Banner Health

Title: **Compliance: Reporting and Investigating Potential Compliance Issues**	
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Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner—University Medical Center Phoenix Banner—University Medical Center South Banner—University Medical Center Tucson Community Hospital East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional MedCenter Washakie Medical Center	**Banner Corporate** **Ambulatory Services** Banner Health Clinics Banner Imaging Services Banner MD Anderson Cancer Center Banner Surgery Centers Banner Urgent Care Centers B—UMCP Sleep Center Occupational Health/Employee Services Rural Health Clinics **Banner Home Care and Hospice** **Insurance** Banner Health Network Banner Plan Administration University Physicians Health Plans **Banner Pharmacy Services** **Post-Acute Care Services** **Research**

I. Purpose/Population:

A. **Purpose**:
   1. To establish a Disclosure Program at Banner Health (Banner) that enables Covered Persons to report Potential Compliance Issues without fear of retaliation.
   2. To ensure that Reportable Events are identified and reported to the U.S. Department of Health and Human Services Office of Inspector General (OIG) within 30 days as required by Banner's Corporate Integrity Agreement (CIA).

B. **Population**: All Covered Persons

II. Definitions:

A. Abuse: Includes actions that may, directly or indirectly, result in unnecessary costs to Federal Health Care Programs. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

B. Corporate Integrity Agreement (CIA): A five-year agreement that Banner entered into on April 9, 2018 with the OIG as part of a settlement with the Department of Justice.

C. ComplyLine: Banner's confidential compliance hotline, which is available 24 hours a day, 7 days a week and can be accessed by calling 888-747-7989 or online at https://bannerhealthcomplyline.alertline.com.

D. Covered Persons: Includes:
   1. Board of Directors;
   2. All full-time and part-time employees and volunteers of Banner and of any discrete operating unit owned, operated, or controlled by Banner except those subsidiaries, affiliates or units owned, operated, or controlled by Banner where the compliance function has been assigned to another entity;
   3. All contractors, subcontractors, agents, and other persons/entities who provide patient care items or services or who perform billing or coding functions on behalf of Banner, excluding such persons/entities providing such items, services, or functions for any subsidiaries, affiliates or units owned, operated, or controlled by Banner where the compliance function has been assigned to another entity and excluding vendors whose sole connection with Banner is selling or otherwise providing medical supplies or equipment to Banner.
   4. All physicians and other non-physician practitioners who are credentialed providers at the 12 hospitals named in the CIA[1].

E. Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded in whole or in part by the United States Government (other than the Federal Employees Health Benefit Program) or any State health care program (as defined in 42 U.S.C. § 1320a-7(h)). Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Indian Health Service,

[1] The 12 hospitals are Banner Baywood Medical Center, Banner Heart Hospital, Banner Boswell Medical Center, Banner Del. E. Webb Medical Center, Banner Desert Medical Center, Banner Estrella Medical Center, Banner Gateway Medical Center, Banner University Medical Center Phoenix, Banner Ironwood Medical Center, Banner Thunderbird Medical Center, North Colorado Medical Center, and McKee Medical Center.

TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.

F. Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any Federal Health Care Program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any Federal Health Care Program.

G. Ineligible Person: An individual or entity who:
   1. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal Health Care Programs or in federal procurement or non-procurement programs, as evidenced by the individual's or entity's inclusion on the OIG's List of Excluded Individuals/Entities (LEIE), General Services Administration's System for Award Management (SAM), State Medicaid Exclusion Lists, and any other lists required by the OIG or Centers for Medicare and Medicaid Services (CMS); or
   2. Has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a)[2] but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

H. Overpayment: Any funds received in excess of the amount due and payable under Federal Health Care Program requirements.

I. Potential Compliance Issue: Any suspected violation of Banner's Code of Conduct or policies and procedures and/or any suspected violation of laws or regulations relating to a Federal Health Care Program, including, but not limited to, the False Claims Act, the Physician Self-Referral (Stark) Law, and the Anti-Kickback Statute. Potential Compliance Issues include, but are not limited to, Fraud, Waste, and Abuse.

J. Reportable Event: Any event or series of events that involves:
   1. A Substantial Overpayment;
   2. A matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal Health Care Program for which penalties or exclusion may be authorized, including, but not limited to, the False Claims Act, Stark law, Anti-Kickback Statute, Emergency Medical Treatment and Labor Act (EMTALA), and Health Insurance Portability and Accountability Act (HIPAA);
   3. The employment of, contracting with, or granting privileges to an Ineligible Person; or
   4. The filing of a bankruptcy petition by Banner.

K. Substantial Overpayment: For purposes of this policy, a "Substantial Overpayment" is defined as a single Overpayment or a series of Overpayments that (1) meets a threshold amount of $100,000 and (2) is considered substantial based on several factors, including, but not limited to, the number of affected claims, the time period over which the Overpayment(s) occurred, the dollar amount involved, and the nature of the error that led to the Overpayment(s).

[2] The statute provides for mandatory exclusion from participation in any Federal Health Care Program for individuals and entities convicted of (1) program-related crimes, (2) patient abuse, (3) felonies relating to health care fraud, and (4) felonies relating to controlled substances.

L. Waste: The overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to Federal Health Care Programs. Waste is generally considered the misuse of resources.

III. Policy:

A. **Reporting Potential Compliance Issues**
1. Covered Persons must, and any other persons may, immediately report Potential Compliance Issues upon discovery.
   a. Covered Persons should contact the Ethics & Compliance Department if they have any questions whether an issue is a Potential Compliance Issue.
   b. Covered Persons must report HIPAA violations by complying with the respective HIPAA policies.
2. Banner has implemented several avenues for reporting Potential Compliance Issues.
   a. Covered Persons may report Potential Compliance Issues directly to the following:
      i. Their supervisor;
      ii. Their department manager or director;
      iii. The applicable Compliance Officer for the hospital, clinic, business area, or insurance division; or
      iv. The Ethics & Compliance Department.
      Note: If a Potential Compliance Issue is reported to a supervisor or a department manager or director, the individual who receives the report will immediately contact the Ethics & Compliance Department.
   b. Covered Staff may also use the ComplyLine to report Potential Compliance Issues if they want to remain anonymous or do not feel comfortable reporting directly to their supervisor, department manager or director, Compliance Officer, or the Ethics & Compliance Department. See Compliance: ComplyLine.
3. Covered Persons may report Potential Compliance Issues in good faith without fear of retribution or retaliation. *See* Prohibition Against Retaliation for Protected Activities.

B. **Assigning Issues to Investigator(s)**
1. The Ethics & Compliance Department will determine if the matter is a Potential Compliance Issue and, if so, will assign investigative responsibility to the applicable department or individual.
   a. If the matter is not a Potential Compliance Issue, the Ethics & Compliance Department will refer the matter to the appropriate department for handling.
   b. If the Potential Compliance Issue involves more than one facility, clinic, business area, or insurance division, investigative responsibility may be assigned to more than one department or individual. If this occurs, the departments or individuals will coordinate their investigations to minimize redundancies in interviews and document requests to the extent possible.

C. **Investigating Potential Compliance Issues**
1. The assigned investigator(s) – which generally includes the applicable Compliance Officer – will investigate the Potential Compliance Issue and will involve other individuals or departments as needed.
   a. The investigation may include reviewing documents, conducting interviews, and/or performing other activities as appropriate. If appropriate, the investigator(s) will involve the Legal Department and/or outside legal counsel.

b. If an investigation reveals that the Potential Compliance Issue may be a potential Reportable Event, the investigator(s) will immediately contact and submit additional information to the Ethics & Compliance Department. Refer to Section III.D.
   i. Potential Reportable Events include, but are not limited to, the issues identified in **Appendix A**.
   ii. HIPAA and EMTALA violations will be addressed in accordance with applicable policies. Under certain circumstances, these violations may also constitute Reportable Events.

c. Investigations will be completed as soon as reasonably possible, but the time spent on each investigation may vary depending on the nature and complexity of the issue(s). Investigations will generally be completed within six (6) months or receipt of credible information of a potential Overpayment, except in extraordinary circumstances.

2. Once an investigation is completed, the investigator(s) will, if necessary, work with appropriate departments to implement a corrective action plan (CAP).
   a. A CAP may include creating/revising a policy and procedure, providing specialized or remedial education, conducting monitoring activities, repaying Overpayments, and/or implementing corrective (disciplinary) action.
   b. The Ethics & Compliance Department will report and return any Overpayments to the applicable Federal Health Care Programs no later than sixty (60) days after their identification in accordance with the Compliance: 60-Day Report/Repay Overpayments policy.
3. The investigator(s) will maintain an electronic or paper investigative file, which includes, at a minimum, a description of the Potential Compliance Issue, the investigation, and any actions taken as a result of the investigation (such as a CAP). As a general rule, these investigative files are confidential and will not be shared with third parties or other departments absent approval from the Ethics & Compliance Department or the Legal Department. Any files maintained by other departments will be provided to the Ethics & Compliance Department upon request.

D. **Investigating Reportable Events**

1. The Ethics & Compliance Department will lead or coordinate the investigation of any potential Reportable Events.
2. The investigation of a potential Reportable Event will be conducted in a similar manner as a Potential Compliance Issue, which includes reviewing documents, conducting interviews, and/or performing other activities as appropriate.
3. If it appears that a Reportable Event may have occurred, the issue will be referred to the Reportable Events Committee (REC).
4. The Ethics & Compliance Department will continue to provide monthly updates to the OIG on the Reportable Event until it is fully resolved.
5. The investigative file related to the Reportable Event will be maintained by the Ethics & Compliance Department or will be made available to the Ethics & Compliance Department upon request.

IV. Procedure/Interventions:

A. **Reporting Potential Compliance Issues** (**COVERED PERSON**)

1. Immediately report a Potential Compliance Issue to a supervisor, department manager, department director, Compliance Officer, or the Ethics & Compliance Department or the ComplyLine.
2. Request anonymity, if desired.
3. Provide as much information as possible about the Potential Compliance Issue.

B. **Forwarding Potential Compliance Issues** (**SUPERVISOR OR DEPARTMENT MANAGER/DIRECTOR**)
   1. Forward the Potential Compliance Issue reported by Covered Persons to the Ethics & Compliance Department.

C. **Assigning Issues to an Investigator** (**ETHICS & COMPLIANCE DEPARTMENT**)
   1. Follow the Compliance: ComplyLine policy if the Potential Compliance Issue is reported using the ComplyLine.
   2. If reported directly to a supervisor, department manager or director, Compliance Officer, or the Ethics & Compliance Department, determine if the matter reported is a Potential Compliance Issue:
      a. If a Potential Compliance Issue, assign investigative responsibility.
         i. The applicable Compliance Officer or another individual from the Ethics & Compliance Department is usually involved in the investigation of a Potential Compliance Issue.
      b. If not a Potential Compliance Issue, assign to the appropriate individual or department based on the type of issue:
         i. **HIPAA**: Patient privacy issues are referred to the HIPAA Privacy Office.
         ii. **Human Resources**: Human resources issues (e.g., hostile work environment, employee relations, and staffing/scheduling issues) are referred to the Human Resources Department.
         iii. **Risk Management**: Risk management issues (e.g., certain patient safety issues and litigation matters) are referred to the Business Health Department (risk management).
      c. A Potential Compliance Issue involving or relating to a Banner Board Member or the Banner President/CEO, regardless of how the matter is brought forth, will be handled as follows:
         i. The Vice President of Ethics & Compliance will immediately notify the Chair of the Board's Audit Committee of the allegations. The Chair will decide whether the Audit Committee will oversee the investigation into the allegations and, if it does, will use any internal and/or external resources deemed appropriate.

D. **Investigating Potential Compliance Issues** (**INVESTIGATOR(S)**)
   1. Make a preliminary, good faith inquiry into the Potential Compliance Issue to determine whether further investigation is warranted.
   2. If appropriate, investigate the Potential Compliance Issue, which may include:
      a. Obtaining relevant documents from the identified department, clinic, or business area, or insurance division;
      b. Interviewing individuals who may have relevant information; and/or
      c. Performing other activities as appropriate, which may include involving the Legal Department or outside legal counsel.
   3. Contact the Ethics & Compliance Department immediately if the investigation reveals that the issue may be a potential Reportable Event. *See* Section IV.E.
   4. Determine whether a CAP is necessary and, if so, ensure that the CAP is developed and implemented.
   5. Report and return any Overpayments to the applicable Federal Health Care Program no later than sixty (60) days after they are identified in accordance with the Compliance: 60 Day Report/Repay Overpayments policy.

6. Provide a response, if appropriate, to the Covered Person who initially reported the Potential Compliance Issue.
7. Maintain an electronic or paper file that includes the documentation related to the Potential Compliance Issue, including, but not limited to, the initial report, investigative notes, and any actions taken as a result of the investigation (including a CAP).
8. Retain investigative files in accordance with the Records Retention and Destruction Policy or as required by the CIA, whichever is longer.

E. **Investigating Reportable Events** (**ETHICS & COMPLIANCE DEPARTMENT**)
1. Lead or assist in the investigation of the potential Reportable Event.
2. If it appears that an actual Reportable Event has occurred, complete the applicable form for that type of Reportable Event and attach any supplemental information that will allow the REC to make a determination of whether a Reportable Event occurred.
    a. If the REC decides that the issue is a Reportable Event, the Ethics & Compliance Department will provide appropriate notification to the OIG within 30 days of that decision and will continue to make monthly updates to the OIG until the Reportable Event is resolved.
3. Decide if, when, and how to notify appropriate third-party payers.
    a. Any notification should be provided in accordance with contract requirements.
4. Continue investigating the Reportable Event using the same methods as described for investigating a Potential Compliance Issue.
5. Determine whether a CAP is necessary and, if so, ensure that it is developed and implemented.
6. Report and return any Overpayments to the applicable Federal Health Care Program no later than sixty (60) days after they are identified in accordance with the Compliance: 60 Day Report/Repay Overpayments policy.
7. Provide a response, if appropriate, to the Covered Person who initially reported the Reportable Event.
8. Maintain an electronic or paper file that includes all documentation related to the Reportable Event, including, but not limited to, the initial report, investigative notes, and any actions taken as a result of the investigation (such as a CAP or documents provided to or received from the OIG or another government authority).
9. Retain investigative files in accordance with the Records Retention and Destruction Policy or as required by the CIA, whichever is longer.

V. Procedural Documentation:

A. Any corrective (disciplinary) action must be documented in accordance with the Corrective Action Policy.

VI. Additional Information:

A. N/A

VII. References:

A. N/A

VIII. Other Related Policies/Procedures:

A. Code of Conduct (Ethics and Compliance Website)
B. Compliance: ComplyLine
C. Compliance: 60 Day Report/Repay Overpayments

D. Prohibition Against Retaliation for Protected Activities
E. Records Retention and Destruction Policy
F. Corrective Action Policy

IX. Keywords and Keyword Phrases:

A. Reporting
B. Investigating
C. Potential Compliance Issue
D. Non-Retaliation
E. Reportable Event
F. Overpayment
G. ComplyLine

X. Appendix:

A. Appendix A: Examples of Potential Reportable Events

APPENDIX A
Examples of Potential Reportable Events*

Substantial Overpayment

- Coding and/or billing error(s) resulting in a Substantial Overpayment (≥ $100,000 + consideration of the applicable factors)

Probable Violation of the Law

- False Claims Act Violations
  - False or fraudulent documentation
  - Submission of false or fraudulent cost reports

- HIPAA Violation
  - Privacy breach reported to the Office for Civil Rights (OCR)
  - Security or privacy breach affecting 500 or more individuals

- Stark & Anti-Kickback Violations
  - Providing office space, equipment, or compensation to physicians or other referral sources without a contract

- EMTALA
  - Transferring an unstable patient without acceptance from the receiving facility
  - Failing to perform medical screening examinations on patients who come to the emergency department

Excluded Individuals or Entities

- Services provided by employees or providers who are excluded from Federal Health Care Programs

* This Appendix only provides a few examples of potential Reportable Events and does not represent a comprehensive list of all potential Reportable Events. If you have any questions regarding whether an issue is a potential Reportable Event, please contact the Ethics & Compliance Department.