

Medical Staff Compliance & HIPAA Program Overview Certification

I. Compliance Program

Introduction

Davis Regional Medical Center has developed and implemented a Compliance Program that is designed to deter, detect, and prevent fraud, abuse, and mistakes.

Examples of potential fraud, abuse, and mistakes include the following:

1. Billing for goods or services that were not provided.
2. Billing for goods or services that are not documented or not sufficiently documented.
3. Billing for goods or services that were not medically necessary.
4. Providing a referral source anything of value in exchange for referrals.
5. A financial relationship between a hospital and a referring physician, physician group, or immediate family member of a referring physician, without a written agreement.
6. Paying a referring physician, physician group, or immediate family member of a referring physician above fair market value for services rendered.
7. Charging a physician less than fair market value rent for space or equipment.

Written Standards, Policies, and Procedures

The Compliance Program structure and requirements are set forth in the Compliance Manual and Compliance Policies and Procedures. Both of these documents are available on the hospital intranet at hma-info.com. In addition, a paper copy of the Compliance Manual can be obtained from the Director of Human Resources, Davis Regional Medical Center.

Oversight

Kyle Johnson is the Hospital Compliance Officer responsible for making sure that the Compliance Program has been implemented and is operating in accordance with the requirements of the Compliance Manual and Compliance Policies and Procedures. The Hospital Compliance Officer works in conjunction with a Divisional Compliance Officer Matt Tormey and reports to the Vice President of Compliance on all compliance related matters.

Training

In order to successfully deter, detect, and prevent potential fraud, abuse, and mistakes, it is critical that all individuals working in the hospital, including medical staff members, are aware of the existence, purpose, elements, and requirements of the Compliance Program. Consequently, we have developed this Compliance Program Overview Certification to introduce and/or remind you of the elements and requirements of Davis Regional Medical Center's Compliance Program. In addition, you may contact the Hospital Compliance Officer, Kyle Johnson, CFO (704) 838-710, at anytime should you have any questions or concerns.

Audits

Each year, a risk assessment is performed to identify risk areas that can be proactively monitored and audited. A Compliance Work Plan is developed based upon the risk assessment and the Compliance Work Plan describes the mandatory internal and external auditing and monitoring activity. Significant portions of the Compliance Work Plan audits relate to validating that services are adequately documented and medically necessary. In addition, all financial relationships with physicians, physician groups, and immediate family members of physicians are audited to verify that any transfer of remuneration is pursuant to a written agreement that is supported by evidence that the financial relationship is fair market value.

Anonymous Reporting Mechanisms

As part of the of Davis Regional Medical Center's Compliance Program, we have contracted with an outside vendor to provide a mechanism, the Compliance Helpline, for associates to anonymously report suspected

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misconduct 24/7. The Compliance Helpline number is: 1-888-462-0380. All matters reported through the Compliance Helpline are emailed to the Vice President of Compliance for the hospital's parent company. The Vice President of Compliance reviews the reports and determines the appropriate person to investigate the concern.

In addition, associates can also anonymously report suspected misconduct by sending their concerns to a confidential post office box at the following address: Health Management Associates, P.O. Box 770621, Naples, Florida 34107. Similar to communications through the Compliance Helpline, all communications through the P.O. Box are reviewed by the Vice President of Compliance and then forwarded for investigation.

Investigations

All reports of suspected misconduct must be entered into the hospital's compliance log and investigated. The Hospital Compliance Officer will oversee all investigations and is responsible for involving when necessary, legal counsel and/or subject matter experts.

If the Hospital Compliance Officer cannot perform the investigation due to a conflict, then the Vice President of Compliance will determine who will conduct the investigation. If the investigation reveals fraud, abuse, or mistakes, then these conclusions must be reported to the Vice President of Compliance and an appropriate corrective action plan must be established to address all noted deficiencies.

Conclusion

The success of our Compliance Program depends on each and every of Davis Regional Medical Center associate helping to establish and maintain a culture that is focused on our mission of providing compassionate high quality healthcare services that improve the quality of life for our patients, physicians, and communities that we serve and showing zero tolerance for illegal, unethical, or otherwise inappropriate behavior.

II. HIPAA Program

To be in compliance with the HIPAA regulations, all healthcare providers should be knowledgeable about Health Management Associates' HIPAA policies and procedures.

Key Message Points Relating to HIPAA compliance include:

- The HIPAA Privacy Rule establishes national standards to control the use and disclosure of what is known as Protected Health Information (PHI).
 - PHI is any health information that is collected from the patient or created or received by a health care provider or facility that relates to the past, present or future physical or mental health or condition of a patient that could potentially identify that individual.
 - Unsecured PHI: All PHI we deal with is unsecured. Paper records are unsecured.
 - Secured PHI: PHI is secured only if it is encrypted by NIST standards or has been destroyed.
 - Disclosure: PHI brought outside the organization
- **The Privacy Rule gives patients the right to:**
 - Receive a Privacy Notice
 - Inspect and get a copy of their PHI
 - Amend their PHI if incorrect
 - Request restrictions on disclosures of PHI
 - Request alternative means of communication
 - Obtain accounting of non-routine disclosures of PHI

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- **The obligation of the hospital's workforce and medical staff is to:**
 - Use or disclose PHI only for work related purposes
 - Limit uses and disclosures to the "minimum necessary" to achieve those work purposes
 - Exercise reasonable caution to protect PHI under their control
 - Understand the HIPAA policies and follow them
 - Try to remedy any privacy problems or to report them to the Privacy Officer of Davis Regional Medical Center. **The Privacy Officer is Emma B. Phillips, who can be reached at (704) 838-7191.**
 - Recognize that the hospital will not retaliate or discriminate against any patient, member of the workforce, or medical staff member who exercises their right to express a privacy or other HIPAA concern

Do not:

- Throw PHI in the trash or leave on the copier – use a shredder or dispose of paper-based PHI in the secured trash receptacles located throughout the facility
- Share your password to any computer system. Your password is your "key" and you will be held responsible for others that view information.
- Use your personal cell phone or camera to take pictures of patient's body parts, X-rays, or other PHI.

Be aware that:

- Audits are done regularly to see who accessed PHI in our systems. Every associate, physician, and VIP admitted to the hospital will have their account reviewed for inappropriate access.
- A new law (HITECH: 2009 – Health Information Technology for Economic and Clinical Health Act) empowers individual State Attorney General's to investigate and recover damages from **INDIVIDUALS** in federal court (anti-snooping measure). The new law mandates civil monetary penalties for certain violations and can include fines and jail time for the **INDIVIDUAL**.
- The new law also requires written notification to patients (as of 9/23/09) of inappropriate access of their unsecured PHI and notification to the Federal Government and local media if 500 or more patients are affected.
 - Exceptions from notifying the patient or Federal Government about breaches:
 - Breaches that were not intentional and did not disclose information outside of the facility. (Note – outside the facility includes HIPAA information found in the facility by a non-employee or individual covered by our HIPAA policy.)
 - If a stolen laptop is protected by encryption software *approved by the Federal Government*.

Physicians/AHPs and students are expected to follow facility policies concerning privacy and security. The HIPAA and HITECH regulations provide a range of penalties for non-compliance depending on the context of the violation and the offender's intent. For individuals who knowingly release information inappropriately, the penalties could include jail time, loss of licensure, and/or significant financial penalties.

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I have received and read the Medical Staff Compliance and HIPAA Program Overview and have had the opportunity to ask questions, request a copy of the Compliance Manual, and discuss the Compliance and HIPAA Programs with the Hospital Compliance Officer, Kyle Johnson, and Privacy Officer Emma B. Phillips.

I am aware that as a member of Davis Regional Medical Center's medical staff, I agree to report even suspected HIPAA issues to the Hospital Privacy Officer, Emma B. Phillips, and suspected misconduct to the Hospital Compliance Officer Kyle Johnson, or through one of the anonymous reporting mechanisms.

Unless otherwise noted below, I do not have knowledge of any illegal, unethical, or otherwise inappropriate conduct at Davis Regional Medical Center.

Physician Signature

Date

Print Physician Name