

Cheyenne Regional Medical Center	Area: Compliance
Title: CRMC Compliance Program Number:	Page 1 of 12
Originator: Chief Compliance Officer	Policy Applies to: Entire Institution
Authorized by: Board of Trustees	Revision Date:
Policy Reference:	Effective Date: June 1, 2009

POLICY STATEMENT: The Compliance Program is designed to give current guidance to staff members related to sound and ethical business practices.

POLICY PURPOSE: Cheyenne Regional Medical Center’s Board of Trustees, Administration, and Employees are committed to fostering a culture that promotes a high standards of honest, caring, and quality relationships with patients, physicians, co-workers, business partners, community and various government entities. We are committed to carrying out our mission by establishing a Compliance Program to document our commitment to carry out our duties with honesty, integrity, and to the best of our abilities.

Mission: The mission of the Corporate Compliance & Privacy Office is to affirm Cheyenne Regional Medical Center’s commitment to honest and ethical corporate conduct by providing an effective compliance and privacy program that increases the likelihood of preventing, identifying, and correcting unlawful and unethical behavior, encourages our workforce to report potential problems to allow for appropriate internal investigation and corrective action, and demonstrates Cheyenne Regional’s good faith effort to comply with applicable statues, regulations, and federal health care program requirements and standards.

Vision: The Corporate Compliance & Privacy Office will be a resource to all members associated with Cheyenne Regional.

Values: The Corporate Compliance & Privacy Office serves as Cheyenne Regional Medical Center’s Values through our commitment to honesty, integrity, confidentiality and Service Excellence.

Our establishment of a Compliance Program is to help prevent, detect, correct and resolve practices that conflict with identifiable laws and regulations. Additionally, our program exists to help create and sustain a culture in which our mission, vision and values are woven into the fabric of the organization.

If you have any questions about the Manual or the Compliance Program, please contact: Chief Compliance Officer, Cheyenne Regional Medical Center at (307) 432-6622

Compliance and Privacy Program Structure

The Cheyenne Regional Medical Center Board of Trustees appoints the Chief Compliance Officer (CCO). Presently, Sherry A. Conner currently holds this position and was appointed on October 23, 2008. As CCO, Ms. Conner oversees the implementation and operation of the Compliance and Privacy Program, coordinates the seven elements of an effective compliance program, drafts the annual work plan, provides orientation to new employees and ongoing training to incumbent employees, conducts compliance investigations, and acts as the primary liaison with the Hospital Compliance Committee.

The Corporate Compliance & Privacy Office is comprised of the CCO, one Nurse Auditor, the Contract Coordinator, and an Executive Secretary.

The Board of Trustees, General Counsel, and CCO comprise the Hospital Compliance Committee, which serves as the oversight body of the Compliance & Privacy Program. The Hospital Compliance Committee has created a Hospital Compliance Subcommittee, to which it has delegated operational authority. The Subcommittee reports to the Hospital Compliance Committee on, at minimum, a quarterly basis.

Policy

The framework of the Compliance & Privacy Program was communicated at its inception through policy development, and has subsequently been augmented with new and revised policies. A review of the enclosed policies offers a fundamental understanding of the Compliance & Privacy Program, its mission, and its role in the daily operation of Cheyenne Regional Medical Center. A list of our Compliance Policies are listed on our web site:

http://crmcnotes/Intranet/WebPages.nsf/COMPLIANCE_Welcome?OpenForm

Communication

The Chief Compliance Officer (CCO) serves as a resource for anyone seeking clarification of compliance related issues or anyone who wishes to report in good faith suspected compliance violation. Retaliation for reporting compliance issues is not tolerated at Cheyenne Regional Medical Center.

Another communication resource is through a contracted service "We Care" which is a 24 hour, 7 day a week operation who will log in complaints and directly report issues to the Chief Compliance Officer. The caller has the option of either identifying themselves or remains anonymous. The "We Care" toll free hot line number is: 1-888-299-6546 or through email at: www.wecarecrmc.org

Cheyenne Regional Medical Center's workforce is our best defense in detecting and preventing fraud and abuse in healthcare. Open and honest communication is essential for creating and sustaining a culture of compliance.

Common Definitions related to Compliance Programs:

- A. Cheyenne Regional Medical Center (Cheyenne Regional) refers to all legal entities that are directly or indirectly controlled by Cheyenne Regional Medical Center. An entity is controlled by Cheyenne Regional Medical Center if Cheyenne Regional has (1) the authority, either directly or indirectly, to act as the controlling member, shareholder or partner of the entity, (2) the authority to appoint, elect or approve at least a majority of the individual members, shareholders, or partners of the entity, or (3) the authority to appoint, elect or approve at least a majority of the governing body of the entity.
- B. Board of Trustees- A governing board entrusted with the overall operations of Cheyenne Regional. Memberships are appointments made by the Laramie County Commissioners.
- C. Audit Committee a sub part of the Cheyenne Regional Medical Center's Board of Trustees.
- D. Audit Services are provided either internally or contracted to an outside auditing agency.
- E. Contractor means an individual (i) who has an independent contractor agreement with Cheyenne Regional to provide goods or services to Cheyenne Regional or its patients, or (ii) who owns, is employed by, or otherwise works for an organization with such a contract, and who has direct contact with any Participant in the performance of the contract.
- F. Chief Compliance and Privacy Officer (CCO) means that individual assigned responsibility for overseeing the development, implementation and operation of the Cheyenne Regional Compliance Manual.
- G. Compliance Manual means the overall program developed and implemented by Cheyenne Regional to ensure compliance throughout Cheyenne Regional.
- H. Compliance Sub-Committee means the committee appointed by the CCO to assist the CCO in the development, implementation, and ongoing operation of the Compliance Program, and to perform duties described here within.
- I. Compliance Program or Compliance Manual means the written plan governing the development, implementation, and operation of the Compliance Program, including Standards of Conduct, Compliance and Privacy policies and procedures that are applicable to all involved with Cheyenne Regional's operations.
- J. Legal Counsel means the attorney or law firm designated by the Chief Compliance Officer to provide legal advice and assistance in the

development, implementation, and maintenance of the Compliance Program.

- K. Participant means an individual subject to the Compliance Program. Participants shall include all employees of Cheyenne Regional; all directors and officers of Cheyenne Regional; and all Contractors and Professional Staff Members whom Cheyenne Regional determines should be subject to the Compliance Program.

Core Goals for our Compliance Program

1. Heightened awareness and sensitivity to high risk areas through education and communication. The Compliance Department will provide compliance and HIPAA education to all newly hired employees and annual training for our retained employees, physicians, volunteers, and other personnel who are part of our operations. Additionally, as we identify risk areas, the department will develop specific training to increase awareness.
2. Empower employees, physicians, contractors, and our community to voice concerns related to Cheyenne Regional's operations including such topics as patient/employee safety, accurate documentation and billing, quality of care, human resources, and other areas that are regulated by Cheyenne Regional's policies, state and federal laws and regulations.
3. Emphasis on proactive procedures and self-review: The Compliance Program will provide guidance through the development of standards of conduct and procedures to be followed in identified risk areas, and will provide self-review and audit to monitor compliance with these standards and procedures.
4. Comply with State and Federal laws and regulations to the best of our ability. By working with high risk departments with education, processes, auditing and monitoring their respective risk, as well as documenting the department(s) progress, we will effectively demonstrate our commitment to an effective compliance program.
5. Appointment to high level personnel to implement and monitor the Compliance Program. Cheyenne Regional will involve high level personnel in all aspects of the Compliance Program and assign a high level staff member to serve as the Chief Compliance Officer (CCO). The CCO will monitor the effectiveness of the program and involve senior leaders to help identify root causes for non compliance and help develop corrective action plans (if applicable)
6. Integration of existing policies, standards, and guidelines into the Compliance Program to avoid duplication and to ensure compliance.

The Compliance Program will be designed to complement, not duplicate, existing Cheyenne Regional policies and guidelines.

Core Elements of an Effective Compliance Program:

The basics of an effective compliance program are to include the 7 elements established by the Centers of Medicare and Medicaid as well as risk areas specifically related to Cheyenne Regional. In summary they are:

- A. Document and Communicate Cheyenne Regional's Commitment to Compliance. We accomplish this goal by Board Approval of our Compliance Program, Code of Conduct and Compliance related policies.
- B. Designate a Chief Compliance Officer who has the authority to act independently with the authority to oversee all compliance activities and who has direct access to the Chief Executive Officer and Board of Trustees. In addition, the Compliance Program should be fully funded to carry out its compliance program including access to independent resources such as legal council, consultants, and accounting firms.
- C. Designate a Compliance Committee. Currently we have the Hospital Operations Committee that meets at every other month. Membership includes representatives from: Cheyenne Regional's Board of Trustees, Chief Executive Officer (CEO), Chief Financial Officer, Chief Operations Officer, Chief Nursing Officer (CNO), Physicians, and Human Resources.
- D. Compliance Education and Training. Cheyenne Regional provides Compliance and HIPAA training to all new hires and annually thereafter. In addition, specialized training for high risk areas such as admissions, patient financial services, laboratory, radiology, emergency department will be provided from various sources such as conferences, lecture, on-line and/or correspondences. Compliance Training for Management and Physicians should focus on complying with quality, documentation, charging/billing, and human relations.
- E. Routine auditing and monitoring high risk areas such as billing, coding, medical record documentation, medical necessity, EMTALA transfers, and other areas that are identified as having a high risk for non-compliance. The purpose of routine review is to quickly identify and resolve issues with minimal negative impact to the facility.

Auditing areas identified by a risk assessment, OIG work plan, and fraud alerts. Compliance Department will develop an audit matrix designed to identify errors. If an error is detected a corrective action

plan will be developed including root cause analysis, corrective action to prevent re-occurrence, and prompt notification to appropriate government agency as well to management and the board. Notification to government agency should be within 60 days after determining that there is credible evidence of a violation.

- F. Maintaining various avenues for open communication. At Cheyenne Regional, employees, physicians, vendors, and other members of our facility may report concerns directly to the Chief Compliance Officer or through Cheyenne Regional's WeCare hotline and/or email. Anyone reporting a compliance concern in good faith will not be retaliated against.
- G. Enforcing standards through well publicized disciplinary guideline non-employment/retention of sanctioned individuals. An effective compliance program should include guidance regarding disciplinary action for corporate officers, managers, employees, physicians, and other health-care professionals who have failed to comply with the hospital's standards of conduct, policies and procedures, or federal and state laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair the hospital's status as a reliable, honest, and trustworthy health-care provider.

Establishment of a Chief Compliance Officer:

The Chief Compliance Officer (CCO) shall be appointed by the Board of Trustees and will be responsible for the following:

- Develops initiates, maintains, and revises policies and procedures for the general operation of the Compliance Program and its related activities to prevent, detect and minimize illegal, unethical, or improper conduct.
- Manage the daily operations of the Compliance and Privacy Department.
- Review and update the Compliance Program on an annual basis.
- Develop, review, and update Compliance and Privacy policies every three years or earlier due to changes in government regulations.
- Coordinate and provide recommendations for annual risk assessment of key departments.
- Develop annual audit program based on the risk assessment, OIG annual work plan, and other audit reports provided by various Government agencies.
- Collaborate with other departments to improve compliance within their area including developing auditing and monitoring tools to help departments measure and if needed correct compliance deficiencies.

- Acts as an independent review and evaluation body to ensure that compliance issues/concerns within the organization are being appropriately evaluated, investigated and resolved.
- Maintain a compliance log trending concerns and reporting results to CEO and Board.
- Provide monthly updates to the Chief Executive Officer and prepare quarterly reports to the Board of Trustees.
- Evaluate and Develop education programs for Board members, leadership, employees, volunteers, students, affiliated providers, key vendors, and other community organizations as requested by CEO and/or the Board.
- Provide research and reference material to Cheyenne Regional's leaders regarding various Government regulations.
- Coordinates, as appropriate, with outside legal counsel, on compliance issues and/or investigations that require legal guidance.
- Co-Chairs the Compliance Subcommittee

Compliance Responsibilities for the Board of Trustees and Compliance Sub-Committee:

Board of Trustees:

The CCO will give at a minimum a quarterly report to the Board of Trustees. This report will give a summary of the development, implementation and ongoing operations of the Compliance and Privacy programs. In addition, the CCO will present pending Compliance and Privacy Policies for final board approval. The CCO will also provide annual training and additional training as requested by the Board.

The Board of Trustees responsibilities include:

- Review of the Quarterly reports and advisement/approval of proposed policies
- Advise the CCO in the development, implementation, and ongoing operation of the Compliance and Privacy Programs
- Advise the CCO in developing the Standards of Conduct
- Advise specific policies and procedures for implementing the various aspects of the Compliance Program
- Advise CCO in investigating disclosures and reports made by participants in accordance with the Compliance Program, and in developing corrective action plans where appropriate
- Advise together with Legal Counsel, in the monitoring of new laws, regulations and trends with regard to compliance activities

Hospital Operations Committee:

The Compliance Subcommittee consisting of selected Board members and key Executive Team members who meet monthly to review the day to day operations of Cheyenne Regional's Compliance Program.

The Hospital Operations Committee's responsibilities include:

- Annually review and recommend enhancements to the Compliance Program and Code of Conduct for board approval
- Ensure the implementation and ongoing operation of the Compliance Program
- Demonstrate the commitment of Cheyenne Regional to the Program through ethical leadership and conduct
- Review risk assessment results from selected departments and recommend processes, audits and monitoring tools to reduce risk
- Recommend, review and approve annual audit program
- Recommend, review and approve annual training for staff, physicians, and board members
- Ensure excluded provider audit is performed according to CMS recommendations for all new hires and staff, physicians and vendors
- Review quarterly Compliance Log
- Initiation and reporting of appropriate investigations
- Implementation of appropriate task forces to address compliance objectives
- Routine and timely reporting to the Board of Trustees

Risk Assessment:

The CCO and Hospital Operations Committee will recommend at least 15% of Cheyenne Regional departments to perform an in-depth risk assessment using the "Comply-Tracs" risk assessment tool annually. The selected departments with the help of the Compliance Department will use the tool to identify weak areas within the respective department and implement corrective action plans. The respective departments will report their progress to the Compliance Department.

In addition, the Compliance Department will assess the department's risk assessment results and work with departments to decrease/minimize risk by providing research, audit/monitoring tools, and verification audits.

Compliance and HIPAA training:

The intent of an education program is to heighten awareness of the benefits and the operations of the Compliance Program as well as to promote internalization of the responsibilities, processes and underlying policies.

Compliance training will be provided to all new hires and annually to Board members, employees, physicians, and key vendors. Minimum key areas to be covered will include:

1. The basic elements of Cheyenne Regional's Compliance Program
2. Applicable Federal Laws and Regulations
3. Standards of Conduct
4. HIPAA

5. Relevant policies/procedures
6. How to contact the Compliance Officer and the WeCare line
7. Non-retaliation policy

NOTE: Some specialized areas will require additional compliance training. The Board, Compliance Sub-Committee, and high risk areas will review and recommend additional training for high risk departments.

Auditing and Monitoring:

The purpose of performing audits in high risk areas is to help prevent and/or detect non-compliance that may result in poor quality, inefficiency and/or overpayment. The intent of auditing and monitoring key areas is not to uncover all non-compliance but to minimize potential risk and to give a level of comfort that Cheyenne Regional is committed to comply to the best of its ability.

Annually the Compliance Department will make recommendation to the Hospital Operations Committee and Board of Trustees related to audit content focused on the organization's high risk areas such as: anti-kickback arrangements, the physician self-referral prohibition, inpatient/outpatient coding, three day qualifying stays, ancillary billing, and others as identify through risk assessment, fraud alerts, etc.

Audit results will be reported to the Hospital Operations Committee. The Committee will review, advise, and approve corrective action plan (if appropriate). The respective departments will provide the Hospital Operations Committee progress reports until the corrective action plan has been completed. A summary of the audit results and corrective measures will be reported to the Board of Trustees.

Federal Deficit Reduction Act of 2005 (DRA)

The Federal fraud and abuse laws enable the government to take legal action to recover damages and penalties when healthcare providers submit false claims for payment. The Federal Deficit Reduction Act of 2005 requires health care entities to implement certain policies to educate employees about the fraud and abuse laws and the whistle blower protections afforded by such laws. Specifically Cheyenne Regional is required to educate staff, contractors and agents regarding the following:

1. False Claims Act (FCA). Under the False Claims Act, 31 U.S.C. §§ 3729-3733, any person or entity that knowingly submits a false or fraudulent claim for payment of the United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the government's damages, civil penalties ranging from \$5,500 to \$11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally,

- the federal False Claims Act applies to any federal funded program, including claims submitted by healthcare providers to Medicare or Medicaid.
2. Administrative remedies for false claims and statement. Under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. §§ 3801-3812. It provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement for purposes of the PFCRA includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of \$5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim. Currently all new hires are given FCA education during orientation. All employees received annual compliance education that includes the required provision from the Federal Deficit Reduction Act.
 3. Protection of Whistleblowers in False Claim Actions. The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action.

Currently employees are provided with the above information during orientation and annually thereafter. The Compliance Department will work with Material's Management and Physician Services to help educate Physicians and Vendors during FY09.

Maintaining effective lines of communication:

Our goal at Cheyenne Regional is for employees to feel safe to report concerns without the fear of retaliation. We recommend for employees to seek clarification to their concerns by consulting with their respective Chain of Command. Management needs to cultivate a culture of mutual respect and trust. There are times management and/or employees identify an item that needs to be investigated or clarified through in-depth research. Cheyenne Regional has designated the Compliance Department as a resource for employees and management to ask questions and if necessary investigate potential non-compliance issues.

In addition to the Compliance Department, Cheyenne Regional has established an independent "WeCare" phone number and web access to report concerns. Employees, Management and Vendors may report anonymously and given an access number to review the status of their compliant and to provide additional information (if requested).

The CCO will be responsible for overseeing investigations of all issues surfaced through the reporting system. The CCO may delegate specific investigative tasks to Human Resources, Patient Financial Services,

Accounting, other Senior Management, Legal Counsel, and/or other outside consultants. If a violation is confirmed, the CCO will work with the appropriate departments to perform a root cause analysis, implement a corrective action plan, re-audit to ensure corrective action plan is effective and if necessary report findings to the appropriate government agency. The CCO may consult with counsel regarding the best method to report non-compliance to regulatory agencies.

Enforcing standards through well publicized disciplinary guidelines

An effective compliance program should include guidance regarding disciplinary action for Board Members, Management, Employees, Physicians, and other health-care professionals who have failed to comply with the hospital's standards of conduct, policies and procedures, or federal and state laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair the hospital's status as a reliable, honest, and trustworthy health-care provider.

The Compliance Department will work with Human Resources, Medical Staff Services, and Materials Management to develop/revise policies that identify the degrees of disciplinary actions for violators, with more stringent discipline for serious offenses. The type of discipline may range from verbal warning up to termination and/or revocation of privileges. Management should consult with the appropriate department to assist with consistent application of respective disciplinary policies.

Hiring and retention of excluded/sanctioned personnel

Cheyenne Regional will not knowingly hire and/or retain persons who have been sanctioned by the government or state/national credentialing body. Prior to hiring/privileging or contracting with vendors, Human Resources, Medical Staff Services, or Materials Management will perform exclusion screening through the Office of Inspector General (OIG) and Government Service Administration (GSA) web sites. For staff and physicians, Human Resources or Medical Staff Services will perform a background check for persons seeking employment/acceptance to Cheyenne Regional. Depending on the position, background checks may include source verification of license/certification.

The Compliance Department will work with Human Resources, Medical Staff Services, and Materials Management to develop/revise policies regarding background checks and the prevention of hiring, privileging, contracting and continued employment of sanctioned persons including excluded provider audits as recommended by Centers for Medicare and Medicaid (CMS). If a person associated with Cheyenne Regional is sanctioned appropriate action will be followed according to established policies.

In closing this is a brief summary of Cheyenne Regional Compliance Program. Each core element of our compliance program has respective policies that detail the scope, objective, and procedures to guide Board members, leaders, physicians, employees, and vendors. If you have additional suggestions please contact the Compliance Department.

Respectfully submitted,

Sherry A. Conner, MSA, CPA, CHC, CPC-A
Chief Compliance Officer

References used to revise compliance program:

United Medical Center Operational Hospital Compliance Manual, author Kristen Schlattmann

Payment Error Prevention Program (PEPP) Workbook

OIG, Compliance Program Guidance for Hospitals

Saint Thomas Health Services Corporate Responsibility Program, author Cynthia Figaro

North Carolina Baptist Hospital, Incorporated, Compliance, author John Hart, Jerry Clark, and Sherry Conner

Sheehan Phinney Bass and Creen, "Good Company; Federal Deficit Reduction Act of 1995, What It Requires of Health Care Employers.

University of California, How to Blow the Whistle on Suspected Improper Activities and Whistleblower Policies

Redlands Community Hospital, Notice to Employees, Contractors, and Agents on False Claims Recovery

Safeway INC. Deficit Reduction Act of 2005

Replaces Policies:

- B-125 Hospital Compliance Committee
- B-123 Hospital Ethics & Compliance Program
- B-131 False Claims Act

Key Words:

- Compliance
- Integrity
- Whistleblower
- False Claims