

**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 of 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.

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