Banner Health

Title: **Compliance: Reporting and Investigating Potential Compliance Issues**	
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Approved by: Administrative Policy Committee, PolicyTech Administrators, David Bixby 09/05/2018	
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 Banner Health Clinics Banner MD Anderson Cancer Center Banner Health Network Banner Home Care and Hospice Banner Plan Administration Banner Pharmacy Services Banner Surgery Centers Banner Urgent Care Centers Occupational Health/Employee Services Post-Acute Care Services Research Rural Health Clinics University Physicians Health Plans

I. Purpose/Population:

A. To establish a Disclosure Program at Banner Health (Banner) that enables Banner Staff to report Potential Compliance Issues without fear of retaliation.
B. To set forth the expectation that Potential Compliance Issues are promptly and thoroughly investigated and any appropriate corrective actions are implemented.
C. To ensure that Reportable Events are reported to the Department of Health and Human Services Office of Inspector General (OIG) within 30 days as required by Banner's Corporate Integrity Agreement (CIA).
D. This policy applies to all Banner Staff.

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. Banner Staff: Incudes:
   1. All full-time and part-time employees and volunteers of Banner and of any discrete operating unit owned, operated, or controlled by Banner (except Sonora Quest Laboratories and other entities approved by the Chief Legal Officer/General Counsel);
   2. 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 or of any discrete operating unit owned, operated, or controlled by Banner (except Sonora Quest Laboratories and other entities approved by the Chief Legal Officer/General Counsel); and
   3. All physicians and other non-physician practitioners who are members of Banner's active medical staff.
C. ComplyLine: Banner's confidential compliance hotline available 24 hours a day, 7 days a week that can be accessed by calling 888-747-7989 or online at https://bannerhealthcomplyline.alertline.com.
D. 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, TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.
E. 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.
F. 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; or

2. Has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a)[11] but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

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

H. Potential Compliance Issue: Any suspected violation of Banner's Code of Conduct or policies and procedures and/or any suspected violation of any 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.

I. 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 any 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 Stark law, Anti-Kickback Statute, False Claims Act, 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.

J. 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).

K. 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. It is the responsibility of Banner Staff to immediately report Potential Compliance Issues upon discovery.
      a. Banner Staff should contact the Ethics & Compliance Department if they have any questions whether an issue is considered a Potential Compliance Issue.
      b. Banner Staff should also report HIPAA violations by complying with the respective HIPAA policies.
   2. Banner has implemented several avenues for reporting Potential Compliance Issues.
      a. Banner Staff may report Potential Compliance Issues directly to the following personnel:
         i. Supervisor;
         ii. Department manager or director;
         iii. Compliance Officer at the hospital, provider group, ancillary service area, or insurance division; or
         iv. Ethics & Compliance Department.

[1] 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.

If a report is made to a supervisor or a department manager or director, that individual will immediately forward the report to the Ethics & Compliance Department.

b. Banner Staff may also report Potential Compliance Issues through the ComplyLine. Although following the chain of command is encouraged, Banner Staff may use the ComplyLine whenever they want to report anonymously or are uncomfortable for any reason reporting directly to their supervisor, department manager or director, compliance officer, or the Ethics & Compliance Department. If a Potential Compliance Issue is reported through the ComplyLine, the Compliance: ComplyLine policy (#12648) will be followed.

3. Banner Staff are free to 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 business area, clinic, or facility, the 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) – who 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 forward additional information about the issue to the Ethics & Compliance Department. Refer to Section III.D.
      i. Potential Reportable Events include, but are not limited to, the issues identified by way of example in **Appendix A.**
      ii. HIPAA and EMTALA violations will be addressed in accordance with applicable policies. Under certain circumstances, these violations may also constitute potential Reportable Events.
   c. Investigations will be completed as soon as reasonably possible, but the amount of time spent on each investigation may vary depending on the nature and complexity of the issue(s). However, 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 implement any necessary corrective action and will, if appropriate, provide a response to the Banner Staff who initially reported the Potential Compliance Issue.
3. The investigator(s) will document and 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 findings (such as corrective action).

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 will include such things as reviewing documents, conducting interviews, and/or performing other activities as appropriate.
3. If an investigation reveals that a Reportable Event may have occurred, the matter will be referred to the Reportable Events Committee (REC). If the REC determines that a Reportable Event exists, the Ethics & Compliance Department will report the Reportable Event to the OIG within 30 days of that determination.
4. The investigative file related to any Reportable Events will be maintained by the Ethics & Compliance Department.

IV. Procedure/Interventions:

A. **Reporting Potential Compliance Issues** (**BANNER STAFF**)
1. Immediately report a Potential Compliance Issue to a supervisor, department manager, department director, Compliance Officer, or the Ethics & Compliance Department or by contacting the ComplyLine at 888-747-7989 or https://bannerhealthcomplyline.alertline.com.
2. Provide as much information as possible about the Potential Compliance Issue.

B. **Forwarding Potential Compliance Issues** (**SUPERVISOR OR DEPARTMENT MANAGER OR DIRECTOR**)
1. Forward the Potential Compliance Issue reported by Banner Staff 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. A Potential Compliance Issue that appears to be a Reportable Event will involve the Ethics & Compliance Department.
   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 (such as hostile work environment, employee relations, and staffing/scheduling issues) are referred to the Human Resources Department.
      iii. **Risk Management**: Risk management issues (such as certain patient safety issues and issues that may result in litigation) are referred to the Business Health (risk management/loss control) Department.

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 Chair of the Audit Committee of the Banner Board will be notified immediately by the Vice President of Ethics & Compliance of any allegations concerning a Banner Board Member or the Banner President. The Audit Committee may oversee the investigation into the allegations, using any internal and/or external resources deemed appropriate.

D. **Investigating Potential Compliance Issues** (**INVESTIGATOR(S)**)
1. Make a preliminary, good faith inquiry into the allegations of a Potential Compliance Issue to determine whether further investigation is warranted.
2. Investigate the Potential Compliance Issue, if one is deemed necessary, which may include:
    a. Obtaining relevant documents from the identified department, clinic, or business area;
    b. Interviewing individuals who may have relevant information; and/or
    c. Conducting other activities as appropriate (including, when appropriate, involving the Legal Department or outside legal counsel).
3. Contact the Ethics & Compliance Department immediately if the investigation reveals that the matter may be a potential Reportable Event. *See* Section IV.E.
4. Determine whether any corrective actions need to be taken as a result of the investigation and, if so, ensure that the corrective action(s) are 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 Banner Staff who initially reported the Potential Compliance Issue.
7. Maintain an electronic or paper file that includes all documentation related to the Potential Compliance Issue, including, but not limited to, the case report, investigative notes, and any actions taken as a result of the investigation.
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 to determine whether an actual Reportable Event has occurred.
2. If it appears that a Reportable Event has occurred, the matter will be presented to the REC for determination whether it is a Reportable Event.
    a. If so, provide appropriate notification with the information required under the CIA to the OIG within 30 days of that determination.
    b. If not, continue investigating the matter as Potential Compliance Issue. Section IV.D.
3. Continue investigating the Reportable Event in a similar manner as Potential Compliance Issues and provide updates as requested to the OIG.
4. Determine whether any corrective actions need to be taken as a result of the investigation and, if so, ensure that it is implemented.
5. Provide a response, if appropriate, to the Banner Staff who initially reported the potential Reportable Event.
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. Decide if, when, and how to notify appropriate third-party payers.
   a. If it has not done so already, decide whether to involve the Legal Department and/or outside legal counsel.
   b. Ensure that any notification is provided in accordance with contract requirements.
8. Provide a response, if appropriate, to the Banner Staff who initially reported the potential Reportable Event.
9. Maintain an electronic or paper file that includes all documentation related to the potential or actual Reportable Event, including, but not limited to, the case report, investigative notes, and any actions taken as a result of the investigation (including any documentation provided to or received from a government authority).
10. 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 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
  - 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

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.