

**UNIVERSITY OF CALIFORNIA
HEALTH SCIENCES CLINICAL ENTERPRISE
CORPORATE COMPLIANCE PROGRAM**

August 7, 2000

BACKGROUND

The University of California (University) is committed to providing quality health care services, health professional training, and biomedical and behavioral research in compliance with all laws and regulations. Over the years, the University's health sciences clinical enterprise has implemented a number of policies and procedures to provide guidance regarding federal and state laws. However, only in very recent years has the federal government required hospitals and academic medical centers to implement compliance programs in order to reduce fraud and abuse in today's complex and highly regulated health care environment.

In 1998 the Department of Health and Human Services and the Office of the Inspector General issued the *Compliance Program Guidelines for Hospitals* and strongly encouraged all corporations in the health care industry to implement effective corporate compliance programs that would include the following elements: a code of conduct; clearly defined oversight responsibilities; employee training; monitoring and auditing; enforcement and discipline; and procedures to respond to and prevent further offenses once a violation has been detected.

In order to provide incentives for institutions to implement effective compliance programs, the *Compliance Program Guidelines for Hospitals* also instruct federal district judges to consider whether a medical center has an effective compliance program when imposing sentences for criminal violations in the event of a federal investigation or audit.

The University has always taken seriously its commitment to complying with all laws and regulations governing the provision of health care. With its increased oversight of Medicare and Medicaid providers, the federal government has now made it very clear that all University employees are expected to take responsibility for appropriate ethical and legal behavior in the work place. The penalties for wrong doing are considerable.

MEDICARE CONDITIONS OF PARTICIPATION REGARDING PATIENTS RIGHTS

On August 2, 1999 the Health Care Financing Administration finalized regulations introducing a new Patients' Rights section to the Conditions of Participation. The rule sets forth six standards intended to protect each patient's physical and emotional health and safety:

1. The right of each patient to be notified of his/her rights, in advance of furnishing or discontinuing care;
2. The right to participate in the development and implementation of his/her plan of care;
3. The right to personal privacy, to receive care in a safe setting, and to be free from all forms of abuse or harassment;
4. The right to confidentiality of clinical records and to access information contained in the records;
5. The right to be free from restraints used in the provision of acute medical and surgical care unless clinically necessary; and
6. The right to be free from seclusion or restraints used in behavior management, unless clinically necessary.

PURPOSE OF THE UNIVERSITY'S CLINICAL ENTERPRISE CORPORATE COMPLIANCE PROGRAM

The University's Health Sciences Clinical Enterprise Corporate Compliance Program (University's Program) seeks to:

1. Maintain and enhance quality of care;
2. Demonstrate sincere, ongoing efforts to comply with all applicable laws;
3. Revise and clarify current policies and procedures in order to enhance compliance;
4. Enhance communications with governmental entities with respect to compliance activities;
5. Empower all responsible parties to prevent, detect, respond to, report and resolve conduct that does not conform to applicable laws, regulations, and the University's Code of Conduct; and
6. Establish mechanisms for employees to raise questions and concerns about compliance issues and ensure those concerns are appropriately addressed.

A copy of the full description of the University's Program, including the University's Professional Fee Billing Guidelines, Laboratory Compliance Program, and campus Program, is available in the campus Corporate Compliance Office, the Office of the General Counsel and the Office of Clinical Services Development in the University Office of the President.

SCOPE AND RESPONSIBLE PARTIES:

The University's Program applies to all University Personnel, including administrators, directors, managers, faculty physicians, graduate health professions students, and other health care professionals and staff in the University's health sciences programs. The University expects that all outside entities doing business with the clinical enterprise are operating under an appropriate compliance program and are aware that University personnel are expected to comply with the University's Program.

University Personnel

University personnel covered by this program include all administrators, faculty, staff, and graduate health professions students at University health sciences campuses, their medical centers and clinics and respective health sciences schools who are responsible for:

1. the direct provision of patient clinical care services or
2. the provision of staff, business, administrative, or patient care support services.

University Health Sciences Campuses

The University health sciences campuses responsible for implementing the Program include: University of California/Berkeley (School of Optometry); University of California/Davis (School of Medicine); University of California/Irvine (School of Medicine); University of California/Los Angeles (Schools of Dentistry, Medicine, Nursing); University of California/San Diego (School of Medicine); University of California/San Francisco (Schools of Medicine, Nursing, Pharmacy, Dentistry); and other University campuses with health professions programs in the areas of medicine, nursing, dentistry, pharmacy, and optometry.

University Leadership at the Office of the President and Individual Campuses

University leadership with overall delegated responsibility and authority for ensuring that all members of the health sciences clinical enterprise carry out their individual and corporate responsibilities include: the President of the University of California, designated vice presidents within the Office of the President, and chancellors and vice chancellors on campuses with health sciences. Within the Office of the President, the Vice President for Clinical Services Development, in consultation with the Office of the General Counsel, the University Auditor, the Vice President for Financial Management, the Senior Vice President—Business and Finance, and the Vice President for Health Affairs, is responsible for coordinating all compliance activities. At each health sciences campus, the Chancellor has overall responsibility for compliance activities.

The corporate compliance officer and corporate compliance committee shall be appointed at each campus by the Chancellor according to procedures established at each campus in consultation with appropriate Academic Senate Committees.

The executive management team at each campus, which may include the health sciences school deans, medical center CEO, COO, and CFO, the Corporate or Chief Compliance Officer (CO), Senior Medical Director, and will include representatives selected by the faculty and staff, is responsible for:

1. ensuring that procedures are maintained, reviewed, and updated;
2. providing compliance education;
3. responding to employee's questions and concerns;
4. acting on recommendations from staff and management,
5. providing for controls to prevent and reduce errors and identify wrongdoing;
6. working with campus academic and administrative leadership to implement remedial actions and take appropriate corrective and disciplinary actions; and

7. causing reports of possible compliance wrongdoing by administration, faculty or staff to be investigated in accordance with University policy.

Affiliated Individuals and Entities

In the case of entities doing business at either University-owned or leased facilities, the leadership at each campus responsible for negotiating and managing affiliation agreements and provider contracts must inform those entities and individuals about the University's Program.

When University personnel work in an affiliated institution or other institutions where the University has a contract, University personnel should continue to follow the University's Program. In addition, if the affiliated institution has a compliance program and University personnel have received a copy of the compliance program, University personnel should also adhere to the respective affiliate's compliance program. University affiliation agreements should contain language which informs affiliated entities and individuals about the University's Program and the University's expectation that all parties to an affiliation agreement will comply with applicable ethical and legal standards.

Vendors Providing Goods or Services to the University

In the case of an outside entity doing business with the University through a contractual agreement, University personnel who negotiate and/or manage the contract shall inform the vendor of the University's Program.

UNIVERSITY OF CALIFORNIA HEALTH SCIENCES CLINICAL ENTERPRISE CORPORATE COMPLIANCE CODE OF CONDUCT (THE CODE)

The University of California has developed the Code of Conduct (the Code) to provide guidance to University personnel in carrying out their daily activities. The Code provides standards that address issues identified by the federal government as potential areas of risk in both the *Compliance Program Guidelines for Hospitals* and corporate integrity agreements negotiated by the federal government and audited medical centers. By their nature these topics are very complex and are also a high priority for compliance oversight. The University encourages all personnel to seek advice from a supervisor, the campus Compliance Officer (CO), or other campus and Office of the President resources if questions arise regarding the Code or specific standards.

CODE OF CONDUCT PRINCIPLES

The following principles are the foundation for the Code:

1. University personnel shall treat patients without discrimination and with respect, dignity and professionalism without regard to race, age, gender, religion, national origin, medical condition, physical or mental disability, ancestry, marital status, sexual orientation, citizenship, ability to speak English or status as a covered veteran.

2. University personnel shall adhere to all applicable standards of professional practice and ethical behavior in carrying out the business of the clinical enterprise and should not feel forced to take part in unethical, improper or illegal conduct.
3. University personnel are encouraged to report their concerns if they believe that patient care is at risk or the ethical and business standards defined in the Code have not been met. University policy prohibits retaliation against University personnel who report suspected non-compliance or raise concerns about compliance issues.
4. University personnel shall follow campus policy in communicating questions, concerns or reporting suspected violations of the University's Program or the Code. The individual may seek advice in a number of ways, including: notification of a supervisor; the CO; the University General Counsel/campus general counsel; or by contacting the compliance office hotline. See section "Opportunity to Raise Questions and Concerns" for more specific information.
5. University personnel shall immediately communicate questions and concerns to a supervisor if federal regulations, or if a federal or state healthcare insurance carrier's instructions are not clear. The University, federal and/or state government carriers, and other payers should, when necessary, work collaboratively to clarify and revise policies, procedures, and instructions in order to prevent errors or mistakes.
6. Since unintentional errors can occur in the normal course of doing business, it is the responsibility of both the University, as a health care provider, and the federal government's contracted carrier, to report in a timely manner any errors and to adjust reimbursements accordingly for those errors.

CODE OF CONDUCT STANDARD 1: QUALITY OF CARE

The University's academic health centers and health systems will provide quality health care in a manner that is appropriate, medically necessary, and efficient.

1. All patients will be afforded quality clinical services.
2. Urgent and/or medically necessary services will be provided independent of payment methodology. The University's health care professionals will follow current medical and ethical standards regarding physicians and other health care providers' communication with patients, and where appropriate, their representative, regarding the care delivered.
3. The University recognizes the right of patients to make choices about their own care, including the right to do without recommended care or to refuse treatment.
4. University personnel, generally the patient's health care provider or knowledgeable designee, will inform patients about the alternatives and risks associated with the care they are seeking and obtain the informed consent of the patient or their representative. To the extent possible, this will be provided in a language that the patient can understand.

CODE OF CONDUCT STANDARD 2: MEDICAL NECESSITY

The University's academic health centers and health systems shall submit claims for payment to governmental, private, or individual payers for those services or items that are medically necessary and appropriate.

1. When ordering or providing services or items, University physicians (or other health care professionals authorized by law to order items or services) shall only order those services and items that are consistent with generally accepted medical standards for diagnosis or treatment of disease and are determined by the profession to be medically necessary and appropriate.
2. In some cases, a health care professional may determine that services are medically necessary or appropriate, but the patient's health plan may not cover those services. In those cases, a patient should refer to his or her health plan administrator to receive information about the process for disallowed claims or uncovered benefits.
3. Patients may request services that are not covered benefits. Such services may be provided as long as the patient has been given advance notice and has agreed to pay for the services. In these cases, the patient may request the submission of a claim for the services to protect his or her appeal rights with respect to those services or to determine the extent of the coverage provided by the payer.
4. Professional coding and documentation will be consistent with the standards established in the University and Campus Programs and relevant policies.

CODE OF CONDUCT STANDARD 3: CODING, BILLING, AND PATIENT ACCOUNTING

University personnel involved in the coding, billing, documentation and accounting for patient care services for the purpose of billing governmental, private or individual payers must comply with all applicable state and federal regulations and campus policies and procedures pertaining to the implementation of the University's Program.

1. The University will bill only for services actually rendered and shall seek the amount to which the University is entitled. The University does not tolerate billing practices that misrepresent the services actually rendered.
2. Supporting medical documentation must be prepared for all services rendered. University personnel shall bill on the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
3. All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws, and contracts and campus policies and procedures. Federal and state regulations take precedence; campus policies and procedures must accurately reflect those regulations.
4. All patients shall be consistently and uniformly charged. Discounts will be appropriately reported and items and services consistently described so that comparability can be established among payers.
5. Government sponsored payers shall not be charged in excess of the provider's usual charges. Any questions regarding the interpretation of this standard should be directed to the campus CO or University Office of the General Counsel.
6. Billing and collections will be recorded in the appropriate accounts. Credit balances must be processed in a timely manner in accordance with applicable rules and regulations. When the cost report process identifies any credit balances, University personnel shall direct those issues to the academic health center or health system's accounting or risk management departments or other personnel responsible for patient accounts.
7. University personnel should be aware of the existence of system-wide and campus Professional Fee Billing Guidelines and Clinical and Laboratory Billing Guidelines. These Guidelines, available through the campus Compliance Office, provide for the policies and procedures to be followed when the University bills payers for professional fees and laboratory services. University personnel responsible for coding, billing and documentation should be knowledgeable about University policies and procedures, federal and state

regulations regarding those activities. The University shall provide these individuals with opportunities for training to allow them to accurately code, document, and bill according to federal and state regulations and the University's policies and procedures. Management at each academic health center campus should ensure that appropriate evaluation processes have been established to assess whether University personnel understand and carry out correct procedures.

8. Elective procedures that are not covered by governmental or private payer can be provided. However, before providing any elective services, the provider must inform the patient that these services may not be covered. The provider should obtain the patient's agreement to pay for the services if payers deny the claim. A patient has the right to have a claim submitted even if services are excluded from coverage.
9. An accurate and timely billing structure and medical records system is critical to ensure that University personnel can effectively implement and comply with required policies and procedures. Demonstrated lapses in the information and billing systems infrastructure should be remedied in a timely manner by the campus executive management team, other designated University personnel and billing entities.

CODE OF CONDUCT STANDARD 4: COST REPORTS

University personnel who are responsible for the preparation and submission of cost reports must ensure that all such reports submitted to governmental and private payers are properly prepared and documented according to all applicable federal and state laws.

1. In submitting and preparing cost reports, all costs will be properly classified, allocated to the correct cost centers, and supported by verifiable and auditable cost data.
2. It is the University's policy to correct any cost report preparation or submission errors and mistakes in a timely manner and, if necessary, clarify procedures and educate employees to prevent or minimize recurrence of those errors.

CODE OF CONDUCT STANDARD 5: PERSONAL AND CONFIDENTIAL INFORMATION

All efforts will be made to protect personal and confidential information concerning the academic health center and health system's patients and the respective health care practices of those entities.

1. University personnel shall not disclose confidential patient information unless at the patient's request and/or when authorized by law. Appropriate use of patient information for research purposes must be obtained from the Institutional Review Board.
2. Confidential patient information should only be discussed with or disclosed to appropriate University personnel on a limited, "need to know" basis and in response to a legal or authorized request.
3. Confidential patient information should not be discussed with or disclosed to non-University personnel unless requested by the patient. Non-University personnel include the family or business and social acquaintances of the patient or of University personnel, customers, suppliers, or others.
4. In general, patients can request and are entitled to receive copies or summaries of their records with the exception of minors, some mental health patients, and patients being treated for alcohol and drug abuse, who may be provided with copies of the records if it is appropriate as judged by their clinician.

5. Some information may be sought under the *California Public Records Act*, the *Information Practices Act*, or other statutes requiring the release of information. University personnel should review any such information request with a supervisor, CO, general counsel, or, where appropriate, campus general counsel.
6. University personnel who have any questions regarding patient confidentiality should refer to University policies for additional information and consult with appropriate medical records supervisors, risk management, University general or campus. University policies should be updated as necessary to reflect changes to federal and state law regarding medical records privacy, and protection of paper-based and electronic health care information.

CODE OF CONDUCT STANDARD 6: CREATION AND RETENTION OF PATIENT AND INSTITUTIONAL RECORDS

All patient and institutional records are the property of the University. University personnel responsible for the preparation and retention of records shall ensure that those records are accurately prepared and maintained in a manner and location as prescribed by law and University policy.

1. The complete and accurate preparation and maintenance of all records (medical, professional, Electronic, paper and institutional) by University physicians, clinicians, nurses, and others are important for providing quality care and conducting the business of the University's clinical enterprise. Accurate records are required in order for the University hospital or clinic to retain licensure and accreditation.
2. University personnel will not knowingly create records that contain any false, fraudulent, fictitious, deceptive or misleading information.
3. University personnel must not delete any entry from a record. Medical records can be amended and material added to ensure the accuracy of a record in accordance with medical center and medical staff policies and procedures. Whenever University personnel amend a record, they must indicate that the notation is an addition or correction and record the actual date that the additional entry has been made.
4. University personnel must not sign someone else's signature or initials on a record unless they have been authorized and clearly marked that they are signing on behalf of another (e.g. by initialing the signature).
5. University records shall be maintained according to accepted standards and principles of the particular profession and applicable University policies and procedures.
6. Unless authorized by University policy, University personnel shall not destroy or remove any University records from the University's premises.
7. The University's record retention and record destruction policies and procedures must be consistent with Federal and state requirements regarding the appropriate time periods for maintenance and location of records. The premature destruction of records could be misinterpreted as an effort to destroy evidence or hide information.

CODE OF CONDUCT STANDARD 7: GOVERNMENT INVESTIGATION POLICY

University personnel should cooperate with appropriately authorized governmental investigations and audits.

1. The University has developed detailed policy to advise University personnel on the procedures to be followed when representatives of the government arrive unannounced at the respective medical center or at the homes of present or former University personnel.

Generally, these representatives wish to either interview employees or obtain certain documents. The policy outlined in *Appendix B* establishes a procedure for an orderly response to the government's request to enable the medical center to protect its and its patients' interest while fully cooperating with the investigation.

2. When a representative from a federal or state agency contacts University personnel anywhere, such as at home or at the office, for information regarding the medical center or any medical center-affiliated health care entity, or any other entity with which the medical center does business, the individual should contact the hospital director immediately. If the hospital director is not immediately available, the individual should contact the Risk Management Department, the CO or the General Counsel or campus general counsel.
3. University personnel should ask to see the government representative's identification and business card, if the government representative is there in person. Otherwise University personnel should ask for the person's name and office, address and telephone number, identification number and then call the government representative's office to confirm his or her authority.

CODE OF CONDUCT STANDARD 8: PREVENTING IMPROPER REFERRALS OR KICKBACKS

University personnel must not accept or offer, for themselves or for the University, anything of value in exchange for referrals of business or the referral of patients.

1. Federal law generally prohibits anyone from offering anything of value to a Medicare, Medicaid or Tricare patient that is likely to influence that person's decision to select or receive care from a particular health care provider.
2. University personnel may not offer or receive any item or service of value as an inducement for the referral of business or patients to or from University providers or practitioners.
3. In addition to the prohibition regarding exchange of goods or money to induce referral, certain prohibitions exist with regard to receipt of gifts by University personnel.
4. University personnel should adhere to the University's policy as defined in the *Compendium of University of California Specialized Policies, Guidelines and Regulations Related to Conflict of Interest*, the *University's Gifts Policy*, as well as the *California Political Reform Act*.
5. Each campus shall establish procedures for the review of all pricing and discounting decisions to assure that appropriate factors have been considered and that the basis for such arrangements are documented.
6. The following types of business arrangements must be reviewed and approved by one or more of the campus executive management team to assure compliance with University policies and federal regulations. The executive management team may determine that certain business transactions must first be approved, in accordance with University policy, by the University's Board of Regents charged with taking action on such matters:
 - a. pursuing joint ventures, partnerships, corporations;
 - b. developing hospital financial arrangements with hospital-based physicians;
 - c. entering into an arrangement to lease or purchase equipment or supply items from a vendor; or
 - d. acquiring physician practices, hospitals, and other facilities, clinical and ancillary services, or any other entities.

CODE OF CONDUCT STANDARD 9: ADHERENCE TO ANTITRUST REGULATIONS

The University will comply with all applicable federal and state antitrust laws.

1. University personnel should not, for example, agree, or attempt to agree, with a competitor to artificially set prices or salaries; divide markets, restrict output, or block new competitors from the market; share pricing information with competitors that is not normally available to the public; deny staff privileges to physicians or allied practitioner, individually or as a group, when there is no academic programming decision to do so and when such decisions should be based on individual qualifications; or agree to or participate with competitors in a boycott of government programs, insurance companies, or particular drugs or products.

CODE OF CONDUCT STANDARD 10: AVOIDING CONFLICTS OF INTEREST

All University personnel shall conduct clinical enterprise and personal business in a manner that will avoid potential or actual conflicts of interest.

1. University personnel shall not use their official positions to influence a University decision in which they know, or have reason to know, that they have a financial interest.
2. University personnel should follow the *Compendium of University of California Specialized Policies, Guidelines, and Regulations Related to Conflict of Interest* and be knowledgeable about activities that may be an actual or potential conflict of interest. Examples of such activities may include, but are not limited to, the following:
 - a. giving to or receiving gifts, gratuities, loans, or other special treatment of value from third parties doing business with or wishing to do business with the University in a manner that is not in accordance with the University's *Gifts Policy* and the *California Political Reform Act*. Third parties may include, but are not limited to, customers, patients, vendors, suppliers, competitors, payers, carriers, and fiscal intermediaries;
 - b. using University facilities or resources for other than University activities;
 - c. using the University's name to promote or sell non-University products or personal services; and
 - d. contracting for goods or services with family members of University personnel directly involved in the purchasing decision.
3. University personnel should consult with a supervisor, executive management, the campus conflict of interest coordinator, University general counsel or, if available, campus counsel prior to engaging in any activity that could raise conflict of interest issues.

CODE OF CONDUCT STANDARD 11: PATIENT'S FREEDOM OF CHOICE

When referring patients to home health agencies, medical equipment suppliers or long term care and rehabilitation providers, University personnel should respect the patient's right to choose his or her own providers.

1. Some healthcare plans limit the patient's choice of provider, or pay less than the full cost of a provider. The patient may choose a provider outside the health plan, but probably will have to pay for non-covered care.

CODE OF CONDUCT STANDARD 12: EXTERNAL RELATIONS

University personnel shall adhere to fair business practices and accurately and honestly represent themselves and the University's services and products.

1. University personnel will be honest and truthful in all marketing and advertising practices pertaining to the business practices of the University's academic health centers and health systems.
2. Vendors who contract to provide goods and services to the University's academic health centers and health systems will be selected on the basis of quality, cost-effectiveness and appropriateness for the identified task or need, in accordance with University policy.

CODE OF CONDUCT STANDARD 13: FAIR TREATMENT OF EMPLOYEES

The University prohibits discrimination in any work related decision on the basis of race, color, national origin, religion, sex, physical or mental disability, ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran. The University is committed to providing equal employment opportunity and a work environment where each employee is treated with fairness, dignity, and respect.

1. The University will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities. If an individual requires accommodations or needs assistance, he/she should contact the campus Employee Assistance Program or human resources.
2. The University does not tolerate harassment or discrimination by anyone based on the diverse characteristics or cultural backgrounds of those who work for the University pursuant to the *University of California Nondiscrimination and Affirmative Action Policy Regarding Academic and Staff Employment*.
3. Any form of workplace violence or sexual harassment is strictly prohibited. University personnel should refer to campus specific policies dealing with workplace violence or sexual harassment.
4. For employees who observe or experience any form of discrimination, harassment or violence, the University provides a number of ways to report the incident, including, but not limited to the following: a supervisor, the CO, University general counsel, campus counsel when available, human resources, the campus Office of Equal Opportunity & Diversity, the campus Compliance hotline, and appropriate Academic Senate committee

CORNERSTONES OF AN EFFECTIVE COMPLIANCE PROGRAM

OPPORTUNITY TO RAISE QUESTIONS AND CONCERNS

The opportunity for University personnel to ask questions and raise concerns is a cornerstone of a successful corporate compliance program. The University supports open discussion of ethical and legal questions and concerns regarding compliance issues and will not tolerate retaliation against any individual who, in good faith, raises questions or reports suspected violations.

The current health care environment is very complex, with many complicated regulations that dictate how the University must conduct its health care business. The purpose of a compliance program is to establish standards and policies that clearly communicate appropriate ethical and

legal behavior. However, questions may arise. It is better for an individual to raise a question than to be concerned about the legality or ethics of his or her actions or those of a coworker. It is better to ask a question than to do something wrong.

When University personnel have a question regarding what should be the legal or ethical action, a number of options are available, including the following:

1. *Communicate with an immediate supervisor or manager*
The individual can discuss the issue with his or her supervisor, manager, or team leader because these individuals should be the most familiar with the particular job requirements and business practices. The supervisor should provide a timely response to the individual or work with him or her to seek alternative solutions.
2. *Talk with higher level management*
If an individual is not comfortable speaking with a direct supervisor or manager, he or she can contact a higher level manager in the department, the academic health center or campus.
3. *Contact the health sciences clinical enterprise corporate Compliance Officer (CO)*
At each campus, the Chancellor has designated the CO as the individual with lead responsibility for health science clinical enterprise compliance issues. The CO reports directly to executive leadership at the individual campus (see Section on Corporate Compliance Officer responsibilities). At any time, an individual can bring a question or concern to the CO or staff within the Compliance Office. This would include situations where the individual believes that he or she has not received an appropriate, timely or ethical response from a supervisor.
4. *Obtain help from other University resources.*
University personnel can contact management in other administrative or academic departments, or the Office of the President. There are many resources within the University that are available to help, including the campus corporate compliance office, human resources, the Division Academic Senate Chair at each campus, Office of Internal Audit, and University general counsel and, where appropriate, campus counsel.
5. *Call the Campus Compliance Hotline or Helpline*
Each campus has established at least one toll-free campus Hotline and/or Helpline for confidential use by University personnel. At any point, an individual can contact the Hotline/Helpline to raise questions, clarify issues or report suspected violations. Reports will be investigated or referred to appropriate personnel for resolution. University personnel who contact the Hotline/Helpline may choose to remain anonymous.

University personnel may want to maintain a personal record of any communications or questions raised.

REPORTING POTENTIAL ERRORS OR SUSPECTED VIOLATIONS

All University personnel are strongly encouraged to report issues, concerns or suspected violations related to the University's Program. The University's Business and Finance Bulletin G-29, *Procedures for Investigating Misuse of University Resources*, requires reporting and describes the responsibilities and procedures for reporting and investigating known or suspected misuse of University resources by University personnel.

Chancellors are responsible for implementing the provisions of G-29 by designating an official to be responsible for implementation of local procedures and for general oversight of investigation activities. University policy G-29 addresses procedures that University personnel should follow to report suspected misuse, including the following:

“instances of suspected misuse that come to the attention of University employees as part of the performance of their job responsibilities, for example, through the performance of routine control procedures or as a result of evidence disclosed during the course of an audit, shall be immediately reported to either the Chancellor’s designee in accordance with campus procedures or to the person appointed to receive whistleblower reports.”

The University’s *Policy and Procedures for Reporting Improper Governmental Activities and Protection Against Retaliation for Reporting Improper Activities* affirms that the University does not tolerate retaliation against University personnel who report suspected violations.

For additional information regarding the University’s G-29 policy or other University policies, University personnel can contact the local corporate Compliance Office or Internal Audit.

COORDINATION WITH ESTABLISHED POLICIES AND PROCEDURES FOR INVESTIGATIONS AND AUDITS UNDER CURRENT UNIVERSITY POLICY G-29

UC Business and Finance Bulletin G-29 describes the responsibilities and procedures for investigating known or suspected misuse of resources by University personnel, regardless of the type of position held (staff, management, faculty, student employee, or other). The CO for each academic health center will be responsible for establishing local policies and procedures that integrate the corporate compliance activities with the provisions of G-29 in collaboration with the Chancellor designee and the campus Corporate Compliance Committee to clearly define local procedures to include the following:

1. The Chancellor should designate a Compliance Officer for all matters relating to corporate compliance. The CO should serve as the corporate compliance liaison to all Internal Audit and Investigation Committees including appropriate Academic Senate committees, and be responsible for ensuring that there is adequate coordination and reporting among those entities responsible for investigations.
2. The CO, in collaboration with the Internal Audit and Investigation Committees, campus Corporate Compliance Committee, the Academic Senate, the general counsel and others, will:
 - a. develop specific procedures for internal reporting of suspected violations of the University's policy on corporate compliance;
 - b. define how investigations of reports of suspected violations are conducted and who is the responsible for conducting an investigation;
 - c. ensure that all procedures developed are consistent with the provisions of related University of California policies and procedures, including the *University Policy and Procedures for Reporting Improper Governmental Activities and Protection Against Retaliation for Reporting Improper Activities* and related local implementing procedures;
 - d. implement procedures to facilitate communications and enhance cooperation between the campus corporate compliance office, Office of Internal Audit, department chair, dean, the

- Academic Senate, Office of the Chancellor, and other applicable entities and individuals;
and
- e. ensure that Campus Compliance Handbooks clearly communicate to University personnel the manner in which instances of known or suspected misuse are to be reported.
 3. The CO shall maintain a complete and accurate record of each investigation including findings, conclusions, and recommendations for the period prescribed by federal regulations.
 4. In the case of possible criminal activity, the Office of the General Counsel or resident campus counsel and campus police shall be consulted to determine appropriate actions with regard to the investigation and legal proceedings.
 5. The CO will report findings, conclusions and recommendations regarding any and all investigations to the Corporate Compliance Committee. A summary of these findings and investigations will be provided to the Chancellor in the Campus Compliance Program Annual Report. Where required, reports will be made to external agencies having jurisdiction pursuant to Business and Finance Bulletin G-29. When it is determined that a crime probably has been committed, the results of investigative work shall be reported to the District Attorney or other appropriate law enforcement agencies.

INTERNAL CONTROLS, AUDITS, AND MONITORING

The University is committed to consistent application of the University's Program. Towards this end, internal controls, which include regular monitoring activities, are being implemented to assure compliance with the University's Program. In addition, internal audit will review selected aspects of the University's Program in conjunction with the execution of their Annual Audit Plan. External auditors/consultants will be utilized when necessary.

Each department shall implement internal controls, including monitoring activities, to ensure compliance with the University's Program. These controls should be designed and implemented in coordination with the campus controller and local internal auditors.

On an annual basis, each campus CO will provide to the Chancellor for review and approval a copy of the Campus Compliance Program Annual Report. Upon approval by the Chancellor the report will be submitted to the Office of the President. A copy of this report will also be provided to the appropriate deans of all health professions schools and the division Privilege and Tenure Committee for review.

REMEDIAL ACTIONS

Remedial actions are not disciplinary but are done to correct mistakes, and enhance compliance with the corporate compliance program, and state and federal regulations. In most cases, remedial actions are designed to improve the performance of University personnel. The exact nature of and need for remedial action will be identified by supervisors within departments in collaboration with the CO and will involve department chairs, deans and the Academic Senate as appropriate. Upon investigating what appears to be behavior requiring remedial actions, the CO, the executive management team at the campus or, where appropriate, the designated Vice Presidents or General Counsel in the Office of the President, will clarify policies, and will review, and revise if necessary, administrative procedures in order to prevent future errors. If

remedial action is deemed necessary, an affected individual will be notified, informed of the concerns regarding their performance, and made aware, if applicable, of the right to grieve.

Examples of behaviors that could require remedial actions might include the following:

1. failure of an individual to understand and carry out required procedures and policies;
2. inappropriate or improper implementation of the procedures and policies of the University's Program or campus specific corporate compliance policies and procedures;
3. ambiguous communications regarding job performance expectations; or
4. negligent behavior.

The campus CO is responsible for ensuring that remedial actions have been implemented in a timely manner. The CO may work with management or others responsible for the individual or operational area under review in order to reduce the likelihood of future errors. The CO will consult with the campus Corporate Compliance Committee during these actions.

In accordance with the provisions of the applicable personnel policies and collective bargaining agreements, remedial actions may include, among others, the following:

1. the individual or individuals will be required to take part in an education program focused on the problem area;
2. future billings may be handled in a designated manner, including a third party review of all bills and the temporary suspension or delay of some or all billing to allow for quality review prior to the distribution of bills to third parties;
3. the individual may be reassigned or there may be a change of duty until remediation has successfully corrected the errors; and
4. in the case of an over-payment to a provider, there may be an adjustment from the appropriate source in order to refund the payer or pay any fines and penalties.

INVESTIGATORY LEAVE

An employee may be placed on an investigatory leave, with or without notice, to permit the University to review or investigate actions that would warrant removing the employee from the work site.

CORRECTIVE OR DISCIPLINARY ACTIONS

In cases of intentional misconduct, repeated violations, or after documented remedial actions have failed to correct the problem, the University will initiate corrective or disciplinary actions where necessary. The initiation of corrective or disciplinary action by the University does not preclude or replace any criminal proceedings that may be taken by the district attorney.

Should the University initiate corrective or disciplinary action it must do so in accordance with the rules set forth in the *Faculty Code of Conduct*, the *Medical Staff Bylaws*, *Rules and Regulations*, as well as any other existing and applicable personnel policies, collective bargaining agreements, or University policies. The CO, a supervisor, human resources, labor relations, deans of health science schools, department chairs when appropriate, or University General Counsel can provide additional information regarding those types of activities and behavior that may be subject to corrective and disciplinary actions.

University personnel subject to corrective or disciplinary action have due process rights under applicable existing University personnel policy, *Academic Senate Bylaws* or collective bargaining agreements. These policies should be followed during any corrective or disciplinary process.

The disciplinary action imposed will depend on the nature, severity, and frequency of the violation, and may include one or more of the following:

1. verbal and/or written warnings, followed by a written reprimand;
2. the placement of the individual in a different position if the individual is determined to be qualified to perform the essential functions of a different position within the same job classification;
3. reduction of pay;
4. suspension;
5. termination of Medical Staff appointment (pending impact on faculty status), including physicians, nurse practitioners, physician assistants, etc.;
6. termination of employment; or
7. other disciplinary action felt to be appropriate for the specific misconduct.

COORDINATION OF CORRECTIVE AND DISCIPLINARY ACTIONS WITH EXISTING UNIVERSITY POLICY

The following lists existing policies and procedures that address misconduct by University personnel:

1. Academic Senate Faculty Members.

The University Policy on Faculty Conduct and the Administration of Discipline—APM 015-0 Policy and Academic Senate Privilege and Tenure Committee Bylaws 195 & 335.

Academic Senate Bylaw 335 provides for a due process review and or a hearing before the Divisional Committee on Privilege and Tenure in any disciplinary action brought against a faculty member. There may be additional division Academic Senate policies relating to disciplinary matters that must be consulted.

2. Non-Senate Faculty and Other Non-Senate Appointees

Existing policy for imposing corrective or disciplinary action on non-academic personnel varies by the applicable collective bargaining agreement if the individual is represented by an exclusive representative. If an individual is not represented by an exclusive representative, then the *Academic Personnel Manual* applies.

3. Staff and Management Personnel

Existing policy for imposing corrective or disciplinary action on non-academic personnel varies by the applicable collective bargaining agreement if the individual is represented by an exclusive representative. If an individual is not represented by an exclusive representative, then the Personnel Policies for Staff Members applies.

4 Graduate Health Professions Students

Existing policy for imposing corrective or disciplinary action on graduate health professions students, when within the scope of the University's Program as defined under "Scope and Responsible Parties," is by a collective bargaining agreement with a new exclusive representative.

EXCLUSION OF INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE, MEDICAID AND OTHER STATE HEALTH PROGRAMS

42 United States Code section 1320a-7 provides for mandatory and permissive exclusion of certain individuals and entities from participation in Medicare and state health care programs for conviction of offenses defined therein. Further, the civil monetary penalty law, 42 United States Code section 1320a-7a, excludes from coverage for any state or federal health care program any item or service that has been ordered or furnished by any individual or entity during a time when that individual or entity has been excluded from the program.

Specifically, the federal *Health Insurance Portability and Accountability Act of 1996* provides for the exclusion of certain individuals and entities from participation in Medicare, Medicaid and other government programs including, but not limited to, the following OIG Program Exclusion Authorities:

1. Mandatory Exclusion applies to any individual or entity that has been convicted of a criminal offense related to:
 - a. the delivery of any Medicare or Medicaid item or service;
 - b. neglect or abuse of patients;
 - c. health care fraud relating to the delivery of any item or service with respect to any program financed in whole or in part by any Federal, state or governmental agency; or
 - d. the unlawful manufacture, distribution, prescription or dispensing of a controlled substance (after August 21, 1996).

2. The Secretary may exclude any individual subject to the criteria of Permissive Exclusion, which applies to any individual or entity:
 - a. who has been convicted of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of any Medicare or Medicaid item or service;
 - b. who has been convicted of obstruction of an investigation;
 - c. who has been convicted of a misdemeanor relating to a controlled substance;
 - d. whose license has been revoked or suspended by any State licensing authority, including the surrendering of a license when an individual or entity is under investigation for issues related to professional competence, professional performance or financial integrity;
 - e. who has submitted or caused to be submitted claims for excessive charges or unnecessary services or failure to furnish medically necessary services;
 - f. who has committed fraud, received kickbacks or participated in other prohibited activities; or
 - g. who has failed to supply requested information, grant access to federal entities including the OIG, and failed to take required corrective action.

Permissive Exclusion of Entities, Officers or Management Responsible for Sanctioned Individuals or Entities

Federal law states that any entity or individual who is responsible for a sanctioned entity or individual—including officers or managing employees of organizations such as the University of California—may also be subject to permissive exclusion if they know or should know of the actions leading to sanction and do not exclude that individual from performing services. In these cases federal law specifically defines a sanctioned entity or individual as those meeting the criteria of “mandatory exclusion” or those described under section 2a, 2b, and 2c above, all of which involve conviction of certain felonies, misdemeanors or obstruction of investigations.

If the University has notice that University personnel or a contractor has become ineligible for participation in a federal or state health care program, the University, after appropriate due process rights have been exercised and consistent with any decision related thereto, shall remove such person from responsibility for, or involvement with, the University’s business operations related to federal or state health care programs, and shall remove such person from any position for which the person’s salary, or the items or services rendered, ordered, or prescribed by the person, are paid in whole or part, directly or indirectly, by any state or federal program or from any Federal grants, cooperative agreements, contracts of assistance, loans and loan guarantees, until such person is reinstated into participation in the federal health care program.

The University does not knowingly permit any debarred or excluded individual or entity from participating in a federal or state health care program including, but not limited to, activities involving billing, reimbursement and patient care. Each compliance officer is responsible for reporting to his/her chancellor regarding appropriate mechanisms for ensuring that:

- a. the List of Parties Excluded from federal programs and the HHS/OIG List of Excluded Individual/Entities have been checked with respect to all applicant, trainees, residents, fellows, employees, medical staff and contractors;
- b. all University personnel, as defined in the University’s program, have executed the “University Acknowledgment Statement: University’s Health Sciences Clinical Enterprise Corporate Compliance Program” and have provided a personal attestation in connection with his or her exclusion from a governmental health care program; and
- c. all independent contractors have provided a representation that no individuals in their employ are excluded from participation by a state or federal health care program.

Each CO will provide an annual report to his or her chancellor, to the Divisional Committee on Privilege and Tenure (with respect to any proposed faculty disciplinary actions) and the University’s General Counsel regarding any such personnel actions taken relative to debarred or excluded individuals. The University’s General Counsel is responsible for providing The Regents with an annual report regarding any actions taken.

MEDICAL STAFF REVIEW

Healthcare Staff and Healthcare Center Bylaws or regulations will require as a condition of application or continuing privileges at the institution, that an individual who is proposed for exclusion by the OIG or any government health care program immediately notify the Healthcare Staff Office (generally the Medical Staff Office) and the CO. When the University becomes aware that a University employee has been excluded or proposed for exclusion from

governmental health programs, the Medical Staff Office of the University healthcare facility will be notified. As soon as a Medical Staff Office becomes aware from any source of such exclusion or proposed exclusion, it will immediately seek to clarify the circumstances including obtaining information from the individual, the government or any other appropriate source. The clarification process will not exceed ten days, unless extended by the President of the Medical Staff for good cause.

Under most circumstances, exclusion from participation in federally funded programs will exclude the individual from the participation in patient care and will result in termination of Staff privileges until such exclusion expires, after which time the provider may reapply for Staff privileges. Occasionally the Medical Staff may choose to continue privileges with or without modification despite exclusion from government programs.

Acknowledgment Statement
The University's Health Sciences Clinical Enterprise Corporate Compliance Program

My signature on this form acknowledges that I have received and agree to read the University's Health Sciences Clinical Enterprise Corporate Compliance Program and Code of Conduct.

I confirm that I have not been excluded by the federal government from participation in any governmental program nor, to the best of my knowledge, have I been proposed for exclusion. I agree to notify the Corporate Compliance Officer or the University's Office of the General Counsel immediately upon my receiving written or verbal notification that I am proposed for exclusion from any governmental health care program.

Name (Please Print)

Signature

Date

Department

APPENDIX A

The following is a list of policies and web-site URLs that can serve as a resource to University personnel. For additional information or the specific policies, University personnel can access the appropriate web-site, consult with their campus Human Resources department, Compliance Officer, or Division Academic Senate Chair.

Non-University of California Policies and Regulations

California Public Records Act, Government Code Section 6250.

Compliance Program Guidelines for Hospitals - Department of Health and Human Services and the Office of the Inspector General, 1998.

Department of Health & Human Services (DHHS)
www.dhhs.gov

Health Insurance Portability and Accountability Act of 1996.

The Information Practices Act of 1977, California Civil Code Section 1798 or other statutes requiring the release of information.

Medicare Conditions of Participation, section on Patients' Rights - Health Care Financing Administration, August 2, 1999.

Office of the Inspector General (OIG) www.dhhs.gov/progorg/oig

42 United States Code section 1320a-7. OIG PROGRAM EXCLUSION AUTHORITIES –
<http://www.hhs.gov/progorg/oig/cumsan/listing.html>

University of California Policies

The University of California has a number of policies and procedures, including, but not limited to, the following which may be applicable to the Health Sciences Clinical Enterprise Corporate Compliance Code of Conduct. Many of the policies listed can be found at the following URL: <http://www.ucop.edu/ucophome/system/swpolicy.html>

Collective bargaining agreements can be found at <http://www.ucop.edu/humres/labor/>.

Academic Personnel 140.

Academic Senate Bylaw 335.

Academic Senate Privilege and Tenure Committee Bylaws 195.

Applicable Collective Bargaining Agreements.

Compendium of University of California Specialized Policies, Guidelines, and Regulations Related to Conflict of Interest

Faculty Code of Conduct

Healthcare Staff and Healthcare Center Bylaws, Rules and Regulations, unique to each academic medical center.

Personnel Policies for Staff Members.

University Business and Finance Bulletin G-29:

Procedures for Investigating Misuse of University Resources.

University Policy and Procedures for Reporting Improper Governmental Activities and Protection Against Retaliation for Reporting Improper Activities and related local implementing procedures.

University of California Nondiscrimination and Affirmative Action Policy Regarding Academic and Staff Employment.

University's Health Sciences Clinical Enterprise Corporate Compliance Program. A copy of the full description of this University's Program, including the University's Professional Fee Billing Guidelines, Laboratory Compliance Program, and campus Program, is available in the campus Corporate Compliance Office, the Office of the General Counsel and the Office of Clinical Services Development in the University Office of the President.

University Policy on Faculty Conduct and the Administration of Discipline—APM 015-0 Policy.

APPENDIX B – POLICY FOR PROVIDING INFORMATION DURING INVESTIGATIONS

GOVERNMENT INVESTIGATION POLICY

PURPOSE

Occasionally, representatives of the government may arrive unannounced at the _____ Medical Center (“Medical Center”) or at the homes of present or former employees, staff members and contractors (collectively referred to in this policy as “employees”). Generally, these representatives wish to either interview employees or obtain certain documents. The purpose of this policy is to establish a procedure for an orderly response to the government’s requests to enable Medical Center to protect its and its patients’ interests while fully cooperating with the investigation.

POLICY

It is the policy of the Medical Center to comply with all applicable healthcare laws and regulations and to cooperate with appropriately authorized governmental investigations and audits.

I. TYPES OF GOVERNMENT AGENCIES THAT MAY INVESTIGATE HEALTHCARE PROVIDERS

- A. A variety of federal and state governmental agencies may be involved in investigating healthcare providers for various reasons. These agencies include, but are not limited to, the Office of Inspector General (“OIG”), the Health Care Financing Administration (“HCFA”), the Federal Bureau of Investigation (“FBI”), the Department of Defense, the United States Attorney’s Office, Medicare Intermediaries, the California Attorney General’s Office and the California Department of Health Services.

II. PROCEDURES

- A. When a representative from a federal or state agency contacts an employee anywhere, such as at home or at the office, for information regarding the Medical Center or any Medical Center-affiliated health care entity, or any other entity with which the Medical Center does business, the employee should contact the Hospital Director immediately.

If the Hospital Director is not immediately available, the employee should contact the Risk Management Department, the Medical Center’s Corporate Compliance Officer (“Compliance Officer”) or University legal counsel.

- B. The Hospital Director will give the employee instructions on how to proceed.

- C. The employee should ask to see the government representative's identification and business card, if the government representative is there in person. Otherwise, the employee should ask for the person's name and office, address and telephone number, identification number and call the government representative's office to confirm his or her authority.**
- D. If the government representative wishes to speak with the employee personally, the employee should find out why without getting into details. (See Section III, Interviews, below after completing all other tasks in this section.)
- E. If the government representative wants to search the Medical Center facilities or obtain any documents from the Medical Center, the employee should ask to see a legal document authorizing the search, such as a search warrant, and any affidavit supporting the warrant. The employee should make a copy of this legal documentation. (See Section IV, Searches, below after completing all other tasks in this section.) The employee and/or his or her supervisor should send a copy immediately to the Risk Management Department, University legal counsel and the Compliance Officer. If the government representative has appeared at the Medical Center in person, he or she should be escorted to the Hospital Director's office for further assistance. The employee should NOT respond to the request to search the Medical Center facilities or obtain any documents.
- F. If an employee receives a request in person or in the mail from a government representative for documents or a subpoena, the employee should immediately give a copy to his or her supervisor. The employee and/or his or her supervisor should send a copy immediately to the Medical Center's Custodian of Records (if the records sought are under the control of a Medical Center-designated Custodian of Record) and to the Risk Management Department in accordance with the Medical Center's subpoena handling policies. The employee and/or his or her supervisor should also send a copy immediately to the Compliance Officer. The employee should NOT respond to the request.

III. INTERVIEWS

- A. Occasionally, government representatives may ask to speak with individual employees regarding the Medical Center or any Medical Center-affiliated healthcare entity or any other entity with which the Medical Center does business. **EMPLOYEES ARE NOT REQUIRED TO SPEAK TO A GOVERNMENT REPRESENTATIVE ON THE SPOT.** Employees may either agree to be interviewed or refuse to be interviewed - the government representative does not have the right to insist upon an interview. Employees may also make an appointment to speak with the government representative at a later date.
- B. If an investigator contacts an employee at home and the employee wishes to submit to an interview, the employee has the right to insist that the interview take place in the office during normal business hours.
- C. Employees are entitled to have someone with them during any interview with a government representative. The Medical Center will arrange to have an appropriate individual (possibly an attorney) present with the employee during the

interview. The employee may also consult with an attorney of his or her own choosing at the employee's expense if he or she so desires.

- D. If, during the course of an interview, the investigator asks an employee to provide him or her with copies of any hospital records (including but not limited to, patient, billing, financial, quality assurance or peer review records), the employee should refuse explaining that such records can only be provided in response to a lawfully issued subpoena or other lawful methods. University legal counsel will direct the collection and transfer of records and provide other instructions as necessary to assure that the Medical Center responds expeditiously and completely to the demands of the subpoena.
- E. If an employee chooses to be interviewed by a government representative before calling a Medical Center representative as identified above, the employee should contact his or her supervisor and/or the Compliance Officer as soon as possible after the interview. Employees are encouraged to take detailed notes during the interview.
- F. An employee's decision to be interviewed or not will not be used in any way against the employee by the Medical Center.
- G. During the interview with the government representative, employees should follow these tips:
 - 1. **Always tell the truth.** If the employee does not recall something or has no knowledge or insufficient knowledge about the topic that the government representative is asking about, the employee should say so. The employee should not guess or speculate.
 - 2. In talking with the government representative, the employee should be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding as to what the employee is saying. It is important for the employee to make clear to the government representative whether the information he or she is providing is first-hand knowledge or something the employee has heard. The employee SHOULD NOT speculate. In providing information, the employee should not provide information they do not have first hand knowledge of.
 - 3. **The employee should contact the Compliance Officer as soon as possible after the interview.**

IV. SEARCHES

If the government representative wants to obtain documents or search the Medical Center, the government representative should be escorted to the Hospital Director's office for assistance. With respect to searches of the Medical Center, employees should remember the following:

- A. A "search" occurs any time a government representative enters the Medical Center premises and begins to look for any documents or asks questions. A search may not be conducted without a legally valid search warrant. However,

some government agencies have the authority to assess penalties if representatives of the agency are not granted immediate access upon reasonable request to a health care entity. These agencies include the OIG. Therefore, Medical Center employees should strive to be courteous and helpful to government representatives while following the guidelines set forth in this section.

- B. A search warrant is different from a subpoena or a records request. A subpoena or records request requires the production of information but does not allow for a search. Most subpoenas or records requests allow a reasonable time in which to respond. The time frame (typically ranging from 10 to 30 days) will usually be identified on the subpoena itself. In contrast, a search warrant is issued by a magistrate or a judge and allows immediate access to the hospital premises or property which are described in the search warrant.
- C. The employee should request that the investigator wait at the Hospital Director's office until either the Compliance Officer or University legal counsel arrives. If the warrant is valid, the employee may not stop the search. However, before permitting the government representative to proceed with a requested search, University legal counsel should be first allowed to determine the validity of the warrant.
- D. The confidentiality of medical records, patient records, and other hospital records must be maintained even when responding to a subpoena, warrant, or other request for document production. The Compliance Officer and/or University legal counsel will direct the collection and transfer of records and provide other instructions as necessary to assure that the Medical Center safeguards the confidentiality of these records and responds completely and appropriately to the warrant.

V. ADMINISTRATIVE ISSUES

- A. Once a government contact is initiated, the employee should establish a specific file for communications with legal counsel. The employee should caption the file and all of his or her memos to legal counsel with the words "**Confidential Attorney-Client Privileged Communication.**"
- B. The employee should **NOT** make copies other than a file copy and do not distribute confidential communications with legal counsel. Distribution may destroy the privilege of confidentiality.
- C. IF AT ANY TIME, THE EMPLOYEE IS UNSURE OF WHAT TO DO, HE OR SHE SHOULD CONTACT THE COMPLIANCE OFFICER OR UNIVERSITY LEGAL COUNSEL IMMEDIATELY. THIS POLICY CONTAINS GENERAL GUIDELINES. AT ALL TIMES, THE EMPLOYEE SHOULD FOLLOW INSTRUCTIONS FROM THE COMPLIANCE OFFICER AND/OR UNIVERSITY LEGAL COUNSEL.

VI. MEDIA CONTACTS

- A. It is important that employees not discuss their involvement with an investigation or any issue relating to an inquiry by a government agency with other employees or with people outside of the Medical Center. If an employee receives an inquiry from the media or any other outside person, the employee should do the following:
1. If the media representative appears in person:
 - a) Verify their credentials by asking to see their identification and business card.
 - b) Politely state that he or she is unable to comment or respond at the present time, but that he or she will pass along their business card to a person with authority to speak on behalf of the Medical Center.
 - c) Explain that in order to provide the best Medical Center spokesperson, he or she will need to know what information the individual is seeking to obtain about the Medical Center.
 - d) The employee should not answer or respond to any requests for information or provide his or her opinion to any media representative.
 - e) Contact his or her supervisor/department director immediately or if the employee's supervisor/department director is unavailable, the employee should contact the Health Sciences Communications Office at ext. _____.
 2. If an employee is contacted by telephone:
 - a) The employee should ask for the person's phone number and their affiliation for the purpose of returning their call at a more appropriate time.
 - b) The employee should determine the purpose of the call. The employee should never provide information, answer questions, or speculate. What an employee says, when taken out of context, can be misinterpreted. The Health Science Communications Office at _____ will be responsible for coordinating all media contacts.
 - c) The employee should contact his or her supervisor/department director immediately or if his or her supervisor/department director is unavailable, the employee should contact the Health Sciences Communications Office at _____.