

Pima Health System Corporate Compliance Plan



Implemented the twenty-second day of January 2001

Karen Fields
Director

Virginia Rountree RN
Compliance Officer

Effective: January 2001
Revised: January 2007

PIMA HEALTH SYSTEM MISSION

OUR VISION

To improve the quality of life for the community and the people we serve through an integrated system of health and social services.

OUR COMMITMENT

To promote prevention, wellness and maintenance of optimal health by providing and utilizing education, service and treatment.

OUR VALUES

QUALITY

We are dedicated to excellence in delivering quality, comprehensive health care through dedicated, competent personnel.

CUSTOMER

We are dedicated to meeting the needs of all our customers, including members, providers, employees and employees.

COMMUNITY

We are responsive to the health and social service needs of our community.

CARING AND DIGNITY

Each person will be treated with respect and dignity regardless of their ability to pay.

SERVING THE UNDERSERVED

We play a leadership role in the community to ensure that the health care needs of the underserved are met.

EFFECTIVE AND EFFICIENT

We will maintain a highly efficient and effective system through the continuous measurement of clinical and financial outcomes.

CORPORATE COMPLIANCE

The Department of Health and Human Services' Office of Inspector General (OIG) has issued final guidance to help managed care plans design effective voluntary compliance programs to prevent fraud, waste and abuse in government health programs.

The OIG has identified seven fundamental elements for an effective compliance program. Pima Health System is committed to these seven elements as the foundation of the Compliance Program:

- **Implementing written policies, procedures and standards of conduct;**
The development and distribution of written standards of conduct, as well as written policies and procedures, that promote the organization's commitment to compliance and that address specific areas of potential fraud.
- **Designating a compliance officer and compliance committee;**
The designation of a chief compliance officer and other appropriate bodies, e.g. a corporate compliance committee, charged with the responsibility and authority of operating and monitoring the compliance program and who reports directly to the CEO and the governing body.
- **Conducting effective training and education;**
The development and implementation of regular, effective education and training programs for all affected employees.
- **Developing effective lines of communication;**
The development of effective lines of communication between the compliance officer and all employees, including a process, such as a hotline, to receive complaints (and the adoption of procedures to protect the anonymity of complainants and to protect callers from retaliation).
- **Enforcing standards through well publicized disciplinary guidelines and developing policies addressing dealings with sanctioned individuals;**
The use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.
- **Conducting internal monitoring and auditing;**
The development of disciplinary mechanisms to consistently enforce standards and the development of policies addressing dealings with sanctioned and other specified individuals; and
- **Responding promptly to detected offenses, developing corrective action, and reporting to the Government.**
The development of policies to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to Government authorities when appropriate.

PIMA HEALTH SYSTEM CODE OF CONDUCT

How we at Pima Health System accomplish our Mission is as important as the Mission itself. All PHS administrators, managers, supervisors, employees, providers, and others authorized to act on behalf of the System (hereinafter referred to as “PHS colleagues”), must always strive to attain the highest ethical and legal standards in the way we conduct business.

All PHS colleagues shall:

- **Conduct themselves with integrity.**

Our System is only as strong as its weakest link. The unethical actions of but one PHS colleague reflects poorly on us all. All PHS colleagues must take responsibility to conduct themselves with the highest ethical standards when representing the System, whether at the workplace, or in the community.

- **Know and comply with laws and regulations that affect their jobs and/or duties.**

Examples of applicable laws and regulations include, but are not limited to: federal and state laws regarding fraud and abuse, regulations governing participation in the Medicare and Medicaid (Arizona Health Care Cost Containment System) programs; Pima County Merit System Rules and Personnel Policies, other Pima County Policies and Procedures; and all PHS standards and procedures.

- **Perform their jobs/and or duties correctly.**

All PHS colleagues are responsible to be familiar with and adhere to the policies and procedures that apply to their jobs and positions. If an employee has questions about whether he or she is doing the right thing, that employee should seek guidance from a supervisor, manager, or administrator. If a non-employee PHS colleague has questions, he or she may seek answers from the Compliance Office.

- **Report suspected non-compliance.**

All PHS colleagues have a duty to report suspected non-compliance to their supervisor, another manager or the Compliance Office. No PHS colleague will suffer retaliation for making such a disclosure in good faith. PHS administrators, managers and supervisors have a duty to investigate reports of suspected non-compliance. If substantiated, PHS administrators, managers and supervisors must take the appropriate action to correct the non-compliance, prevent its reoccurrence and/or discipline the offender.

- **Be responsible for compliance.**

Everyone at PHS is responsible to fulfill our Mission with integrity and in compliance with all laws, regulations, policies and procedures. Individuals who violate the Code will be subject to discipline.

- **Additionally, Managers and Supervisors are responsible for their staff and must be responsive to them.**

PHS supervisors and managers are responsible for their own actions and those of their employees. They should be proactive in detecting, correcting and preventing non-compliance. They should provide employees with the appropriate tools and information to perform their jobs competently and within the confines of the law. They must listen to their employees' questions and act on their concerns. They will lead by example and make sure their employees understand and abide by this Code. They must discipline Code violators.

PHS is Committed to Compliance.

**REPORTING CORPORATE
COMPLIANCE ISSUES**

PHS Compliance Office-----243-8032
PHS Fraud and Abuse Coordinator—243-8250

or write to:
PHS Compliance Office
PO BOX 27895
Tucson, Arizona 85726

STANDARDS OF CONDUCT

Pima Health System (PHS) is committed to the administration of an effective Corporate Compliance Program that will help achieve compliance by promoting the prevention, detection and resolution of instances of improper and/or illegal conduct including fraud, waste and abuse in accordance with The Deficit Reduction (Act Public Law 109-171).

The PHS Code of Conduct is intended to express PHS's commitment to compliance and convey broad general principles of professional and proper conduct which apply to all PHS colleagues (PHS governing body members, officers, administrators, managers, supervisors, employees and providers).

In addition to the PHS Administrative Standards and Procedures, which are maintained by each department and address each function of PHS, Standards of Conduct for risk areas have been developed to accompany the PHS Code of Conduct. These Standards are not intended to replace but rather to complement the existing PHS Administrative Standards and Procedures. These Standards include but are not limited to the following:

- Anti-Kickback Statute and Other Inducements
- False Claims and Whistleblower Protections
- Data Collection and Submission Processes
- Disenrollment/Services Closure
- Marketing Practices and Personnel
- Members' Right to Privacy/Confidentiality of Member Information
- Members' Right to Culturally Competent Health Care.
- Underutilization, Overutilization and Quality of Care

ANTI-KICKBACK STATUTE AND OTHER INDUCEMENTS

PHS is committed to ensuring that there are no incentives directly or indirectly which will influence a member's decision to order or receive items of services from a particular provider, practitioner or supplier reimbursable under a state or Federal health care program.

Anti-kickback Statute: This law provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration to induce the referral of business reimbursable under a Federal health care program.

For the purpose of the anti-kickback statute, "remuneration" includes the transfer of anything of value, in cash, or in-kind, directly or indirectly, covertly or overtly.

Safe Harbors: Regulations within the law that immunize certain payments and business practices that are implicated by the anti-kickback statute from criminal and civil prosecution under the statute.

To be protected by a safe harbor, certain conditions must be met and must precisely meet all the conditions set forth in the safe harbor.

FALSE CLAIMS AND WHISTLEBLOWER PROTECTIONS

PHS understands and is committed to its responsibilities under the Deficit Reduction (Act Public Law 109-171), 31 USC 3729, 3730, 3731, 3732 and 3733 and applicable Arizona Revised Statutes 13-1802, 2002, 2310, 2311 and 36-2918. The False Claims Act requires any entity that receives or makes annual Medicaid payments of at least \$5 million to require that all employees and management including contractors and agents receive written information on the Act. Training and education of PHS employees and providers is an essential component of the Compliance Program. Training activities include but are not limited to inservice training, New Employee Orientation, Quarterly PHS Compliance Alert Newsletter, annual Compliance training, Provider meetings, and the PHS Provider Newsletter.

Whistleblowers (someone who reports wrongful conduct to a government agency responsible for enforcing the law or to the media) are provided protection under 31 USC 3730 (h). PHS does not terminate, demote, suspend, threaten, harass, or in any other manner discriminate against an employee for reporting wrongful conduct. Pima County employees are further protected from reprisals under Pima County Merit System – General Provisions 2.3

DATA COLLECTION AND SUBMISSION PROCESSES

PHS is committed to ensuring that all data collection and submissions are accurate, timely and complete by:

- submitting accurate data to funders in return for reimbursement
- maintain an information collection and reporting system reasonably designed to yield accurate information
- provide periodic checks to verify the system's accuracy
- certify the accuracy, completeness, and truthfulness of relevant data
- strive to maintain a high level of accuracy

DISENROLLMENT/SERVICE CLOSURE

PHS is committed to ensuring that members are not inappropriately disenrolled from a service as a cost benefit to the plan. PHS will use due diligence in coordinating any process with closure or termination of services inform members of their rights to appeal any adverse decision.

- PHS will not request, nor encourage members to disenroll.
- PHS following established Standards & Procedures with regards to the denial, reduction, or termination of a service. For example: the case manager and physician determine that services are no longer necessary, the member moves to a different provider service areas or the member remains eligible for one service but not another, or when the plan is unable to provide the covered medical items or services needed by the member, or when a member is no longer financially eligible.

MARKETING PRACTICES AND PERSONNEL

PHS is committed to the adherence of ethical marketing practices. PHS marketing materials will contain accurate and complete information so that potential enrollees can make an informed choice about their health care options. The fact that all marketing and outreach materials must be approved by AHCCCS before distribution does not relieve PHS employees of the responsibility to ensure that this material accurately and completely describes plan information.

Marketing personnel play a critical role in representing PHS to members and potential members. PHS is committed to ensuring that marketing personnel present clear, complete and accurate information to members and potential enrollees.

PHS is committed to ensuring that all marketing material for the enrollment of members follows applicable HCFA and AHCCCS guidelines. To comply with these guidelines, PHS:

- **will not** engage in selective marketing (“cherrypicking”) or otherwise discriminate in the marketing and enrollment process based upon an enrollee’s degree of risk for costly or prolonged treatment;
- **will not** engage in limiting, denying or conditioning the coverage or furnishing of benefits to individuals eligible to enroll in PHS based on any factor related to health status, which includes but is not limited to: medical condition (including mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
- **will not** inappropriately target healthier individuals by marketing the plan in places where healthy enrollees are more likely to congregate, such as health or exercise clubs, or in places individuals with disabilities would have difficulty accessing, such as upper floors of buildings that do not have elevators.
- **will not** engage in selective enrollment by providing inducements to enroll that encourage younger, healthier individuals to enroll, such as, offering free gym

memberships or sports lessons that would appeal to a healthier class of enrollees, thereby discriminating against less active more disabled enrollees.

MEMBER’S RIGHT TO PRIVACY/ CONFIDENTIALITY OF MEMBER INFORMATION

PHS is committed to protecting and enhancing the rights of members by providing them access to their health information and controlling the inappropriate use of that information. PHS committed to protecting the privacy of individually identifiable health information in accordance with the Department of Health and Human Services, 45 CFR 160 and 164 for Standards for Privacy of Individually Identifiable Health Information (also referred to as the Privacy Rule) and applicable Arizona State laws and regulations

MEMBERS’ RIGHT TO CULTURALLY COMPETENT HEALTH CARE

In accordance with 28 C.F.R. Part 42, Subpart F; Americans with Disabilities Act: 42 U.S.C. Chapter 126; Title VI of the Civil Rights Act of 1964 and AHCCCS Policy PHS has a comprehensive Cultural Competency Program. The goal of the Program is to create a corporate culture within PHS that embraces cultural diversity and that eliminates barriers for members to health care due to culture.

PHS is committed to providing quality health care services to each eligible member without regard to race, sex, age, religion, national origin, genetic information, sexual orientation, physical or mental disability, source of payment, life style, or limited English proficiency.

PHS promotes and supports the attitudes, behaviors, knowledge, and skills necessary for staff and its provider network in all services and settings to work respectfully and effectively with members and with each other.

PHS takes action to prevent, identify, and remove language barriers or practices that may be discriminatory in intent or which may affect PHS members who need health care services. PHS takes adequate steps to ensure that members receive the language assistance necessary to afford them meaningful access to health care services at no charge to the member.

UNDERUTILIZATION, OVERUTILIZATION AND QUALITY OF CARE

PHS is committed to ensuring that all covered services are available and accessible to members and is committed to the provision of quality health care services to its members. PHS is committed to monitoring, tracking and trending of data and taking corrective actions to address the following:

- underutilization of services which is the inappropriate withholding or delay of services;
- overutilization of services which is the inappropriate authorization or provision of unnecessary services; and
- quality of care and services provided.

To this end PHS takes many actions including but not limited to:

- Contracting with sufficient institutional and individual providers to accommodate all members
- The selection of providers through a credentialing process which ensures that each provider has a valid license to practice, clinical privileges in good standing, and appropriate educational qualifications.
- Enforcement of compliance by providers through training, education and the ability to issue sanctions as appropriate.
- The provision of geographically reachable services to all members
- Timely approving or denying referrals for services
- Employing non-burdensome utilization review (UR) procedures which allow members to reasonably fulfill UR requirements
- Not categorically denying the payment of claims
- Prohibiting “gag rules” which interfere with a health care professional’s advice to his or her patient about such things as the patients’ health status, medical care and treatment options, the risks, benefits, or consequences of treatment or non-treatment, or the opportunity for the patient to refuse treatment and to express preferences about future treatment options.
- Complying with all applicable regulations concerning Physician Incentive Plans (PIPs) (including disclosure) such that the PIP does not provide incentives to limit medically necessary care and does not put physicians at “substantial financial risk” for referral services.
- Management of a comprehensive Quality Management Program including thorough investigation of all quality of care concerns.
- Reporting and review at the Quarterly Quality Management/Process Improvement Committee meetings.
- Reporting and review at the Quarterly Medical Management Committee meeting.

COMPLIANCE PROGRAM MANAGEMENT

The PHS Office of Corporate Compliance consists of the Compliance Committee, the Compliance Officer, the Fraud and Abuse Coordinator, the Compliance Coordinator, and the Compliance Attorney.

THE COMPLIANCE COMMITTEE

1. Analyzes the organization's regulatory environment and the legal requirements with which it must comply.
2. Directs appropriate departments, as well as affiliated providers, to develop internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations; and maintains standards of conduct policies and procedures that promote allegiance to the PHS Compliance Program.
3. Directs appropriate departments to provide corrective and preventive actions as a result of any investigation of concern or impropriety, or as determined by internal and external audits.
4. Directs appropriate departments to ensure that providers and employees do not appear in the List of Excluded Individuals/Entities and General Services Administration (GSA) list of debarred contractors.

THE COMPLIANCE OFFICER

1. Is an on-site executive manager who is available to all employees with designated and recognized authority to access and provide records and make independent referrals to the AHCCCSA Office of Program Integrity.
2. Oversees, monitors, and is the focal point of the PHS Compliance Program.
3. Communicates the elements of the PHS Code of Conduct to Pima Health System administrators, officers, and employees.
4. Oversees and monitors the development and implementation of educational and training programs to focus on the elements of the compliance program which seeks to ensure that all appropriate employees and management are knowledgeable of and comply with pertinent Federal and State standards including those related to confidentiality and release of protected health information under Department of Health and Human Services, 45 CFR 160 and 164 for Standards for Privacy of Individually Identifiable Health Information (also

referred to as HIPAA or the Privacy Rule) and PHS Standard and Procedure: Prevention, Detection & Reporting of Provider or Member Fraud and Abuse Activities, QM-VII-F. Delegates the responsibility of employee education and training to the Compliance Coordinator.

5. Reviews department manager's activities in the development and implementation of programs, policies and procedures to ensure compliance with applicable federal and state laws and health care program requirements.
6. Annually monitors PHS Division Standards and Procedures Manuals for compliance and provides feedback to the Plan Administrator.
7. Monitors the activities of department administrators and managers in procedures that encourage employees to report suspected fraud and other improprieties without fear of retaliation and maintains all information confidential to the extent possible.
8. Provides a system to solicit, evaluate, and respond to complaints and problems, and makes appropriate recommendations to the Compliance Committee for changes as needed.
9. Provides support and assistance to the Compliance Attorney with regards to any investigation into matters of law related to compliance issues, as appropriate.
10. Reports to the Compliance Committee on issues related to the development and management of the Compliance Program.
11. Periodically revises the Compliance Program procedures when laws and policies change which affect the program.
12. Determines the appropriate strategy/approach to promote compliance with the program and maintains any hotlines and other suspected fraud reporting mechanism.
13. Reviews concerns of non-compliance for appropriate action. Delegates to the PHS Fraud and Abuse Coordinator the review, investigation, maintaining a log of the concerns, and reporting to AHCCCSA Office of Program Integrity of fraud and abuse concerns.
14. Forwards for action any substantiated non-compliance issues to appropriate departments or agencies, and/or the Compliance Attorney, as necessary or required by law.

15. Periodically communicates general information to providers, members, and PHS employees on the compliance program, the Privacy Rule, related information concerning compliance and reporting procedures.
16. Regularly attends and participates in AHCCCS, Office of Program Integrity work group meetings.
17. Regularly attends and participates in the Pima County Integrated Health System Quarterly Compliance meeting.

THE COMPLIANCE ATTORNEY

1. Provides independent investigations and act on matters related to non-compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with all departments, providers, agents, and if appropriate, independent contractors.
2. Maintains awareness of laws and regulations that may affect the PHS Compliance Program including HIPAA rules and regulations.
3. Coordinates with Pima County Human Resources to direct implementation of disciplinary procedures in conjunction with the Pima County Merit System Rules and Personnel Policies for employees who violate the PHS Code of Conduct.
4. Assists in internal compliance reviews and monitoring activities as needed.
5. Provides professional advice in the development of policies and procedures related to compliance; and keeps familiar with PHS contracts with AHCCCS and providers related to compliance.
6. Provides legal advice, representation, and assistance to PHS in all matters related to compliance violations.
7. Provides professional assistance to and oversees the activities of the Compliance Committee in the discharge of their duties related to compliance.
8. Communicates with the PHS governing body, the Compliance Committee, PHS CEO, the office of Pima County Attorney, or other governmental entities in all matters related to compliance violations, as required.
9. Reports to the Healthcare Integrity and Protection Data Bank (HIPDB) on all adjudicated actions or decisions as applicable.

DEFICIT REDUCTIONS ACT FALSE CLAIMS ACT

As a result of new Federal law effective January 2007, PHS developed and implemented the following actions to comply with The Deficit Reduction Act (DRA) Public Law 109-171 and the False Claims Act under 31 USC 3730:

1. The Pima County Attorney and the Pima County Compliance Officer developed and trained all PHS employees on the False Claims Act – December 2006 – March 2007. The training met each employee’s annual Compliance training requirement for 2007.
2. All new PHS employees receive training as a part of the New Employee Orientation (NEO) Corporate Compliance training which was updated with DRA and False Claims Act information effective the first NEO class of 2007 (February 2007).
3. The PHS Compliance Officer and the Fraud and Abuse Coordinator receive training from AHCCCS at the Quarterly Compliance Officers Network group Meeting in addition to the required training for PHS employees.
4. PHS providers have been provided with training through Provider meetings, Newsletters, site visits and the PHS website. A PowerPoint presentation will be available on the website for review by providers with an attached Attestation form. A False Claims Act brochure was developed and is distributed to providers to provide information regarding False Claims.
5. In accordance with the Pima County Attorneys Office and PHS Contracts Division, provider contract language was developed and contracts were amended with the new False Claims Act language as contract renewals were due.

PHS Standards and Procedures **AD-VIII- 0004 – Corporate Compliance** and **QM-VII-F – Prevention, Detection and Reporting of Fraud and Abuse** provide the standards and guidance for the implementation of this Plan.

**PIMA HEALTH SYSTEM
ADMINISTRATIVE
STANDARDS AND PROCEDURES**

SUBJECT: Corporate Compliance	Administration Compliance AD-VIII-0004
APPLICABLE TO: All Pima Health System Staff	
EFFECTIVE DATE: 1/08 APPROVED BY: <i>Karen Fields by signature</i>	
SUPERSEDES: 5/01; 4/03; 1/04. 1/07	

I. STATEMENT OF PURPOSE:

The purpose of this standard and procedure is to establish procedures and guidelines for the implementation and administration of the Pima Health System (PHS) Compliance Program¹ to prevent the occurrence of abuse of members and fraud and abuse by members, PHS contracted providers, and/or PHS employees.

Statutory Basis: The Department of Health and Human Services Office of Inspector General final guidance published in the Federal Register Vol. 64, No. 219 and Vol. 64, No. 206, the Federal Sentencing Guidelines, Arizona Revised Statute Sections 46-451, 13-3623, Arizona Administrative Code R9-22-511 and AHCCCS Division of Health Care Management Policy and Procedure.

II. DEFINITIONS:

Abuse of a Member means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault (A.R.S. Section 46-451 and 13-3623).

Abuse by a Provider means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program (42 CFR. 455.2 Definitions).

Adjudicated Actions or Decisions means formal or official final actions taken against a health care provider, supplier or practitioner by a Federal or State governmental agency or health plan which include the availability of a due process mechanism, and are based on acts or omissions that affect or could affect the payment, provision or delivery of a health care item or service. It does not include

¹ The Department of Health and Human Services Office of Inspector General (OIG) issued final guidance to help managed care plans design effective voluntary compliance programs to prevent fraud, waste and abuse in government health programs (CFR Vol 64, No. 219 61893).

clinical privileging actions or paneling decisions. As referenced in FR Vol.64, No.206 part 61.3 Definitions, 57760

Civil Judgment means a court-ordered action rendered in a Federal or State court proceeding, other than a criminal proceeding. As referenced in FR Vol.64, No. 206, part 61.3 Definitions,

Code of Conduct conveys the general principles of PHS of professional and proper conduct.

Compliance Officer means the person responsible to implement, oversee, and administer PHS compliance program including fraud and abuse control.

Deficit Reduction Act (DRA) Public Law 109-171 works to eliminate fraud, waste and abuse in the Medicaid Program.

False Claims Act 31² under USC 3729 establishes liability for false claims.

Fraud by a member or provider means an intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 C.F.R. 455.2 Definitions).

Healthcare Integrity and Protection Data Bank (HIPD) is the federal reporting mechanism of any civil judgments related to the delivery of health care items or services, other adjudicated actions or decisions related to the delivery, payment, or provision of a health care item of service³.

Whistleblower is an employee who reports wrongful conduct to a government agency responsible for enforcing the law or to the media.

Whistleblower Protection is provided under 31 USC 3730 (h). It prohibits termination, demotion suspension, threats, harassment, or in any other manner discrimination against an employee for reporting wrongful conduct.

III. STANDARDS:

A. Compliance Program:

1. Pima Health System is committed to the implementation of an effective voluntary Compliance Program by promoting the prevention, detection and resolution of instances of improper and/or illegal conduct. The seven

² Refer to False Claims Act , 31 USC 3729, 3730, 3731, 3732 & 3733

³ In part, 45 CFR Part 61.5 and 61.9 states: *Reports are made to the HIPDB within 30 calendar days from the date the final adverse action was taken or the date when the reporting entity became aware of the final adverse action; or by the close of the entity's next monthly reporting cycle, whichever is later. Failure to report can result in civil monetary penalties of \$25,000 for each instance of failure to report.*

fundamental elements of the Federal Sentencing Guidelines⁴; are part of the PHS Compliance Program's goals:

- Implementing written policies, procedures and standards of conduct;
 - Designating a compliance officer and compliance committee;
 - Conducting effective training and education;
 - Developing effective lines of communication;
 - Enforcing standards through well publicized disciplinary guidelines and developing policies to address dealing with sanctioned individuals;
 - Conducting internal monitoring and auditing;
 - Responding promptly to detected offenses, developing corrective action, and reporting to the Government.
2. The Office of Corporate Compliance oversees, directs the functions of the Compliance Program, and promotes a high level of ethical and lawful conduct throughout PHS. The Office of Corporate Compliance consists of the Compliance Committee, Compliance Officer, Fraud and Abuse Coordinator, Compliance Coordinator, and a Legal Representative as Compliance Attorney who work together to ensure PHS's compliance activities effectively achieve the Compliance Program goals.
 3. As part of the PHS Compliance Program, all PHS employees are required to understand and follow PHS Standards and Procedures, regulations governing participation in the State AHCCCS programs, Federal and State laws regarding fraud and abuse, other applicable State or Federal rules and regulations; and the rules established to protect the privacy of identifiable health information and procedures used to authorize the use and disclosure of this information,⁵ and applicable State laws and regulations.
 4. The PHS Office of Corporate Compliance adheres to the requirements of the False Claims Act through written standards, educational information and contract provisions with all providers.
 - a. The False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud. It covers the following fraudulent activities:
 - knowingly presenting (or causing to be presented) to the Federal Government a false or fraudulent claim for payment;
 - knowingly using (or causing to be used) a false record or statement to get a claim paid by the Federal Government;
 - conspiring with others to get a false or fraudulent claim paid by the Federal Government; and
 - knowingly using (or causing to be used) a false record or statement to

⁴ The Federal Sentencing Guidelines (42CFR 422.501) (b)(vi) are detailed policies and practices for the Federal criminal justice system that prescribe appropriate sanctions for offenders convicted of Federal crimes.

⁵ As defined in PHS Standard and Procedure: Compliance with Privacy of Individual Health Information, AD VIII 0006 and PHS Standard and Procedure: Uses and Disclosure of Member's Health Information, AD-VIII-0010; and the PHS Privacy Policy Notice.

conceal, avoid, or decrease an obligation to pay money or transmit property to the Federal Government; where “knowingly” or “knowing” means that a person, with respect to information:

- 1.) has actual knowledge of the information,
 - 2.) acts in deliberate ignorance of the truth or falsity of the information; or
 - 3.) acts in reckless disregard of the truth or falsity of the information.
5. The liability for violating the False Claims Act is equal to three (3) times the dollar amount that the Government is defrauded (i.e. treble damages) and civil penalties of \$5,500 to \$11,000 for each false claim.
6. Arizona statutes that relate to the False Claims Act are as follows:
- a. ARS 13-1802: Theft,
 - b. ARS 13-2002: Forgery,
 - c. ARS 13-2310: Fraudulent schemes and artifices,
 - d. ARS 13-2311: Fraudulent schemes and practices; willful concealment, and
 - e. ARS 36-2918: Duty to report fraud.
7. An individual Whistle Blower, can report wrongful conduct to a government agency responsible for enforcing the law or to the media and is protected under the False Claims Act for reporting. The Act states that any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the individual in furtherance of an action under the Act is entitled to relief necessary to make the employee whole.
8. An individual can receive an award for “blowing the whistle” (reporting) under the Act.
- a. In order to receive an award, the individual must file a *Qui Tam* lawsuit.
 - b. The Whistleblower that filed a False Claims Act suit receives an award only if and after, the Government recovers money from the defendant as a result of the lawsuit.
 - c. The award that an individual can receive for filing a *Qui Tam* lawsuit is generally between fifteen (15) and thirty (30) percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon if the Government participates in the suit and the extent to which the person substantially contributed to the prosecution of the action.
9. All PHS contracts with providers shall include language about the False Claims Act including requirements under the Act that all employees, management and agents have received and read the written policies

regarding the False Claims Act.

B. Code of Conduct:

1. As part of Pima Health System's Compliance Program, all PHS employees are required to follow the approved PHS Code of Conduct. The PHS Code of Conduct expresses PHS' commitment to compliance by conveying broad general principles of professional and proper conduct. The Code of Conduct is intended to complement other standards and procedures already in existence within PHS.
2. The PHS Code of Conduct (**Exhibit A**) is distributed at the New Employee Orientation to newly hired employees and again at the annual training class on Corporate Compliance.

C. Standards and Procedures:

1. PHS department managers are responsible for the development, updating and maintenance of their department standards and procedures in accordance with the PHS Administrative Standards and Procedures: Maintenance of PHS Standards and Procedures, AD-VIII- 0005.
2. Department managers promote the prevention of non-compliance with Federal and State law, rules and regulations, and the federal rules and regulations or the Department of Health and Human Services, 45 CFR 160 and 164 for Standards for Privacy of Individually Identifiable Health Information (also referred to as the Privacy Rule).

D. Training and Education:

1. PHS employees are trained in the general concepts and applications of the PHS Compliance Program. To achieve the course objective of a basic understanding and principles of compliance, the course includes:
 - The fundamental principles of compliance and their relationship to the PHS employee's job duties;
 - The elements of due diligence of compliance and their relationship to the PHS employee's job duties;
 - Information on enforcement standards and guidelines for any non compliance with the Code of Conduct and PHS Standards and Procedures;
 - Information on the lines of communication and reporting procedure;
 - The organizational goals and objectives of implementing the Code of Conduct and related standards and procedures;
 - Instructions to the PHS employee in his/her role in the successful implementation of the Code of Conduct
 - Overview of the Deficit Reduction and False Claims Act including established liabilities and Whistleblower protections.
 - Rules and regulations for the protection of privacy of member information.

2. Newly hired employees are required to complete a two-hour class on Corporate Compliance and Confidentiality of Member Information within one month of hire.
3. Current employees are required complete a one-hour class on Corporate Compliance and Confidentiality of Member Information within 12 months of their last attended class.
4. Failure to comply with timely training requirement is cause for disciplinary action by the supervisor and is reflected on the employee's performance appraisal.
5. Providers are given information and training as a part of initial provider orientation to PHS, at on site visits, at Provider Education meetings, on the PHS website and via the Provider Newsletter.

E. Lines of Communication:

1. To Members: PHS Standards and Procedures: Member Handbook MS-I-0004 (Acute) and Member Handbook MS I-0005 (ALTCS) applies as the process of communicating with members and their rights to report fraud or abuse or non-compliance issue. Reporting information is published in the Member Newsletter.
2. To Providers: PHS Standards and Procedures: Provider Communication PS-I-0007, and PHS Standards and Procedures: Provider Education, PS -I-0008 applies as the process of communicating with Providers and their obligations to report non compliance. Reporting information and other pertinent compliance issues are published in the Provider Newsletter or through flyers.
3. To Employees: PHS Standards and Procedures are published on the PHS Network drive and provided through routine communication such as interoffice written or oral communication, and meetings.

F. Monitoring:

1. PHS promotes regular, periodic compliance by internal and external audits.
2. PHS Administrative Standards and Procedures: Facilitating the Financial Audit Processes Budget and Finance 0001 applies for annual financial audits.
3. Contract Providers are monitored in accordance with PHS Standards and Procedures: Network Monitoring, Adequacy and Provider Compliance PS-I-0002; Member's concerns are monitored in accordance with PHS Standards and Procedures: Quality Concern Resolution Process Related to Individual Members, QM-III-A; and PHS Standards and Procedures: QM Site Reviews QM-V-A.

4. PHS Standards and Procedures: Credentialing/Recredentialing, QM-I-A and PHS Administrative Standards and Procedures: Delegation of Credentialing/Recredentialing, QM-I-C is uniformly applied to ensure each practitioner is qualified by training and experience to deliver quality patient care.
5. Monitoring member quality of care follows standards are required by AHCCCSA. Quality of care is monitored in accordance with PHS Standards and Procedures: Quality Management Site Reviews Standards QM-V-A.
6. Each department manager regularly reviews their department's Standards and Procedures Manuals to ensure:
 - a) Standards and procedures are followed;
 - b) Standards and procedures conform to Federal and State Law and AHCCCSA rules; and
 - c) Are current.
7. PHS administrators, managers and supervisors are monitored by the Corporate Compliance Office for their commitment to:
 - a) Promptly investigating incidents of suspected non-compliance in the department;
 - b) Taking prompt and appropriate action to correct and prevent non-compliance;
 - c) Disciplining/sanctioning the compliance offenders; and
 - d) Responsiveness to their staff's concerns reporting.

G. Reporting:

1. Anything that may seriously endanger PHS may be reported. For example: a report can be made of someone's (employee, member, or provider) misconduct, a suspected intent to act in a fraudulent way, or failure to follow the rules and regulations of any federal, state, or local laws pertaining to PHS business practices.
2. The following issues are reported to the Compliance Officer for investigation:
 - a) Cases of fraudulent billing practices by providers;
 - b) Situations of non-compliance by contracted providers with PHS Standards and Procedures, rules and regulations, or AHCCCSA policy;
 - c) An employee's non-compliance with PHS Standards and Procedures, rules and regulations or AHCCCSA policy; or
 - d) Member's complaint of privacy violations⁶.
3. The following issues are reported directly to the Fraud and Abuse Coordinator⁷ for investigation:⁸

⁶ In accordance with Complaint Resolution Process Related to Privacy of Health Information, AD VIII-0008

⁷ If the issue involves an Assisted Living Facility, those issues are also reported to the Assisted Living Facility Manager and investigated in accordance with PHS Standard and Procedure: Reporting and Investigation of Complaints, ALF-

- a) Cases of physical, (includes verbal, emotional or sexual) abuse of an AHCCCS member;
 - b) Exploitation of an AHCCCS member; or
 - c) Suspected fraud by a member, contracted provider, or PHS employee.
4. Employees who have information about the physical abuse or neglect of a member must:
 - a) Make a report to either local law enforcement agencies and/or Adult Protective Services, as required by law;⁹ and
 - b) Notify the Arizona Department of Health Services or other licensing authority if the member resides in a facility licensed by that agency.
 5. A U.S. Post Office box is made available to member, providers and PHS employees as a confidential and anonymous means of reporting. To maintain confidentiality, the PO Box is accessed only by the Compliance Officer.
 6. The Code of Conduct and phone numbers of where to report and the location of the PO Box are kept posted in conspicuous areas in each PHS department.
 7. PHS lines of communication between the PHS Compliance Office, all employees, contracted providers, and members enrolled with PHS are encourage to provide open or anonymous reporting.
 8. The identity of any person, who makes a report, is held confidential and not disclosed except as permitted or required by law. All reports are held in confidence and in a secure manner. Disclosure of such confidential information is made only on a need to know basis and as permitted or required by law.
 9. Intimidation, discrimination, or any other retaliatory action against anyone who has exercised their right to report is a violation of Pima County policy.

H. Sanctions:

1. Any disciplinary action or sanctions specific to PHS employees' non-compliance are consistently enforced and follow Pima County Merit System Rules and Personnel Policies.
2. Other PHS employees, not covered by Pima County Merit System Rules and Personnel Policies, are disciplined/sanctioned according to the terms of Pima County Ordinances and/or other laws, rules, regulations. PHS contracted

III. If the issue involves a Behavioral Health Facility, those issues are forwarded to Provider Services for additional investigation.

⁸ in accordance with PHS Standards and Procedures: Prevention, Detection & Reporting of Provider or Member Fraud and Abuse Activities, QM VII-F.

⁹ As required in A.R.S. 46-454 Duty to Report Abuse, Neglect and Exploitation of Incapacitated or Vulnerable Adult. A report to law enforcement or Adult Protective Services requires an accounting of the disclosure as in PHS Standard and Procedure: Accounting of Disclosures of Member's Health Information, AD-VIII-0007.

providers are sanctioned according to contract provisions and/or PHS Administrative Standards and Procedures governing such actions.

3. Sanctions and other actions may be taken in accordance with PHS Standards and Procedures: Medicare/Medicaid Sanction Activity, QM-I-J and PHS Standards and Procedures: Suspended or Debarred Providers, PS I-0014, Quality Management Responsibility In Contract Negotiations, QM-VII-D.
4. A non-compliance issue involving a contracted provider is forwarded to the Provider Services Manager or Assisted Living Facility Manager with recommended corrective action, as appropriate.

IV. PROCEDURES:

- A. Compliance Program Management: The Office of Corporate Compliance consists of the Compliance Committee, Compliance Officer, Fraud and Abuse Coordinator, Compliance Coordinator, and the Compliance Attorney.

THE COMPLIANCE COMMITTEE

1. Analyzes the organization's regulatory environment and the legal requirements with which it must comply.
2. Directs appropriate departments, as well as affiliated providers, to develop internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations; and maintains standards of conduct policies and procedures that promote allegiance to the PHS Compliance Program.
3. Directs appropriate departments to provide corrective and preventive actions as a result of any investigation of concern or impropriety, or as determined by internal and external audits.
4. Directs appropriate departments to ensure that providers and employees do not appear in the List of Excluded Individuals/Entities and General Services Administration (GSA) list of debarred contractors.
5. Meets on at least a bi-annually basis as a part of Executive Management meetings.

THE COMPLIANCE OFFICER

1. Oversees, monitors, and is the focal point of the PHS Compliance Program¹⁰.
2. Communicates the elements of the PHS Code of Conduct to Pima Health System administrators, officers, and employees.

¹⁰ As described in AHCCCS Policy and Procedure: Policy for the Prevention, Detection and Reporting of Fraud and Abuse October 1, 1994, revised 10/1/03.

3. Oversees and monitors the development and implementation of educational and training programs to focus on the elements of the compliance program which seeks to ensure that all appropriate employees and management are knowledgeable of and comply with pertinent Federal and State standards including those related to confidentiality and release of protected health information under Department of Health and Human Services, 45 CFR 160 and 164 for Standards for Privacy of Individually Identifiable Health Information¹¹ (also referred to as HIPAA or the Privacy Rule) and PHS Standard and Procedure: Prevention, Detection & Reporting of Provider or Member Fraud and Abuse Activities, QM-VII-F.
4. Reviews department manager's activities in the development and implementation of programs, policies and procedures to ensure compliance with applicable federal and state laws and health care program requirements.
5. Annually monitors PHS Division Standards and Procedures Manuals for compliance and provides feedback to the Plan Director.
6. Monitors the activities of department administrators and managers in procedures that encourage employees to report suspected fraud and other improprieties without fear of retaliation and maintains all information confidential to the extent possible.
7. Provides a system to solicit, evaluate, and respond to complaints and problems, and makes appropriate recommendations to the Compliance Committee for changes as needed.
8. Provides support and assistance to the Compliance Attorney with regards to any investigation into matters of law related to compliance issues, as appropriate.
9. Reports to the Compliance Committee on issues related to the development and management of the Compliance Program.
10. Periodically revises the Compliance Program procedures when laws and policies change which affect the program.
11. Determines the appropriate strategy/approach to promote compliance with the program and maintains any hotlines and other suspected fraud reporting mechanism.
12. Reviews concerns of non-compliance for appropriate action. Delegates to the PHS Fraud and Abuse Coordinator the review, investigation, maintaining a log of the concerns, and reporting to AHCCCSA Office of Program Integrity of fraud and abuse concerns.

¹¹ Refers to PHS Standards and Procedures: Compliance with Privacy of Member's Health Information, AD-VII-0006, and Uses and Disclosure of Member's Health Information, AD-VIII-0010.

13. Forwards for action any substantiated non-compliance issues to appropriate departments or agencies, and/or the Compliance Attorney, as necessary or required by law.
14. Periodically communicates general information to providers, members, and PHS employees on the compliance program, the Privacy Rule, related information concerning compliance and reporting procedures.
15. Regularly attends and participates in AHCCCS, Office of Program Integrity work group meetings.
16. Regularly attends the Pima County Integrated Health System Quarterly Compliance Committee meetings.

THE COMPLIANCE ATTORNEY

1. Provides independent investigations and act on matters related to non-compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with all departments, providers, agents, and if appropriate, independent contractors.
2. Maintains awareness of laws and regulations that may affect the PHS Compliance Program including HIPAA rules and regulations.
3. Coordinates with Pima County Human Resources to direct implementation of disciplinary procedures in conjunction with the Pima County Merit System Rules and Personnel Policies for employees who violate the PHS Code of Conduct.
4. Assists in internal compliance reviews and monitoring activities as needed.
5. Provides professional advice in the development of policies and procedures related to compliance; and keeps familiar with PHS contracts with AHCCCS and providers related to compliance.
6. Provides legal advice, representation, and assistance to PHS in all matters related to compliance violations.
7. Provides professional assistance to and oversees the activities of the Compliance Committee in the discharge of their duties related to compliance.
8. Communicates with the PHS governing body, the Compliance Committee, PHS CEO, the office of Pima County Attorney, or other governmental entities in all matters related to compliance violations, as required.
9. Reports to the Healthcare Integrity and Protection Data Bank (HIPDB) on all adjudicated actions or decisions as applicable.

B. Training and Education- Corporate Compliance: Training for PHS employees is scheduled and provided through the PHS Training Center and the Office of Corporate Compliance.

1. Newly hired employees receive Compliance training as a part of the two-day New Employee Orientation program. New employees are scheduled to be trained within 30 days of hire.
2. Annual training is conducted in several sessions at the beginning of each calendar year. All employees are required to attend.
3. Current employees, who are due to attend the annual training class, receive a notice by interoffice mail, phone, or e-mail from the Training Center of the annual training and the available sessions. Employees must RSVP with the training Center for the class.¹²
4. The Training Center maintains a log of those who attended classes and when due.
5. The Compliance Officer provides the class material and conducts the training on the scheduled dates.
6. The Compliance Officer addresses any non compliance with attendance with the employee's department Manager. A notice (EXHIBIT C, D. OR E) is sent to the employee's supervisor of any non-attendance by the employee as required.
5. Upon completion of the training, the attendee is asked to complete and sign an Attestation (Exhibit B). The signed Attestation forms are forwarded to PHS Human Resources for the employee personnel file.
6. Department managers or supervisors provide additional training to their employees in the correct administration of the relative standards and procedures for their department staff so they can perform their job/duties correctly.
7. In those departments where additional risk has been determined by the Compliance Officer, the department manager or supervisor provides additional training to any employee in order to avoid problems in these areas. Specific areas of risk have been identified as:
 - 1) Member confidentiality;
 - 2) Members right to culturally competent health care;
 - 3) Under/utilization, overutilization and quality of care;
 - 4) Data collection and submission processes;
 - 5) Marketing;

¹² Employees may be granted an additional month to complete the class. Employees on medical leave of absence falling on their due date will be required to attend as soon as they return to work.

- 6) Claims;
- 7) Anti-kickback statutes and other inducements; and
- 8) Disenrollment.

Other areas of risk may be included as they become known.

8. Contract providers are given technical assistance by the Compliance Coordinator in the development of their own compliance standards and self monitoring activities as needed or requested.

C. Monitoring:

1. PHS Credentialing staff review the monthly list of exclusions from the Healthcare Integrity and Protection Data Bank (HIPDB).¹³The list is:
 - a) Reviewed for any names of individuals or companies, health care practitioners, providers or suppliers under contract to PHS and for those requesting to contract with PHS for the delivery of health related services.
 - b) Forwarded to the appropriate department and to the Compliance Officer. Any individual or entity on the excluded list is prohibited from contracting with or otherwise doing business with PHS.
2. Each PHS department manager or supervisor:
 - a) Regularly reviews whether compliance elements have been satisfied to ensure that the department is operating within the compliance requirements that apply to the department;
 - b) Takes appropriate action and resolution for the non-compliance when non compliance is detected;
 - c) Monitors the PHS employee's commitment and compliance with the PHS Code of Conduct and the PHS Standards and Procedures which include:
 - 1) compliance with all applicable laws and other governing authority;
 - 2) the employee responsible efforts to know such laws of the governing authority and to do their jobs correctly;
 - 3) good faith reporting of incidents of suspected non-compliance;
 - 4) timely participation in the PHS Compliance Training Program;
 - 5) otherwise abiding by the PHS Code of Conduct; and
 - 6) compliance with the member's rights as stated in the PHS Privacy Policy notice.
 - d) Reflects the employee's compliance with a), b), and (c) on the employee's annual performance appraisal.
 - e) Takes appropriate action to discipline/sanctions the employee in accordance with PHS Standards and Procedures and Pima County Merit System Rules and Personnel Policies if the employee violated the Code of Conduct.

D. Reporting and Corrective Action Process:

1. Reports of non-compliance made by PHS employee:

¹³ Refers to the Secretary of Health and Human Services national health care fraud and abuse data collection program for reporting and disclosing of certain final adverse actions taken against health care providers, suppliers or practitioners.

- a) Reports of any suspected non-compliance are made through the established chain of command beginning with an immediate supervisor;
 - b) An exception to reporting to an employee's immediate supervisor applies if:
 - 1) a conflict of interest exists. In situations where the accused, or whoever works for the accused, is an individual within the chain of command, the report should not be made to this individual, but rather should be made to someone else outside the chain of command who does not have a conflict or the report is made directly to the Compliance Officer;
 - 2) if reporting through the chain of command proves unproductive, this should be documented by the employee, and reported directly to the Compliance Officer; or
 - 3) in other situations where reporting through the chain of command would otherwise prevent the person from making the report, for whatever reason, the person may report directly to the Compliance Officer or through the anonymous post office box number.
 - c) Supervisors must ensure the reporter that no adverse action or retaliation is taken against them, who in good faith, made a report regarding suspected non-compliance.¹⁴
 - d) The person who receives the report of suspected non-compliance:
 - 1) conducts a preliminary investigation within one business day of receiving the report;
 - 2) log the report and results of the investigation into a confidential file;
 - 3) takes appropriate corrective action if the issue involves a PHS employee by:
 - i. notifying the Compliance Officer or the Fraud and Abuse Coordinator if the investigation results in an action against the PHS employee;
 - ii. forwarding the issue to the Human Services Manager for appropriate personnel action; and/or
 - iii. taking appropriate action as directed by the PHS Plan Director.
 - 4) or forwards the issue to another division for investigation, as appropriate¹⁵;
2. Reports of non-compliance made by a PHS member, PHS contracted provider or other person or entity:
- a) Reports of non-compliance are forwarded to the Compliance Officer who:
 - 1) conducts a preliminary investigation into the issue;
 - 2) forwards it to the appropriate department for further investigation as appropriate;
 - 3) forwards it to the Fraud and Abuse Coordinator for further investigation as appropriate;
3. Compliance issues investigated by the Compliance Officer:

¹⁴ Pima County Merit System Rules and Personnel Policies.

¹⁵ Including such other Divisions as QM Fraud and Abuse; Assisted Living Facility; Member; Case Management; Behavioral Health, etc.

An issue of suspected non-compliance is forwarded to the Compliance Officer. The Compliance Officer:

- a) Conducts an investigation into the suspected non-compliance;
- b) Prepares the PHS Office of Corporate Compliance Reporting Suspected Non Compliance Form (Exhibit F);
- c) Updates the form until the investigation is complete. Upon the conclusion of the investigation one of the following general categories is assigned:
 - Not substantiated. There is no basis for the report;
 - Administrative issue. Not compliance related but could include issues which should be reported to HR or other departments for correction;
 - Substantiated, not material. Involves issues which require corrective action but do not represent a material violation; or
 - Substantiated. Unclear as to whether or not a material violation may exist.
- d) If the investigation indicates that the issue is “not substantiated”, the investigation is considered closed and no further action is taken;
- e) If the investigation indicates the issue is “administrative”, the issue is forwarded to the department involved in the issue for disposition or for appropriate corrective action;
- f) If the investigation indicates the issue is “substantiated, not material”, or “substantiated, unclear as to whether or not material”,¹⁶ the issue is forwarded to the Fraud and Abuse Coordinator for further investigation, and for reporting purposes;¹⁷
- g) If the issue requires additional investigation or action and involves another PHS department, individual, or provider, the Compliance Officer or Fraud and Abuse Coordinator will contact the department, individual, or provider for further information;
- h) If a letter addressing the non-compliance is sent to the provider by the Compliance Officer, the letter will include a request for an explanation of the non-compliance issue. A Corrective Action Plan may be requested detailing the corrective measures to be taken by the provider to correct the non compliance to avoid future problems. The provider’s response must be provided to the Compliance Officer within two weeks.
- i) Upon receipt of a response from the provider, the Compliance Officer:
 - evaluates the response and/or plan of correction if it meets the requirement for correcting of the action;
 - notifies the provider of the acceptance of the plan by letter; or notifies the provider of the non-acceptance if the explanation or plan does not meet compliance and what additional steps to take to come into compliance or types of actions or remedies that may be imposed; and
 - notifies the Fraud and Abuse Coordinator of the outcome for documentation and reporting purposes.

¹⁶ Refers to a serious pattern of conduct in violation of compliance policies, laws, rules, or regulations governing health care which may trigger disclosure considerations.

¹⁷ In accordance with PHS Standard and Procedure: Prevention, Detection & Reporting of Provider of Member Fraud and Abuse Activities, QM VII F.

- j) For outcomes that require actions or remedies, the following examples of actions or remedies may be imposed:
 - 1) an administrative directive to correct the defective practice or procedure;
 - 2) the reversal of an overpayment through normal repayment channels (e.g. to the payor);
 - 3) a request for a change in procedure to prevent similar future occurrences, including development and implementation of clarifying policies and procedures and/or educational programs;
 - 4) disciplinary/sanction actions are taken, if any, as may be appropriate given the facts and circumstances;
 - 5) a financial remedy is sought to correct the non-compliance; and/or
 - 6) legal action is pursued.
4. In cases of fraud or abuse against a member, as defined in PHS Standards and Procedures: Prevention, Detection & Reporting of Provider or Member Fraud and Abuse Activities, QM VII-F, the Compliance Officer will coordinate the investigation and resolution of the issue with the PHS Fraud and Abuse Coordinator.
5. Reports of substantiated non-compliance reported directly to the Compliance Office or the Fraud and Abuse Coordinator are documented and logged into the Fraud and Abuse data base by the Fraud and Abuse Coordinator as to types of non-compliance, types of actions taken, and dates of the report.
6. The PHS Fraud and Abuse Coordinator forwards the results of any investigation to AHCCCS Office of Program Integrity as required in all cases of suspected fraud or abuse, whether against the system or a member and updates the outcome of the report in the Fraud and Abuse Data base.
7. A report of all fraud and abuse concerns including compliance issues logged in the Fraud and Abuse data base is compiled monthly during the contract year by the Fraud and Abuse Coordinator and forwarded to the PHS Plan Director. The Plan Director reviews the report for trends, makes recommendations, and/or forwards questions to the Fraud and Abuse Coordinator. The Fraud and Abuse Coordinator provides a written response to the Director.
8. If, in the opinion of the Compliance Officer, the issue requires legal advice or action, the Compliance Officer will promptly notify the Compliance Attorney to initiate an independent investigation and take appropriate action. The Compliance Attorney:
 - a) Notifies the Compliance Committee by confidential legal memorandum setting forth the legal advice resulting from the investigation; and/or
 - b) Recommends any administrative actions or legal actions to be taken.
9. Following the actions of the Compliance Attorney, the initial report is updated by the Compliance Officer including any legal actions taken.

10. All completed reports are kept in a confidential file in the PHS Quality Management Division.

G:\Corporate\Standards & Procedures\Administration\Corporate Compliance.doc (Dev. By MN) (Rev. 4/03 MN)(Rev01-07VR)(Rev 1/08)

PIMA HEALTH SYSTEM CODE OF CONDUCT

How we at Pima Health System accomplish our Mission is as important as the Mission itself. All PHS administrators, managers, supervisors, employees, providers, and others authorized to act on behalf of the System (hereinafter referred to as “PHS colleagues”), must always strive to attain the highest ethical and legal standards in the way we conduct business.

All PHS colleagues shall:

- **Conduct themselves with integrity.**

Our System is only as strong as its weakest link. The unethical actions of but one PHS colleague reflects poorly on us all. All PHS colleagues must take responsibility to conduct themselves with the highest ethical standards when representing the System, whether at the workplace, or in the community.

- **Know and comply with laws and regulations that affect their jobs and/or duties.**

Examples of applicable laws and regulations include, but are not limited to: federal and state laws regarding fraud and abuse, regulations governing participation in the Medicare and Medicaid (Arizona Health Care Cost Containment System) programs; Pima County Merit System Rules and Personnel Policies, other Pima County Policies and Procedures; and all PHS standards and procedures.

- **Perform their jobs/and or duties correctly.**

All PHS colleagues are responsible to be familiar with and adhere to the policies and procedures that apply to their jobs and positions. If an employee has questions about whether he or she is doing the right thing, that employee should seek guidance from a supervisor, manager, or administrator. If a non-employee PHS colleague has questions, he or she may seek answers from the Compliance Office.

- **Report suspected non-compliance.**

All PHS colleagues have a duty to report suspected non-compliance to their supervisor, another manager or the Compliance Office. No PHS colleague will suffer retaliation for making such a disclosure in good faith. PHS administrators, managers and supervisors have a duty to investigate reports of suspected non-compliance. If substantiated, PHS administrators, managers and supervisors must take the appropriate action to correct the non-compliance, prevent its reoccurrence and/or discipline the offender.

- **Be responsible for compliance.**

Everyone at PHS is responsible to fulfill our Mission with integrity and in compliance with all laws, regulations, policies and procedures. Individuals who violate the Code will be subject to discipline.

- **Additionally, Managers and Supervisors are responsible for their staff and must be responsive to them.**

PHS supervisors, and managers are responsible for their own actions and those of their employees. They should be proactive in detecting, correcting and preventing non-compliance. They should provide employees with the appropriate tools and information to perform their jobs competently and within the confines of the law. They must listen to their employees’ questions and act on their concerns. They will lead by example and make sure their employees understand and abide by this Code. They must discipline Code violators.

PHS is Committed to Compliance.

**REPORTING CORPORATE
COMPLIANCE ISSUES**

PHS Compliance Office-----243-8032

PHS Fraud and Abuse Coordinator—243-8250

or write to:
PHS Compliance Office
PO BOX 27895
Tucson, Arizona 85726

**PIMA HEALTH SYSTEM
COMPLIANCE ATTESTATION FORM**

I, _____, do hereby acknowledge and confirm that I have received the general session training on Pima Health System’s Compliance Program and HIPAA Privacy Standards. I further acknowledge I have received a copy of the Pima Health System Code of Conduct, **and the Pima Health System Standard and Procedure: Prevention, Detection, and Reporting of Provider or Member Fraud and Abuse Activities**. I confirm that I have read these, understand their meaning, and will abide by its terms. As a Pima Health System employee, I will:

- Conduct myself with integrity;
- Know and comply with all laws and regulations that affect my job and/or duties;
- Perform my job and/or duties correctly;
- Report any suspected non-compliance immediately; and
- Take responsibility for remaining in compliance at all time.
- Comply with HIPAA and PHS policies related to confidentiality of protected health information.
- Protect and ensure the integrity of all PHS data and system information.

Additionally: If I am an administrator, manager, or supervisor, I will assume the responsibility for maintaining compliance in my areas of responsibility and responding appropriately to issues as soon as they occur.

By signing this form, I acknowledge that I understand that a violation of the Code of Conduct and any related PHS Standards and Procedures can be grounds for disciplinary action up to and including termination pursuant to Pima County Merit System Rules and Personnel Policies. Possible legal action may also be taken against me as a result of such a violation.

I further acknowledge that I understand the critical nature of ensuring the integrity of information and data within the PHS core business system, QXNT. I understand that predetermined roles and responsibilities have been established for each PHS employee, as appropriate, for access to the system and that a change in those roles and responsibilities must follow established procedures. Any breach of system security can be grounds for disciplinary action up to and including termination pursuant to Pima County Merit System rules and Personnel Policies.

Signature _____, Title _____

Date Signed _____

H:/Corporate Compliance/Attestation form (A 12/27/00mk) (Rev. 12/12/01) mjn (Rev. 01/10/03,3/30/06, 04/09/07, 1/24/08)



MEMORANDUM

TO: _____

FROM: PHS CORPORATE COMPLIANCE OFFICE,
_____, Compliance Officer

DATE: _____

RE: Non Compliance with PHS Requirements

This is to inform you that _____ last attended Corporate Compliance Class on _____. This employee did not attend the class within one year of this date and is now _____ out of compliance with this requirement. Participation in annual corporate compliance class is part of the employee's duty as a PHS employee. This employee requires counseling regarding this non-compliance. Please document this non-compliance by forwarding me written verification of counseling provided.

This non compliance with non-timely attendance should be noted on his/her annual performance appraisal.

Used for those who did not attend the annual class when due.



MEMORANDUM

TO: _____

FROM: PHS CORPORATE COMPLIANCE OFFICE,
_____, Compliance Officer

DATE: _____

RE: Non Compliance with PHS Requirements

This is to inform you that _____ did not attend the PHS Compliance Class as scheduled on _____. This employee is now out of compliance. The next class is scheduled on _____. Please assure attendance requirements are met. If there is a reason this employee is unable to attend due to a leave of absence, please let me know and enroll the employee in the next available class upon the employee's return.

Participation in corporate compliance class is part of the employee's performance appraisal and should reflect their timely attendance.

Used for new hires who did not attend within one month of hire.



MEMORANDUM

TO: _____

FROM: PHS CORPORATE COMPLIANCE OFFICE,
_____, Compliance Officer

DATE: _____

RE: Non Compliance with PHS Requirements

This is to inform you that _____ has not attended PHS New Hire Compliance Class within one month of hire as required. **Please encourage your staff to attend classes when due. Participation in corporate compliance class is part of the employee's performance appraisal and should reflect their timely attendance.**

EXHIBIT F

**PIMA HEALTH SYSTEM OFFICE OF CORPORATE COMPLIANCE
REPORTING SUSPECTED NON- COMPLIANCE
(Used by Compliance Office for issues reported to Compliance Officer.)**

Please do not write in box below

Date received _____
Date logged _____
Date completed _____
By _____

FRAUD: means the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.	ABUSE: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.	ABUSE OF A MEMBER: means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.
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Date of Report _____ Source of Report (Check one) Mail Phone E Mail Other _____

Report taken by: _____, Title: _____, Phone No. _____

Name of person initiating the report: _____, phone: _____ If anonymous, check here

Report is concerning (check all that apply): Member PHS Employee PHS Provider

Narrative description of the issue.

NOTICE OF CONFIDENTIALITY:The information contained in this report is confidential and may be legally privileged or protected by law. This report shall be held in confidence and in a secure manner. The information is intended for the use of individuals on a need to know basis or as required by law.

Check here if other reporting form is attached (ie:report made to PHS Fraud and Abuse Coordinator; report to APS; report to Assisted Living Program; etc.

DISPOSITION: After the preliminary investigation is completed.

- Not substantiated.
- Administrative issue.
- Substantiated, not material.. *Forward to Fraud and Abuse Coordinator*
- Substantiated, unclear as to whether or not material. *Forward to Fraud and Abuse Coordinator*

NARRATIVE NOTES OF ACTION TAKEN TO CORRECT:

OTHER AGENCIES/DEPARTMENTS/OFFICIALS NOTIFIED:

Name _____	Date Notified _____	Phone _____
Name _____	Date Notified _____	Phone _____
Name _____	Date Notified _____	Phone _____
Name _____	Date Notified _____	Phone _____

To be completed by the Corporate Compliance Office:

- The person initiating the report has been informed that PHS will strive to keep his/her identity confidential but the investigative process may result in the disclosure of the reporter's identity to the extent of the investigation.
- The person initiating the report has gone through the chain of command to the extent possible.
- The report requires no further action.
- The report has been forwarded for further investigation. To: _____ Date _____

**PIMA HEALTH SYSTEM
STANDARD AND PROCEDURE**

SUBJECT: Prevention, Detection, and Reporting Fraud And Abuse	Admin.
APPLICABLE TO: Acute, Long Term Care, KidsCare	
EFFECTIVE DATE: 01/2007 APPROVED BY: <i>Karen Fields by signature</i>	QM-VII-F
SUPERSEDES: 10/06, 10/05, 10/04, 04/04, 10/03, 02/03, 05/02, 12/01, 5/01, 09/00, 10/98, 4/98, 8/97, 1/97	

I. STATEMENT OF PURPOSE:

To establish guidelines for preventing, detecting, and reporting potential/actual incidents of member abuse and provider or member fraud and abuse within the Arizona Health Care Cost Containment System (AHCCCS) System in accordance with AACR9-22-511, *The Deficit Reduction Act-Public Law 109-171*, *The False Claims Act-31 USC 3729*, the AHCCCS Acute Care Contract Renewal [Section (D)(62)], the AHCCCS Long Term Care (LTC) Contract [Section (D)(70)], and the AHCCCS Fraud and Abuse Policy.

II. DEFINITIONS:

- A. Abuse (of Member) means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual, or emotional abuse or sexual assault. (*ARS Sections 46-451 and 13-3623*)
- B. Abuse (by Provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (*42 CFR 455.2*)
- C. Contracted Provider means any entity or individual providing health care or other services.
- D. Corporate Compliance or compliance means a set of standards intended to prevent fraud, abuse, and waste in a government health program.
- E. Corporate Compliance Officer is an on-site executive manager who oversees, monitors and is the focal point for Pima Health System’s (PHS) compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting.
- F. Corporate Compliance Training Program is a series of classes designed to provide PHS employees with general knowledge and understanding of the PHS Compliance Program. Attendance at new hire corporate compliance

training is required for all new employees. Following new hire training, all employees are required to attend annual refresher training.

- G. Deficit Reduction Act (DRA) Public Law 109-171 works to eliminate fraud, waste and abuse in the Medicaid Program.
- H. False Claims Act ¹⁸ under 31 USC 3729 establishes liability for false claims
- I. Exploitation is the illegal or improper use of an incapacitated or vulnerable person's resources for another person's profit or advantage. An incapacitated person is a person who is mentally or physically impaired to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions. A vulnerable person is a person who is unable to protect himself/herself from harm due to a mental or physical impairment. (ARS 46-451)
- J. Fraud, (by Member or Provider) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or some other person. It includes any act that constitutes fraud under applicable Federal or State laws. (42 CFR 455.2)
- K. Grievance is defined as a concern, or complaint and the means by which a member expresses dissatisfaction or disagreement, other than an action taken by PHS, involving service delivery and/or quality of care issues which may have an adverse outcome to the member. Grievances/concerns/complaints may include but are not limited to type of service, service levels, availability or access to services, dissatisfaction with services, medical management, fraud and abuse, initial and continued authorization of services, plan/program contractor change requests.
- L. Member means an individual who has chosen or been auto-assigned to PHS to receive AHCCCS acute or long term care services.
- M. The Office of Corporate Compliance oversees, directs the functions of the Compliance Program and promotes a high level of ethical and lawful conduct throughout PHS. The Office of Corporate Compliance consists of the Compliance Committee, Compliance Officer, Fraud and Abuse Coordinator, Compliance Coordinator and a Legal Representative as Compliance Attorney who work together who work together to ensure PHS' compliance activities effectively achieve the compliance program's goals.
- N. Whistleblower is an employee who reports wrongful conduct to a government agency responsible for enforcing the law or to the media.
- O. Whistleblower Protection is provided under 31 USC 3730 (h). It prohibits

¹⁸ Refer to False Claims Act , 31 USC 3729, 3730, 3731, 3732 & 3733

termination, demotion suspension, threats, harassment, or in any other manner discrimination against an employee for reporting wrongful conduct.

III. STANDARDS:

- A. As stated in *ARS 13-2310*, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises or material omissions is guilty of a Class 2 felony.
- B. In the course of performing their duties, PHS employees and contracted provider staff have the responsibility to protect PHS members from incidents of fraud and abuse.
- C. PHS employees and contracted provider staff are required to report any incident of suspected/potential fraud and abuse in accordance with the procedures defined in this standard.
- D. By Division, PHS will maintain internal controls and standards and procedures to help detect, prevent and report potential fraud and abuse activities. These include but are not limited to:
 - 1. Claims Division:
 - a. claims edits (i.e., duplicate claims, codes not in a particular contract, information submitted does not match authorized services),
 - b. pre/post processing review of claims (information submitted does not match authorized services, unbundling), and
 - c. reports to look for coding discrepancies such as diagnosis/age; diagnosis/gender.
 - 2. Utilization Management/Medical Management:
 - a. prior authorization,
 - b. provider/member profiling,
 - c. concurrent review,
 - d. discharge review,
 - e. retrospective review when indicated (i.e., readmission, medical indication)
 - f. over/under utilization of services, and
 - g. inappropriate practitioner prescribing patterns.
 - 3. Quality Management:
 - a. credentialing/recredentialing activities,
 - b. on-site audits during the contract period,
 - c. medical record reviews, and
 - d. quality of care/medical mismanagement concern/grievance investigations.
 - 4. Grievance Coordinator: grievances and appeals investigated and trended
 - 5. Member Services:
 - a. satisfaction surveys,

- a. non-QOC concern/grievance investigations including transportation issues, and
 - b. member education.
6. Contract/Provider Services:
- a. contract language describes provider's/subcontractors responsibilities to:
 - 1.) comply with all applicable Federal, State and local laws, rules and regulations,
 - 2.) maintain professional standards,
 - 3.) maintain and furnish records and documents as required by law, rules and regulations,
 - 4.) report Fraud and Abuse issues,
 - 5.) abide by applicable laws, rules, regulations and contract provisions to avoid:
 - [a.] termination of the contract;
 - [b.] false claims liability;
 - [c.] anti kick-back language and reference to self-referrals.
 - b. provider education including training required under the Deficit Reduction Act related to the False Claims Act, and
 - c. monitor providers for non-compliance with PHS and AHCCCS rules, contracts, standards and procedures.
7. Maternal Child Health Division:
- a. case management activities,
 - b. prenatal assessments,
 - c. Early Periodic Screening, Diagnosis, and Treatment audits, and
 - d. lead screening audits.
8. Disease Management Division:
- a. non-Quality of Care (QOC) concern/grievance investigations through case management activities and
 - b. review of emergency department utilization.
9. LTC Case Management:
- a. Institutional
 - 1.) service delivery plan reviews, and
 - 2.) non-QOC concern/grievance investigations.
 - b. HCBS Programs
 - 1.) service delivery plan reviews, and
 - 2.) non-QOC concern/grievance investigations.
10. Assisted Living Facility Program:
- a. QOC and non-QOC concern/grievance investigations,
 - b. annual contract compliance monitoring, and
 - c. annual license renewal monitoring (Adult Foster Care [AFC] homes only).
11. Behavioral Health Programs:
- a. Acute:
 - 1.) case management activities, and
 - 2.) monitoring of behavioral health services by PCPs.

- b. LTC
 - 1.) Intake, ongoing assessment and ongoing therapy during clinical supervision and
 - 2.) monitoring of behavioral health treatment plans.
- 12. Training Center:
 - a. provider training
 - b. Attendant Care Worker (ACW) training
 - c. community member training
 - d. PHS employee training

See each division's individual standards and procedures for a more detailed description.

- E. Potential/actual fraudulent provider practices that have been identified, trended, and failed corrective action are confidentially reported to AHCCCS, Office of Program Integrity (OPI), for further evaluation.
- F. Detection of potential/actual fraudulent member eligibility issues are confidentially reported to AHCCCS, Member Fraud Investigations Unit, for further evaluation.
- G. As required, PHS reports incidents of member abuse, neglect, and/or exploitation by a representative, caretaker, or facility to the appropriate agency (i.e., Department of Health Services [DHS], Arizona Medical Board, Adult Protective Services [APS], Child Protective Services [CPS], local law enforcement agency, Drug Enforcement Agency [DEA]), as well as AHCCCS Division of Health Care Management (DHCM) when appropriate.
- H. The Corporate Compliance Officer is an on-site executive manager who is available to all employees with designated and recognized authority to access and provide records and make independent referrals to the AHCCCSA Office of Program Integrity.
- I. The QM Program Manager serves as the Fraud and Abuse Coordinator for PHS and works in conjunction with the Corporate Compliance Officer. On a regular basis, the Coordinator reports issues regarding fraud and abuse policy, identified cases and outcomes directly to the PHS Director. The Coordinator has direct access to the PHS Director, governing body, senior management and legal counsel and has the authority to independently refer potential member and provider fraud and abuse cases to AHCCCS. Responsibilities include:
 - 1. Oversight and monitoring of fraud and abuse prevention, detection, and reporting activities.
 - 2. Periodic review and revision of the Fraud and Abuse S&P to meet changing regulations or trends.

3. Review of all documents that are relevant to a potential fraud and abuse incident.
 4. Maintenance and monitoring the PHS fraud and abuse tracking system.
 5. Regular attendance and participation in AHCCCS, Compliance Officers Network Group (CONG) meetings with the PHS Compliance Officer as directed.
- J. PHS participates in a voluntary Corporate Compliance Program which promotes the prevention, detection, and resolution of instances of improper and/or illegal conduct in accordance with PHS Standards and Procedures: Corporate Compliance, AD VIII-0004. The Corporate Compliance Officer ensures that:
1. All employees, providers and members receive adequate training/information by overseeing a comprehensive training program which addresses fraud and abuse prevention, recognition, reporting and the False Claims Act and encourages employees, providers and members to report fraud and abuse without fear of retaliation with assurances provided in accordance with Whistleblower Protections under 31 USC 3730 (h).
 2. An internal reporting procedure is in place that is well defined and made known to all employees.
 3. A process is in place for employees, providers and members to report potential fraud and abuses issues anonymously.
- K. Information pertaining to fraud and abuse is released only on a “need to know” basis. Protected HIV related information is not disclosed (ARS 36-664I).
- L. Members or providers are informed of mechanisms for resolving issues external to the PHS process when applicable.
- M. Each investigation is conducted in a manner which takes into consideration the member or provider’s cultural customs, values and beliefs.
- N. PHS permits and cooperates with onsite reviews conducted by AHCCCS, OPI and/or DHCM.
- O. PHS researches potential overpayments identified by an AHCCCS F&A investigation or audit.
1. PHS attempts to recover any overpayments identified due to erroneous, false or fraudulent billings, after conducting a cost benefit analysis as warranted.

2. OPI is advised of the final disposition of such research and is advised of actions, if any, taken by PHS.

IV. PROCEDURE:

- A. All PHS employees are required to immediately report potential/actual incidents of fraud and abuse. **(see ATTACHMENT I for Examples of Fraud and Abuse)**
 1. The incident should be reported verbally to the immediate supervisor and/or directly to the PHS Fraud and Abuse Coordinator or Corporate Compliance Officer.
 2. A completed PHS QM Concern/Grievance Referral form should be submitted directly to PHS Fraud and Abuse Coordinator or Corporate Compliance Officer as soon as all supporting documentation is available. **(see ATTACHMENT II for the PHS QM Concern/Grievance Referral Form)**
- B. Employees of contracted providers should immediately report potential/actual incidents of fraud and abuse according to the contracted provider's standard and procedure.
 1. The PHS Fraud and Abuse Coordinator or Corporate Compliance Officer should be notified, verbally, within one working day of the incident.
 2. The contracted provider should send a written report to the PHS Fraud and Abuse Coordinator as soon as all supporting documentation is available.
- C. Eligible PHS members are educated and advised to report potential/actual incidents of fraud and abuse to the PHS Member Services Division or their PHS case manager.
 1. A confidential form is sent to the member requesting information in writing. **(ATTACHMENT III)** A stamped self-addressed envelope will accompany the form for easy return to the Fraud and Abuse Coordinator or the Corporate Compliance Officer.
 2. A Member Services employee or PHS Case Manager records the necessary information on the confidential form if the member is unable to complete the form. This information is forwarded to the Fraud and Abuse Coordinator or the Corporate Compliance Officer.
 3. All information is kept confidential unless stipulated by law.

- D. Corporate compliance issues are to be reported to the Corporate Compliance Officer.
1. The Corporate Compliance Officer verifies the information and sends it to the appropriate division employee for investigation.
 2. The Corporate Compliance Officer reviews the facts and determines if there is a corporate compliance issue.
 3. If a compliance issue is identified the Corporate Compliance Officer:
 - a. Reports the findings to Health and Human Services-Office of the Inspector General or the US Department of Health and Human Services (HHS), Office of Civil Rights as applicable.
 - b. Makes recommendations to the appropriate PHD division for corrective action.
 - c. Ensures revision of standards and procedures if indicated.
 - d. Reports findings to PHS Executive Management.
 - e. Provides and/or ensures that additional training is provided to PHS employees I indicated.
 - f. Maintains a confidential file of all related information.
 4. The Corporate Compliance Officer tracks and trends compliance issues and provides a compliance report to the PHS Compliance Committee and to the PHS QM/PI Committee.
- E. All member and provider Fraud and Abuse are sent directly to the Fraud and Abuse Coordinator/designee and are processed in collaboration with the Corporate Compliance Officer as needed. The Coordinator/designee:
1. Assures that an investigation is completed and evidence is collected.
 2. Makes a determination of an occurrence of potential/actual fraud or abuse.
 3. Takes appropriate action based on the determination.
 4. Secures and reports issues related to fraud and abuse in the manner described in this standard and procedure (S&P).
 5. Maintains a separate file with all related information in a locked cabinet to ensure confidentiality.
 6. Enters essential information regarding each issue in an Access Fraud and Abuse database.
- F. The Fraud and Abuse Coordinator/designee:

1. Reviews and analyzes the information for trends with input from the Corporate Compliance Officer, as needed.
 2. Forwards a report from the Fraud and Abuse database reflecting issues received in the current contract year to the PHS Director on a monthly basis.
 3. Provides follow-up action as appropriate.
 4. Submits quarterly and annual reports to the PHS QM/PI Committee for review.
 5. Provides a report at the Corporate Compliance Committee Meeting.
- G. The Fraud and Abuse Coordinator/designee reports by mail, or secure AHCCCS/OPI e-mail site, any incident of potential/actual member or provider fraud/abuse to the appropriate AHCCCS division within ten (10) working days of discovery, as resources allow.
1. Reported incidents include acts of potential/actual fraud or abuse that were resolved internally but involved AHCCCS funds, contractors or sub-contractors. (**ATTACHMENT IV**)
 2. Any pertinent documentation and/or investigative reports that would assist AHCCCS' preliminary investigation accompany the member or provider report or are forwarded as soon as they are available.
 - a. Examples include, but are not limited to, medical record documents, facility investigation, employee time sheets, length of time employee worked for provider, and/or history/substantiation of other allegations.
 - b. Names of agencies and/or individuals used for background checks; dates and contact persons of governmental agencies notified; and perpetrators involved in the incident shall be documented in the report.
 3. Provider and member (including eligibility) fraud and abuse reports are sent to:

Director, AHCCCS Office of Program Integrity	Telephone: 602-
417-4045	
801 E. Jefferson, Mail Drop 4500	Fax: 602-
417-4102	
Phoenix, AZ 85034	Toll Free 1-800-645-8713
ext.7-4045	

4. Allegations of member (patient) abuse reports are sent to:

AHCCCS, Division of Healthcare Management
Clinical Quality Management Unit
701 East Jefferson, Mail Drop 6500 Telephone: 602-417-
4410
Phoenix, AZ 85034 Fax: 602-417-
4162

H. AHCCCS is notified prior to the release of any information to the news media or, as soon as possible after the release.

1. The notification includes all information relative to the incident.
2. The content of the information released to the media is specified by the PHS Director and/or designee.

I. Each PHS employee is made aware of this S&P through:

1. initial orientation and annually via the Corporate Compliance Training Program,
2. in-service at employee meetings,
3. electronic distribution of this S&P through the PHS Company-wide LAN, and/or
4. electronic distribution of a quarterly compliance newsletter.

J. Each contracted provider is made aware of fraud and abuse (F&A) and how to report incidents through:

1. the PHS Provider Manual (**ATTACHMENT V**),
2. redistribution of this S&P when revisions are made, as appropriate,
3. in-service at Provider Meetings, onsite, as requested or needed and/or
4. updates in the Provider Newsletter.

K. Each eligible member is made aware of F&A and how to report incidents through:

1. the Member Handbook (**ATTACHMENT VI A&B**), and
2. updates in the Member Newsletter.

L. PHS uses several methods to attempt to prevent repeated incidents of member abuse.

1. See IV: I, J and K above.
2. In extreme cases:
 - a. the PHS provider contract will be canceled.
 - b. the PHS employee will be terminated.

M. Potential overpayments that are identified by an AHCCCS F&A investigation or audit will be investigated by PHS as follows:

1. the overpayment will be researched,
2. a cost benefit analysis will be conducted,
3. an attempt to recover any overpayments identified due to erroneous, false or fraudulent billings will be made, as warranted, and
4. a summary of the final disposition of the research and action(s) taken, if any, will be forwarded to AHCCCS OPI.

****Attachments for this Standard and Procedure can be found in the hard copy version.**

G:/Corporate/Standards and Procedures/Quality Management/Prevention, Detection, and Reporting of Provider or Member Fraud & Abuse Activities.doc (Dev. by PF/VR)

