MMP

MID-MICHIGAN PHYSICIANS, P.C.

COMPLIANCE PROGRAM

Approved: May 13, 2008

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I. OBJECTIVE

The key objective of this Compliance Program is to develop and implement a corporate compliance program on an ongoing basis to enable Mid-Michigan Physicians, P.C. ("MMP") to operate its business in compliance with federal, state and local laws and regulations and avoid wrongdoing, whether by mistake, through inadvertence, or intentional.

II. DESCRIPTION OF THE PRINCIPAL LAWS INVOLVED IN THE COMPLIANCE PROGRAM

A. The False Claims Laws and Related Statutes

Individuals or entities that knowingly file fraudulent or false claims that are payable by the Medicare program are subject to both criminal and civil liability. Set forth below is a description of some of the most important criminal and civil statutes involved.

1. Criminal False Claims Laws

Whenever someone causes a claim to be filed with a health insurance program, public or private, knowing at that time that the claim is false, he or she risks a criminal violation, punishable by fines or time in jail, or both. There are three principal criminal statutes.

Under the Criminal False Claims Act, individuals or entities that knowingly file such claims may receive a fine of up to $10,000, imprisonment of up to five years, or both. 18 U.S.C. § 287.

Under the Medicare and Medicaid Patient and Program Protection Act, 42 U.S.C. § 1320a-7a, individuals or entities that knowingly make or cause to be made a false statement or misrepresentation on any claim that is submitted for payment by the Medicare or Medicaid program may also be subject to civil and criminal liability. The penalty for violation of this Act is up to five years in prison, and/or a $25,000 fine.

Finally, federal law also contains a criminal penalty for "knowingly and willfully" defrauding any health care benefit program (including such private insurers as BCBSM, PHP, Aetna, etc.) or for obtaining, by means of "false or fraudulent pretenses" any money from any health care benefit program. Someone who violates this provision – and most false claims would – can be fined or imprisoned for not more than 10 years, or both.

The false statements statute is another popular antifraud statute available to the government and often is included with a criminal indictment under the False Claims Act ("FCA") because the making of a false claim also involves making a false statement. This statute makes it a crime knowingly and willfully to make a false statement to the United States or any department or agency thereof. The law includes three broad categories of offenses: (1) falsifying, concealing, or otherwise covering up a material fact by any trick, scheme, or device; (2) making materially false, fictitious, or fraudulent statements or representations; and (3) making or using a writing

or document with knowledge that such document contains materially false, fictitious, or fraudulent statements.

In some cases, the prosecutor in bringing charges for violation of the FCA or False Statements Act also may charge the provider with mail or wire fraud under 18 U.S.C. §§ 1341, 1343. In many cases, the false claims are included in payment requests or claims mailed or transmitted electronically to the government. The mailing or transmission of such false claims constitutes a violation of the mail or wire fraud statute. The government need not prove that the defendants actually mailed or transported anything themselves in furtherance of the scheme; it is sufficient if they simply caused the claims to be mailed or transmitted.

2. Civil False Claims Laws

Under the Civil False Claims Act, an individual or entity that knowingly files false claims is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus up to three times the amount of damages which the Government sustained, **for each false claim filed**. 31 U.S.C. § 3729. Moreover, private persons may bring civil actions against individuals or entities for violation of the Civil False Claims Act on behalf of the Government, and they may share in any proceeds ultimately recovered as a result of the suit. These are known as qui tam or whistleblower cases.

3. Common Sources of False Claims Violations

MMP should pay particular attention to whether the following activities are taking place within MMP, as such activities are those most frequently found to violate the False Claims Acts: (1) upcoding; (2) billing for services not rendered; (3) filing of false cost reports; (4) billing for services where there is no or inadequate documentation in the medical record; and (5) double-billing. "Upcoding" is the process of inflating bills by using diagnosis billing codes that suggest a more expensive illness or treatment. "Double-billing" occurs by charging more than once for the same goods or service. As this list is not exhaustive, MMP should be aware of any activity in which an individual or entity may be filing claims it knows to be false or fraudulent to either the Medicare or Medicaid program.

There are also, in addition to the federal laws described above, Michigan laws governing the submission of fraudulent or false claims. These laws prohibit the submission of such claims to all third party payors, including non-governmental, insurance companies.

4. Exclusion From Participation In Federal Health Care Programs

In certain situations, the U.S. Department of Health and Human Services Office of Inspector General ("HHS-OIG") has the power to exclude entities and individuals from participation in Medicare, Medicaid and other federally funded health care programs. Exclusion means that no payment will be made by any such health care programs for services and/or goods prescribed, ordered, furnished or performed by an excluded entity or individual. In addition, no payment

will be made to any entity that employs or contracts with an excluded individual. Given the percentage of patients typically covered by federal health care programs, such as Medicare and Medicaid, exclusion is usually a death sentence for any excluded practice or provider organization.

Several provisions of the Social Security Act grant the HHS-OIG exclusionary powers. Depending on the type and severity of the violation, the HHS-OIG may be required to exclude the provider for a specified period of time (mandatory exclusion) or it may have the option of excluding the provider (permissive exclusion).

Situations in which mandatory exclusion is required include:

- Conviction of a federal health care program related crime;
- Convictions relating to patient abuse or neglect;
- Felony convictions relating to healthcare fraud, and
- Felony convictions for the unlawful manufacture, prescription, distribution or dispensing of controlled substances.

A conviction of any of the above offenses will result in a mandatory minimum exclusion of five years and exclusions of up to twenty years are not uncommon.

In addition, the HHS-OIG has the discretion to exclude providers for a wide range of prohibited activities. Activities that may result in permissive exclusions include:

- Misdemeanor conviction relating to health care fraud or fraud in any program operated or financed in whole or in part by any federal, state of a local government agency;
- Conviction for obstructing a health care fraud investigation;
- A determination by the Secretary of HHS (even in the absence of a conviction) that an entity or individual has engaged in fraud or been involved in kickbacks;
- Claims for unnecessary medical services;
- Claims for excessive charges;
- License suspension or revocation; or
- Failure to grant immediate access upon a reasonable HHS-OIG request to examine records, document and other data

Whenever an individual or entity is excluded, that person must apply to the Secretary of HHS for termination of the exclusion. In other words, after the exclusionary period has run, the exclusion does not expire automatically. Instead, the Secretary of HHS must determine that there is no basis for the continuation of the exclusion and that there are reasonable assurances that the conduct which formed the basis for the original exclusion has not recurred and will not recur.

The HHS-OIG also has the authority under the Civil Monetary Penalties and Assessment Act, 42 USC 1320a-7a (6), to impose civil monetary penalties on any provider that contracts, by employment or otherwise, with an individual or entity that the provider knows or should know is excluded from participation in federal health care programs. The HHS-OIG has repeatedly stated that this "knowledge" standard imposes an affirmative burden on providers to check the exclusion status of individuals and entities prior to hiring and/or contracting with them. Thus, if a provider employs an excluded physician without checking his or her exclusion status and submits claims to a federal health care program for services provided by such excluded physician, the provider could be liable for a civil penalty of $10,000 for each item or service claimed, as well as an assessment of up to three times the amount claimed. Moreover, the provider may itself be excluded from federal health care program participation for employing or contracting with the excluded physician.

B. The Anti-Kickback Statute

The Anti-Kickback provisions of the Medicare and Medicaid Patient and Program Protection Act of 1987 ("Anti-Kickback Statute") prohibit the knowing and willful solicitation, receipt, offer or payment of "any remuneration (including any kickbacks, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in return for or to induce the referral, arrangement or recommendation of Medicare of Medicaid business. 42 U.S.C. §1320a-7b(b). Violation of the Anti-Kickback Statute is a felony and may result in a fine of up to $25,000, imprisonment for up to 5 years, or both. In addition, the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") is empowered to suspend or exclude providers or suppliers from participation in the Medicare or Medicaid Programs if it determines, in its discretion, that a provider or supplier has violated the Anti-Kickback Statute. 42 U.S.C. §1320a-7b(b)(7). Note the breadth of this Statute:

> COURTS HAVE INTERPRETED THE ANTI-KICKBACK STATUTE VERY BROADLY, FINDING THAT REMUNERATION CAN INCLUDE "ANYTHING OF VALUE IN ANY FORM WHATSOEVER." COURTS ALSO HAVE FOUND THAT REMUNERATION IS ILLEGAL IF THE REMUNERATION IS INTENDED EVEN IN PART TO INDUCE REFERRALS.

For example, in both United States v. Greber, 760 F.2d 60 (3d Cir. 1985), and United States v. Kats, 871 F.2d 105 (9th Cir. 1988), courts reasoned that where remuneration is paid to an independent contractor referral source, it may be inferred that one purpose of the payment is to induce referrals, even if another purpose of the payment is to provide compensation for

services rendered. The Kats court further stated that any remuneration must be "wholly and not incidentally attributable to the delivery of goods and services." 871 F.2d at 108.

Arrangements that satisfy all of the requirements of certain "safe harbors" set forth in the regulations are immune from both criminal prosecution and administrative enforcement by the OIG. Arrangements that do not qualify under a safe harbor, however, are not necessarily illegal. Such arrangements will be scrutinized under the Anti-Kickback Statute to determine whether, through the particular arrangement, remuneration was given or offered as an inducement for referrals. If it is determined that remuneration was, in fact, given or offered to induce referrals, the arrangement will violate the Anti-Kickback Statute. Note also that claims filed as a result of referrals that violate this law also are considered false claims and subject individuals involved to potential civil and criminal liability.

The Compliance Officer, together with the Board of Directors, will attempt to structure all relationships such that they do not violate the Anti-Kickback Statute. Generally, the more safe harbor elements an arrangement or a relationship meets, the more likely the particular arrangement may be determined to be consistent with the Anti-Kickback Statute. Thus, relationships will generally be structured to comply with at least the key elements of the relevant safe harbor.

Comparable Michigan statutes regulate remuneration furnished in connection with health care services covered by Medicaid, Blue Cross and other payors.

C. The Stark Act

The Ethics in Patient Referral Act ("Stark Act") prohibits, with certain statutory exceptions, a physician who has an ownership interest in, or a compensation arrangement with, an entity from referring patients to that entity for the provision of "Designated Health Services" if payment for those services may be made by Medicare. 42 U.S.C. § 1395nn. The Stark Act provides CMS authority to publish regulations to clarify and implement the Act. The Stark Act also imposes substantial fines and penalties for Medicare claims filed in violation of the Act.[1]

"Designated Health Services" are defined as:

- Clinical laboratory services;
- Radiology services and certain other imaging services including CT, MRI, ultrasound and nuclear;
- Durable medical equipment and supplies;
- Radiation therapy services and supplies;

[1] The Michigan Public Health Code contains additional licensure sanctions that may be imposed on a physician who refers a patient in violation of the Stark Act, regardless of the payor.

- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Parenteral and enteral nutrients, equipment and supplies;
- Outpatient prescription drugs;
- Prosthetics, orthotics and prosthetic devices and supplies;
- Home health services; and
- Inpatient and outpatient hospital services.

Physicians may only own interests in or have financial relationships with providers or entities that bill for Designated Health Services referred by the physician if the relationships or operations are structured to qualify for at least one of the exceptions to the Stark Act. MMP periodically reviews referrals where the provider to which the request is made bills for Designated Health Services to ensure that one of the statutory exceptions is met.

MMP regularly reviews its own operations to ensure that it satisfies the requirements of the Stark Act, including compliance with the "in-office ancillary services" exception, and the group practice definition.

D. Repayments

Both state and federal law contain provisions which require MMP to repay any reimbursement received to which MMP is not entitled. This includes moneys received in violation of the Civil False Claims Act (and its state counterpart), as well as moneys received because of errors in billings. It also includes moneys received where the documentation in the medical record is inadequate to support the bill submitted. Michigan law extends this obligation to moneys received from any health corporation, which is the statute's designation for Blue Cross and Blue Shield of Michigan, and from any other health care insurer, public or private. In addition, federal law has a broad provision that anyone with knowledge of anything affecting his/her/its right to a payment from any federal health care program who retains the money despite this knowledge is guilty of a felony.

In addition to these state and federal laws, most provider agreements between MMP and health insurers contain provisions which require that MMP repay any money which MMP has received to which it is not entitled.

In short, repayment of moneys received to which MMP is not entitled is required by state law, federal law and contracts. The failure to do so can constitute a crime, punishable by fines and imprisonment.

MMP is committed to repay moneys which it receives from third party payors to which it is not entitled.

E. HIPAA Electronic and Privacy Standards

The Health Insurance Portability and Accountability Act, commonly referenced as HIPAA, was enacted in 1996 and brought sweeping changes to several areas of health care activity. The primary intent of HIPAA was to improve the portability and continuity of health insurance coverage to protect workers who lose or change their jobs. In addition, however, HIPAA included significant changes to the statutory scheme of health care fraud and abuse enforcement and provisions to encourage the establishment of medical savings accounts. Finally, HIPAA contained provisions to simplify the administration of health insurance by standardizing the electronic transmission of certain administrative and financial transactions and to protect the privacy of individually identifiable health information.

The Department of Health and Human Services ("HHS") issued regulations to protect the privacy of individually identifiable health information that is transmitted electronically, maintained electronically, or transmitted or maintained in any other form or medium (including oral statements). The final HIPAA regulations were published on August 14, 2002.

Generally, all individual or group health plans, including managed care organizations and ERISA plans, all government plans, including Medicare and Medicaid programs, all health care clearinghouses, and any health care providers choosing to transmit certain health information electronically are required to use the standards by the implementation date. These entities are considered "covered entities" under HIPAA.

Under HIPAA, HHS issued a rule to protect the privacy of medical records that are transmitted or maintained electronically and the paper print-outs from these records created by health plans, providers, hospitals and health care clearing houses. The privacy rule only protects "individually identifiable information" that has been maintained or transmitted in electronic form. Electronic form includes information on magnetic tape, disk, or CD as well as information transmitted via Internet, private networks, extranet, and leased or dial up line. Information that is covered by the rule by virtue of its being stored or transmitted electronically is also protected even after it is printed, discussed orally or otherwise modified in format. The original paper version of the information also becomes protected after the information is transmitted or stored electronically.

Covered entities may not avoid compliance by contracting out administrative services related to standardized electronic transactions. The regulations provides that a covered entity that uses a business associate to conduct all or part of a standard transaction must require the business associate to not only comply with all applicable requirements, but also require any agent or subcontractor to comply with all specific requirements.

The security standards under HIPAA and the privacy regulations both aim to protect the confidentiality and the integrity of health data as well as ensure that the information is

available in the delivery of health care services. The focus of the standards is different though, in that the privacy standards target the rights and expectations of patients with respect to how their private medical information is handled by providers and organizations. The security standards on the other hand, provide guidance to organizations and providers on how to protect the integrity and confidentiality of medical information.

Covered entities must take measures to limit the external and internal disclosures of health information to the minimum amount of health information necessary to accomplish the purpose for which the information is used or disclosed. This "minimum necessary" standard requires covered entities to apply an element of good judgment and discretion in responding to requests for health information and to train staff members involved in responding to these requests accordingly. Computer systems and software may also need to be reconfigured to insert tighter access features, so that employees can only access the portion of patient records that is necessary to allow them to perform their duties.

The rule also contains provisions that give individuals an organized process for accessing and controlling their health information. Covered entities must provide patients with a notice which explains their privacy practices and informs the patients of their rights under the covered entity's privacy policies and the privacy regulations. Covered entities must obtain a patient's acknowledgement that he or she has read and understands the notice of privacy practices before they may use and disclose protected health information for purposes of treatment, payment and health care operations. Covered entities must also obtain an authorization from an individual before using or disclosing protected health information for other purposes. The regulations outline several requirements for obtaining authorization to disclose health information to ensure that the individual's authorization is voluntary. Individuals have the right under the regulations to inspect and copy their health records and request amendment or corrections of inaccurate information. Covered entities are required under the regulations to keep a history of most disclosures for purposes other than treatment, payment and health care operations and make this history accessible to patients.

HHS may impose sanctions for failure to comply with requirements of the rule, including fining entities up to $25,000 per year for each civil violation. In addition, HHS may impose criminal penalties for certain wrongful disclosures. The criminal penalties vary depending on whether the offense is committed under false pretenses or with the intent to sell the information or use it for personal gain. Individuals do not have a private right of action under regulations. In addition, the regulations create a system allowing individuals to make complaints to HHS about potential violations of the regulations and require covered entities to develop a process to review complaints about such violations.

It is MMP's commitment to be proactive and to incorporate these standards in its activities in the handling of each patient's health data information. MMP maintains a HIPAA Policy Manual which should be consulted for additional information or if questions arise.

III. COMPLIANCE COMMITTEE AND COMPLIANCE OFFICER

A. Members of the Compliance Committee

1. Number of Members

The Compliance Committee shall consist of seven (7) members. All votes of the Compliance Committee shall be by majority, except as otherwise provided in this document. A majority of Committee members, present either in person or by proxy, shall constitute a quorum for purposes of Committee meetings.

2. Appointment/Removal of Members

The members of the Compliance Committee shall be appointed by the Compliance Officer and approved by Board of Directors of MMP for two (2) year terms. Any member may be removed by the Board.

3. Functions of the Compliance Committee

The Compliance Committee shall have the following responsibilities and functions:

(a) Analyze the healthcare industry, identify legal requirements with which MMP must comply, and identify specific risk areas for MMP's operations;

(b) Assess existing policies and procedures, legal requirements and risk areas for possible incorporation into the Compliance Program;

(c) Work with appropriate individuals within MMP to develop standards of conduct and policies and procedures to promote compliance with Compliance Program requirements;

(d) Recommend and monitor development of internal systems and controls to carry out MMP's standards, policies and procedures as part of its daily operations;

(e) Determine the appropriate strategy/approach to promote compliance with Compliance Program requirements and detection of potential violations;

(f) Develop a system to solicit, evaluate and respond to complaints and problems;

(g) Address such other functions as the Board of Directors may deem appropriate to implement the Compliance Program fully.

B. Designation of Compliance Officer

1. Identification of Compliance Officer

The Compliance Officer for MMP shall serve as the focal point for MMP's compliance activities. The Compliance Officer shall be a shareholder of MMP, shall be appointed by the Board of Directors, and shall be the Chairperson of the Compliance Committee.

2. Delegation of Authority to Compliance Officer by Board of Directors

The Board of Directors shall delegate primary responsibility for development and implementation of the Compliance Program to the Compliance Officer and may delegate such specific acts, tasks and functions necessary or appropriate for implementation of the Compliance Program to the Compliance Officer from time to time by resolution of the Board.

3. Specific Responsibilities of Compliance Officer

Subject to the broad delegation of authority to the Compliance Officer for development and implementation of the Compliance Program, the Compliance Officer shall:

(a) Appoint the members of the Compliance Committee, subject to the approval of the Board of Directors.

(b) Have overall responsibility for operating, overseeing and monitoring the implementation and effectiveness of the Compliance Program;

(c) Serve as the liaison between the Compliance Committee and the Board of Directors and report as needed to the Board of Directors on the progress of implementation of MMP's Compliance Program and the activities of the Compliance Committee;

(d) Have authority to schedule, establish the agenda and conduct both regular and special meetings of the Compliance Committee;

(e) Periodically revise the Compliance Program, after discussion with the Compliance Committee, in light of changes in the needs of MMP and changes in the law, policies and procedures of government and, as applicable, private payor health plans;

(f) Develop, coordinate and participate in educational and training programs that focus on the elements of the Compliance Program, and seek to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards;

(g) Coordinate the education of employees and independent contractor staff with respect to requirements of the Compliance Program and with respect to specific requirements for billing, coding and other pertinent regulatory requirements;

(h) Respond to day-to-day questions regarding compliance and receive all complaints, grievances and inquiries regarding MMP's Compliance Program and its compliance with federal and state laws;

(i) Initiate investigations of all complaints, grievances and allegations of noncompliance with the assistance of legal counsel and appropriate Company personnel;

(j) Report results of all investigations to the Compliance Committee or, if appropriate, in the sole discretion of the Compliance Officer, directly to the Board of Directors;

(k) Coordinate investigations of all matters related to compliance, including the design and coordination of internal investigations both randomly and in response to reported problems or suspected violations, and, in conjunction with the Compliance Committee, implement Corrective Action under Section X below (such actions are referred to in this program as "Corrective Action") (but not including disciplinary action of a physician employee or independent contractor, which must be approved by MMP's CEO) to address noncompliance issues appropriately;

(l) Encourage employees to report suspected fraud and other improprieties without fear of retaliation; and

(m) Use best efforts to maintain the confidentiality and ethics of MMP's Compliance Program.

4. Mandatory Consultation with the Board of Directors and CEO

The Compliance Officer shall be required to consult with the CEO of MMP for approval prior to taking action on the following:

(a) Initiation of an audit of MMP or any division using an outside audit firm;

(b) Notification or other correspondence to any third party payor, including Medicare and Medicaid, with respect to any alleged noncompliance with billing or reimbursement requirements and regulations;

(c) Initiation of any disciplinary action as Corrective Action under Section X below against a physician employee or independent contractor staff as a result of noncompliance, reporting or failure to report noncompliance with the Compliance Program or standards of conduct developed by MMP.

(d) Making a decision not to comply with any safe harbor established under any state or federal law or regulation that is relevant to MMP's operations; and

(e) Initiation of an investigation of alleged non-compliance with this Program.

(f) Initiation of investigations of all complaints, grievances and allegations of noncompliance with the assistance of legal counsel and appropriate MMP personnel.

5. Compliance Officer Access to Company Records and Documents

The Compliance Officer shall have the authority to review all documents and other information relevant to compliance activities of MMP, including, but not limited to, patient records, billing records, contracts, marketing efforts, and MMP's arrangements with other parties, including employees, independent contractor staff, billing companies, and suppliers.

IV. AUDITING AND MONITORING ACTIVITIES

A. General

MMP has determined that an ongoing evaluation process is critical to the success of the Compliance Program. The auditing and monitoring activities described in this Section are designed to provide for one or more mechanisms for MMP to obtain periodic information regarding the effectiveness of its compliance efforts.

B. Ongoing Audit Program

MMP's Board of Directors has approved a policy which provides that every provider – physicians, physician's assistants and nurse practitioners – will be audited by trained Company coding auditors at least twice each year. Such audits are for the purpose of determining whether bills submitted to third parties as a result of each provider's services to patients are supported by appropriate documentation and are otherwise in accordance with billing/coding rules and regulations.

The policy adopted from time-to-time by the Board of Directors will specify what constitutes unacceptable performance on such audits. It will also describe those steps to be taken by the Compliance Committee and other Company personnel to correct errors uncovered by the audits. These steps may include education, re-audits, and Corrective Action (as described in Section X below), and will involve repayment of amounts incorrectly received.

All unacceptable audits, as defined by the policy, will be forwarded as soon as possible after preparation to MMP's CEO, Operations' Manager, Compliance Officer, Controller, Billing Manager, and Human Resource Manager.

C. Periodic Evaluation of Compliance

1. Monitoring Ongoing Compliance

The Compliance Committee shall periodically discuss with MMP's coding auditors and Compliance Officer whether the audit program is revealing deviations from the Compliance Program. Significant deviations from the compliance policy will trigger a reasonable inquiry to determine the cause of the deviation. If an inquiry determines that a deviation from compliance policy occurred for legitimate, explainable reasons, no change in policy or practice may be required. However, if it is determined that a deviation from the compliance policy was caused by improper procedures, a misunderstanding of applicable policies, procedures or regulatory requirements, including fraud and systematic billing errors, the Compliance Committee and the Compliance Officer shall take prompt steps to correct the problem, which may include recommendations to the Board of Directors.

2. Periodic Reviews of Other Compliance Program Elements

Periodically, but no less than annually, the Compliance Committee shall review whether other elements of the Compliance Program are working acceptably. These periodic reviews shall focus on all elements of the Compliance Program, with special emphasis on evaluating whether:

(a) Effective efforts have been, and are being, made to disseminate appropriate information to employees and independent contractor staff of MMP regarding compliance;

(b) Effective efforts have been, and are being, made to educate and train employees and independent contractor staff to improve compliance with established standards of conduct;

(c) Effective systems have been, or are being, established by MMP for reporting noncompliance and whether the systems in place have identified any incidents of noncompliance; and

(d) Corrective Action taken with respect to noncomplying employees and independent contractor health professionals was appropriate and implemented in accordance with the requirements of Compliance Program guidelines.

3. Acceptable Techniques for Periodic Reviews

Periodic reviews may utilize any or all of the following techniques:

(a) Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities;

(b) Questionnaires developed to solicit impressions of a cross-section of employees and staff;

(c) Reviews of written materials and documentation prepared by individuals with responsibility for all aspects of MMP's operations; and

(d) A review of coding audits performed internally and by outside auditors.

4. Evaluative Reports and Follow-Up

After each periodic review, the Compliance Officer shall prepare and present to the Compliance Committee and the Board of Directors oral or written evaluative reports on compliance activities. The reports shall specifically identify areas where correction of policies, procedures or practices is needed and may be prepared with the assistance of legal counsel. All reports to the Board of Directors shall be noted in the minutes.

D. Quality Assurance and Utilization Review Activities

MMP also may undertake any appropriate quality assurance and utilization review activities which may be independent of the audits and compliance monitoring activities described in this document. The results of quality assurance and utilization review activities shall be coordinated with compliance activities in a manner designed to identify potential compliance problems. Data, records, and knowledge acquired during quality assurance and utilization review activities may be segregated from other compliance information if such data, records, and knowledge is peer review privileged, or otherwise confidential, information.

E. Documentation of Compliance Efforts

MMP shall document all of its efforts to comply with applicable statutes, regulations and federal health care program requirements. MMP shall seek clarification of Medicare and Medicaid payment policies and similar regulatory advice from legal counsel. All written requests for clarification or other regulatory advice by MMP or legal counsel shall be maintained in a regulatory correspondence file established for that purpose. Records shall be maintained which demonstrate efforts by MMP to implement advice obtained from regulatory agencies.

V. WRITTEN POLICIES AND PROCEDURES

A. Establishment of Code of Conduct

MMP, through the efforts of the Compliance Committee, shall establish a code of conduct for all employees and independent contractors of MMP. The code of conduct shall state MMP's mission, goals and ethical requirements of compliance and shall include a clear commitment to compliance with applicable federal, state, and local laws and regulations. A statement relating

to the code of conduct shall be included in all employment and independent contractor agreements.

B. Specific Standards of Conduct - Development of Written Policies and Procedures

MMP, through the efforts of the Compliance Committee, shall develop standards of conduct in the form of written policies and procedures which address specific regulatory risk issues which are germane to MMP's operations. Specific policies and procedures shall be coordinated with appropriate training and educational programs, with particular emphasis on areas of special concern that have been identified by the OIG through its investigative and audit functions. The written policies and procedures shall be maintained by the Compliance Officer, shall be periodically reviewed and updated as necessary to reflect applicable statutes, regulations and state and federal health care program requirements and copies of the relevant policies and procedures shall be distributed to appropriate individuals.

C. New Employee Policy

For all new employees or independent contractor staff who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, MMP shall perform reasonable and prudent background investigations, including a reference check, before every offer of employment or contracting arrangement. All applicants for employment shall be required to disclose any criminal convictions, as defined by 42 U.S.C. §1320a-7(i), debarment, or exclusion actions. It is the express policy of MMP to prohibit the employment of, or contracting with, individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs, as defined by 42 U.S.C. §1320a-7b(f). If any such actions or charges are pending at the time an offer of employment is about to be made or a contract for an independent contractor to be finalized, MMP shall not make a determination regarding employment or contracting until such actions or charges have been resolved. With respect to locum tenens physicians, MMP will contract only with physicians or locum tenens companies that comply with the requirements set forth in this paragraph. MMP will use its best efforts to verify compliance.

VI. AREAS OF COMPLIANCE

A. Anti-Kickback Act

The Compliance Committee shall make available to all employees and independent contractor staff, as appropriate, based on the position and areas of responsibility of such individuals, copies of pertinent statutory provisions, regulations, safe harbors, special fraud alerts and advisory opinions regarding the Medicare and Medicaid anti-kickback statute and Civil Monetary Penalties Law, and written policies and procedures developed for compliance with anti-kickback and law requirements.

B. Stark Law

The Compliance Committee shall make available to all employees and independent contractor staff, as appropriate, based on the position and areas of responsibility of such individuals, copies of pertinent statutory provisions, regulations, and advisory opinions regarding the Stark physician self-referral law; written policies; and procedures developed for compliance with Stark physician self-referral law requirements.

C. Reimbursement and Billing Regulations

The Compliance Committee shall distribute to all employees and independent contractor staff, as appropriate based on the position and areas of responsibility of such individuals, copies of pertinent statutory provisions, regulations and other guidance which address specific identified areas of concern for Medicare and Medicaid reimbursement and billing. Specific identified areas of concern include, without limitation:

(a) Billing for items or services not actually rendered;

(b) Providing medically unnecessary services;

(c) Upcoding;

(d) Duplicate billing;

(e) Supervision requirements for services furnished by ancillary personnel as "incident to" services;

(f) Credit balances or failure to refund amounts due to patients and third party payors;

(g) Knowing failure to provide medically necessary services based on type of third party payor; and

(h) Documentation issues with respect to physician services.

D. Annual Review of HHS-OIG Work Plan

Each year, the Compliance Committee shall review the then-current HHS-OIG Work Plan to determine if any areas of MMP's operations, other than those listed above, will be the focus of the OIG's operations. Any such areas relevant to MMP's operations which are not being examined by the Compliance Committee shall be added to the Committee's work for that year.

VII. LINES OF COMMUNICATION AND REPORTING

A. Access to the Compliance Officer

It is the intent of MMP in establishing this Compliance Program that there is an open line of communication between the Compliance Officer and personnel of MMP. All Company personnel, employees and independent contractor health professionals may seek clarification from the Compliance Officer or any other member of the Compliance Committee in the event any confusion or question exists with respect to Company policies and procedures, anti-kickback statute issues, Stark physician self-referral issues, or billing and reimbursement requirements. Questions and responses shall be documented when possible including the date of the inquiry. Prior to issuing a response to an inquiry, the Compliance Officer may consult with legal counsel, accountants or other consultants. If appropriate, questions and responses may be shared with other personnel so that standards, policies and procedures can be updated and improved to reflect any necessary changes or clarifications. The Compliance Officer shall consider the input of employees and independent contractor staff professionals when developing paths for reporting fraud, waste or abuse. The Compliance Officer shall establish lines of communication and/or reporting channels in a manner which minimizes the ability of such reports to be diverted.

B. Forms of Communication

MMP shall establish a mechanism which may be utilized by employees on an anonymous basis. This mechanism shall be made readily available to all employees and independent contractors and the procedures for communication with the Compliance Officer shall be communicated to all relevant personnel. This mechanism may be by secure voice mail, secure email or a suggestion lock box. Matters reported through these communication devices that suggest substantial violations of compliance policies or established standards of conduct shall be documented and investigated promptly to determine the veracity of the information. The Compliance Officer shall maintain a record of all communications and shall report such communications to the Compliance Committee, the Board of Directors and legal counsel, as appropriate. All reports shall be on an employee/personnel anonymous basis, if possible, until the veracity of the information can be ascertained. ***All employees and personnel of MMP, including independent contractor health professionals, should be aware that, although MMP will strive to maintain the confidentiality of a reporting individual's identify, there may be a point where the individual's identity may become known or may have to be revealed when governmental authorities become involved. Legal counsel should be consulted on all reports which allege a substantial violation of compliance policies or established standards of conduct.***

C. No Reprisals for Reporting

MMP will not tolerate reprisals of any kind by any employee or independent contractor toward someone who reports a suspected violator of the Compliance Program. Any reprisal for a

report made in good faith is a violation of this Compliance Program and the person engaging in such reprisal(s) will be subject to Corrective Action up to and including discharge as provided for in Section X.

VIII. EDUCATION AND TRAINING

A. Mandatory Participation in Education and Training Sessions

The Board of Directors will require, upon recommendation of the Compliance Committee, that Company employees and agents participate in training and education deemed necessary for the Compliance Program. This may include appropriate training in state and federal statutes, regulations and guidelines, and corporate ethics which emphasize MMP's commitment to compliance with applicable legal requirements and policies. Periodic retraining sessions will occur to update prior information. An initial compliance session will be provided to new employees and staff members as part of the orientation process for such individuals. MMP shall maintain records of training and educational sessions offered to employees and independent contractor staff, including attendance logs and materials distributed at training sessions. Periodic professional education courses also may be required for certain Company personnel pursuant to continuing education requirements imposed by state or federal law or accrediting bodies.

Attendance and participation in training programs shall be a condition of employment and shall be included in each new independent contractor agreement after the date this Compliance Program is implemented. All employees and independent contractor staff shall be informed in writing that failure to comply with training requirements will result in Corrective Action, including possible termination, when such failure is serious and shall acknowledge in writing receipt of such information.

MMP shall use such outside consultants as the Compliance Committee deems necessary.

B. Specific Requirements for Training and Educational Sessions

Training programs offered by MMP shall include sessions which highlight MMP's Compliance Program, including those specific risk areas identified. Training programs may include fraud and abuse laws, coding requirements, claims development and submission practices, and documentation requirements for Medicare and Medicaid reimbursement, provided that, sessions shall be offered to various levels of employees and independent contractor staff as appropriate to that individual's job and responsibilities. MMP shall make every effort to fill positions within MMP only with individuals who have received appropriate educational background and training. Individuals in positions of key responsibility within MMP shall periodically assist the Compliance Officer or the Compliance Committee in identifying areas that require training and in carrying out such training. Training instructors may come from inside or outside MMP. MMP shall make every effort to make training and education materials available to physicians working for MMP on a locum tenens basis.

C. Teaching Methods for Training and Educational Sessions

MMP may use a variety of teaching methods for training and educational sessions. MMP shall attempt to implement all training sessions in a manner which effectively transmits relevant information to session participants.

D. Targeted Training and Educational Sessions

Targeted training and educational sessions shall be provided to corporate officers, managers, physician and other employees/independent contractor staff whose actions affect the accuracy of the claims submitted to third party payors, including employees/independent contractor staff involved in the coding, billing, and marketing processes for MMP. The Compliance Officer shall give due consideration to appropriate coordination and supervision of the training and educational efforts by MMP to address the complexity and interdependent relationships between various operational areas of MMP's business. Specific training and educational sessions designed to address identified risk areas are described in MMP's policies and procedures. All employees and independent contractor staff shall be targeted early in their employment/contract for appropriate training in accordance with policies and procedures developed for this express purpose.

IX. INVESTIGATION OF REPORTS OR REASONABLE INDICATIONS OF SUSPECTED NONCOMPLIANCE

A. Prompt Investigation

Upon reports or reasonable indications of suspected noncompliance, the Compliance Officer shall initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. If it is determined that a material violation has occurred, Corrective Action shall be taken in accordance with Section X of this document.

B. Case-by-Case Determination

Whether a material violation of applicable law or the requirements of the Compliance Program has occurred must be determined on a case-by-case basis. The existence, or amount, of a monetary loss to a health care program shall not be solely determinative of whether or not conduct should be investigated, whether action should be taken to correct the violation, and whether Corrective Action should be taken with regard to the individuals involved. Overpayments by third party payors which do not implicate fraud or False Claims Act liability should still be evaluated by the Compliance Officer as potential issues of noncompliance even if standard procedures for repayment of such amount are being utilized. Under these circumstances, the Compliance Officer should evaluate such overpayments to look for trends or patterns that demonstrate a systemic billing/claims management problem.

C. Internal Investigation

Depending on the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents. ***Legal counsel shall be retained, as appropriate, to assist with any internal investigation. Upon the recommendation of legal counsel, auditors and other health care advisors may be retained by legal counsel to assist in the investigation. Legal counsel shall prepare or assist in preparation of all internal investigation documentation.*** Records of the investigation, prepared with the assistance of legal counsel, shall include:

(1) Documentation of the alleged violation;

(2) Description of the investigative process;

(3) Copies of interview notes and key documents;

(4) Log of witnesses interviewed and the documents reviewed;

(5) Results of the investigation, including any recommended Corrective Action to be taken and any action to be taken to correct identified issues; and

(6) Corrective Action and other actions actually implemented.

D. Preserving the Integrity of the Internal Investigation Process

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at risk because of the presence of employees or independent contractor staff under investigation, those individuals may be temporarily removed from their assigned work activity, including the Compliance Committee, with pay in accordance with the individual's employment agreement with MMP until the investigation is completed and a final determination has been made. Additionally, the Compliance Officer should take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

X. CORRECTIVE ACTION

A. Reporting to Government Authorities

If the Compliance Officer or the Compliance Committee discovers from any source credible evidence of criminal violations of the health care fraud and abuse laws described in Section II above that results in an overpayment to MMP, and after a reasonable inquiry and internal investigation, MMP confirms that such criminal conduct may have occurred, then MMP shall report the existence of the conduct to the appropriate governmental authority within a reasonable period of time, but not more than sixty (60) days after determining that there is credible evidence of a violation. ***Legal counsel shall be consulted prior to reporting any***

alleged criminal conduct to governmental authorities. It is MMP's belief that prompt reporting will demonstrate MMP's good faith and willingness to work with governmental authorities to correct and remedy the problems. Any reports of criminal conduct to governmental authorities shall be prepared and submitted in a manner which preserves patient privacy and the confidentiality of patient medical records and information as required under state or federal law.

B. Correcting Non-Compliance

Upon a determination that activities have occurred, or are occurring, which do not comply with requirements of the Compliance Program, standards of conduct developed by MMP, or applicable laws, regulations, policies and procedures, the Compliance Officer shall have primary responsibility for correction of the noncompliance. MMP shall establish specific policies and procedures for correcting specific types of noncompliance. Copies of such specific policies and procedures shall be attached to the Compliance Program, as appropriate.

C. Discipline of Responsible Party

1. Written Corrective Action

Policies shall be developed by MMP which set forth the degrees of disciplinary action which may be imposed upon corporate officers, managers, employees, physicians and independent contractor staff for failing to comply with MMP's standards and policies and applicable statutes and regulations. These policies shall be known as Corrective Action policies. ***Any current employee or independent contractor staff who is convicted of a criminal offense related to health care, or who is debarred or excluded or otherwise ineligible for participation in a federal health care program, as defined in 42 U.S.C. §1320a-7b(f), shall be terminated from employment or as a contractor with MMP. Intentional or reckless noncompliance shall subject transgressors to significant sanctions, including possible termination of employment or contract status. Disciplinary action also may be imposed, if appropriate, where a responsible employee or independent contractor staff person should have, but did not, detect and report a violation and MMP determines that such failure constituted negligent or reckless conduct.***

2. Consistent Application of Disciplinary Policies

MMP shall use all reasonable efforts to apply Company Corrective Action policies and procedures on a fair and equitable basis. Management individuals and supervisory staff shall be instructed as to their responsibilities to undertake Corrective Actions in an appropriate and consistent manner with respect to all employees and independent contractor staff. The consequences of noncompliance shall be consistently applied and enforced with the intent that such action by MMP will deter employees and independent contractor staff from being involved in noncomplying activities.

3. Notice of Written Disciplinary Policies

Upon implementation of this Compliance Program and periodically, but no less than annually, thereafter, all employees and independent contractor staff shall receive express written notice that individuals who fail to comply with MMP's Code of Conduct, policies and procedures, and federal and state law, will be subject to Corrective Action in accordance with policies established by MMP. All Corrective Action policies shall be published in written format and disseminated to all corporate directors, officers, managers, supervisors, employees and independent contractor staff, as appropriate based on position and areas of responsibility, on a regular basis.