Corporate Compliance Program

Code of Conduct

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I. Welcome

Dear Pacesetters,

Welcome to Pacesetter Health ("PSH" or the "Company"). We are very excited to have you as a colleague as, together, we bring first-class lower extremity care services to patients across the country. At Pacesetter, we take compliance matters seriously, which is why we have assembled this guide to serve as an educational tool for you.

Please note that, while you may find this guide useful, it does not and cannot cover every circumstance that may be considered a compliance matter. If there is any question about whether there is a compliance violation by any employee, the Company, or management, do not let your question go unanswered. Immediately seek advice from your supervisor.

Alternatively, employees may file a concern using our Compliance Hotline or Compliance Email. Calls may be made anonymously, though callers should take note that a caller's participation in an investigation will help facilitate a more thorough investigation. The Hotline number is: **1-888-272-8003**. Employees may also flag a concern using the Pacesetter Compliance E-mail: **compliance@pacesetter-health.com**.

As a healthcare organization, it is imperative that we are following best practices as well as any and all applicable laws and regulations, so that we may provide the best care to our patients. Therefore, we strongly encourage you to take the time to familiarize yourself this guide.

Thank you for doing your part as a valued member of our organization.

II. Importance of Compliance

a) Why Corporate Compliance?

In 1991, the federal government enacted the Organizational Sentencing Guidelines (Chapter 8 of the Federal Sentencing Guidelines), with the goal of encouraging "good corporate citizenship". The Sentencing Guidelines make the penalties for corporate crime both uniform and predictable. Penalties under the guidelines include fines and imprisonment, as well as an integrity agreement or "corporate probation." In the case of a corporation which does not have an effective compliance program in place, an "integrity agreement" is mandatory. An integrity agreement or "probation" involves federal compulsory monitoring of the organization and adoption of a government-imposed compliance program, which can be far more expensive and intrusive than a voluntary compliance program.

Much like the name infers, the Guidelines have a base fine for each crime or violation which is then either increased or decreased based upon the presence of certain aggravating and/or mitigating factors. Each crime or violation is assigned a base fine. One such mitigating factor is the existence of an effective corporate compliance program. Under the Guidelines, an organization which has an effective corporate compliance program might avoid corporate "probation" and criminal prosecution, or at the very least receive a reduced fine. Effective corporate compliance programs have reduced settlements with the federal government by as much as 95%. The Federal Sentencing Guidelines incentivize corporate compliance programs for all types of corporate organizations and industry, not just healthcare.

According to its website, the Health and Human Services ("HHS") Office of the Inspector General ("OIG") ("HHS-OIG") is "the largest inspector general's office in the Federal Government, with more than 1,700 employees dedicated to combating fraud, waste, and abuse and to improving the efficiency of HHS programs. A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country's most vulnerable citizens." The OIG is responsible for policing healthcare provider compliance.

b) Costs of Healthcare Fraud

1) Monetary Costs to the Government and Recoveries in 2021

In July 2022, the Department of Justice (DOJ) published its Annual Report for Fiscal Year 2021. In 2021, the DOJ won or negotiated over $5.0 billion in health care fraud judgments or settlements. As a result of these efforts, as well as those of preceding years, in FY 2021, approximately $1.9 billion was returned to the Federal Government or paid to private persons. Of this $1.9 billion, the Medicare Trust Funds received transfers of approximately $1.2 billion during this period, and $98.7 million in Federal Medicaid money was similarly transferred separately to the Treasury as a result of these efforts. Since the inception of the program in 1997, over $31 billion has been returned by the Health Care Fraud and Abuse Control Program ("HCFAC") account to the Medicare Trust Funds.

2) Enforcement Actions

In FY 2021, the DOJ opened 831 new criminal health care fraud investigations. Federal prosecutors filed criminal charges in 462 cases involving 741 defendants. A total of 312 defendants were convicted of health care fraud related crimes during the year. Also, in FY 2021, DOJ opened 805 new civil health care fraud investigations and had 1,432 civil health care fraud matters pending at the end of the fiscal year. Federal Bureau of Investigation ("FBI") investigative efforts resulted in over 559 operational disruptions of criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 107 health care fraud criminal enterprises. In FY 2021, investigations conducted by HHS's Office of Inspector General resulted in 504 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid, and 669 civil actions, which include false claims and unjust-enrichment lawsuits filed in federal district court, and civil monetary penalty ("CMP") settlements. HHS-OIG also excluded 1,689 individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. Among these were exclusions based on criminal convictions for crimes related to Medicare and Medicaid or to other health care programs, for beneficiary abuse or neglect, and as a result of state health care licensure revocations.

3) Impact of 2021 Sequestration

Sequestration of mandatory funding generally results in DOJ, FBI, HHS, and HHS-OIG having fewer resources to fight fraud and abuse of Medicare, Medicaid, and other health care programs. Due to sequester suspension, no funds were sequestered from the HCFAC program in FY 2021. However, a combined total of $150.6 million in mandatory funds have been sequestered in the past nine years. Including funds sequestered from the FBI ($70.0 million in the past nine years), $220.6 million has been sequestered from mandatory HCFAC funds since FY 2013.

c) Government Partnerships for Fraud Recovery

The first Medicare Fraud Strike Force ("Strike Force") was launched in March 2007 as part of a South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse in South Florida. The Strike Force is comprised of interagency teams made up of investigators and prosecutors that focus on the worst offenders in regions with the highest known concentration of fraudulent activities. The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud hot spots—cities with high levels of billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another.

Based on the success of these efforts and increased appropriated funding for the HCFAC program from Congress and the Administration, DOJ and HHS expanded Strike Force operations to a total of twenty-four districts in the United States. Strike Force accomplishments from cases prosecuted in all nine cities during FY 2021 include: 281 indictments, informations, and complaints involving charges filed against 444 defendants who allegedly collectively billed the Medicare program approximately $1.7 billion; 288 guilty pleas negotiated, and 23 jury trials litigated, with guilty verdicts against 21 defendants; and imprisonment for 175 defendants sentenced during the fiscal year, averaging more than 49 months of incarceration. Since its inception, Strike Force prosecutors in Strike Force districts filed more than 2,400 cases charging more than 5,000 defendants who collectively billed federal health care programs and private insurers

approximately $24.7 billion, more than 3,300 defendants pled guilty and over 400 others were convicted in jury trials, and more than 400 defendants were sentenced to imprisonment for an average term of approximately 49 months. Medicare payment trends demonstrate the positive impact of Strike Force enforcement and prevention efforts.

d) Benefits

According to the OIG, providers stand to gain several benefits from the implementation of a compliance program:

- Demonstrates commitment to honest and responsible corporate conduct.
- Increases the likelihood of preventing unlawful and unethical behavior or identifying and correcting such behavior.
- Encourages employees and others to report potential problems which permits correction and avoids or reduces the risk of false claims.
- Minimizes financial loss.
- Enhances patient satisfaction and safety.
- Improves the practice reputation for integrity and quality.

e) Patient Protection and Affordable Care Act Public Law 111-148 ("PPACA")

The PPACA of 2010 establishes that any provider that chooses to enroll in or stay enrolled in the Medicare/Medicaid programs will have to establish a Corporate Compliance Program that meets certain "core elements" to be established by the Secretary, in consultation with the Inspector General of the Department of Health and Human Services. The regulations for Compliance and Ethics Programs can be found at 42 CFR 483.85.

III. Government Tools to Handle Fraud and Abuse

a) Civil False Claims Act (31 U.S.C § 3729)

The False Claims Act ("FCA") prohibits submitting claims to the federal government when the submitter knows or should know that the claim is false. Specifically, the FCA prohibits:

- Knowingly presenting, or causing to be presented, a false claim for payment or approval;
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- Having possession, custody, or control of property or money used or to be used by the government and knowingly delivering or causing to be delivered less than all of that money or property;
- Certifying receipt of property used or to be used by the government on a document without completely knowing that the information is true;
- Knowingly buying government property from an unauthorized officer of the government;
- Knowingly making, using, or causing to be made or used a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government; and
- Conspiring to do any of the above.

1) Intent

To violate the False Claims Act, a person must submit a claim with "knowledge" that it is false. In this context, "knowingly" means that a person (1) has actual knowledge of the information, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. In essence, the person must have known or should have known that the information was false in order to be held liable under the FCA. Specific intent to defraud is not required.

2) Penalties under the False Claims Act

Civil monetary penalties of $5,500 - $11,000 per claim plus three times the amount of damages which the government sustains because of the act of that person. Penalties may also include possible exclusion from federal health care programs, which means that federal health care programs will not pay for items or services rendered by an excluded entity or individual.

3) Similar State False Claims Act Laws

Illinois has a similar law to the False Claims Act.[1] Indiana,[2] Kansas,[3] Michigan,[4] and Missouri[5] also have state false claims act laws that apply to commercial insurers (e.g. Blue Cross Blue Shield, Humana, Cigna, etc.) in addition to government insurers.

b) Civil/Qui-Tam Actions (Whistleblower Lawsuits) under the False Claims Act

"Qui tam" is an abbreviation of the Latin phrase "qui tam pro domino rege quam pro se ipso" which means "[he who] sues on behalf of himself as well as the king." Therefore, the qui tam provision in the False Claims Act allows a private citizen ("relator") to file a False Claims Act suit on behalf of himself and the government. This type of lawsuit is often referred to as a "whistleblower claim." A qui tam action is initiated when the relator files a civil complaint in federal court. All qui tam lawsuits are filed "under seal," meaning that they are confidential and only the government knows about the case. After a complaint is filed, the government has 60 days to investigate the claim and decide whether it would like to join the relator, or "intervene", in the lawsuit.

If the government decides to intervene, it will have the primary responsibility for prosecuting the case. If the government decides not to intervene, the relator may pursue the case on his own. If the case is settled or the court decides the case in favor of the government/relator, the relator may receive 15-30% of the settlement or the proceeds of the action, depending on whether the government intervened and how much the relator helped with the case.

The False Claims Act prohibits retaliation against relators. Retaliation is defined as discharging, demoting, suspending, threatening, harassing, or discriminating against a relator in any other manner because of lawful actions by an employee, contractor, or agent in furtherance of pursuing a qui tam lawsuit or attempting to stop a violation of the False Claims Act. Victims of retaliation are entitled to reinstatement with the same seniority status that the individual would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages incurred as a result of the discrimination, including litigation costs and reasonable attorneys' fees. A civil action for retaliation must be brought within three years after the date the retaliation occurred.

Indiana (Ind. Code § 5-11-5.5-8), Kansas (Kan. Stat. Ann. § 75-7506), Michigan (Mich. Comp. Laws Ann. § 400.610c), and Missouri (Missouri Rev. Stat. § 191.908) all have whistleblower protections similar to the FCA's. Illinois (Illinois 740 ILCS 174/15), Michigan (Mich. Comp. Laws § 15.361 et seq.), and Missouri (Mo. Ann. Stat. § 285.515) have general whistleblower protection laws. Additionally, Missouri has a law prohibiting retaliation against employees of nursing homes (Mo. Ann. Stat. 198.301).

[1] 740 ILCS 175/3; 305 ILCS 5/8A-15.
[2] Ind. Code § 5-11-5.5-1 *et seq*.; Ind. Code § 35-43-5-7.1 to § 35-43-5-7.2; Ind. Code § 35-43-5-4.5.
[3] Kan. Stat. Ann. § 75-7501 *et seq.*; Kan. Stat. Ann. § 21-5927; Kan. Stat. Ann. § 40-2,118.
[4] Mich. Comp. Laws Ann. § 400.601 *et seq*.; Mich. Comp. Laws Ann. § 752.1001 *et seq*.
[5] Mo. Ann. Stat. § 191.900 *et seq*.; Mo. Ann. Stat. § 375.991; Mo. Code of Regs. Ann. tit. 13, § 70-3.030(3)(A).

c) ***The Physician Self-Referral Law ("Stark Law") (42 U.S.C. § 1395nn)***

The Stark Law prohibits a physician from referring patients for designated health services payable by Medicare or Medicaid to entities with which the physician or an immediate family member has a financial relationship unless an exception applies.

Designated health services are:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Radiology and certain other imaging services;
- Radiation therapy services and supplies;
- DME and supplies;
- Pareneteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

A financial relationship may be:

- An ownership interest;
- A compensation arrangement (e.g., a consulting agreement, speaker engagement, etc.); or
- Other things of value (e.g., cash, gifts, entertainment, free or below-cost products or services, free or below-cost space rentals, etc.).

1) Intent

The Stark Law is a strict liability statute, which means that proof of specific intent to violate the law is not required.

2) Penalties

If the referral does not fall under any of the statutory exceptions, then a health care provider is subject to the following penalties: Civil monetary penalties of up to $15,000 for each service furnished in violation of the Act. Civil monetary penalties of up to $100,000 if the physician or entity entered into an arrangement or scheme which the parties should know has the primary purpose of assuring a physician's referrals to the entity (and such referrals, if directly made to the entity, would violate Stark). Penalties may also include denial of federal health care program payments for services and/or exclusion from federal health care programs.

3) Similar State Laws (often called "mini-Stark laws")

Illinois's mini-Stark law (225 ILCS 47/1 et seq.), unlike the federal Stark law, applies to referrals for all services and all payors, not just to government payors and Department of Human Services. Indiana does not have a mini-Stark law. Kansas's mini-Stark law (Kan. Stat. Ann. § 65-2837(b)(29)) only prohibits referrals to a health care entity in which the physician has a significant investment interest if the physician did not first disclose the interest to the patient in writing. Michigan's mini-Stark law (Mich. Comp. Laws Ann. § 333.16221(e)(iv)) contains two provisions: (1) one that incorporates the federal Stark law and (2) one that prohibits non-physician licensees from requiring that an individual purchase a drug, device, treatment, procedure, or service from a person or entity in which the non-physician licensee has a financial interest. Missouri's mini-Stark law is narrow (Mo. Ann. Stat. § 334.2) and only prohibits physician referrals for physical therapy to an entity in which the physician, his employer, or an immediate family member has a financial relationship.

d) Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

The Anti-Kickback Statute ("AKS") is a criminal law that prohibits knowingly and willfully soliciting or receiving any remuneration (which means anything of value, like cash, gifts, meals, entertainment, certain kinds of discounts, equipment, and office space, etc.) in exchange for:

- Referring an individual to a person or entity for furnishing or arranging for the furnishing of any item or service partially or entirely paid for by a Federal health care program, or
- Purchasing, leasing, ordering, or arranging (or recommending the same) any good, facility, service, or item partially or entirely paid for by a Federal health care program.

Unlike the Stark Law, which applies only to physicians and their immediate families, the AKS applies to everyone. Similar to Stark Law's exceptions, the AKS does permit some kinds of remuneration between parties that might otherwise be prohibited if the remuneration meets certain conditions (known as a "safe harbor").

1) Intent

According to the Statute, an individual must "knowingly and willfully" engage in the prohibited conduct. The United States Court of Appeals for the Seventh Circuit (which includes Illinois and Indiana) uses the "one purpose" test to determine whether someone has made payments in violation of the AKS. This test states that the AKS has been violated if at least one purpose of the payment was to induce future referrals. Other circuits have adopted the "primary purpose" test, which states that the AKS has been violated if the primary purpose of the transaction was to induce future referrals. Actual knowledge or specific intent to commit a violation of the AKS is not required.

2) Penalties

Civil monetary penalties of up to $25,000. Penalties may also include imprisonment of up to five (5) years and/or exclusion from federal health care programs.

3) Similar State Laws

Illinois (305 ILCS 5/8A-3 and 5/8A-16(b)(5)), Indiana (Indi. Code § 12-15-24-2), Kansas (Kan. Stat. Ann. § 21-5928), Michigan (Mich. Comp. Laws. Ann. § 400.604), and Missouri (Mo. Code of Regs. Ann. tit. 13, § 70-3.030(3)(A)(27) and Mo. Ann. Stat. § 191.905(2)-(3)) all have laws similar to the AKS prohibiting kickbacks. Only Illinois (740 ILCS 92/1 et seq.) and Michigan (Mich. Comp. Laws Ann. § 752.1004) have mini-AKS laws that apply to commercial insurers. Michigan (Mich. Comp. Laws Ann. § 333.16221(d)(ii)) is the only state which has a provision in its licensing statute prohibiting kickbacks. Finally, Missouri's Omnibus Nursing Home Act also contains a mini-AKS provision.

e) Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a)

The Social Security Act authorizes HHS to seek civil monetary penalties ("CMPs") and assessments (essentially, fines) for many types of conduct including violations of the FCA, Stark Law, AKS, and exclusion authorities. The penalties are high and amounts vary based on the type of violation ($20,000-$100,000 per violation). In addition to the penalties, a violator will be required to pay up to three times the amount of improper claims or remuneration.

f) Criminal Health Care Fraud Statute (18 U.S.C. §§ 1347, 1349)

These statutes prohibit knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, money or property owned or controlled by any health care benefit program.

1) Penalties

Fines and/or imprisonment of a term not more than 10 years unless the violation results in serious bodily injury (not more than 20 years) or death (any term of years or for life).

IV. Standards of Conduct

PSH personnel shall comply with the following:

a) ***Ethical and professional standards.*** PSH personnel shall comply with and perform their services consistent with high ethical and professional standards. They shall treat patients, co-workers, and others in a professional manner with honesty, fairness, dignity, and respect.

b) ***PSH policies and procedures.*** PSH personnel shall comply with all applicable PRACTICE policies and procedures, including but not limited to those policies and procedures relevant to the Compliance Program.

c) ***Laws, regulations, and program requirements.*** PSH personnel shall comply with all applicable federal and state laws, regulations, and third-party payor program requirements.

d) ***Non-discrimination.*** PSH personnel shall not discriminate against other PSH personnel, patients, or others on the basis of race, color, sex, religion, age, national origin, ancestry, disability, or sexual orientation.

e) ***Offering or receiving items of value to induce referrals.*** Federal and state laws prohibit paying, offering, or receiving anything of value to induce referrals for healthcare business unless certain conditions are met. PSH personnel shall not offer, solicit, pay, or accept anything of value in exchange for healthcare referrals without first obtaining approval from the Compliance Officer. This applies to offering or receiving any money, gifts, free or discounted items or services, professional courtesies, or other arrangements with the intent to induce referrals. This applies to any such transactions involving potential referral sources, including transactions with other health care providers, vendors, or patients. Violations may subject PSH and its personnel to criminal and administrative penalties.

f) ***Financial relationships with physicians and other referral sources.*** Federal and state laws affect contracts, agreements, and other financial relationships with physicians, practitioners, vendors, and other referral sources.

   1) PSH personnel shall not enter any contract or other financial arrangement with or give or receive anything of value to or from, an outside physician, a physician's family member, or other referral source without the prior approval of the Compliance Officer.

   2) If PSH has a contract or other financial relationship with an outside physician or a member of the physician's family, PSH personnel shall not bill Medicare for any items or services referred by that physician without the prior approval of the Compliance Officer.

   3) PSH personnel must strictly comply with the terms of any approved contract or other financial arrangement with outside physicians, their family members, or referral sources. Failure to perform or improper modifications of such contracts or arrangements may violate applicable laws.

g) ***Improper inducements to Medicare or Medicaid beneficiaries.*** Inducements to Medicare, Medicaid, or other government beneficiaries may violate applicable law. PSH personnel shall not waive or discount government beneficiary co-pays unless such discount complies with PSH's charity care policy. PSH personnel shall not offer any other discount, gift, free items or service, or other inducements to government beneficiaries without first obtaining approval from the Compliance Officer.

h) ***Professional courtesies.*** PSH personnel shall not offer or receive any free or discounted items or services to or from other health care providers, their family members, or their office staff unless such offer is consistent with PSH's Professional Courtesy Policy, or the offer has been approved by the Compliance Officer.

i) ***Improper billing activities.*** PSH personnel shall not engage in false, fraudulent, improper, or questionable billing practices. Such improper activities include, but are not limited to:

j) ***Billing for items or services that were not actually rendered.***

1) Billing for or rendering items or services that were not medically necessary.

2) Submitting a claim for physician services when the services were actually rendered by a non-physician, or where a physician failed to provide the level of supervision required by applicable laws or regulations.

3) Submitting a claim for payment without adequate documentation to support the claim.

4) Signing a form for a physician without the physician's authorization.

5) Improperly altering medical records.

6) Prescribing medications and procedures without proper authorization.

7) Using a billing code that provides a higher payment rate than the correct billing code (i.e., "upcoding").

8) Submitting bills in fragmented fashion to maximize reimbursement even though third-party payors require the procedures to be billed together (i.e., "unbundling").

9) Submitting more than one claim for the same service (i.e., "duplicate billing").

10) If PSH personnel have a question about the proper standard or procedure for documenting or submitting a claim, they should contact the Compliance Officer as described below.

k) ***Unfair competition and deceptive trade practices.*** Federal and state antitrust laws prevent certain anti-competitive conduct, including collusive agreements among competitors to set prices;

divide patient care or services; boycott other entities; etc. PSH personnel should not engage in collusive discussions with competitors over such things as prices, employee wages, services to be rendered or eliminated, or division of patients or patient services without the Compliance Officer's prior approval. Similarly, PSH personnel should not discuss exclusive arrangements with third-party payors, vendors, and providers without first discussing the matter with the Compliance Officer. Finally, PSH personnel should not engage in any deceptive acts or practices relating to PSH.

l) ***Privacy and confidentiality.*** PSH personnel shall maintain the confidentiality of patients' protected health information as required by PSH's privacy policies and applicable law, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA") and its accompanying regulations, 45 C.F.R. part 164. PSH personnel should not access patient information unless they have a need to access the information because of their job duties. To the extent feasible and allowed by law, PSH personnel shall maintain the confidentiality of communications and records containing confidential information concerning co-workers; communications and records relating to PSH's confidential financial or business operations, trade secrets, credentialing, or peer review actions; documents prepared in anticipation of litigation; and communications with legal counsel for PSH. This section shall not be construed to prohibit activity protected by the National Labor Relations Act.

m) ***Entities that contract with PSH.*** PSH personnel shall ensure that vendors and other entities which contract with PSH comply with the Compliance Program and cooperate with PSH's compliance efforts. If a contract or arrangement with an outside entity implicates any of the compliance concerns discussed above, PSH personnel should refer the contract or matter to the Compliance Officer for review. Nothing in this policy or Compliance Program shall be construed as an undertaking by PSH to inspect, assume liability for or guarantee the performance of work or activities by independent contractors or other agents.

n) ***Report suspected violations.*** PSH may have an obligation to promptly repay money it improperly receives from third party payors within 60 days. It is essential that PSH personnel:

1) Comply with applicable laws, regulations, and policies; and

2) Immediately report suspected violations or compliance concerns to their supervisor, department leader, or the Compliance Officer.

o) ***Non-retaliation.*** PSH personnel shall not retaliate against any person for reporting a suspected violation of any law, regulation, program requirement, or PSH policy relevant to the Compliance Program.

V. Compliance Officer Responsibilities

a) In addition to any other actions that may be necessary to fulfill the purpose of this Compliance Program, the Compliance Officer shall:

1) Oversee, monitor, and coordinate the implementation and maintenance of an effective Compliance Program.

2) Serve as the Chairperson of the Compliance Committee.

3) Report directly to the CEO and the Compliance Committee concerning compliance activities.

4) Periodically revise the Compliance Program as necessary to meet the needs of PSH and comply with relevant laws, regulations, and third-party payor program requirements.

5) In cooperation and coordination with Human Resources, develop and direct programs that educate and train PSH personnel concerning the Compliance Program and the requirements of relevant laws, regulations, and program requirements.

6) Ensure that contracts, financial arrangements, marketing initiatives, or other transactions that may implicate fraud and abuse laws and regulations are reviewed for compliance.

7) Take reasonable steps to ensure that independent contractors and agents who furnish health care services or related services are aware of and/or act consistently with applicable laws, regulations, and policies, including the Compliance Plan. In the event that the Compliance Officer becomes aware of a violation of applicable laws, regulations or policies by independent contractors or agents, the Compliance Officer shall take appropriate steps to address the situation, including, where appropriate, modifying or terminating the relationship. Nothing in this policy or Compliance Program shall be construed as an undertaking to inspect, assume liability for or guarantee the performance of work or activities by independent contractors or other agents.

8) Coordinate with Human Resources or other appropriate PSH personnel to ensure that PSH does not employ, contract with, grant privileges to, or bill for services rendered by entities excluded from government health programs. The National Practitioner Data Bank and Cumulative Sanction Report must be queried:

1) Before offering employment, granting, or renewing privileges, or contracting or renewing a contract with any person or entity providing health care services.

2) At least biannually thereafter for each such entity.

9) Coordinate with Human Resources or other appropriate PSH personnel to ensure that appropriate background checks are performed so that PSH does not employ persons who have

been recently convicted of a felony or a criminal offense related to health care or health care fraud and abuse.

10) Work with PSH managers and the Compliance Committee to establish appropriate internal compliance reviews and evaluation procedures for relevant departments. Among other things, the reviews may, but are not necessarily required to, address items such as:

11) Develop policies and procedures that encourage and allow PSH personnel to report suspected compliance violations and other improprieties without fear of retaliation. Where possible, provide a method for anonymous reporting.

12) Take appropriate action on matters that raise compliance concerns, including but not limited to reports or complaints of suspected violations. The Compliance Officer shall have flexibility to design and coordinate internal investigations and any resulting corrective action with relevant PSH departments, providers, agents and, if appropriate, independent contractors.

13) In coordination with Human Resources or the appropriate manager and upon the approval of the Administrator, promptly initiate appropriate disciplinary or corrective action against any PSH personnel for violations of the Compliance Program as the circumstances warrant. The Compliance Officer shall review applicable bylaws, policies, procedures, and contracts to ensure that the action taken is consistent with applicable standards and processes, if any.

14) If any systemic errors have resulted that would violate the Compliance Program or applicable laws and regulations, recommend appropriate corrective action to the CEO.

15) Establish and maintain a record of every complaint received involving a potential violation of any law or regulation related to health care fraud and abuse.

16) Maintain records of substantive contact with any government agency relevant to the Compliance Program, including but not limited to decisions, guidance, or advisory opinions concerning PSH compliance.

17) Maintain the confidentiality of any compliance issues brought before the Compliance Officer consistent with applicable PSH policies, laws, and regulations.

b) Except as prohibited by applicable laws or regulations, the Compliance Officer shall have authority to review all documents and other information relevant to compliance activities, including but not limited to patient records; billing records; marketing records; and agreements with other parties such as employees, staff professionals, independent contractors, suppliers, agents, PRACTICE-based physicians, etc.

c) Government regulators recognize that assertions of fraud and abuse raise numerous complex legal and management issues that should be examined on a case-by-case basis and, therefore, the

Compliance Officer should work closely with legal counsel, who can provide guidance regarding such issues. See 63 F.R. 8995 (2/23/98).

VI. Compliance Committee Responsibilities

a) The purpose of the Corporate Compliance Committee is to advise the Corporate Compliance Officer and to assist in the implementation of the compliance program. The Corporate Compliance Committee benefits from having members with various backgrounds that they bring to the table such as operations, finance, audit, human resources, and clinical management (e.g., the medical director), as well as employees and managers of key operating units. The Compliance Officer must be an integral part of the Committee. The Company shall designate a Corporate Compliance Committee to advise the Corporate Compliance Officer and to assist in the implementation of the compliance program.

VII. Discipline and Enforcement

a) All officers, employees, contractors, or other personnel involved in PSH activities must fully understand this Compliance Program and agree to follow the Standards of Conduct, as well as all relevant laws and regulations.

b) Violation of the Compliance Program, as well as any relevant laws and regulations (whether outlined in this document or not), may result in disciplinary, legal, or regulatory action.

c) This Compliance Program shall go into effect immediately.