing non-compliant conduct and to reduce the prospect of such conduct in the future. The University of Kentucky and UK HealthCare already operate under many policies and procedures that have been developed to maintain compliance with applicable laws as well as with professional, academic, and business ethical standards. These policies and procedures will continue to be part of UKHC's overall compliance effort. Accordingly, regardless of whether they are specifically cited in the text of the Program, all relevant UK Governing and Administrative Regulations, Medical Staff Bylaws, College of Dentistry policies, Human Resources policies and UK Hospital and Clinic policies are hereby incorporated into the CCP.

Statutes, regulations, and policies cited in the CCP do not replace or alter the wording of their original text. Rather, the selected text is designed to give the reader an idea of the spirit and intent of the referenced provisions.

II. PURPOSES AND OBJECTIVES

The purposes and objectives of the CCP are to:

(1) establish standards and procedures to be followed by **all UK HealthCare** employees to effect compliance with applicable federal, state and local laws, regulations and ordinances, as well as UK Governing and Administrative Regulations, Medical Staff Bylaws, College of Dentistry policies, Human Resources policies, and UK Hospital and Clinic policies;

(2) designate the UKHC official responsible for directing the effort to enhance compliance including implementation of the CCP;

(3) document compliance efforts;

(4) ensure Discretionary Authority is given to appropriate persons;

(5) provide a means for communicating to all UKHC employees the legal and ethical standards and procedures all UKHC employees are expected to follow;

(6) establish minimum standards for billing and collection activities, including a system of monitoring and oversight of billing activity to ensure adherence to the standards and procedures established;

(7) provide a means for reporting apparent illegal or unethical activity to the appropriate authorities;

(8) provide for the enforcement of the ethical and legal standards;

(9) provide a mechanism to investigate any alleged violations and to prevent violations in the future;

(10) increase training of medical staff members and billing personnel concerning applicable billing requirements and UKHC's policies; and

(11) provide for regular review of overall compliance efforts to ensure that practices reflect current requirements and that other adjustments are made to improve the CCP.

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CHAPTER 2: STANDARD OPERATING PROTOCOL

I. COMPLIANCE PROGRAM OVERSIGHT

A. Operational Duties of the Chief Compliance Officer

The Chief Compliance Officer shall:

(1) be responsible for overseeing the daily operation and ongoing strategic planning of the CCP;

(2) chair the Executive Compliance Committee and the Clinical Services Compliance Committee;

(3) brief, as necessary, the Executive Vice President for Health Affairs (EVPHA) (and other parties when appropriate) on issues relating to the CCP;

(4) direct the CCP in a manner which encourages every employee to report any conduct that the employee, in good faith, believes is a violation of the CCP;

(5) investigate, according to policy or as otherwise directed by the EVPHA, any reports of alleged illegal conduct;

(6) ensure that all audits, investigations, records, and proceedings of UK HealthCare be reported or available to the Chief Compliance Officer;

(7) provide an annual certification report of substantial compliance with the CCP to the EVPHA and other parties as directed by the EVPHA;

(8) ensure that policies and procedures necessary for the effective operation of the CCP are adopted;

(9) ensure that all new UK HealthCare affiliates are provided with a copy of the CCP;

(10) ensure that effective procedures are in place to prevent UK HealthCare from employing or contracting with providers who have been banned from participating in the Medicare and Medicaid Programs;

(11) ensure that CCP education is carried forth in a manner that facilitates the overall objectives of the CCP;

(12) after consultation with and approval by the EVPHA and others, as appropriate, take any action deemed necessary to effectively execute the CCP; and

(13) monitor the overall compliance efforts of UK HealthCare and implement changes as needed to ensure an effective program.

B. Annual Report to the EVPHA

The Chief Compliance Officer annually shall prepare and submit to the EVPHA, a written report that summarizes the overall operation of the CCP during the preceding year. The report must include the Chief Compliance Officer's suggestions regarding any amendments that are appropriate to ensure the CCP is effective.

Additionally, the report shall verify that UK HealthCare has:

(1) established and maintains compliance standards and procedures that are reasonably capable of reducing the prospect of unethical/illegal conduct and detecting ongoing unethical/illegal conduct;

(2) designated specific individuals with a sufficient level of authority and expertise to oversee specific high-risk areas of compliance;

(3) not delegated discretionary authority to individuals who previously have shown a propensity to engage in illegal or unethical conduct;

(4) communicated effectively the standards and procedures to be followed by employees, and maintained a mechanism by which employees can report possible illegal/unethical conduct without threat of retribution;

(5) employed monitoring and auditing systems reasonably designed to detect illegal activities; and achieved substantial compliance with the applicable standards and procedures;

(6) enforced appropriate disciplinary mechanisms consistently and fairly against individuals who have been found to have committed illegal/unethical acts or who recklessly have failed to detect illegal conduct; and

(7) implemented effective compliance practices to prevent reoccurrence of illegal conduct; responded appropriately to any reports of possible illegal conduct; and modified standards and procedures as necessary to achieve compliance.

Within a reasonable time after the EVPHA has received the annual report, the EVPHA and the Chief Compliance Officer will meet to evaluate the report and to consider any recommendations.

C. Evaluation of the Chief Compliance Officer

At the end of each calendar year, the EVPHA shall prepare a written evaluation of the Chief Compliance Officer's performance. The Chief Compliance Officer's performance shall be judged upon criteria including, but not limited to: (1) the effectiveness in facilitating the CCP educational process for all employees of UK HealthCare; (2) the extent to which all periodic internal audits are initiated and completed on schedule; (3) reliability in instituting immediate investigations of all credible complaints under the CCP; (4) diligence in performing oversight responsibilities such as performing audits, and analyzing incidences of non-compliance; (5)

overall effectiveness in directing the daily operations of the program; (6) CCP strategic planning.

II. INVESTIGATION OF POTENTIAL VIOLATIONS

A. Reports of Illegal, Unethical or Abusive Conduct

Upon receiving a credible report of possible illegal, unethical, or abusive conduct, the Chief Compliance Officer promptly shall initiate an investigation after consultation with appropriate UK HealthCare officials as outlined below. The Chief Compliance Officer, in accordance with applicable law, shall maintain a complete and accurate record of each investigation, including recommendations for corrective action. Upon the conclusion of an investigation, the Chief Compliance Officer will, among other things, recommend corrective action to the EVPHA, if appropriate.

The goal of the CCP is to prevent, detect, and promptly correct activity that does not comply with legal, ethical and professional standards as well as the standards adopted pursuant to the CCP. Attempts always should be made to discuss and resolve issues in cooperation with the individuals involved. Nonetheless, conduct that violates the CCP shall be dealt with promptly, and shall be reported to outside authorities as deemed appropriate by legal counsel and the EVPHA after consultation with the Chief Compliance Officer. Corrective action shall be consistent with the nature of the conduct and the surrounding circumstances.

B. Protocol

The Chief Compliance Officer shall facilitate receipt of either anonymous or attributable reports from UK HealthCare employees (or any other individual or individuals) of suspected misconduct. In this regard, the Chief Compliance Officer shall oversee the operation of a telephone system (thereinafter Comply-Line) to receive reports of violations. The Chief Compliance Officer also shall facilitate the receipt of written reports through other appropriate

means, such as through the mail.

To the extent possible, the Office of Corporate Compliance will ensure the integrity and confidentiality of all reports of misconduct. The OCC shall strive to prevent retaliation directed at employees who, in good faith, report possible misconduct. If a report of retaliation is made, the OCC will investigate the alleged behavior and report the findings and recommendations to the EVPHA.

Every credible report of misconduct or retaliation that is received by the OCC, whether written or oral, shall be reviewed promptly. The OCC, or its designee, shall document pertinent data, such as the date the report was received, results of the initial review, and whether any investigative or audit activity was taken to evaluate the allegations contained in the report. For every report of a violation received, the OCC shall record each decision that is made and action initiated regarding the report. All reports of violations shall be documented, reported and retained with the intent of maintaining the attorney-client privilege. All compliance documents shall be destroyed in accordance with applicable federal and state statutes and regulations.

If the OCC concludes that the report does not merit further investigation after an initial inquiry into the allegation, that conclusion and an appropriate explanation supporting the recommendation shall be recorded in writing.

Should the OCC conclude, based on the preliminary inquiry, that a report contains allegations that warrant further investigation, the reasons for reaching that conclusion shall be recorded in writing. Within a reasonable time after determining that a full investigation should be initiated, the Chief Compliance Officer shall discuss with the EVPHA and legal counsel, as appropriate, the allegation and the status of the investigation.

It shall be exclusively within the discretion of the EVPHA, after consultation with legal counsel and the Chief Compliance Officer, where appropriate, to conduct or decline to conduct an investigation into alleged illegal, unethical or abusive conduct.

The EVPHA, after consultation with the Chief Compliance Officer, legal counsel and others as appropriate shall decide whether any corrective and/or disciplinary action will be taken pursuant to the CCP and/or whether the matter should be referred to a government agency or professional body.

Should the Chief Compliance Officer conclude that additional issues disclosed by the original investigation, but not alleged in the initial report, require examination, it shall be recommended to the EVPHA.

Nothing in this or any other section of the CCP shall prevent University legal counsel from conducting a separate investigation or from taking any necessary action to protect the legal interest of the University of Kentucky.

III. EMPLOYEE CREDENTIALING

The objective of this section is to prevent the hiring or retention of any employee excluded from participation in care programs, or who is not otherwise ineligible to participate, in a "Federal health care program" as defined in 42 U.S.C. section 1320a-7b(f) or in any other state or federal government payment program and/or who has a reasonably discoverable propensity to engage in illegal, unethical or abusive behavior. The Office of Corporate Compliance will, on a regular basis, compare the DHHS OIG exclusion list with the UK Human Resources roster in an effort to identify any UKHC employee who is or becomes excluded during the course of his/her employment. Any employee identified as an excluded party will be referred to UK Human Resources. In addition, UKHC hiring officials shall act in accordance with all applicable University standards related to the hiring and termination of faculty and staff.

It is important to expressly note that nothing in this section replaces, eliminates, or alters the appointment or reappointment process set forth under the University of Kentucky bylaws and rules and regulations of the medical staff.

IV. CONTRACTOR AND VENDOR CREDENTIALING

UKHC officials will exercise due diligence in the selection of contractors and vendors. It is the intent of UKHC not to enter or remain in relationships with entities or individuals who have shown a propensity to engage in illegal, unethical or abusive conduct. For example, UKHC will take reasonable steps to avoid relationships with individuals or entities where: (1) the organization or any controlling member thereof, has ever been convicted (including plea bargain or other arrangement with prosecuting officials) or otherwise sanctioned or found liable for a health-care related criminal, civil, or administrative offense or other offense involving theft, fraud, or embezzlement; (2) the organization or any controlling member thereof, is listed by a federal or state agency as disbarred, excluded or otherwise ineligible or prohibited from working, in federally supported health care-related projects or programs. In addition, individuals and entities having a contractual relationship with UKHC will be notified of the following: (1) their relationship with UKHC is conditioned upon their adherence with the CCP; (2) they have been encouraged to familiarize themselves with the CCP and have been told that a copy is available for review in the Corporate Compliance Office during business hours or on the UKHC Corporate Compliance Website; (3) they are under an affirmative obligation to report immediately to UKHC's Chief Compliance Officer any actions by an agent or employee of UKHC which they believe, in good faith, violates the CCP or any ethical, professional or legal standard.

In an effort to facilitate these objectives, all contracts involving UKHC will contain the below stated language, unless otherwise approved by UK legal counsel.

> Contractor affirms that it is not excluded from participation, and is not otherwise ineligible to participate in a "Federal health care program" as defined in 42 U.S.C. section 1320a-7b(f) or in any other state or federal government payment program. In the event that Contractor is excluded from participation, or becomes otherwise ineligible to participate in any such program, during the term of this agreement, Contractor will notify UK HealthCare Office of Corporate Compliance, 2333 Alumni Park Plaza, Suite 200, Lexington Kentucky 40517 in writing, by certified mail within 48 hours after said event, and upon the occurrence of any such event, whether or not appropriate notice is given, the University of Kentucky, shall

immediately terminate this Agreement upon written notice.

Additionally, Contractor affirms that it is aware that UKHC operates in accordance with a Corporate Compliance Program, employs a Chief Compliance Officer and operates a 24-hour, seven-day-a-week compliance Comply-line. **Contractor** has been informed that the **UKHC** compliance plan is on file in the Purchasing Office or can be viewed online at http://www.ukhealthcare.uky.edu/forstaff/compliance/comply_about.htm and is encouraged to review the plan from time to time during the term of this agreement. It is understood that should Contractor be found to have violated the UKHC compliance plan, UKHC can, at its sole discretion, terminate this Agreement upon written notice. Contractor recognizes that it is under an affirmative obligation to immediately report to UKHC's Chief Compliance Officer (through the Comply-Line 1-877-898-6072, in writing, or directly (859) 323-8002 any actions by an agent or employee of UKHC which Contractor believes, in good faith, violates an ethical, professional or legal standard.

Nothing in this Agreement contemplates or requires that any party act in violation of federal or state law. Nonetheless, should any term or condition set forth in this Agreement later be credibly alleged, suspected or determined to be illegal, the parties agree to immediately cease the questioned activity and negotiate modification to the effected portion of the Agreement for a thirty day period. If at the end of this period, no compromise can be reached, the Agreement will terminate.

False or deceptive statements or material omissions related to issues addressed in this section will be considered good cause for cancellation of the contract. If reasonable questions as to the entities' or individuals' background or status arise, additional information may be solicited from the entity or individual at the discretion of the Chief Compliance Officer.

Contractors and vendors who are found to have a propensity to engage in illegal, unethical or abusive behavior will be subject to disciplinary action up to and including cancellation of their contract.

V. TRANSACTION REVIEW

Currently, all transactions, (i.e. contracts, arrangements, etc.) entered into on behalf of UKHC, or any unit of UKHC must be reviewed by legal counsel prior to the initiation of the transaction. Legal approval of the transaction is evidenced by the reviewing attorney's signature.

In order to further UKHC's compliance efforts, legal counsel will consult with the Chief Compliance Officer, as needed, regarding compliance issues during the course of the formation and review process.

The goal of the review process is threefold. First, it is intended to prevent UKHC from entering into a relationship which, in form or substance, may violate federal and/or state statute and in turn expose UKHC to criminal, civil, or administrative penalties. Second, it is intended to provide a process by which UKHC completely can assess the merit of a proposed transaction. Third, it will further UKHC's ongoing efforts to formulate transactional strategies that are compliant with federal, state and local law.

VI. EDUCATION AND TRAINING

It shall be the responsibility of each unit of UKHC with assistance from the Office of Corporate Compliance, as requested, to develop and execute a compliance education plan. The compliance education plan's primary objective will be to communicate effectively the CCP's Standard Operating Protocol and Standards of Conduct to all UKHC employees.

It is mandatory that all UKHC employees receive the appropriate level of education and training needed to help ensure that UKHC has an effective CCP. Attendance will be mandatory at all required training sessions and failure to attend will be grounds for discipline under the CCP. Employees who have not received the required education and training within 90 days of their date of hire will be forbidden from acting on behalf of the organization until they have completed the training process. The Chief Compliance Officer or the highest authority within the individual's unit may provide employees with a grace period to obtain training if extraordinary circumstances have prevented the individual from completing the educational requirement under the plan.

The basic training process will emphasize that employees not only must avoid violating

the CCP Standards themselves, but also that they have an affirmative obligation to report to their supervisor or the Chief Compliance Officer any suspected violations committed by others. The Chief Compliance Officer will emphasize that any violation of the Standards of Conduct (including failure to report the suspected misconduct of other employees) will be viewed as a serious infraction, and that punishment, including appropriate personnel procedures that may result in termination of employment, will be imposed upon employees who violate the CCP.

Employees who are promoted, or change positions or departments, must, within a reasonable time, obtain any additional compliance training required for their new assignment. It will be the duty of the individual's direct supervisor to ensure that any additional training that is required is obtained.

In an effort to provide employees with ongoing compliance education, departmental and division directors or their designees are encouraged to, from time to time, discuss corporate compliance concepts and issues with their faculty and staff. Further, they are encouraged to invite representatives from the Office of Corporate Compliance to departmental and staff meetings to discuss specific concerns or topics. Such individuals may use a variety of sources and materials to facilitate such discussions. For example, they can discuss journal, newspaper, and other articles or materials dealing with compliance and professional ethics. Regardless of the source used, the purpose of these meetings should be to reinforce compliance-related information the employee obtained during basic compliance education, answer any related questions and to inform the employee of departmental-specific compliance issues.

VII. MONITORING AND AUDITING

UKHC recognizes that it is not enough just to promulgate Standards of Conduct. Appropriate actions must be taken to help ensure that the standards set forth in the CCP become integral to UKHC's daily operations. It shall be the responsibility of each unit of UKHC to

follow the guidance and direction of the UKHC Office of Corporate Compliance regarding auditing and monitoring activities related to the implementation and administration of an effective compliance program. In addition, the Office of Corporate Compliance will work to support the individual units in their efforts as well as identifying matters requiring non-routine monitoring and auditing.

A. Protocol

The objective of the monitoring and auditing process is to examine standards set forth under the CCP in order to detect and prevent illegal, unethical and abusive conduct as well as scrutinize the general operations of the CCP itself.

This process is intended to facilitate the following: (1) spot check the standards described under the CCP; (2) verify that individuals who have discretionary authority under the plan have carried out their duties mandated under the CCP; (3) mandatory reviews of key compliance program tasks.

In general, high risk areas and/or practices will be audited with greater frequency than those that do not pose a sufficient threat to the effectiveness of the CCP. For matters necessitating non-routine audits the Office of Corporate Compliance shall, in consultation with the Executive Compliance Committee and others, as needed, determine who should comprise the audit teams. In addition to UKHC employees, audit teams may include, but are not limited to, outside legal counsel and accountants, University legal counsel and auditors, and outside consultants. The Chief Compliance Officer will provide notification of any significant unscheduled audit to the EVPHA within a reasonable time of commencing the audit. The notification will indicate why an unscheduled audit should be undertaken, and who will perform the audit.

Assignment to the team will be based on the particular expertise required to fully audit the specific area or standard being evaluated. All analysis and documentation related to each

unscheduled audit shall be compiled at the direction of the Chief Compliance Officer and/or legal counsel and shall be treated as attorney-client work product.

All audit reports shall be completed in a timely fashion and include, at a minimum, the following information:

(1) audit objectives and scope;

(2) audit procedures employed;

(3) results obtained;

(4) conclusions concerning accomplishment of the audit objectives;

(5) details concerning any deficiencies noted; and

(6) recommendations for corrective action or improvement.

B. CCP Audits

The Chief Compliance Officer also will design, direct and/or conduct periodic internal audits of the CCP. The Office of Corporate Compliance shall discuss the results of all these audits in the annual report.

These audits shall focus on the following:

(1) verification that the appropriate level of training is being provided to all employees;

(2) verification that any reports and inquiries received by the OCC have been investigated and resolved;

(3) verification that employees are able to effectively report suspected violations of the CCP to the OCC without threat of retaliation;

(4) verification that the OCC effectively has investigated every credible allegation of misconduct that has been reported and that the findings and any follow-up activity have been documented

appropriately;

(5) review of disciplinary procedures to ensure that the CCP has been applied consistently to all employees;

(6) verification and documentation of sanctions and discipline imposed upon employees for violating the CCP;

(7) verification that the OCC is aware of new federal and state law, regulations, policies and procedures, and that the OCC is disseminating this information to appropriate individuals, and that it is being incorporated into the CCP and reflected in periodic training sessions for employees; and

(8) verification that the Executive Compliance Committee effectively is performing its duties and that it has the necessary resources to continue to operate in this manner.

VIII. COMMUNICATION AND REPORTING

A. Mandatory Good Faith Reporting of Misconduct

UKHC employees are required, within 24 hours of discovery, to report any misconduct that they, in good faith believe is potentially illegal, unethical, abusive or otherwise not in adherence with the sprit or intent of UKHC's CCP. This affirmative obligation extends to all independent contractors, vendors and agents of UKHC as well as to their employees. Failure to report such conduct can result in disciplinary action up to and including termination for employees and sanctions, including contract termination for contractors, vendors and agents. All reports are taken seriously and will be investigated properly and fully within a reasonable time period.

Everyone is entitled to make compliance inquiries or report suspected misconduct anonymously. However, as discussed below, choosing not to identify yourself greatly could hamper UKHC's follow-up on our inquiry or investigation of your report of misconduct. An individual who has made an inquiry or report may call the OCC or the Comply-Line to inquire whether the question or report has received attention. Those who report anonymously will be given a random identification number that they can use to check on the status of their inquiry. However, regardless how the report was received the person who made the report only will be told whether an investigation was initiated or whether some other form of follow-up action was taken. Specific information regarding the action/investigation will not be released.

As discussed below, compliance inquiries or reports of misconduct can be made in a variety of ways. In addition, UKHC employees are expected to consult with the OCC regarding specific compliance-related questions or concerns. The OCC also is available to provide general compliance guidance and advice as well as compliance education opportunities.

B. Comply-Line 1-877-898-6072

The Comply-Line is a toll-free, 24-hour-a-day, seven-day-a-week phone line that is operated by an independent contractor. These calls are not recorded, traced or in anyway received in a manner that would reveal the identity of the caller or the location from which the call was placed. A communications specialist will answer your call and make handwritten notes regarding the nature and content of your report.

The purpose of the Comply-Line is to provide employees and others with an additional way to make compliance inquiries or report suspected misconduct. Furthermore, it allows the reporting individual the opportunity to notify UKHC of compliance issues or suspected misconduct anonymously and/or without talking directly with a UKHC official.

C. Confidentiality

Confidentiality regarding the issues employees raise will be protected up to the limits of the law and to the extent reasonably possible. Of course, if they choose, employees can make their report anonymously simply by not leaving their name or address. Employees who wish to remain anonymous will be given an identification number that they can use to identify themselves in future conversations with, or messages from the OCC. However, remaining anonymous, in many cases, will impede UKHC's ability to fully investigate the caller's report. For example, it often is critical that the OCC be able to obtain additional information from the reporter during the course of the investigation. Therefore, you are encouraged to leave your name and a phone number or address at which you can be contacted.

D. Reporting Channels

Employees always are permitted to make inquiries or report misconduct directly to the OCC or Comply-Line. However, the OCC or Comply-Line should not be viewed as a routine alternative for following the normal chain of command. Accordingly, employees are encouraged to first discuss their concerns with their departmental supervisor, or other authority within their department or division. This is especially true of informational and consultative inquiries. In such cases, departmental or division management is normally the best source of department/division-specific information.

E. Inquiries or Allegations

Inquiries or allegations of misconduct made at the department level should be reported according to the following guidelines. Please note that, as with all other employees, a supervisory employee receiving a report can inform the OCC of the inquiry or allegation of misconduct directly.

1. Questions and Inquiries

All questions and inquiries made by employees directly to supervisors, managers, chairs, etc., should be reported through the normal reporting channels to the department's or division's highest authority. The OCC should be consulted as needed to ensure that the employee's question or inquiry has been documented adequately and that UKHC has reacted appropriately.

2. Allegations of Misconduct

Supervisory employees who receive information regarding an allegation of suspected illegal, unethical or abusive behavior must forward that information to the highest authority in their department or division or their designee within 24 hours of receiving the report. The department's or division's highest authority or their designee will advise the OCC of the report within a reasonable time after receipt, not to exceed 72 hours. As appropriate, the OCC will assist the department or division to ensure that the employee's concerns have been documented adequately and that UKHC has reacted appropriately.

F. Anti-Retaliation

To protect individuals making reports and to encourage them to appropriately report any facts or information relative to suspected misconduct, the reporting individual shall not be subject to reprisal/retaliation of any kind. Accordingly, UKHC employees shall not directly or indirectly use or threaten to use any official authority or influence, in any manner whatsoever, which tends to discourage, restrain, depress, dissuade, deter, prevent, interfere with, coerce, or discourage, against any employee who, in good faith, makes such reports or disclosures. Any suspected violation of this section must be reported to the OCC immediately.

The above paragraph does not, in any way, imply that employees can exempt themselves from the consequences of impropriety or inadequate performance. Rather, the anti-retaliation provision is meant to ensure that employees who, in good faith, report compliance concerns do

not suffer adverse consequences for making a report. The EVPHA can, in whole or in part and at his complete discretion, consider an individual's compliance report a mitigating factor when determining the appropriate corrective action to be taken against a "self-reporting" individual.

IX. ENFORCEMENT AND DISCIPLINE

A. Protocol

The highest authority in each department or division is responsible for promoting and ensuring compliance under the CCP in the department/division. Accordingly, this individual shall be diligent in his/her efforts to recognize potential problems and to consult the OCC when reasonable questions arise as to the appropriateness of ongoing or proposed conduct. Additionally, the individual responsible for the department or division or his/her designee will serve as a contact for the OCC. This individual also is responsible for reporting to the OCC under section VIII sub-section E of this chapter.

B. Sanctions

University policies and procedures applicable to an individual's employment status will govern sanctions imposed on employees for violations of the CCP. In addition to termination, some or all of the following sanctions may be imposed: written warning (noted in personnel record); written reprimand (noted in personnel record); probation; demotion; temporary suspension; required reimbursement of losses or damages; referral for criminal prosecution or civil action.

In affixing a punishment based on a violation of the CCP, if the employee is a first-time offender, the following may be considered:

(1) whether the employee reported his/her own wrongful conduct;
(2) whether the employee's report provided the original notice to UKHC of the violation and/or the employee's involvement;
(3) whether the employee has provided full and complete cooperation during the OCC's investigation of the violation; and
(4) whether the employee formally has agreed to cooperate fully with any outside agency involved in the investigation.

C. Misconduct of Subordinates

Supervisory and management personnel may be disciplined for failing to detect compliance violations by their subordinates, which they knew or should have known. Disciplinary action in such cases will be at the discretion of the EVPHA after consultation with the OCC, legal counsel and others, as appropriate. The University Policy and Procedures applicable to their employment status will govern any sanctions imposed on supervisory or management employees based upon their failure to detect violations of the CCP. Where the failure to detect the misconduct of a subordinate results from mere negligence, discipline shall not result in termination. On the other hand, if a supervisor or manager, due to intentional conduct, reckless disregard or willful blindness, facilitates or prolongs misconduct of another, then a penalty commensurate with the seriousness of the violation will be imposed, up to and including termination.

D. Abuse of Compliance Program Procedures

Employees will be subject to disciplinary action up to and including termination if they intentionally and maliciously report a false allegation or otherwise recklessly abuse UKHC's Corporate Compliance Program procedures.

X. POST-VIOLATION RESPONSE

A. Response Protocol

Within a reasonable time after an investigation reveals credible evidence that a violation of the CCP has occurred, the OCC will meet with the EVPHA to brief him on the preliminary results of the investigation. Legal counsel and other UKHC employees will be consulted where appropriate. In coordination with legal counsel, the OCC shall provide the EVPHA with a status report which may include: a summary of the investigation to date; the scope and direction of the investigation; and an estimated time by which a final report will be presented. Within a reasonable time after receiving the final report, the EVPHA will meet with the OCC, legal counsel and other appropriate individuals to determine how UKHC will respond to the violation.

B. Prevention of Repeated Violations

Once a violation has been substantiated, UKHC will take all reasonable steps necessary to prevent further, similar offenses. When a violation has been confirmed to the satisfaction of the EVPHA, all necessary action shall be taken to demonstrate good faith efforts to: (1) foreclose further violations of the same kind; and, (2) ensure that other categories of violations also are not occurring in the same department or departments.

XI. AMENDING THE CCP

The UKHC CCP has been designed to adjust to new regulatory and legal developments, as well as to implement necessary changes discovered during routine audits or investigations of suspected misconduct. It is the responsibility of the Chief Compliance Officer and the Executive Compliance Committee to ensure that UKHC is aware of new legal, ethical and regulatory developments affecting the organization’s ability to have an effective compliance program.

Alterations to the CCP based on changing statutes, regulatory conditions or procedures, or changes necessitated by oversights or defects in the plan will require immediate distribution to

all employees. The OCC will design methods for updating and distributing manuals to appropriate personnel.

I. PATIENT CARE

A. Care and Treatment

UK HealthCare (UKHC) is committed to providing patient care in accordance with recognized legal, ethical and professional standards. Licensing and accreditation is maintained by numerous professional organizations, including UK Hospital's accreditation by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Employees are expected to follow all applicable federal, state and local laws regarding patient care and treatment. Additionally, each employee is obligated to follow all applicable standards of external licensing, regulating, and accrediting agencies and all applicable UK Governing and Administrative Regulations as well as UK Hospital policies and procedures.

B. Medical Staff Credentialing

Medical providers who practice medicine or dentistry at UK HealthCare must be a member of the UK Hospital medical staff. Accordingly, they shall abide by the UK Hospital "Bylaws, Rules and Regulations of the Medical Staff." No member of the medical staff individually or collectively will act in a way that unfairly prevents other qualified physicians from practicing at UKHC.

C. Patient Information Maintenance and Confidentiality

All medical records, including lab reports, must be complete, accurate and retained and maintained in accordance with federal and state law and UK policy. The information contained within an individual's medical records is confidential and, therefore, ***may only be released in accordance with UK policy. The Health Insurance Portability and Accountability Act (HIPAA), and applicable state law.*** Responses to any such orders or requests must comply with UK policy, HIPAA and state law. UKHC employees shall maintain at all times the confidentiality of patient records and medical information as required by law and codified in UK policy.

D. Mandatory Testing and Reporting

UKHC employees shall report to the proper authority any and all patient-related information as required by state or federal law. All such information must be reported accurately and honestly. Employees who are uncertain about their duty to make a particular report must consult with the appropriate UKHC official to determine the extent of their reporting obligation. Likewise, UKHC employees are required to perform all medical testing as required by law. All applicable UK policies and procedures must be followed when such tests are administered. Only those tests that are required by law shall be performed without the consent of the patient or patient's family.

E. Patient Transfer and Discharge

UKHC employees are prohibited from knowingly or willfully reducing or limiting medically necessary services provided to patients who are entitled to receive medical care. All required examinations, tests and reports must be completed properly and documented according to recognized standards. For example:

1. **UKHC employees shall screen all individuals seeking treatment at the Emergency Department to determine whether an emergency condition exists or whether the patient is in active labor. Any patient determined by a UK physician to require emergent care or to be in active labor will be treated until the condition is stabilized. The patient may be released or transferred before being stabilized if the patient refuses treatment or requests a transfer or if the physician certifies that the medical benefits of treatment at the receiving facility outweigh the risk involved in transfer.**

2. **UKHC employees shall not falsify or misrepresent any examination, test result or any entry in any report. UKHC employees are prohibited from knowingly giving false or misleading information that reasonably could be expected to influence the decision when to discharge a person from the hospital.**

F. Drug and Device Usage

UKHC employees shall not illegally or unethically distribute or use drugs or devices that are unapproved, adulterated or misbranded. With some exception, UKHC employees only may use and dispense drugs and devices that the Food and Drug Administration (FDA) has approved. However, because UKHC operates in a teaching and research setting, drugs and devices that have not received final approval by the FDA are employed by UKHC employees under government-approved guidelines.

Additionally, UKHC is obligated to report all incidents in which a medical device contributes to or causes death, serious illness, or serious injury to a patient or employee.

Examples of prohibited conduct in this area would include:

1. **using unapproved drugs or devices without strict compliance with University, UKHC, FDA, NIH, and/or HCFA guidelines;**

2. **making any false or misleading representation or suggestion about whether the FDA has approved a specific drug or device;**

3. **representing that a certain drug or device is something that it is not;**

4. **failing to report a reportable event under the Safe Medical Devices Act as set forth in UK Hospital policy 4-13.**

II. PATIENT BILLING AND REIMBURSEMENT ISSUES

A. General Requirements

Numerous requirements surround patient billing and provider reimbursement. Billing standards, assignments and reimbursement requirements can be complex and at times seem ambiguous. Nonetheless, it is extremely important that UKHC carry out its billing, assignments and reimbursement procedures accurately at all times.

B. Billing Practice

Billing activities are expected to be performed in a manner consistent with Medicare, Medicaid and other third-party payors' regulations and requirements including the Medicare Hospital Manual (HIM 10), the Kentucky Administrative Code for Medicaid, the American Medical Association's Physicians' Current Procedure Terminology (CPT), the Medicare Diagnostic Related Group (DRG) coding requirements and other applicable regulations. Specific examples of prohibited conduct under this subsection include: billing for services that were not provided; misrepresenting the nature of services that have been provided; filing false cost reports; misrepresenting provider credentials or treatment remedies; and providing unnecessary or substandard services.

UKHC employees shall not engage, encourage or condone the following conduct when billing patients, third-party payors or others, including Medicare and Medicaid:

1. **knowingly and willfully making, or causing to be made, any false statement or representation of material fact in any application for any benefit or payment** (42 U.S.C. § 1320a-7b(a)(1));

2. **knowingly and willfully making, or causing to be made, any false statement or representation of a material fact for use in determining rights to a benefit or payment** (42 U.S.C. § 1320-7b(a)(2));

3. **concealing or failing to disclose an event affecting the initial or continued right to any benefit or payment, with the intent to fraudulently secure the benefit or payment in an amount greater than is due or when no such benefit is authorized** (42 U.S.C. § 1320a 7b(a)(3)(b));

4. **knowingly and willfully converting a benefit or payment for a use other than**

for the use of the person in whose name the application for the benefit was made (42 U.S.C. § 1320a-7b(a)(4));

5. **presenting, or causing to be presented, a claim:**

   (a) for an item or service that is known or should have been known not to have been provided as claimed (42 U.S.C.§ 1320a-7a(a)(1)(A));

   (b) for an item or service that is known or should have been known to be false, improper or fraudulent (42 U.S.C. § 1320a-7a(a)(1)(B));

   (c) for physician services, or an item or service incident to the physician services where the individual was not licensed as a physician, the license was obtained through a misrepresentation of material fact, or it was falsely represented to the patient that the physician was certified in a medical specialty (42 U.S.C. § 1320 a-7a-7a(a)(1)(C));

   (d) intentionally requesting payment for medical services not warranted (i.e. reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member) by the patient's current and documented medical condition (42 U.S.C. § 1395y(a)(1)(A));

   (e) containing a billing code that provides a higher payment rate than the billing code that accurately reflects the service furnished to the patient (42 U.S.C. § 1320a-7a(a)(1)(A));

   (f) containing a DRG code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient (42 U.S.C. § 1320a-7a(a)(1)(A));

   (g) containing charges for non-physician outpatient services that already were included in the hospital's inpatient payment under the Prospective Payment System (PPS);

   (h) for the same service, which has been billed to more than one primary payor at the same time (42 U.S.C. § 1320a-7a(a)(1)(A)).

6. **Knowingly presenting, or causing to be presented, a request for payment in violation of the terms of an assignment or an agreement with the payor** (42 U.S.C. § 1320a-7a(a)(2));

7. **Knowingly filling a false or fraudulent claim for payment to the federal or state government, knowingly using a false record or statement to obtain payment on a false or fraudulent claim, delivering less property than certified in a receipt, or making a false statement to conceal an obligation**

(31 U.S.C. § 3730);

8. **submitting, or causing to be submitted, false cost reports, including those which inaccurately reflect the provider's operating cost due to the provider inappropriately shifting certain costs to cost centers that are below their reimbursement cap and shifting non-Medicare related cost to Medicare cost centers** (42 U.S.C. § 1320a-7b(a)(1));

9. **submitting or causing to be submitted, bills piecemeal or in a fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together** (42 U.S.C. § 1320a-7b(a)(2);

10. **submitting, or causing to be submitted, a reimbursement claim for the full amount of the DRG related to a transferred patient, rather then seeking reimbursement for charges based on a per diem rate** (42 U.S.C. § 1320a-7b(a)(2));

11. **entering into any agreement, combination, or conspiracy to defraud the federal or state government or any department or agency thereof, by obtaining or attempting to obtain the payment or allowance of any false or fictitious claim** (31 U.S.C.§ 3730);

12. **claiming, charging, accepting or receiving any payments for laboratory services, unless the test components are medically necessary and billed in accordance with the** Medicare Hospital Manual (HIM 10, Sec. 439), and Kentucky Administrative Regulation (907 KAR 1:028), as applicable;

13. **claiming, charging, accepting or receiving any payments for physician services rendered by Residents in a non-provider settings (such as nursing homes, free standing clinics or physician offices), unless the time spent by the Resident in patient care activities in the non-provider setting is not included in the hospital's full-time equivalency count for direct graduate medical education ("GME") cost purposes (**42 C.F.R § 415.200, et. seq.);

14. **claiming, charging, accepting or receiving any payments for the services of Residents providing Moonlighting Services;** (42 C.F.R § 415.200, et. seq.);

15. **claiming, charging, accepting or receiving any payments for services furnished in "Teaching Settings" involving Residents unless the services are personally furnished by the Teaching Physician or unless otherwise permitted as set forth in the next section below** (42 C.F.R §415.170, et. seq.).

C. Services Furnished by Teaching Physicians and Residents

Whenever services are provided in a Teaching Setting involving Residents, UKHC and its employees are prohibited, under the regulations promulgated at 42 C.F.R. §§ 415.150 to 415.184 and Kentucky Physician Manual §§ III(G); V(3), from billing patients, third-party payors or others, including Medicare and Medicaid, for such services, **unless the services are furnished:**

(1) personally by a Teaching Physician who is not a Resident; or
(2) jointly by a Resident and a Teaching Physician; or
(3) by a resident with the Teaching Physician present during the critical or key portions of the service(s) that a Resident performs (excluding the exception described in Number 2 below).

1. Evaluation and Management ("E&M") Services

(a) The Teaching Physician must be present for the key portion of the time during the performance of the service for which payment is sought. If the Teaching Physician believes that a key portion of an entire evaluation cannot be identified, the Teaching Physician should be present for the entire service. The Teaching Physician need not duplicate the Resident services. However, the Teaching Physician is required to verify key portions of a service and perform certain key portions.

(b) In the case of services such as E&M services, for which there are several levels of service available for reporting purposes, the appropriate billing level must reflect the extent and complexity of the service if the service has been furnished fully by the Teaching Physician. If the medical decision making in an individual service is highly complex to an inexperienced Resident, but straightforward to the Teaching Physician, the charge submitted should be at the lower level reflecting the involvement of the Teaching Physician in the service. Therefore, when determining at what level the Teaching Physician's services should be billed, consideration should be given to the level of service required to be performed by the Teaching Physician in accordance with the Centers for Medicare & Medicaid Services (CMS) *Documentation Guidelines for Evaluation and Management Services, and the Physician Manual, the American Medical Association's Current Procedural Terminology (CPT), and* (907 KAR 3:005, 3:010).

(c) Regardless of whether a patient receives E&M services on an inpatient or outpatient basis, the Teaching Physician must be present during the key portion of the visit. Note, however, that there is an exception to the physical presence requirement for certain low- and mid-level evaluations in the office setting (see number 2 below).

(d) The Teaching Physician must, in a timely fashion, personally document in writing or dictated note in the medical record that he/she was physically present during the portion of any E&M service that determines the level of service billed; specifically, the Teaching Physician must document:

- that he/she performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- his/her participation in the management of the patient.

(e) **Documentation illustrations:**

1. If a Resident does not see the patient, the Teaching Physician should document as if he/she would document an E&M service in a non-teaching setting.

2. If a Teaching Physician's service follows a Resident's service, then the Teaching Physician's documentation should refer to the Resident's note and provide summary comments that establish, revise, or confirm the Resident's findings and the appropriate level of service required by the patient. For example, the Teaching Physician would not have to restate the review of systems and past/family/social history; however, the Teaching Physician would have to independently perform the critical or key portion(s) of the service and, as appropriate, discuss the case with the resident. The Teaching Physician must document that he/she personally saw the patient, personally performed the critical or key portions of the service, and participated in the management of the patient. Combined, the entries must be adequate to substantiate the level of service required by the patient.

   Ex. "I saw and evaluated the patient. I reviewed the Resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

3. If all the required information is obtained by the Resident in the presence of, or jointly with, the Teaching Physician, but documented by the Resident, the Teaching Physician's note may reference the resident's note. The Teaching Physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. Combined, the entries must be adequate to substantiate the level of service required by the patient.

   Ex. "I was present with the Resident during the history and exam. I discussed the case with Resident and agree with the findings and plan as documented."

2. Exceptions to E&M services Furnished in Certain Primary Care Centers

(a) In the case of certain E&M codes of lower and mid-level complexity, the Teaching Physician may claim payment from Medicare and Medicaid for services furnished by a Resident without the presence of the Teaching Physician only if

the services are provided in a hospital or another ambulatory care entity in which the time spent by the Residents in patient care activities is included in determining direct GME payments to a Teaching Hospital by the hospital's fiscal intermediary.

(b) The only acceptable CPT-4 codes that can be used by approved primary care programs are new patient codes: 99201, 99202, 99203, and established patient codes: 99211, 99212, and 99213 and IPPE exams for new Medicare beneficiaries code: G0344.

(c) Family Practice, General Internal Medicine, Geriatric Medicine, Pediatrics and Obstetrics/Gynecology residency programs may qualify for an exception upon application for the exception and approval by the appropriate Medicare or Medicaid carrier. To qualify for this exception, **the following criteria must be met:**

1. The patients seen must be an identifiable group of individuals who consider the primary care center to be the continuing source of their health care in which services are furnished by Residents under the supervision of Teaching Physicians;

2. The range of services provided by Residents at the primary care center must include: (i) acute care for undifferentiated problems or chronic care or ongoing conditions, (ii) coordination of care furnished by the physicians, and (iii) comprehensive care not limited by organ system or diagnosis;

3. The services are provided by Residents who have completed more than six months in an approved residency program; and

4. The Teaching Physician does not supervise more than four (4) Residents at any one time, the Teaching Physician is immediately available to assist and has no other conflicting responsibilities, the Teaching Physician reviews with each Resident during or immediately after each patient visit the patient's medical history, physical examination, diagnosis and record of tests or therapies, and the Teaching Physician documents in the medical record his or her management responsibility and participation in the review and direction of the services furnished to each patient.

3. Surgical and High-Risk Procedures (including Endoscopic Operations)

(a) Major Surgery

1. In the case of surgical, high-risk or other complex procedures, the

Teaching Physician must be present during all critical or key portions of the procedure. The Teaching Physician may use his or her medical judgment as to what constitutes the critical or key portion. However, if the Teaching Physician is not present for the entire procedure, the Teaching Physician must document what is considered the critical or key portion of the surgery and that he/she was present during that critical or key portion. The Teaching Physician's presence is not required during opening and closing of the surgical field unless it is considered the critical or key portion.

2. The Teaching Physician must be immediately available to furnish services during the entire procedure. If the Teaching Physician is not immediately available, the Teaching Physician must arrange for another physician to be immediately available to intervene.

3. As part of the major surgery, the Teaching Physician is responsible for pre-operative, operative, and post-operative care. The Teaching Physician may determine which post-operative visits are to be considered critical or key and require the Teaching Physician's presence. However, if the patient's post-operative period extends beyond the patient's discharge and the Teaching Physician will not be involved in the patient's follow-up care, the Teaching Physician must follow the instructions for billing less than the global surgical fee.

4. If the Teaching Physician bills for two overlapping surgeries, the Teaching Physician must be present during the critical or key portion of both operations. The Teaching Physician must personally document the critical or key portion of both procedures in a manner sufficient to clearly reflect that the Teaching Physician was immediately available to return to either procedure in the event of a complication. The critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure.

5. In the case of three concurrent surgical procedures, the role of the teaching surgeon (not anesthesiologist) in each of the cases is classified as supervisory service rather than a physician service to an individual patient and **is not** payable under the physician fee schedule.

(b) Minor Procedures

1. In the case of minor procedures, considered to be procedures which only take a few minutes to complete such as a simple suture, the Teaching Physician must be present for the entire procedure in order to bill for the procedure. NOTE: CMS defines a minor procedure as one that typically

takes less than five (5) minutes to perform.

(c) High-Risk Procedures

1. In the case of other complex or high-risk procedures, where Medicare policy or the CPT description indicates that the procedure requires the personal supervision of its performance by a physician, the Teaching Physician must be physically present with the resident during the entire procedure. High-risk procedures include:

   (i) interventional, radiological and cardiologic supervision and interpretation codes;

   (ii) cardiac catheterization;

   (iii) cardiovascular stress tests; and

   (iv) transesophageal echocardiography.

(d) Diagnostic Services

1. In the case of diagnostic procedures performed through an endoscope the Teaching Physician must be present during the entire viewing, which includes insertion and removal of the device.

2. In the case of interpretation of diagnostic radiology and other diagnostic tests, the Teaching Physician must personally review the image and the Resident's interpretation, document such review and indicate whether the Teaching Physician is in agreement with the findings of the Resident or edit the findings. If the teaching physician's signature is the only signature on the interpretation, it is assumed that he or she is indicating that he or she personally performed the interpretation. A co-signature by the Teaching Physician on the Resident's interpretation is not sufficient.

3. In the case of pathology, the Teaching Physician must review the specimen or study and the Resident's interpretation, document such review and indicate whether the Teaching Physician is in agreement with the findings of the Resident or edit the findings.

(e) Time-Based Services

1. For procedure codes determined on the basis of time, the Teaching Physician must be present for a period of time for which the claim is made. The Teaching Physician may **not** add time spent by the Resident in the absence of the Teaching Physician to the time spent by the Resident and the Teaching Physician with the patient.

2. Examples of services falling into this category include:

   (i) individual medical psychotherapy;

   (ii) critical care services;

   (iii) E&M codes in which counseling or coordination of care dominates more than 50 percent of the encounter, and time is considered the key controlling factor to qualify for a particular level of E&M service;

   (iv) prolonged service; and

   (v) care plan oversight.

(f) Anesthesia

1. The teaching anesthesiologist is present in the operating room for the critical or key portions of the procedure, including induction and emergence, and he or she is available immediately to furnish services during the entire procedure;

2. The teaching anesthesiologist documents in the medical record as to the key portions of the service for which he or she is present; and

3. The teaching anesthesiologist is in the operating suite during the portions of the procedure not considered to be critical or key;

4. The teaching anesthesiologist's presence is not required during pre-operative or post-operative visits.

(g) Endoscopy Procedures

1. To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy subsection A, above) the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure throught a monitor in another room does not meet the teaching physician presence requirement.

(h) Psychiatry

1. In the case of psychiatry, the Teaching Physician concurrently observes the service provided by the Resident by the use of a one-way mirror or video equipment. Monitoring by audio-only equipment is not sufficient. When a

one-way mirror or video equipment is not used, the Teaching Physician must be present for a period of time for which the claim is made. The Teaching Physician may **not** add time spent by the Resident in the absence of the Teaching Physician to the time spent by the Resident and the Teaching Physician with the patient.

(i) Assistance During Surgery.

1. CMS will **not** pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedures and has a qualified resident available to perform the service. However, if a qualified resident is not available, reimbursement is allowed if the teaching physician certifies that a qualified resident was not available and the certification is attached to the corresponding claim.

2. The services of an assistant at surgery justify the services of a physician assistant due to exceptional medical circumstances, such as emergency, life-threatening situations like multiple traumatic injuries that require immediate attention.

3. If a primary surgeon has an across-the-board policy of never involving Residents in the pre-operative, operative or post-operative care of patients, billing for assistant at surgery services may be allowable.

4. Teams of physicians may be required for complex medical procedures, such as multistage transplant surgery and coronary bypass surgery. Each Teaching Physician is engaged in a different level of activity different from assisting the surgeon in charge of the case. If a team surgery charge is submitted, additional billing should not be submitted.

(j) Medical Student Documentation.

1. Medical student documentation for evaluation and management services, i.e. the review of systems (ROS) and past family and social history (PFSH), may be referred to and utilized by the teaching physician.

2. The teaching physician may not utilize medical student documentation for the history of present illness, exam and medical decision making process. The teaching physician must perform and document these elements of the service.

(k) Generic Attestations and Signatures

1. The use of generic attestations is never acceptable for evaluation and management services.

2. The use of generic attestations is acceptable when used on radiology and other diagnostic test reports and routine anesthesia reports.

3. Each entry should be dated and include legible signature or identity.

4. Electronic signatures are acceptable as long as the presence of the teaching physician during the key portions of the service is indicated.

(l) Addendums

1. Addendums to documentation are acceptable only if added for legitimate medical reasons. Any such addendum should be dated and signed. If it is necessary to make a correction to the documentation, a single line should be drawn through the incorrect word or phrase, with the correction above that line, along with the date and time the correction was made.

2. Addendums made solely for billing purposes are prohibited.

3. Retrospective documentation, i.e. documentation added after the related charge is submitted, prepared primarily to assure compliance with documentation requirements is prohibited.

(m) Macros

In the context of an electronic medical record, the term ‘marco’ means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician macro, either the resident of the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.

(n) Modifiers

1. Modifiers must be submitted on every charge that includes resident involvement. Modifier **GE** must be used for services performed under the outpatient exception rule. Modifier **GC** is to be used for all other services.

2. Lack of a modifier indicates that the teaching physician performed the service personally without a resident.

D. Services of Residents

As previously noted, services furnished in hospitals by Residents in approved GME programs generally are **excluded** from being paid as "physician services." Rather, they are payable as hospital services. This general exclusion applies whether the resident is licensed to practice under the laws of the state in which he or she performs the service. Additionally, specific guidelines dictate how Residents are to be treated for reimbursement purposes when they are providing patient care in non-traditional settings. When services of Residents are employed in such a manner, all UKHC employees must comply with applicable standards including those specific billing requirements set forth under **42 CFR §§ 415.200 - 415.208.**

1. **Assuming that the conditions regarding patient care activities and training of residents are met, services of residents furnished in non-provider settings, such as clinics, nursing facilities, and physician offices, are payable in one of the following two ways:**

   (a) as direct GME payments, included in determining the number of full-time equivalency residents in the calculation of a teaching hospital's count, or

   (b) covered as physician services and payable under the physician fee schedule if the following requirements are met:

      1. the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the state in which the service is performed, and

      2. the time spent in patient care activities in the non-provider setting is not included in a teaching hospital's full-time equivalency resident count for the purpose of direct GME payments.

   (c) If the requirements listed in sub-section (b) are met:

      1. payment may be made regardless of whether a Resident is functioning within the scope of his or her GME program in the non-provider setting.

      2. however, if fee schedule payment is made for the Resident's services in a non-provider setting, payment **must not** be made for the services of a Teaching Physician.

      3. furthermore, the carrier **must** apply the physician fee schedule payment rules to payments for services furnished by a Resident in this setting.

2. Moonlighting services provided by licensed residents and performed outside the scope of an approved GME program must be submitted for reimbursement in accordance with the following standards:

(a) **Services provided in GME program hospitals.**

1. The services of residents to inpatients of hospitals where the residents have their approved GME program are not covered as physician services and are payable only as direct GME payments.

2. Services provided by residents that are not related to their approved GME programs and are performed in an outpatient department or emergency department of a hospital where they have their training program are covered as physician services and payable under the physician fee schedule if **all** of the following criteria are met:

   (i) the services are identifiable as physician services and meet the conditions for payment of physician services;

   (ii) the Resident is fully licensed to practice by the State in which the service is performed; and

   (iii) the services performed can be identified separately from those services required as part of the approved GME program.

3. If the criteria specified in (a)(2) are met, the Resident's Moonlighting Services are considered to have been furnished by the individual in his/her capacity as a physician. Related service agreements and contracts should reflect the requirements set forth in (a)(2), in order to ensure compliance.

4. Reimbursement **will not** be sought for services of a Teaching Physician associated with moonlighting services, and the time spent furnishing these services **may not** be included in UKHC's full-time equivalency count **or** the indirect GMC payment and for the direct GMC payment.

(b) **Services provided in non-GME program hospitals.**

1. Moonlighting services of a licensed Resident in an approved GME program furnished outside the scope of that program in a hospital or other setting that does not participate in the approved GME program are payable under the physician fee schedule.

III. ORGANIZATIONAL INTEGRITY

A. Personal Relationships and Conflicts of Interest

Integrity, objectivity, and the absence of self-dealing are essential at all levels and in all aspects of government and private activities. All UKHC employees owe a fiduciary duty of loyalty to UKHC. Conflicts of interest, and even the appearance of conflicts, must be avoided. UKHC employees shall conduct all business transactions consistent with the duty of loyalty they owe UKHC. UKHC employees must accurately and honestly represent UKHC and their relationship with UKHC. A conflict of interest arises if a person's judgment and discretion is or may be influenced by personal considerations, or if the interests of UKHC are, in any way jeopardized. The University of Kentucky's conflict of interest policy sets forth specific relationships and activities that both employees and members of their families may not participate in. **(UKHosp. 01-03)**. ***See also,*** **(UKAR II 4.0-4).** However, it is important to remember that each relationship is different, and many factors often will need to be considered to determine whether a conflict of interest exists. Therefore, it is the responsibility of the individual employee to immediately disclose to the UKHC Chief Compliance Officer any situation that may lead to a conflict so that the relationship can be reviewed by the appropriate UKHC official. Additionally, UKHC employees shall not divulge or otherwise use any confidential UKHC information for a period of six months or longer if provided for by law, after termination.

B. Buying or Selling Influence

In all interactions with government officials, representatives of external agencies, special interest groups, or the general public, UKHC employees may not engage in any illegal or unethical behavior with the intent to influence the decision making or performance of a public or private individual, agency, or organization. Likewise, UKHC employees are forbidden from selling their influence to any public or private individual, agency, or organization. **(UKHosp. 01-02)**.

UKHC employees shall not:

1. **solicit, accept, or agree to accept any pecuniary benefit upon agreement or understanding that their opinion, judgment, exercise of discretion or other action as a UKHC employee thereby will be influenced.**

2. **offer, confer or agree to confer any pecuniary benefit upon a public servant or private individual with the intent to influence an individual's vote, opinion, judgment, exercise of discretion or other action in his/her official capacity.**

3. **act in any way toward a public or private individual, agency, or organization which constitutes extortion or coercion.**

C. Business Practice

UKHC employees shall conduct all business transactions consistent with the duty of loyalty they owe UKHC. UKHC employees must accurately and honestly represent UKHC and their relationship with UKHC. UKHC employees shall not, under any circumstances, engage in any unlawful business practice or act in any manner intended to defraud any individual or entity of money, property or services.

The following behavior is specifically forbidden with regard to the business operations of UKHC:

1. **unlawfully monopolizing the provision of medical services;**

2. **unlawfully controlling fees or prices;**

3. **unlawfully conditioning the sale of one product on an agreement to do other business;**

4. **unlawfully boycotting suppliers, payors or providers; or**

5. **misrepresenting their relationship with UKHC.**

D. Financial Reporting and Record Keeping

UKHC employees honestly and accurately shall develop and maintain financial records in accord with recognized standards.

The following behavior specifically is forbidden with regard to the books, records, and financial reports which reflect the assets, liabilities, balances, revenues, expenses, and activities of UKHC:

1. **establishing or maintaining numbered or secret accounts or unrecorded funds or assets;**

2. **making or directing false or misleading entries on official books or records for any reason; including, but not limited to, improperly reporting bad debts and/or credit balances;**

3. **approving or making transactions or payments with the intention, understanding or knowledge that any part of such payment or transaction is to be used for any purpose other than that described by the documents supporting the payment or transaction;**

4. **submitting bills or statements for services containing false or misleading entries; or**

5. **destroying records other than in accordance with the applicable records retention and destruction policy.**

E. Kickbacks/Illegal Remuneration

UKHC employees are required to follow all applicable federal, state and local laws as well as UK governing and administrative regulations and UK policy when interacting and transacting with providers of goods and services. The standards set forth below encompass any and all transactions, regardless of whether the goods or services provided directly are related to the delivery of health care services.

Note that remuneration includes anything of value. Therefore, if solicited, received, offered or given with the intent to influence the decision making process, even remuneration that is of minimum value could violate the law as well as UK policy.

UKHC employees are prohibited from knowingly and willfully soliciting or receiving, or offering or paying, any remuneration (including any kickback, bribe, forgiveness of debt or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for, or as an inducement to:

1. **referring an individual to a provider for the furnishing of, or arranging for the furnishing of, any item or service for which payment may be made under a federal health care benefit program; or**

2. **purchasing, leasing, ordering, arranging, or recommending purchasing, leasing, ordering, of any good, facility, service or item for which payment may be made in whole or in part by a federal health care benefit program;**

3. **submitting or causing to be submitted claims to Medicare or Medicaid for patients who were referred to the hospital pursuant to contracts and financial or business arrangements that were designed to induce such referrals;**

4. **entering into financial or business arrangements with hospital-based physicians that are designed to provide inappropriate remuneration to the hospital, for example compensating physicians for less than the fair market value of services they provide to the hospital or requiring them to pay more than market value for services provided by the hospital, (i.e. token or no payment for Part A supervision and management services; requirements to donate equipment to the hospital; and excessive charges for billing services) in return for the physician's ability to provide services to federal health care benefit program beneficiaries at that hospital;**

5. **entering into financial or business arrangements with physicians that result in**

the physician receiving, for example, excessive payment for medical directorships, free or below market rents or fees for administrative services, and interest-free loans and excessive payment for intangible assets in physician practice acquisitions; or

6. **otherwise influence or attempt to influence the decision making process surrounding a transaction in an illegal, unethical, or abusive manner.**

- **Safe Harbor Exemptions:**
  It is important to remember that there are a significant number of specifically drafted exemptions (often referred to as "safe harbors") to the Anti-Kickback prohibition. The safe harbors essentially permit certain conduct that would otherwise be prohibited by the statute. However, because these exceptions are narrow in scope, and are accompanied by numerous requirements, employees may not agree to, or engage in any transaction, that involves any form of potentially prohibited remuneration without approval from the UKHC Chief Compliance Officer or UK legal counsel.

F. Self Referrals

The anti-referral statute often referred to as "Stark" is designed to prevent possible conflicts of interest related to patient referrals made by physicians and the resulting claims for reimbursement. **Anti-Referral Statute "Stark I & II" (42 U.S.C.§1395nn).**

Accordingly,

1. **UKHC physicians shall not make a referral for a designated health service to an entity in which he or she (or an immediate family member) has a financial relationship.**

2. **UKHC shall not knowingly submit or cause to be submitted a bill or claim for reimbursement for services provided pursuant to such a prohibited referral.**

For purposes of this prohibition, the term **"financial relationship"** includes:

(a) Ownership or investment interest through equity, debt, or other means including an interest in an entity holding an ownership or investment interest in any entity actually furnishing the designated health services; or
(b) Compensation arrangement involving any remuneration to physician or immediate family member.

For purposes of this prohibition, **"designated health services" include:**

(a) Laboratory services
(b) Physical therapy services
(c) Occupational therapy services

(d) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services
(e) Radiation therapy services and supplies
(f) Durable medical equipment and supplies
(g) Parenteral and enteral nutrients, equipment and supplies
(h) Prosthetics, orthotics, and prosthetic devices and supplies
(i) Home health services
(j) Outpatient prescription drugs
(k) Inpatient and outpatient hospital services

- **Safe Harbor Exemptions.**
  It is important to remember that there are a significant number of specifically drafted exemptions (often referred to as "safe harbors") to the Self-Referral prohibitions. The safe harbors essentially permit certain conduct that would otherwise be prohibited by the statute. However, because these exceptions are narrow in scope, and are accompanied by numerous requirements, employees may not agree to, or engage in any transaction, that involves any form of potentially prohibited remuneration without approval from the UKHC Chief Compliance Officer or UK legal counsel.

G. False Statements and Representations

All statements and representations, ***whether oral or written***, made on behalf of UKHC must be backed by an adequate basis for belief or made in a context in which the lack of such basis is clearly understood. The deliberate organization of information in such a way as to mislead or misinform those who receive it is prohibited. It is important to remember that these standards must be followed not only when conducting the day-to-day business operations of UKHC, but also in non-routine situations such as investigative questioning by government agents. **False Statements (18 U.S.C. §1001).**

UKHC employees must report and record all information accurately and honestly, whether on patient records, private or governmental requests for payment or other information, time cards, clinical research records, financial reports or otherwise. UKHC employees shall not:

1. **knowingly and willfully falsify, conceal or cover up by any trick, scheme, or device a material fact;**

2. **make any false, fictitious or fraudulent statement or representation;**

3. **make or use any false writing or document knowing it to contain any false, fictitious or fraudulent statement or entry; or**

4. **falsely make, alter, or forge any proposal, contract, or other writing.**

H. Fraudulent Use of the Mails/Wires

UKHC employees shall not use or cause the use of the mails or wires in furtherance of any scheme or intended scheme to defraud or obtain money or property by means of false or fraudulent pretenses, representations or promises. Because of the broad scope of the related statutes under this sub-section, virtually anyone who so much as even attempts or plans to defraud the government could be charged with mail and/or wire fraud.

Mail Fraud/Wire Fraud (18 U.S.C. §§1341, 1343).

Prohibited behavior includes:

1. **furthering fraudulent behavior by placing or causing to be placed in any authorized mail depository, anything to be sent, delivered, or to be received from the Postal Service.**

2. **furthering fraudulent behavior by transmitting or causing to be transmitted, any writings, signs, pictures or sounds by some means of wire, including telephone, radio, or television communication.**

I. Conspiracy

UKHC employees are prohibited from entering into an agreement, with one or more other individuals, (regardless of whether the other(s) individuals are employees) to commit any local, state or federal offense. An employee's agreement to commit an unlawful act is an illegal activity in itself, above and beyond the actual commission of any other unlawful behavior.

J. Theft

UKHC employees shall not embezzle, steal, take, convert, consume or use any record, voucher, money, or thing of value of the United States or the Commonwealth of Kentucky or any of their respective departments or agencies. Any employee who embezzles, steals, etc., from UKHC could be charged under both federal and state anti-theft statutes.

K. Research

UKHC employees shall comply with all federal and state laws, regulations, ordinances, University and hospital policies and ethical standards relating to investigational research. These standards must be followed during ***all phases*** (including funding, whether public or private) of any investigational study which is in any way affiliated with UKHC.

L. Prescription Medications and Controlled Substances

All controlled substances that enter, are used by, or are dispensed from UKHC shall be handled in accordance with all federal, state, and local regulations. UKHC employees are forbidden from illegally possessing, attempting to posses, embezzling, selling, trafficking, misbranding or misusing any controlled substance for any reason.

Examples of prohibited conduct in this area include:

1. **altering or forging any record, prescription, label or license;**

2. **selling, purchasing or trading a drug sample;**

3. **failing to dispense a prescription drug without correct copies of all printed matter that is required to be included in any package in which the drug is distributed or sold;**

4. **dispensing a prescription drug that fails to bear the statement "Caution: Federal Law prohibits dispensing without a prescription;"**

5. **prescribing a drug without properly evaluating the medical necessity for the prescription;**

6. **providing or distributing prescription or scheduled drugs without requiring a prescription;**

7. **dispensing drugs without the appropriate authority or license to do so.**

M. Facility Certification

UKHC employees may not make or cause another individual to make any false statement or representation about any aspect of the operation or control of UKHC. It is essential that UKHC provide accurate information to state and federal agencies in order to maintain its participation in the Medicare and Medicaid programs.
Medicare/Medicaid Fraud (42 U.S.C.§1320a-7b(c)).

UKHC employees shall not:

1. **knowingly and willfully make, or cause to be made, a false statement or representation of material fact with respect to the conditions or operation of any institution, facility or entity in order that such entity may qualify, either initially or upon re-certification, for participation in the Medicare or Medicaid Program; or**

2. **knowingly and willfully make, or cause to be made, a false statement or representation of material fact with respect to information regarding ownership and control of a facility.**

IV. COMPLIANCE PROGRAM INTEGRITY

A. Responding to Government Investigations

UKHC employees shall not act in a way that illegally obstructs the administration of justice. UKHC demands that all of its employees provide accurate information to government investigators, and in testimony before administrative, governmental and judicial bodies. **Obstruction of Justice (18 U.S.C. §§ 1503, 1505, 1512, 1622).**

Numerous behaviors can lead to an individual or organization being charged with obstruction of justice or related crimes. Specific examples include:

1. **corruptly, or by threats or force, or by threatening letter or communication, endeavoring to influence, intimidate, or impede the administration of the law.**

2. **engaging in intimidation, force, threats, misleading conduct or corrupt persuasion with the intent to influence testimony of any person in any official proceeding.**

3. **procuring an individual to commit perjury.**

4. **corruptly destroying, altering, or misplacing documents.**

B. Whistleblower Protection

UKHC shall not engage in illegal retaliation, (whether personal or job related) which is directed against an employee who, ***in good faith, reports*** to a government agency or official alleged unlawful conduct by UKHC.

Additionally, UKHC shall not retaliate, in any way that tends to discourage, restrain, depress, dissuade, deter, prevent, interfere with, coerce, or discriminate against an employee who reports any facts or information that the reporting individual believes, in good faith, to be relative to actual or suspected illegal, unethical or abusive conduct.

The above paragraphs do not, in any way, imply that employees can exempt themselves from the consequences of impropriety or inadequate performance. Rather, these provisions are

meant to ensure employees who, in good faith, report compliance concerns do not suffer adverse consequences for making a report. The EVPHA can, in whole or part and at his complete discretion, consider an individual's compliance report a mitigating factor when determining the appropriate corrective action to be taken against a "self-reporting" individual.

C. Failure to Adhere to Compliance Program Standards

Failing to adhere to compliance program standards, directives, or policies and procedures can result in disciplinary action, including termination. Sanctions imposed under the CCP will be carried out according to University policies and procedures, consistent with the individual's employment status. *See* Chapter 2 Section IX.

D. Abuse of Compliance Program Procedures

Employees will be subject to disciplinary action up to and including termination if they intentionally and maliciously report a false allegation or otherwise intentionally or recklessly abuse UKHC's Corporate Compliance Program procedures. *See* Chapter 2 Section IX.

UK HealthCare Clinical Enterprise

CLINICAL ENTERPRISE POLICY & PROCEDURE

Title: Government Inquiries and Request for Documents

Number: 04-01

I. INFORMATION:

The provision of health care services is one of the most highly regulated industries in the United States. Accordingly, UK HealthCare customarily is subject to audits and investigations conducted by various government agencies. During the course of these inquiries, government investigators may arrive unannounced at UK HealthCare or the homes of present or former employees and seek interviews and documentation. The purpose of this policy is to establish a mechanism for a fair and orderly response to government inquiries to enable UK HealthCare and its employees to respond appropriately during the investigatory process.

II. POLICY:

It is the policy of UKHC to cooperate with any appropriately authorized government investigation or audit in accordance with recognized legal standards and practice.

III. PROCEDURE:

In person requests

If a government representative appears in person, for the purpose of investigating or auditing any aspect of UKHealthCare, its employees, agents or medical staff, employees should proceed as follows:

1. Ask to see his or her identification and business card. If these materials are unavailable, ask for the person's name and title, office address and telephone number, as well as his or her agency identification number. If more than one government representative appears, there often will be one representative in charge. Obtain the above information from the agent in charge.

2. Immediately contact your supervisor as well as UK HealthCare's Office of Compliance and/or the University's Office of Legal Counsel. UK Hospital employees should first contact Hospital administration. Relay all of the above information and documentation which you have gathered.

3. If a government representative wants to speak with an employee personally, or wishes to conduct a search or otherwise obtain documents from UK HealthCare, politely inform the representative that University officials have been contacted and will arrive shortly to assist with this process. Should the government representative refuse to wait for University officials to arrive before beginning a search, ask to see the legal documents supporting the search and make a copy of this documentation. Finally, inform the government representative that while you will not in any way prevent or obstruct them from acting immediately, you do not have the authority to consent to the search. **Remember employees are forbidden under any circumstances to obstruct the government representative's search and must provide any documents requested in a warrant or other legal document.** Accordingly, employees who, in good faith, assist government representative believing that they are required to do so by law, shall not be deemed to have consented to the government's search on behalf of the University of Kentucky.

Other requests

Employees who receive any written notice (or other type of notice not delivered in person by a government representative) requesting documents, records, interviews, or other information related to UK HealthCare in the course of their job duties should immediately notify their supervisor of the request. The supervisor is responsible for notifying the appropriate administrative office (e.g. Office of the EVPHA, hospital administration or dean's office). Depending on the nature of the request, UK HealthCare Office of Compliance or UK Office of Legal Counsel should be also be notified.

A. INTERVIEWS

Government representatives often will request to interview employees. Although anyone may volunteer to do so, employees are not obligated to consent to an interview.

It is not unusual for government representatives to try to suggest that employees must speak to them when they first contact an employee or for the government representatives to imply that it is wrong to refuse to speak with them during this first contact. Note that government representatives may not threaten an employee in any way whereby requiring an employee to speak with them immediately or suggest that they may offer an employee a “deal” if an employee provides them with information. No matter what the government representative might tell an employee, he or she is allowed to schedule an appointment for sometime in the future during which time such an interview can take place.

An employee is entitled to have someone with him/her during any interview with a government representative. The University can arrange to have its attorney present at no cost to the employee, or, if an employee wishes, he/she may consult with an outside attorney. If the

employee desires outside representation, he/she should contact the University's legal counsel prior to engaging outside legal counsel.

Notwithstanding any policy, an employee always is free to speak with a government representative. However, if an employee chooses to be interviewed by a government representative before contacting the appropriate University representative, the employee is still encouraged to contact the appropriate University representative as soon as possible after the interview.

Regardless of when or where an employee is interviewed, employees should follow these basic principles during an interview with government representatives:

1. Always tell the truth. If an employee does not recall something or has no knowledge about the topic that the government representative is asking about, say so.

2. In talking with the government representative, an employee should be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding. It is important to make clear to the government representative whether the information that an employee is providing is first-hand knowledge, something an employee has heard, or speculation. It is good to avoid speculation, but if an employee does speculate, make sure the government representative knows it.

3. You may request that the interview be stopped or delayed at any time during the interview process.

B. SEARCHES

A "search" occurs any time a government representative enters the company's premises and begins to look for documents or ask questions. If the government representative refuses to wait for University officials to arrive before beginning a search, the employees on site at the time should:

1. Determine who is the highest-ranking employee present. That person will be in charge until UK HealthCare officials arrive on the scene. The employee in charge will be responsible for communicating with government representatives and for initiating and maintaining communication with UK HealthCare officials responsible for responding under this policy.

2. The employee in charge will ask to see the legal documents supporting the search and make a copy of this documentation. Note that some government agencies have the authority to assess penalties if their representatives are not granted immediate access to any location within UK HealthCare upon reasonable request. These agencies include OSHA, state Medicaid fraud control units, the Office of the Inspector General, and the state Medicaid agency. Therefore, regardless of what, if any, legal documents are provided to the UK HealthCare employee in charge, that employee should inform the government representative that while no one will in any way obstruct their investigation. However, even though they are free to take immediate action, he/she does not have the authority to consent to the search.

3. The employee in charge will keep a thorough list of all documents that the government representative inspects, seizes or copies. Further, the employee in charge will assign another employee to follow each government representative during the search. Employees assigned to this task should take detailed notes of everything that the government representatives seize and those documents that the government representatives inspect, but do not seize or copy. A detailed receipt should be obtained from the government representative of all documents/items for which the government has seized or copied, including the number of pages copied for each document. If the government representative wishes to take original documents, ask if those documents first may be copied. If the government representative will not allow copies, be sure to make a list of all documents that the government is taking.

4. It is not unusual for government representatives to seize documents or items such as patient records and computers, whose loss will impede day-to-day operation of the company. If a government representative wants to seize any computers or hard drives, the employee in charge should ask the representative if he/she is permitted to copy all such files onto a disk. If the government representative wishes to seize patient records, ask whether those records may be copied so that patient care or patient confidentiality will not be compromised.

5. If any UK HealthCare employee is asked to sign an affidavit of any kind, he or she should not comment as to the validity of its contents and explain that he/she are not authorized to sign any document prior to review by legal counsel.

6. **All UK HealthCare employees are required to answer questions concerning the location of documents. Remember, it is a crime to obstruct an agent in the lawful execution of his/her duties. Some other examples of unlawful behavior are: altering or destroying documents sought in an investigation; falsely denying knowledge of information; corruptly influencing another person to exercise the privilege against self-incrimination; or intimidating a witness with the intent of influencing testimony or retaliating against a witness for testifying in an official proceeding. However, asking questions and demanding a copy of the warrant are not obstruction. Remain calm, polite and observant.**

C. COMMUNICATIONS REGARDING AN INVESTIGATION

Except as outlined in this policy, UK HealthCare employees are asked not to discuss matters related to a government investigation with anyone other than UK HealthCare officials responsible for investigating the matter on behalf of UK HealthCare.

All media inquiries should be directed to the University of Kentucky Office of Public Relations.

D. CONTACT INFORMATION

UK HealthCare Office of Compliance
Chief Compliance Officer
Office (859) 323-8002

University Office of Legal Counsel
Medical Center Office (859) 323-1161 or Campus Office (859) 257-2936

Office of the Executive Vice President for Health Affairs
(859) 323-5126

University of Kentucky Office of Public Relations
Office (859) 323-6363 or staff member on-call (859) 323-5321

Hospital Administration
Office (859) 323-5211 or the administrator on-call (859) 323-5321

Kentucky Clinic Administration
Office (859) 257-8562

College of Medicine
Dean's Office (859) 323-5567

College of Dentistry
Dean's Office (859) 323-5786

College of Pharmacy
Dean's Office (859) 323-7601

College of Nursing
Dean's Office (859) 323-6533

College of Health Sciences
Dean's Office (859) 323-1100