ACKNOWLEDGMENT OF POLICIES

It is my responsibility as an employee of the Mount Sinai Medical Center to comply with all laws, regulations and institutional policies described in these documents.

I acknowledge that I have received and read the following information:

✔ Employee Handbook
✔ Compliance Manual
✔ Patent & Development Policy
✔ Code of Conduct and Business Ethics
✔ HR Policy - Conflict of Interest

______________________________

Life Number

______________________________

Name (please print)

______________________________

Signature

______________________________

Date
# Table of Contents

## Introduction

## General Principles

### Relationship With Patients
- A. Patient Non-Discrimination
- B. Emergency Care
- C. Safeguarding Patient Privacy
- D. Safeguarding Security of Electronic Protected Health Information (ePHI)

## Reimbursement
- A. Billing for Medical Services
- B. Conditions of Medicare Participation
- C. Fraud and Abuse
  1. Compliance With Anti-Kickback Statutes
  2. Physician Self-Referral Prohibition
  3. Summary

## Employee Relations
- A. Employee Loyalty and Conflicts of Interest
- B. Commitment to Fairness
- C. Occupational Safety
- D. Drug and Alcohol Free Workplace
- E. Immigration
- F. Pharmaceuticals and Controlled Substances
- G. Confidentiality of Information

## Relationships With Government Regulators
- A. Tax-Exempt Status and Licensure
  1. Tax-Exempt Status; Private Inurement
  2. Certificate of Need; Licensure
  3. Fund Raising
- B. Regulation of Activities
  1. Government Investigations
  2. Lobbying and Political Participation
  3. Hazardous Materials and Infectious Wastes
  4. Records Retention/Destruction
- C. Business Ethics
  1. Illegal Payments
  2. Antitrust and Price Fixing
  3. Truth in Advertising and Marketing
  4. Information Owned by Others

## Scientific Research
- A. Misconduct in Research
- B. Conflicts of Interest and Improper Referrals

## Violations, Investigations and Discipline
- A. Reporting of Violations
- B. Investigation of Violations
- C. Discipline for Violations
The health care industry is regulated by federal, state and local authorities. The requirements are often extensive and complex. This manual provides an overview of key legal and regulatory requirements applicable to academic health science centers. It does not contain all rules and requirements on every topic, but is designed as a general guide. If you have any questions regarding information provided in this manual, please call the Office of The Vice President and Chief Compliance Officer.

General Principles

It is the responsibility of all employees and medical staff members to be familiar and comply with all requirements that pertain to their areas of responsibility, recognize and avoid actions and relationships that might violate those requirements, and seek assistance in situations raising legal and ethical concerns. All employees and medical staff members must:

- Adhere to the highest ethical standards of conduct in all business and professional activities, abiding by the letter and spirit of all applicable laws.
- Deal fairly and honestly with patients, other employees, vendors, government agencies, third party payers, and others.
- Promote relationships based on trust and respect, in an environment where employees may question a practice without fear of adverse consequences.
- Require that outside colleagues (e.g., vendors, consultants and others) also adhere to these same standards.

Relationships With Patients

A. Patient Non-Discrimination

Patients may not be discriminated against in any manner on the basis of their race, color, religion, national origin, gender, age, or sexual orientation.

B. Emergency Care

Both the federal Emergency Medical Treatment and Active Labor Act (known as EMTALA) as well as state law requires that medical screening be provided to all patients who come to an Emergency Room seeking examination, regardless of ability to pay. If the patient has an emergency medical condition, provision must be made for further examination and treatment (within a facility’s capabilities) to either stabilize the patient’s condition or make an appropriate transfer, with proper certification, of the individual to another medical facility, unless the facility refuses to accept the patient. Decisions regarding admission of a person in need of immediate hospitalization can not be based on his or her insurance status or ability to pay and neither the patient nor any member of his or her family can be questioned concerning insurance, credit or payment of charges. However, the hospital may request such information promptly after the patient’s admission. All Emergency Department personnel must be familiar with these requirements.
C. Safeguarding Patient Privacy and other Rights

Federal (HIPAA) and state laws regulate how protected health information (PHI) must be handled. Under these regulations as well as Mount Sinai policies, the following guidelines apply:

- To protect individuals against misuse of their personal information, access must be limited only to those authorized to have such access.
- Only legitimate means to collect information should be used and, whenever practical, it should be obtained directly from the individual concerned.
- Special confidentiality rules apply to medical records that include psychiatric, substance abuse, and HIV-related or genetic information. Disclosure of such information must be handled in accordance with these especially restrictive rules.
- Individuals must conduct themselves appropriately when in possession of confidential information; for example, do not discuss patients in public places such as elevators or the cafeteria.
- The transfer of patient information via E-mail, fax, the Internet and other electronic means must be very carefully handled to ensure the data remains confidential.
- Procedures must be implemented to enable patients to request amendments to their medical records, to access their medical records and to request an accounting of disclosures.
- All policies dealing with PHI are found at http://intranet1.mountsinai.org/. Click on Core/Admin Services button at the top of the page and then click on the word "HIPAA" on the left hand drop down listing. This will take you directly to the appropriate policies.

D. Safeguarding Security of Electronic Protected Health Information (ePHI)

The HIPAA Security Rule provides both required and addressable standards that must be met or addressed, including but not limited to:

- Training regarding basic security principles for the entire workforce
- Performance of a risk assessment to determine and prioritize what corrective action must be taken with regard to systems that create, store or use ePHI. Updates to the assessment must be made as needed.
- Development of policies and procedures regarding basic security requirements
- Development and implementation of an incident response process

Reimbursement

A. Billing for Medical Services

Medicare, Medicaid, other federal health care programs and commercial insurers have strict, and often complex, requirements governing billing for medical services. All hospital staff responsible for billing, physicians and physician billing staff must be familiar and comply with these requirements. Failure to comply may lead to civil or criminal liability. It is imperative that all billing statements to patients or third party payers accurately reflect both the services actually provided and the appropriate charges for those services, as well as all other data required by the payer.
Examples of the types of billing practices which should never be employed include, but are not limited to, the following:
- submission of a bill containing any inaccurate statement;
- billing for services not rendered;
- failure to return overpayment or credit balances to a payer or patient;
- charges in excess of the rates which are appropriate for the services provided;
- Submission of a bill which is not supported by adequate or accurate documentation.

B. Conditions of Medicare Participation

The Medicare and Medicaid programs impose strict requirements on providers that are significantly different from, and more extensive than, exist in commercial contracts. It is essential that all Medicare and Medicaid laws and regulations are strictly complied with when services are provided under these programs. In order to participate in the Medicare program, standards regarding types of services provided, staffing requirements, extent of medical supervision, physical plant, equipment and sanitary conditions must be met. In addition, any individual excluded, suspended or debarred from participation in federal health care programs may not have any responsibility for any business operations related to these federal programs or provide services to patients insured by these programs. Employees with responsibilities in these areas must be familiar with these conditions of participation.

C. Fraud and Abuse

The term "fraud and abuse" refers to specific prohibitions and restrictions on the activities of healthcare providers under Medicare, Medicaid and other payment programs. Two particularly sensitive areas of regulation are the ‘anti-kickback’ statutes and the physician ‘self-referral’ prohibition.

1. Compliance With Anti-Kickback Statutes

The anti-kickback statutes are designed to prevent the payment of a "kickback" in exchange for referrals or other services. In essence, the government seeks to prevent healthcare providers from selling to or purchasing from one another the right to perform and receive payment for covered services. Thus, both federal and state laws specifically prohibit the solicitation, receipt, offer or payment of any form of kickback, bribe or rebate (whether made directly or indirectly, overtly or covertly, in cash or in kind) to induce the purchase, recommendation to purchase, or referral of any kind of health care goods, services or items (e.g., patient referrals, leasing or ordering items or services).

The term kickback is interpreted under the law as the giving of anything of value. Care must be taken not to create a situation where it appears that an improper inducement (such as free goods or services, or items priced below market value) is offered to a person who may be in a position to refer or influence the referral of patients. No one should accept any improper inducement from vendors to influence decisions regarding the use of particular products or the referral or recommendation of patients. For example, goods or services offered for free, or at below-market value, as well as awards, discounts, prizes or other forms of remuneration, may be treated as ‘kickbacks’ even if given as part of a promotional program by a vendor or provider (e.g., pharmaceutical company, medical equipment supplier, etc.).
2. Physician Self-Referral Prohibition

The physician self-referral rules are designed to prevent physicians from making referrals to themselves in the guise of an entity in which they have an interest (either by ownership, including by a family member, or a compensation arrangement). Thus, if a physician (or an immediate family member of that physician) has a financial relationship with an entity, as opposed to a bona fide employment relationship, the physician may not make referrals to the entity for the furnishing of certain services. These services currently include inpatient and outpatient hospital services; clinical laboratory services; physical and occupational therapy services; radiology services; radiation therapy services and supplies; DME equipment and supplies; parental and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; and outpatient prescription drugs.

3. Summary

It is virtually impossible to list everything that may violate these prohibitions. However, billing practices must be scrupulously maintained; improper inducement of any kind must be assiduously avoided; and billing for services referred by outside physicians or other health care practitioners must be carefully monitored.

Employee Relations

A. Employee Loyalty and Conflicts of Interest

All institutional decisions must be made solely to promote the best interests of Mount Sinai and its patients without favor or preference based on personal considerations, and all employees are expected to conduct themselves ethically in all institutional matters and activities. Employees must at all times discharge their duties and responsibilities in the best interests of Mount Sinai and use its resources only in furtherance of institutional goals. The theft of institutional assets or the use of an employee’s position or confidential information gained there from to personal advantage will not be tolerated. For more complete information and guidance on these issues, please refer to your Mount Sinai’s policy on conflicts of interest.

B. Commitment to Fairness

Mount Sinai is committed to the following:

- Equal opportunity for employment and advancement on the basis of ability and aptitude without regard to race, color, religion, national origin, age, gender, marital or military status, disability or sexual orientation, except where age, gender or physical status is a bona fide occupational qualification;
- Prohibition of sexual harassment in the work place;
- Protection of the health and safety of employees in their work environment;
- Compensation of employees according to their performance, and equitable benefits within the framework of prevailing practices;
- Full compliance with all applicable laws regulating the employer-employee relationship; and
- Prompt investigation of allegations of all forms of illegal discrimination and sexual harassment.
Mount Sinai maintains a human resource policy manual with specific policies governing employment. Employees should be familiar with these policies.

C. Occupational Safety

Both federal and state laws regarding the promotion of occupational safety and the avoidance of job related hazards are designed to ensure that work environments are safe. Due regard and attention must be paid to those laws and regulations, as well as to institutional safety policies.

D. Drug and Alcohol Free Workplace

The illegal use, sale, purchase, transfer, possession or presence in one’s system of illicit drugs is strictly prohibited. Consumption or presence in one’s system of alcoholic beverages while on duty is also strictly prohibited. While alcohol may be served at institutional events, employees and faculty may not imbibe if they will be returning to work.

E. Immigration

Federal law prohibits employers from hiring employees who are not legally authorized to work in this country. The legal and regulatory requirements which must be complied with in this area are numerous and complex. Accordingly, in all circumstances in which immigration laws may apply (such as the proposed employment of a person who is not a United States citizen), the Human Resources Department must be consulted.

F. Pharmaceuticals and Controlled Substances

The proper distribution and handling of pharmaceutical products is governed by various federal, state and local laws. In addition, these laws prohibit the diversion of any prescription drug or controlled substance, in any amount for any reason to an unauthorized individual or entity. The distribution of adulterated, misbranded, mislabeled, expired or diverted pharmaceuticals is also a violation of federal and state law. All employees must be diligent and vigilant in carrying out their obligations to handle and dispense prescription drugs and controlled substances in accordance with all applicable laws, regulations, and institutional procedures.

G. Confidentiality of Information

A valuable asset of any institution is its body of confidential information. Confidential information includes methods, processes, techniques, computer software, equipment, service marks, copyrights, research data, clinical and pharmacological data, marketing and sales information, donor lists, personnel data, patient lists, financial data, plans and all other institutional know-how and trade secrets which have not been published or disclosed to the general public. The widespread use of computers has caused this information to be accessible to many employees. Failure to protect this information adequately can lead to the loss of highly confidential data that may cause legal or other risks. Because of the risk of harm, no employee shall, without proper written consent, during or following their term of employment, disclose or use any confidential information obtained during the course of employment for personal benefit or for non-job related purposes. Similarly, institutional names, letterhead, and logos may not be used for personal or non-job related purposes.
All employees are responsible and accountable for the integrity and protection of business information and must take steps to protect information that has been entrusted to them. For example, destruction or disclosure of, or inappropriate modifications to information must not be made, except as authorized. Documents and computerized data bases containing sensitive data, including information concerning patients, should be handled carefully during work hours and must be properly secured at the end of the business day. The security and integrity of all confidential data must be diligently protected. These principles also apply to conversations with and disclosures to the media and to the publication of articles relating to institutional activities.

Relationships with Government Regulators

A. Tax-Exempt Status and Licensure

1. Tax-Exempt Status; Private Inurement

Our hospital and school of medicine are charities, exempt from taxation by federal, state and local governments. To maintain this critically important exemption, they must operate for the benefit of the community and must avoid what the tax law calls 'private inurement' and 'private benefit'; that is, the operation of a tax-exempt facility for the benefit of non-tax-exempt individuals or entities. For example, all non-exempt individuals or entities must pay fair market value for the use of a hospital's services or property. Employees may not be compensated in excess of fair market value for their position. In addition, nonexempt individuals or employees may not conduct private activities on institutional premises. Violations of these prohibitions can jeopardize Mount Sinai's tax-exempt status.

2. Certificate of Need; Licensure

State law requires hospitals to obtain a Certificate of Need from the Department of Health before changing the services it provides, purchasing major medical equipment or making other significant capital expenditures.

The State of New York licenses and the Joint Commission on the Accreditation of Healthcare Organizations accredits hospitals, and together these two agencies have numerous requirements that determine the manner in which services are delivered. Each employee is expected to be familiar with the regulations governing his or her area, to stay abreast of new developments, and to alert his or her supervisor of possible noncompliance.

3. Fund Raising

As charities, hospitals and schools of medicine rely upon contributions from donors to support many of their activities. Employees are encouraged to support fund raising efforts but are required to coordinate all activities with the Development Office. Monies or other items received on behalf of Mount Sinai as gifts should be deposited immediately in the appropriate institutional account.

Charitable contributions from vendors may raise issues implicating federal and state anti-kickback laws, and should be reviewed with the Legal Department. Employees who solicit or receive such contributions must make clear to the donors that contributions will not affect the
institution’s or the individual’s professional judgment regarding the goods or services it purchases, recommends or provides to its patients.

B. Regulation of Activities

1. Government Investigations

Given the increased vigilance by law enforcement agencies in the healthcare area, it is important those definitive guidelines on how and when to respond to government inquiries be clearly understood and strictly adhered to. For example, the provision of inaccurate or incomplete information to government officials in response to their inquiries may lead to civil and/or criminal penalties, while unauthorized disclosure of information may jeopardize our patients’ rights to privacy and also expose the institution to liability. Therefore, adherence to the following procedures will ensure the appropriate response to all government investigations.

Access to Information

- Only three agencies are entitled to immediate access to information: the Office of the Inspector General of the United States Department of Health and Human Services, the State Medicaid Fraud Control Unit, and the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS").
- Inspectors and enforcement agents of the United States Food and Drug Administration (FDA) are entitled to access at ‘reasonable’ times, which the FDA interprets to mean during normal business hours. These agents must present written notice to inspect records and reports, as well as equipment, containers and so forth where food, drugs and devices are held.

In the event of a request for information from officials of these agencies, you must ask for, and be shown, proper identification before providing access. In almost all cases, when a request by officials of these agencies is made, access to the requested information should be delayed pending notification of the Legal Department. Notification will ensure that the institution is aware of the inquiry, properly responds to it, and can take whatever action is necessary with regard to it. If access cannot be delayed pending notification of the Legal Department, then the Legal Department should be contacted simultaneously with allowing access to the data.

Other Governmental Agencies

Other governmental agencies may look at documents and other materials only with institutional consent or by proper legal process. These agencies include: the Federal Bureau of Investigation, the Drug Enforcement Administration, the United States Postal Inspector, the United States Department of Labor, the state Attorney General (with the exception of the Medicaid Fraud Control Unit), and local prosecutors and police departments. As noted above, representatives of these agencies must present proper identification.

To ensure that government agencies are provided with the information to which they are entitled on a timely basis and, at the same time, prevent the improper disclosure of private information; it is imperative that you contact the Legal Department as promptly as possible after receipt of any request for information. In addition, please be certain to (1) obtain the name and organizational affiliation of all persons from whom a request for access to information is received or to whom access will be permitted before any access is allowed, (2)
maintain a written record of each and every document to which access is given, (3) keep a
detailed record of all telephone contacts made, including specifically the name and affiliation
of the parties to each conversation, the information requested and the response given during
the conversation.

2. Lobbying and Political Participation

Certain management personnel may periodically be called upon to make contact with
representatives of city, county, state or federal governments to explain and advocate for the
institution’s positions on issues. These persons are expected to abide by applicable laws at
all times.

In addition, lobbyists or lobbying firms may be periodically engaged to help promote
institutional interests and internal controls have been established to assure that all such
activities are appropriate. Written authorization must be obtained prior to engaging any
lobbyist, outside legal counsel or consultant to lobby for or otherwise promote institutional
interests on any legislative, regulatory or other governmental issue.

Participation in the political process is a basic right of our employees. It is important,
however, to distinguish between personal and institutional political activities. Federal and
state laws limit the nature and extent to which an organization may participate in political
activities. For example, federal law prohibits federally tax-exempt organizations such as
hospitals and schools of medicine from contributing to election or reelection campaigns for
political candidates, whether federal, state or local. Healthcare organizations will occasionally
speak out on issues of importance to them, and senior management is responsible for
developing positions on relevant legislative and regulatory issues. Unless employees are
specifically requested to represent the institution before legislative or other governmental
bodies, all personal communication should be clearly labeled as one’s own beliefs. In this
regard, employees may accurately describe their affiliation with an institution in connection
with their professional and institutional activities, but may not otherwise use the institution’s
name without proper approval. For example, such personal communication should not be
written on institutional letterhead or prepared by institutional employees. Any contact by
legislators or regulators regarding the institution’s position on public issues should be referred
to the appropriate government relations officer.

While employees may make personal political contributions or communicate their personal
beliefs to elected officials, no one will be reimbursed for personal political contributions and
institutional resources may not be used for such purposes. Personal compensation may not
be altered in any way under any circumstances to enable or reflect political contributions.
Finally, in a related area of regulation, federal and state laws prohibit giving a gratuity to a
government employee in connection with a business transaction, even if done without the
intent to influence official action. Thus, in order to avoid any ambiguity in such matters, the
giving of gifts, meals or gratuities to government officials without prior authorization from
senior management is prohibited.

3. Hazardous Materials and Infectious Wastes

In the course of operations, hazardous materials and infectious wastes may be used or
generated. Environmental responsibility including the proper handling and disposal of these
materials is critical to the public welfare.
It is therefore essential that everyone who deals with hazardous materials and infectious waste comply with environmental laws and regulations, and follow institutional environmental safety procedures. Any unsafe storage or release of such materials into the environment must be promptly reported and no one may participate in concealing improper discharge or disposal of hazardous materials, pollutants, or infectious wastes.

4. Records Retention/Destruction

All records must be fully and accurately completed and maintained consistent with proper business practices. Medical records serve as a basis for treatment decisions for patients or as a record of historical courses of treatment and support the billing for services. Consequently, the proper and contemporaneous creation of fully accurate and complete records is a duty of all employees.

In addition, the law requires the maintenance of certain types of medical and business records, usually for a specified period of time. Even if a document is retained for the minimum period, legal liability could still result if it is destroyed before its scheduled destruction date. Accordingly, policies have been established in specific areas to assure retention for required periods.

Employees are expected to comply fully with the records retention and destruction schedule for the department in which they work. Questions about document retention beyond the applicable retention period should be addressed to department management and the Legal Department.

C. Business Ethics

1. Illegal Payments

It is a violation of policy for any officer, employee or any other person acting on behalf of, or in the name of, Mount Sinai to make or authorize any bribe, payment for any illegal act, or any other use of an institutional resource which, even if arguably not illegal, could be interpreted as improper or unwarranted. Employees and their relatives may not solicit or accept favors, gifts or other consideration from any person or organization conducting or seeking to conduct business with our institutions. Equally improper is any payment of any kind to consultants, agents, brokers, attorneys, other individuals or firms if there is reason to suspect that some or all of the payment is to be used to do anything that is prohibited by law or policy.

2. Antitrust and Price Fixing

The antitrust laws are applied with increasing frequency to the healthcare industry. Designed to preserve and foster fair and honest competition, these laws prohibit agreements or understandings (expressed or implied, written or oral) which restrict competition or interfere with the ability of the free market system to function properly. The greatest danger for violations of antitrust laws rests in contacts with competitors. In the eyes of the law, good intentions or customer benefits do not justify or excuse violations. A ‘competitor’ may be another hospital, health care provider (depending on the circumstances), or medical school.

To avoid violating the prohibitions of the antitrust laws, employees should not have any discussions, or other communications with competitors about the division of patients, geographic areas, services, marketing efforts, salaries or the circumstances under which
business will be conducted with suppliers, insurance companies, patients or customers (including boycotts). Further, discussions with competitors regarding future business plans should be avoided. Finally, discussions with competitors regarding prices, reimbursement or salary levels should also be avoided. All of these prohibitions apply even if the communication is made during the course of participation in professional and trade associations.

An important area to which these antitrust provisions apply is managed care. One of the dangers that can arise is price fixing. This might occur where a network of associated physicians decide that they will agree to certain prices from payers, such as where the physicians agree among themselves to a fee schedule. Similarly, use of a fee schedule can constitute an illegal boycott where the physicians collectively decide not to contract (or only to contract on certain terms) with a given payer.

This overview does not address every instance in which the federal and state antitrust laws may apply. If you have any questions, contact the Legal Department.

3. Truth in Advertising and Marketing

All marketing and public relations materials must accurately and honestly reflect the services available and the applicable levels of licensure and accreditation and must comply with the applicable laws and regulations of truth in advertising and nondiscrimination. These materials, as well as other communications with outside organizations or individuals, may not disparage a competitor, its facilities or its services but instead may make fair comparisons by stressing with factual accuracy the advantages of the institution's facilities and services.

4. Information Owned by Others

Other organizations and individuals have intellectual property they want to protect. These other parties are sometimes willing to disclose their confidential information only for a particular purpose or to specific people. Employees with access to another party's confidential information must proceed with caution to prevent any accusations of misappropriation or misuse of information.

Receipt of confidential or restricted information, whether oral, visual or written, should not take place until the terms of its use have been formally agreed to by all parties. Entry into such an agreement requires approval by the Legal Department and/or an appropriate member of senior management. Once another party's confidential or restricted information is available it must not be copied, distributed or disclosed unless to do so is in accordance with the terms of the agreement.

These proscriptions apply to the acquisition and use of computer software (such as computer programs, databases and related documentation) from others. As intellectual property, software is protected by copyright laws and may also be protected by patent, trade secret laws, or as confidential information. Computer software should only be used pursuant to, and in strict conformance with, the terms and conditions of the applicable license agreement. Also, software acquired for personally owned equipment should not be copied and or placed on any institutional computer system, or generally brought into the work place.
Scientific Research

Policies and procedures have been established by the Mount Sinai School of Medicine to ensure the highest ethical standards in the conduct of scientific research; the promotion of original research of high quality; the importance of academic freedom; and that work carried out through research grants maintains those high standards and is consistent with federal, state and local rules and regulations. All faculty and employees involved in research must be familiar with the policies and procedures in this area. Questions involving research compliance should be addressed to the appropriate medical school officers.

A. Misconduct in Research

The prevention of any occurrences of misconduct in research is of the highest priority. The term ‘misconduct in research’ refers to the intentional or reckless disregard for ethical practices in the conduct of research. Examples of misconduct in research include, but are not limited to, activities that compromise the integrity of the research results (such as fabrication, falsification or wrongful manipulation of data or results), plagiarism, failure to comply with the guidelines for handling misconduct in research, or failure to comply with policies concerning human or animal research subjects.

‘Scientific misconduct’ is also defined to include failure to: submit research projects for Institutional Review Board (“IRB”) or Institutional Animal Care and Use Committee approval; to obtain informed consent in accordance with the applicable informed consent policy; or to comply with the applicable conflict of interest policy or any other policy on research activities. Fiscal improprieties and issues concerning the ethical treatment of human or animal subjects are also included in the definition of scientific misconduct.

B. Conflicts of Interest and Improper Referrals

Faculty and staff must identify, as early as possible in the grant writing process, any conflicts of interest between sources of grant funds and themselves. Conflicts of interest include any actual or potential financial interest of a recipient in the outcome of the proposed research. In addition, faculty and staff must be vigilant in considering whether grants could involve improper inducements for the referrals of patients. This could occur, for example, in a study of drug efficacy underwritten by a pharmaceutical company if the protocol were not properly designed and thus resulted in substantial benefits to the institution by way of referrals of patients and receipt of funds for a study that was of questionable scientific value or that required little or no actual scientific pursuit. If improper, such referral practices would constitute ‘kickbacks’ in violation of federal and state law. The Reimbursement Section (above) describes kickbacks and related issues in greater detail. Any questions as to whether the anti-kickback or other statutes may be involved in a research proposal should be directed to the Legal Department.

Violations, Investigations, and Discipline

This Manual is designed to provide a general overview of the legal and ethical requirements that must be adhered to by all employees and medical staff members. It is not intended to replace any existing or future policies. Questions regarding the applicability or interpretation of this Manual may also be directed to the Office of Corporate Compliance and Ethics or the Legal Department.
A. Reporting of Violations

As part of the commitment to ethical and legal conduct, employees are expected to bring immediately to the attention of their supervisor, the Compliance Officer, the Office of Corporate Compliance and Ethics or the Legal Department, information regarding suspected improper conduct. Employees may also call the Compliance Helpline at 1 (800) 853-9212. The Compliance Helpline is available to all employees and medical staff to discuss concerns about possible violations of the law or institutional policy. Anonymous calls will be accepted. Because failure to report criminal or other improper conduct can be understood to condone such conduct, employees are required to come forward with any information regarding an actual or possible violation, without regard to the identity or position of the suspected offender. Those who fail to report knowledge of wrong doing may be subject to disciplinary action. There shall be no reprisals for good faith reporting of actual or possible violations of the law or institutional policies. The identity of anyone reporting a violation will be kept confidential to the extent permitted by law unless doing so prevents a full and effective investigation of an alleged violation. The confidentiality of any employee who is the subject of such a report will also be protected consistent with legal obligations.

B. Investigation of Violations

All reported violations of the law or institutional policies will be promptly investigated. Employees are required to cooperate fully in the investigation of an alleged violation.

C. Discipline for Violations

Disciplinary actions may be taken for:

- Authorization of or participation in actions that violate the law or institutional policies.
- Failure to report a violation or to cooperate fully in an investigation.
- Failure by a violator’s supervisor(s) to detect and report a violation if such failure reflects inadequate supervision or lack of oversight.
- Retaliation against an individual for reporting a violation or possible violation.
- Deliberately making a false report of a violation.
- In addition, in situations where violations of the law or institutional policies have been identified, corrective action will be taken to ensure prevention of similar offenses occurring in the future.
PATENT & DEVELOPMENT POLICY

I. General Policy Statement

The prompt and open dissemination of the results of MSSM research and the free exchange of information among scholars are essential to the fulfillment of MSSM’s obligations as an institution committed to excellence in education, research, and patient care. Matters of ownership, distribution, and commercial development, nonetheless, arise in the context of technology transfer, which is an important aspect of MSSM’s commitment to the improvement of patient care and public health. Technology transfer is, however, subordinate to education, research and patient care; and the dissemination of information must, therefore, not be delayed beyond the minimal period necessary to define and protect the rights of the parties.

II. Technology Ownership Policy Statement

MSSM will own Technology made or created by MSSM faculty, students, staff, visitors, employees, volunteers and others (referred to herein collectively as "MSSM faculty") participating in MSSM programs except for Technology that is owned by the Inventors/Authors.

Inventors/Authors will own Technology that is:

a. Developed outside the area of research of the Inventor/Author conducted under a sponsored Research Project

b. Not created as a "work-for-hire" by operation of copyright law or not created pursuant to a written agreement between the Author/Inventor and MSSM providing for a transfer of copyright, patent or other intellectual property right ownership to MSSM or a third party; and

c. Not developed with the use of funds or facilities administered by MSSM. Technology will not be considered to have been developed using MSSM funds or facilities only if:

1) No more than a minimal amount of unrestricted funds have been used; and

2) No more than insignificant MSSM facilities and equipment have been utilized. Use of individual office, library facilities, and of traditional desktop personal computers are examples of facilities and equipment that are not considered significant.
III. **Certain Publications**

   a. MSSM does not claim ownership of rights to books, articles and other scholarly publications, or to popular novels, poems, musical compositions, or other works of artistic imagination that are created by the personal effort of faculty, staff and students that do not make use of MSSM funds.

   b. The rights to textbooks developed in conjunction with class teaching, unless such textbooks were developed using MSSM administered funds paid specifically to support textbook development, will be owned by the Author.

   c. In general, theses are subject to this policy and the applicable policies of CUNY.

IV. **Responsibility To Comply With Policy**

   All faculty, students, staff, visitors and others participating in research at MSSM are deemed to be aware of their obligation to assign rights to MSSM and sign Invention and Copyright Agreements as provided under Part 5.

   All MSSM personnel and visitors are responsible for complying with the terms of any agreement sponsoring their research. They should contact the Grants and Contracts Office (GCO) for information or assistance regarding interpretation of research contract terms. The terms of such sponsored research agreements apply to Technology made by faculty, students, staff, visitors, and others who participate in performing research supported by such agreements.

V. **Trade and Service Marks**

   Trade and service marks relating to goods and services developed at MSSM will be owned by MSSM.

VI. **Software Acquisition and Use**

   Whether the software and databases used at MSSM are owned by users or third parties and are protected by copyright and/or other laws, or subject to license or other contractual arrangement, it is the policy of MSSM that users abide by any legal restrictions imposed by the owner of the software or database. It is the responsibility of the owner of the protected software or database to make the nature of the restrictions known to the user.
To Our Colleagues,

We would like to take this opportunity to speak to you about one of our most important commitments: our absolute pledge of lawful and ethical behavior to our patients, communities, government regulators and one another. Just as we take pride in our reputation for the highest quality and leadership in patient care, medical education and research, we should be equally proud of our ethical reputation, which has been achieved largely through the contributions of you and your fellow employees. This is more than a source of pride for us; it is one of our greatest assets. In an increasingly complex health care environment, the integrity and values demonstrated by our faculty and staff will help us to maintain our leadership in the years to come.

Our Compliance and Ethics Program helps ensure we maintain our commitment to legal and ethical conduct by all faculty and employees. Jane Whitney, our Vice President and Chief Compliance Officer, is in charge of the Mount Sinai Medical Center Compliance Office, which oversees this Program.

This is your personal copy of the Code of Conduct and Business Ethics, which sets forth our general standards of legal and ethical conduct.

The Code is supplemented by the more detailed Mount Sinai Medical Center Compliance Manual and institutional policies and procedures pertaining to specific areas. Please familiarize yourself with the contents of this Code and continue to uphold these legal and ethical principles without exception. If you are in doubt about how our principles, standards or policies apply, seek answers from your supervisor, the Office of Corporate Compliance and Ethics or other appropriate individuals.

Remember that violations of legal or ethical requirements jeopardize the welfare of OUR INSTITUTION, our employees and patients, and the communities we serve. Remember too, that standards of conduct mean little without personal commitment. Ultimately, the responsibility for ethical behavior—and thus for our reputation—rests largely in your hands.

General Statement of Compliance and Ethics

All employees will abide by the letter and spirit of all applicable legal requirements and adhere to the highest ethical standards of conduct in all activities.

We will deal fairly and honestly with those who are affected by our actions and treat them as we would expect to be treated if the situation were reversed.

We will promote relationships based on trust and respect and provide an environment in which employees may question a practice without fear of adverse consequences. We also expect outside colleagues, e.g., vendors, consultants and others whose actions could be attributed to OUR INSTITUTION, to adhere to these same standards when acting on our behalf.
Rule 1: Compliance with Legal Requirements
We must abide by the letter, as well as the spirit, of all applicable laws and regulations.

Rule 2: Adherence to Ethical Standards
We must adhere to the highest ethical standards of conduct in all activities.

Rule 3: Respect for Patients
All patients are entitled to equal access to care and to be treated with care and respect. In addition, we must respect the privacy of patients and comply fully with special confidentiality rules.

Rule 4: Respect for Other Employees
All employees are entitled to be treated fairly and respectfully. Discrimination and harassment based on race, color, religion, national origin, age, gender, marital status, military status, disability, citizenship, genetic predisposition, spousal abuse or any other characteristic protected by law are strictly prohibited.

Rule 5: Maintenance of Accurate Records and Documents
All records, documents and reports must be accurate, complete and in compliance with institutional and governmental requirements. All bills for services must be based on the services actually provided, medically necessary and supported by the required documentation.

Rule 6: Avoidance of Conflict of Interest
We must discharge our duties and responsibilities in the best interests of OUR INSTITUTION and may not use our position (or confidential information gained there from) for personal advantage. We must comply fully with the Mount Sinai Medical Center policies on Conflicts of Interest.

Rule 7: Adherence to Proper Business Practices
We must conduct our business activities on the basis of fair competitive practices. All purchases of services and supplies must be from qualified and reliable sources, based upon objective factors and may not personally benefit employees.

Rule 8: Compliance with Environmental Laws
We must comply fully with all environmental laws and regulations. All hazardous materials and infectious waste must be stored, handled and disposed of in full compliance with all laws, regulations and institutional policies. Unsafe storage or release of such materials into the environment must be promptly reported.

Rule 9: Protection of Occupational Safety
To ensure a safe work environment, we must abide by all laws and regulations regarding occupational safety.

Rule 10: Maintenance of a Drug and Alcohol Free Workplace
The illegal use, sale, purchase, transfer, possession or presence in one’s system of illicit drugs is strictly prohibited. The use, sale, purchase, transfer, possession or presence in one’s system of alcoholic beverages while on duty is prohibited.
Reporting of Violations

Employees are required to come forward with any information regarding an actual or possible violation of this Code or institutional policy and cooperate fully in the investigation of any alleged violation.

Reports should be made either in person, by telephone or in writing to any of the following:

- Your Supervisor
- The Human Resources and Labor Relations Department (212) 241-8381
- The Mount Sinai Medical Center Compliance Office
- The Compliance Helpline: 1-800-853-9212, available to all employees to discuss concerns about possible violations of the law or institutional policy

There shall be no reprisals for good faith reporting of actual or possible violations of the Code. We will endeavor to keep the identity of anyone reporting a violation confidential to the extent permitted by law unless doing so prevents us from fully and effectively investigating an alleged violation.

Discipline for Violations

We will take disciplinary action, including dismissal when appropriate, against any employee who violates any legal requirements or institutional policies, including anyone who fails to report violations or retaliates against any individual for reporting in good faith a possible violation.

Questions Regarding the Code

This Code is designed to remind you of the general legal requirements and institutional policies that you must adhere to as an employee or faculty member of Mount Sinai Medical Center. It is not a substitute for existing and future policies of Mount Sinai Medical Center. A more detailed Compliance and Ethics

If you have any questions regarding the Code, you may direct them to any of the resources listed in section "Reporting of Violations."

The Compliance Helpline:

1-800-853-9212
A. **PURPOSE:** This statement sets forth Mount Sinai's policy on conflicts of interest and related issues pertaining to employees. The purpose of this policy is to ensure that all institutional decisions are made solely to promote the best interests of Mount Sinai without favor or preference based on personal considerations, and to provide for the highest ethical conduct with respect to the actions and business relationships of all employees.

B. **GENERAL STANDARD:** All employees shall exercise the utmost good faith in all matters relating to the discharge of their duties and responsibilities at Mount Sinai and, shall at all times act in the best interest of Mount Sinai. Employees shall not use their positions, or confidential information gained therefrom, to their personal advantage. Furthermore, the judgment and independence of employees may not be impaired or appear to be impaired in the discharge of their duties and responsibilities on behalf of Mount Sinai because of any activity in which they may engage or any personal or financial interest or relationship they may have. For purposes of this policy, a "conflict of interest" is defined to be any activity that violates, or could potentially violate, the foregoing standard.

Each employee is responsible for recognizing the possibility of a conflict of interest and for disclosing it pursuant to the procedures described below.

C. **SPECIFIC ACTIVITIES:** It is not possible to describe every instance in which a conflict of interest might arise. Without limiting the general standards set forth in Part A above, the following are specific instances of activities that may create a conflict of interest or are so inherently inconsistent with the norms of proper and ethical behavior that they almost invariably will be prohibited:

1. **Financial Interests:** Direct or indirect financial or other interests in or relationships (including interests or relationships of Related Parties, including spouse, parents, descendants, parents' descendants and spouse's parents' descendants) with any business or entity which has a business, financial or other relationship with, or is a competitor of, Mount Sinai (an employee shall not be deemed to have an interest in, or relationship, with any corporation, firm, association or other entity whose securities are publicly traded solely because such person and Related Parties own, in aggregate, or have an aggregate beneficial interest in, less than 5% of the company's outstanding shares).

2. **Service In Other Entities:** Service as a director, trustee, officer, partner, member of a scientific advisory board, employee, manager or consultant, or other activity taken on behalf of a business or entity which has a business or financial relationship with, or is a competitor of, Mount Sinai.
3. **Acceptance of Gifts, Etc.:** Solicitation or acceptance by employees or Related Parties of gifts, gratuities, payments or consideration of any kind, loans (other than from established banking or financial institutions), or other favor from any person or organization arising because such person or organization does, or is seeking to do, business with, or establish a relationship with Mount Sinai, except (i) de minimis gifts whose aggregate value does not exceed $100 per annum, (ii) reasonable business meals and entertainment provided in the regular course of business and (iii) other business travel and entertainment which has been disclosed and approved pursuant to this policy.

4. **Use of Confidential Information:** Disclosure or other use of confidential or privileged information gained because of such person's relationship to Mount Sinai for direct or indirect personal advantage. Without limiting the generality of the foregoing, it is Mount Sinai's policy (and also the law) that use of any such information for personal gain in connection with the purchase or sale of securities or other investment activities is prohibited.

D. **PROCESS FOR DISCLOSURE; RESOLUTION OF CONFLICTS:** It is recognized that part-time employees frequently have the interest and relationship described in subparagraphs 1 and 2 of Part B above and this policy requires disclosure only where they create a conflict of interest. However, for full-time employees all such interests and relationships must be disclosed pursuant to this Part C.

In the event an employee has a conflict of interest or must otherwise make a disclosure as required by the preceding paragraph, such employee shall disclose it immediately in writing to the President or if such conflict arises in connection with the work of a trustee committee, such disclosure shall be made to the chairman of the committee. If the President, the Chairman of the Board or the Chairman of a trustee committee, as the case may be, determines that there is a conflict of interest, the conflict of interest will be resolved as follows:

1. Unless otherwise authorized, the individual with the conflict of interest may take no part in Mount Sinai decisions to which the conflict relates.

2. In addition, with reference to employees, the activity giving rise to the conflict of interest may be prohibited by the President or the Chairman of the Board, as the case may be.
E. ADVISORY COMMITTEE: An advisory committee (the "Advisory Committee") consisting of the Senior Vice President for Business and Finance, the Senior Vice President and General Counsel, the Director of Internal Audit, the Chairman of the Audit Committee of the Board of Trustees, the Chairman of the Legal Committee of the Board of Trustees and a member of the institution's independent outside auditors shall be established to advise the President and the Chairman of the Board concerning specific conflicts of interest as well as to assist in the overall administration and monitoring of the implementation of this policy.

F. COMPLIANCE/QUESTIONNAIRE: It is the responsibility of all employees to familiarize themselves with this policy and to comply and ensure compliance of Related Parties with this policy. To that end, in addition to the appropriate disclosures required by this policy, (1) non-trustee officers and members of the purchasing department, (2) employees and members of the voluntary staff who are in a position to influence vendor selection, to approve a transaction with a third party or to approve the expenditure of funds, and (3) such other employees as determined from time to time by the President are required to complete annually a questionnaire substantially in the form attached hereto as Attachment A and to return it to the office of Internal Audit - Box 1092.

G. RELATIONSHIP TO OTHER POLICIES: This policy is intended to supplement and not replace existing or future policies of Mount Sinai, including the policy to be released governing the fraud and abuse provisions of the federal and state reimbursement laws.

H. REPORT TO BOARD OF TRUSTEES: A report of all conflicts of interest shall be made by the Chairman of the Board and the President at least once annually to the Audit Committee of the Board of Trustees.

I. INFRACTIONS: This policy will be strictly enforced. Employees who violate this policy will be subject to disciplinary action including possible dismissal.

J. QUESTIONS: Questions as to the applicability and interpretation of this policy should be directed to the Office of the Dean of the School of Medicine, the Office of the Director of the Hospital, the Director of Internal Audit or the Office of General Counsel.