Banner Health

Title: Compliance: Reporting and Investigating Potential Compliance Issues		
Number: **264**	**Version**: 16	**Original Date**: 01/21/2007
Effective Date: 12/02/2021		**Last Review/Revision Date**: 12/02/2021
Next Review Date: 12/02/2022		**Owner**: Ethics & Compliance Department; Andrew Glosenger
Approved by: Administrative Policy Committee, Chief Legal Officer/General Counsel, PolicyTech Administrators		

Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Behavioral Health Hospital
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 Ocotillo 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
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Banner Corporate

Ambulatory (Outpatient) Services
Banner Health Clinics
Banner Imaging Services
Banner Imaging Services Colorado
Banner MD Anderson Cancer Center
Banner Sleep Center
Banner Surgery Centers
Banner Urgent Care Services
Occupational Health/Employee Health Services
Rural Health Clinics

Banner Home Care and Hospice (BHCH)

Insurance
Banner Health Network
Banner Plan Administration
Banner University Health Plan

Banner Pharmacy Services

Post Acute Services (PAC)

Research

I. Purpose/Population:

A. **Purpose**:
   1. To ensure Banner Health allows Covered Persons and others 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 Banner Reporters

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 Reporter: Includes Covered Persons, physicians and non-physician practitioners credentialed at any Banner hospital or doing business with Banner, patients, beneficiaries, and other interested persons.

C. Corporate Integrity Agreement (CIA): A five-year agreement that Banner entered into on April 9, 2018 with the Department of Health and Human Services Office of Inspector General (OIG) as part of a settlement with the Department of Justice.

D. ComplyLine: Banner's confidential compliance hotline, which is available 24 hours a day, 7 days a week and can be accessed by calling 1-888-747-7989 or online at bannerhealthcomplyline.ethicspoint.com.

E. Covered Persons: Includes:
   1. Banner Board of Directors (Board Members);
   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 (Employees);
   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 (Vendors);
   4. All physicians and other non-physician practitioners who are credentialed providers at the 12 hospitals named in the CIA (Providers)[1];
   5. Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected

[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.

to work more than 160 hours during a Reporting Period (April 9 – April 8), except that any such individuals shall become "Covered Persons" at the point when they work more than 160 hours; and

6. Other categories as required by the Ethics & Compliance Department or by law or regulation.

F. Disclosure: An issue or question:
   1. Reported by an individual to Compliance from outside of the department, generally through (a) the ComplyLine, (b) a phone call, (c) an email, or (d) a walk-in visit;
   2. associated with Banner's policies, conduct, practices, or procedures;
   3. with respect to a Federal health care program; AND which are
   4. believed by the individual or a Compliance team member to be a potential violation of criminal, civil, or administrative law.

G. 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.

H. 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.

I. 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.

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

K. 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.

L. Reportable Event: Any event or series of events that involves:

[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.

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 or contracting with an Ineligible Person; or
4. The filing of a bankruptcy petition by Banner.

M. 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).

N. 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 to be caused by the misuse of resources.

III. Policy:

A. **Reporting Potential Compliance Issues**

1. Covered Persons must, and other Banner Reporters should, immediately report Potential Compliance Issues upon discovery.
   a. Banner Reporters should contact the Ethics & Compliance Department if they have any questions as to 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. Banner Reporters may report Potential Compliance Issues directly to::
      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.
   b. If a Potential Compliance Issue is reported to anyone outside of the Ethics & Compliance Department, the individual who receives the report must immediately contact the Ethics & Compliance Department.
   c. Banner Reporters may also use the ComplyLine to report Potential Compliance Issues if they wish 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. Banner Reporters 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 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). For example, investigations that involve credible information related to a potential Overpayment, will generally be completed within six (6) months, except in extraordinary circumstances.
2. If necessary, the investigator(s) will work with appropriate departments to implement a corrective action plan (CAP) once an investigation is completed.
   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 unless approved by 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) for determination.

4. 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, as necessary, until the Reportable Event is 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** (**BANNER REPORTER**)
1. Immediately report any concern believed to be a Potential Compliance Issue to a supervisor, department manager, department director, Compliance Officer, 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**
If not reported directly to the Ethics & Compliance Department, forward the Potential Compliance Issue 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 via the ComplyLine.
2. The Ethics & Compliance Department, will determine if the matter reported is a Potential Compliance Issue:
    a. If believed to be a Potential Compliance Issue:
        i. Notify the applicable Compliance Officer or another individual from the Ethics & Compliance Department that will be responsible for the investigation. .
            (i) If involves or is related to a Banner Board Member or the Banner President/CEO, regardless of how the matter is brought forth, the report will be handled as follows:
                (a) The Vice President of Ethics & Compliance, in consultation with Banner's General Counsel, will 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.
        ii. If it meets the definition of a Disclosure, the applicable Compliance contact must log the Disclosure within 2 business days of the receipt of the Disclosure. The Ethics & Compliance Department will maintain a disclosure log that, at a minimum, includes a summary of each disclosure received, the date reported, the date logged, whether anonymous or not, the status of the investigation, and any corrective actions taken in response.
    b. If not a Potential Compliance Issue, assign to the appropriate individual or department based on the type of issue:
        i. **Privacy**: 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. **Clinical Risk Management / Patient Relations Service Center**: Clinical risk management issues (e.g., certain patient safety issues, clinical care concerns, and potential or actual litigation matters) are referred to the Business Health Department (Clinical Risk Management and/or Patient Relations Service Center).

iv. **Other:** Issues involving other business areas not previously specified are investigated by those areas in conjunction with the Ethics & Compliance Department.

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, 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 Reportable Event form 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, as necessary, to the OIG until the Reportable Event is resolved.
3. Continue investigating the Reportable Event using the same methods as described for investigating a Potential Compliance Issue.
4. Determine whether a CAP is necessary and, if so, ensure that it 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 Banner Reporter who initially reported the Reportable Event.
7. If the investigation confirms that the activities involved Fraud, Waste, Abuse, or a violation of criminal, civil or administrative laws, Banner will notify impacted third-party payers as required by contract and as permitted by law.
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 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
F. Corrective Action Policy

IX. Keywords and Keyword Phrases:

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

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

- Performing patient care items/services with an expired licensure/certification or other applicable standard that is required by Federal, State or local laws.

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.