Corporate Compliance Module

Course Objectives

After completing this course, you should correctly:

- Recognize how a compliance program operates;
- Explain your role in compliance;
- Recognize how compliance program violations should be reported;
- Identify and be able to understand the Standards of Conduct, high-risk areas, fraud, waste and abuse (FWA) laws, policies and procedures, and know who needs to follow them; and
- Understand how FWA is prevented, detected, and corrected.

Overview

The healthcare industry is one of the most regulated industries in the United States.

In addition to operating numerous hospitals, specialty programs and services, Memorial Hermann Health System participates in many special programs including Medicare Advantage plans and an Accountable Care Organization in order to coordinate high quality care for our patients.

It is critical that everyone does their part to ensure that we fully comply with the many laws, regulations, policies and procedures that govern how we operate.

Why do I need training?

Every year **billions** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you**. This training helps you detect, correct, and prevent FWA. **You** are part of the solution.

Compliance is everyone's responsibility.

As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Medicare Parts C & D Compliance

Memorial Hermann and its affiliated entities provide services to the beneficiaries of Medicare Advantage Plans. Memorial Hermann Health Plan also operates a Medicare Advantage Plan (Medicare Part C) including a Medicare Prescription Drug Plan (Medicare Part D). In addition, Memorial Hermann contracts with other Medicare Advantage Plans.

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in a MA plan.

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare Beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or a MA Prescription Drug (MA-PD) plan. Medicare-approved insurance companies or other companies provide prescription drug coverage to individuals living in a plan's service area.

Compliance Program Requirement

The Centers for Medicare & Medicaid Services (CMS) requires Memorial Hermann to implement and maintain an effective compliance program.

An effective compliance program must:

- Articulate and demonstrate an organization's commitment to legal and ethical conduct;
- Provide guidance on how to handle compliance questions and concerns; and
- Provide guidance on how to identify and report compliance violations.

What Is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance;
- Is fully implemented and is tailored to an organization's unique operations and circumstances;
- Has adequate resources;
- Promotes the organization's Standards of Conduct; and
- Establishes clear lines of communication for reporting non-compliance.

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core requirements:

1. **Written Policies, Procedures, and Standards of Conduct**
   - These articulate Memorial Hermann's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight**
   - Memorial Hermann must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
     - Memorial Hermann's Chief Compliance Officer is Charles Bumpass.
   - Memorial Hermann's senior management and governing body must be engaged and exercise reasonable oversight of Memorial Hermann's compliance program.

Seven Core Compliance Program Requirements

3. Effective Training and Education

- This covers the elements of the compliance plan as well as preventing, detecting, and reporting fraud, waste and abuse. This training and education should be tailored to the different responsibilities and job functions of employees.

4. Effective Lines of Communication

- Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith compliance issues reporting at all levels, including Memorial Hermann Health System, Memorial Hermann Physician Network, Memorial Hermann Health Plan, and Memorial Hermann Accountable Care Organization.

5. Well-Publicized Disciplinary Standards

- Memorial Hermann must enforce standards through well-publicized disciplinary guidelines.

Seven Core Compliance Program Requirements

6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

- Conduct routine monitoring and auditing of Memorial Hermann operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.
- **NOTE:** Memorial Hermann must ensure that entities performing delegated administrative or health care service functions concerning the Medicare Program comply with Medicare Program requirements.

7. Procedures and System for Prompt Response to Compliance Issues

- Memorial Hermann must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Ethics–Do the Right Thing!

As part of the Medicare Program, and Memorial Hermann, you must conduct yourself in an ethical and legal manner.

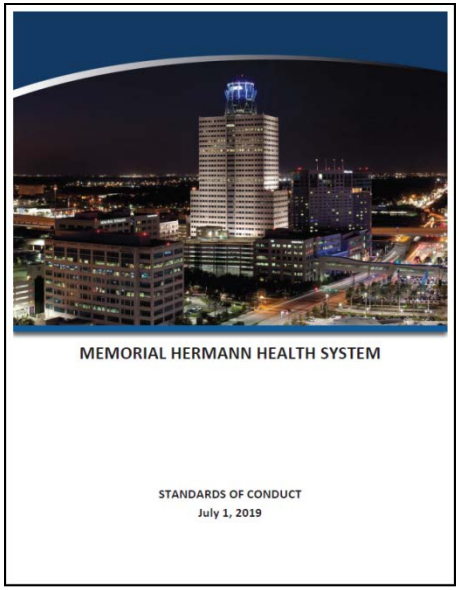
It’s about doing the right thing!

- Act fairly and honestly;
- Adhere to high ethical standards in all you do;
- Comply with all applicable policies, laws, regulations, and CMS requirements; and
- Report suspected violations.

Memorial Hermann Standards of Conduct

The Memorial Hermann Standards of Conduct have been put in place to communicate our commitment to comply with all applicable laws and regulations, as well as our own policies and procedures. The Standards of Conduct create a uniform code and are guidelines to clarify specific ethical questions that may arise in the course of your work.

Reporting Standards of Conduct violations and suspected non-compliance is everyone's responsibility.



Memorial Hermann Standards of Conduct

The Memorial Hermann Standards of Conduct can be located on the OneSource page:

- Select the **Business Units** tab
- Select the **Corporate Compliance** link
- Select the **Standards of Conduct** link

The Standards of Conduct must be observed by **everyone,** including:

- Employees and Volunteers
- Vendors and Contractors
- Physicians and Allied Health Professionals
- Anyone else engaged in work at Memorial Hermann or acting on behalf of the organization

Memorial Hermann Standards of Conduct

Some of the topics addressed in the Memorial Hermann Standards of Conduct include:

- Quality of Care
- Compliance with Laws and Regulations
- Human Resources
- Billing and Coding
- Protection and Use of Information, Property and Assets
- Conflicts of Interest
- Physician, Patient and Vendor Gifts
- Health and Safety
- Physicians and Allied Health Professionals
- Vendors and Contractors

Standards of Conduct: Quality of Care

- We are committed to providing quality care and services. Our first responsibility is to the patients we serve and their families.
- We will not discriminate against any patient based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.
- We will continually monitor and evaluate the delivery of care and related services to assure that appropriate standards of practice are met.
- We have a responsibility at every level of the organization to maintain integrity and quality in our job performance.
- We have a responsibility to address any deficiency or error by reporting it to a supervisor who can assess the problem, take appropriate action and follow the problem to resolution.

Standards of Conduct: Compliance with Laws and Regulations

- We are committed to ethical standards of business and professional ethics and integrity.
- We will provide patient care and conduct business while following all applicable laws, regulations and policies.

Standards of Conduct: Physician, Patient and Vendor Gifts

- We are committed to avoiding situations that might create an actual or potential conflict of interest by limiting the offering or acceptance of certain gifts and favors.

- There are distinct policies that deal with gifts to physicians and gifts from patients and vendors.

Standards of Conduct: Patient Gifts

Many times people want to express appreciation for caring service. We are committed to providing high quality service regardless of a patient's ability to pay or provide gifts.

When it comes to gifts from patients and family members:

- Never solicit gifts from patients and family members.
- Always consult with your supervisor before accepting a gift.
- Never accept cash of any amount.
- Never accept non-cash gifts (including gift cards) in excess of $25.
- Never accept any gifts that might influence or appear to influence the provision of patient care or our duties to Memorial Hermann.

Standards of Conduct: Gifts to Patients

Regarding service recovery gifts offered to patients or their family members:

- Only approved service recovery gift items may be offered.
- Approved service recovery gifts may be distributed by and at the discretion of the Patient Relations Department or an equivalent designee (i.e., Operations Administrator or Clinic/Practice Manager).
- Service recovery gifts may not be used to influence the patient to order or receive items or services from MHHS.
- Refer to the Service Recovery Policy for additional guidance.

Standards of Conduct: Vendor Gifts

If you are offered a gift from a vendor, please refer to the Receipt of Gifts and Favors from Vendors Policy (available on OneSource) for guidance. The policy includes the following guidelines related to vendor gifts.

- Do not accept cash or cash equivalent (such as a visa gift card or check) gifts from vendors.
- Do not accept gift certificates or gift cards in excess of $25.
- Gifts may not exceed $100 per occurrence from each vendor (includes entertainment events, tickets, meals, gift baskets, plants, etc.).
- Gifts and favors should be accepted only on an infrequent basis (defined as occurring no more than 4 times per vendor in a calendar year).
- Do not accept donations from a vendor for a personal interest, whether charitable or not.
- Vendor-sponsored education and training must be approved by a Senior Vice President or above.
- Speaker honorariums cannot be retained by an employee (if one is provided, it can be endorsed over to the Memorial Hermann Foundation).

Standards of Conduct: Human Resources

- We recognize that our employees are our most valuable assets.
- We are committed to creating a workplace where employees are treated with respect and fairness while being empowered to get the job done at or above expectations.
- We strive to maintain open lines of communication.
- We will have all employees in a position requiring licensure or certification properly licensed or certified by the appropriate federal, state, local or professional agency.

Standards of Conduct: Billing and Coding

- We are committed to fair and accurate billing that is in accordance with all federal and state laws, which means we will submit correct claims for payment or reimbursement.

- We will assign diagnostic, procedural and billing codes that accurately reflect the services that were provided. Upcoding, unbundling or any other means of artificially enhancing reimbursement is unlawful and strictly prohibited.

- We will bill only for services that are medically necessary, actually provided and documented in the patient's medical record.

Standards of Conduct: Protection and Use of Information, Property and Assets

- We are committed to protecting Memorial Hermann Health System's property and information against loss, theft, destruction and misuse.

- We will strive to honor the privacy of our patients and not reveal or discuss patient-related information except with health care personnel involved in their care, and with payers and others duly authorized to review patient information.

- We will strive to protect confidential corporate information and not use or reveal such information except in the proper performance of duties.

Standards of Conduct: Conflicts of Interest

- A conflict of interest may exist whenever an employee or a related party (such as a family member or friend) receives a personal benefit from any decision or action taken by the employee on behalf of Memorial Hermann.
- The mere appearance of a conflict of interest can be just as damaging as an actual conflict of interest.
- We are committed to acting in good faith in all aspects of our work.
- We will not use our position with Memorial Hermann for personal gain.

Fraud, Waste and Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments that the patient failed to keep;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of actions that may constitute Medicare **waste** include:

- Conducting excessive office visits or writing excessive prescriptions;
- Prescribing more medications than necessary for treating a specific condition; and
- Ordering excessive laboratory tests.

Examples of actions that may constitute Medicare **abuse** include:

- Unknowingly billing for unnecessary medical services;
- Unknowingly billing for brand name drugs when generics are dispensed;
- Unknowingly excessively charging for services or supplies; and
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

Understanding FWA

To detect FWA, you need to know the law. The following pages provide high-level information about the following laws and principles:

- False Claims Act
- Anti-Kickback Statute
- Deficit Reduction Act
- Health Care Fraud Statute
- Stark Law (Physician Self-Referral Law)
- Civil Monetary Penalties (CMP) Law
- Exclusion

For details about specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

Healthcare Laws: Federal False Claims Act

The Federal False Claims Act prohibits "knowingly" presenting a false or fraudulent claim, record, or statement to a federal health care program for payment or approval.

"Knowingly" includes:

- Having actual knowledge of the information;
- Acting in deliberate ignorance of the truth or falsity of the information; or
- Acting in reckless disregard of the truth or falsity of the information.

Areas of risk include inaccurate coding, billing or unnecessary services, insufficient documentation, or not returning a Medicare or Medicaid overpayment within 60 days of identification.

IMPORTANT: Systems must be in place to ensure the accuracy of claims.

Healthcare Laws: False Claims Act continued

False Claims Act Whistleblower Provisions

- Permit a private person (a “qui tam relator”) to bring a civil action on behalf of the Government.
- Provide protection from retaliation for taking this action.

Texas Medicaid Fraud Prevention Act

- Texas has a False Claims Act that generally mirrors the Federal False Claims Act, but applies to Texas Medicaid.

Review the Memorial Hermann False Claims Policy for additional information about Fraud, Waste, and Abuse laws.

Healthcare Laws: Anti-Kickback Statute

The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving anything of value to influence referrals for patient services payable by a federal health care program.

- Violation of the Anti-Kickback Statute can lead to criminal and civil penalties for those involved.
- In our dealings with physicians, patients, and vendors, do not offer or accept anything of value in order to induce referrals.

Health Care Laws, Continued

The Deficit Reduction Act requires that providers:

- Establish policies and procedures for detecting fraud, waste or abuse; and
- Educate employees, physicians, and contractors about federal and state false claims laws, including penalties under the laws and whistleblower protections.

The Health Care Fraud Statute states, “whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.”

Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law. If the violations result in serious bodily injury, such person may be fined and serve 20 years imprisonment. If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

For more information, refer to 18 U.S.C. Section 1347.

Healthcare Laws: Stark Law - Physician Self-Referral

The Stark Law prohibits most referrals from physicians who have a financial relationship with Memorial Hermann, unless an exception applies.

- Financial relationships include arrangements such as medical directorships, call arrangements, recruitment, and office leases.
- All Memorial Hermann-physician arrangements implicate the Stark Law and therefore require legal review to ensure an exception applies.

Healthcare Laws: Stark Law - Physician Gifts

- The basic principle for offering or giving gifts, meals and other valuable consideration is that you should never offer, or give anything of value that could affect, or have the appearance of being able to affect, the recipient's objective business judgment in his or her dealings with Memorial Hermann.

- Examples of physician gifts include anything of value such as dinner at a restaurant to recognize physician achievement or tangible items like flowers.

- Keep these guidelines in mind when giving gifts to physicians:
  - All gifts must be tracked, and must be pre-approved by the designated facility leader.
  - Gifts must not exceed the limit set per policy.
  - No gifts of cash or cash equivalents (gift cards or gift certificates) may be provided.
  - Gifts should never be given to physicians with the intent to reward or induce referrals.

- For more information, please refer to the Gifts to Potential Referral Sources (Physicians) Policy, and additional information available on the Corporate Compliance OneSource page.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of and failing to report and return an overpayment;
- Making false claims; or
- Paying to influence referrals.

For more information, refer to 42 U.S.C. 1320a-7a and the Act, Section 1128A(a).

Damages and Penalties: The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item; or
- Of remuneration offered, paid, solicited, or received.

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 U.S.C. Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901.

Compliance-Related Policies

In addition to following the Standards of Conduct and all laws and regulations, employees are also expected to follow all Memorial Hermann policies and procedures. These policies have been written to provide guidance to help you do your job and to promote our commitment to Compliance. A few of the compliance-related policies include:

- Compliance Helpline
- Conflicts of Interest
- False Claims
- Problem Reporting and Non-Retaliation
- Reporting and Refunding Payments to Federal Healthcare Programs
- Sanction Screening
- Voluntary Disclosure to Agencies

Sanction Screening

Memorial Hermann is obligated to perform sanction screenings, as recommended by the law, to reduce the likelihood of doing business with an individual or company who has been excluded from participation in Medicare or Medicaid.

- An individual or company may be excluded for many reasons, including:
  - Failure to pay a student health education assistance loan
  - Conviction of patient abuse or neglect
  - Healthcare fraud
  - Licensing board actions

If Memorial Hermann were to employ or contract with someone excluded from a government-funded healthcare program, we could be subject to fines and be required to refund any reimbursement received for services provided by that individual or company.

- This applies to employees, physicians, vendors, volunteers and contract personnel. It also includes administrative and management services not directly related to patient care.
- Use the MHHS Vendor Vetting Process for potential vendors.
- Use Central Staffing for contract staff.

Conflicts of Interest

A conflict of interest may exist whenever an employee or a related party (family member, friend) receives a private benefit from any decision or action taken by the employee on behalf of Memorial Hermann.

Employees should at all times:

- Exercise good faith and fair dealing in all transactions that involve their responsibilities to Memorial Hermann.
- Maintain unbiased relationships with actual and potential vendors.
- Report actual or perceived conflicts of interest to your supervisor.

Examples of potential conflicts of interest:

- Soliciting personal business from Memorial Hermann patients or their families, employees, physicians or vendors.
- Engaging in an outside employment relationship with a competitor or vendor.
- Accepting prohibited gifts from patients or vendors.
- Disclosing or using information belonging to Memorial Hermann for personal profit or advantage, or to the detriment of Memorial Hermann.
- Misusing your position with Memorial Hermann for personal gain.
- Using System resources or facilities to conduct outside business.

What is Non-Compliance?

Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethical and business policies. CMS has identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation;
- Appeals and grievance review (for example, coverage and organization determinations);
- Beneficiary notices;
- Conflicts of interest;
- Claims processing;
- Credentialing and provider networks;
- Documentation and timeliness requirements;
- Ethics;
- FDR oversight and monitoring;
- Health Insurance Portability and Accountability Act (HIPAA);
- Marketing and enrollment;
- Pharmacy, formulary, and benefit administration; and
- Quality of care.

What is Non-Compliance?

Memorial Hermann's Corporate Compliance Program also guides our conduct with respect to other high risk areas prone to fraud, waste and abuse including:

- Admissions
- Coding
- Billing and refunds
- Business relationships
- Patient rights
- Employee rights
- Confidentiality

For more information, refer to the Corporate Compliance OneSource page.

How Do You Prevent FWA?

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely data and billing;
- Ensure coordination with payers;
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance; and
- Verify all received information.

Correction

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures you are in compliance with CMS requirements.

Develop a plan to correct the issue. Consult the compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action; and
- Monitor corrective actions continuously to ensure effectiveness.

Know the Consequences of Non-Compliance

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences including:

- Contract termination;
- Criminal penalties;
- Exclusion from participation in all federal health care programs; or
- Civil monetary penalties.

Additionally, Memorial Hermann must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training;
- Disciplinary action; or
- Termination.

Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance, we all risk:

Harm to beneficiaries and patients, such as:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Less money for everyone, due to:

- Fines and penalties
- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

How to Report Potential Non-Compliance

1. Talk to your Supervisor, or talk with your Human Resources representative if it is a human resources issue or question.

2. If you are not comfortable contacting your supervisor, or if you did not receive a satisfactory response, talk to another member of the management team.

3. If for any reason you feel that you cannot follow the previous steps, or you want to remain anonymous, you may call the Corporate Compliance Helpline at 713-338-4140 or 1-877-448-4140.

4. You may report your concerns to the Chief Compliance Officer Charles Bumpass (713-338-4113), or any member of the Corporate Compliance Department (contact information available on Corporate Compliance OneSource page).

5. You may also choose to report your concerns through http://healthplan.memorialhermann.org/compliance/ or another Medicare Advantage Plan's website, or by calling 1-800-Medicare.

Don’t Hesitate to Report Non-Compliance

When you report suspected non-compliance in good faith, Memorial Hermann can’t retaliate against you.

All calls to the Helpline are:

- Anonymous (if requested);
- Confidential;
- Non-retaliatory;
- Thoroughly investigated;
- Not recorded or traced;
- Available 24 hours a day, 7 days a week; and
- Available in multiple languages.

What Happens after Non-Compliance is Detected?

Non-compliance must be investigated immediately and corrected promptly. Internal monitoring should ensure:

- No recurrence of the same non-compliance;
- Ongoing compliance with CMS requirements;
- Efficient and effective internal controls; and
- Protected enrollees.

What Are Internal Monitoring and Audits?

- Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

- Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures.

- **Monitoring for compliance is a key management function and helps identify concerns early. It is important to have routine checks of critical functions in your department to verify that you are meeting requirements.**

What to Report

Memorial Hermann is committed to creating an open environment for communication for you to be able to address compliance questions and concerns.

The following are examples of what to report:

- Non-adherence to policies and procedures, unethical behavior, employee/management problems, or conflicts of interest;
- Violations of safety regulations or policies, or faulty equipment;
- Fraudulent or false claims (including overbilling, upcoding, or duplicate billing);
- Embezzlement or theft;
- Failure to provide proper services, refusal to provide emergency services based on an inability to pay, or billing for unnecessary services;
- Security violations, misuse of information, or misuse of company property;
- Unethical accounting practices and cost reporting, concerns about contracts/agreements, or vendor concerns;
- Acceptance of prohibited gifts from patients or vendors; and
- Acceptance or the provision of kickbacks, bribes, rebates, or anything of value in order to influence the referral of patients or services.

What to Report

It is Memorial Hermann's policy to refund overpayments received from a federal healthcare program within 60 days, as required by law. Failure to promptly refund these amounts can result in liability under the False Claims Act.

Potential overpayments must be promptly and thoroughly investigated. Please contact Corporate Compliance if you have any related questions or concerns.

When in Doubt

If you are unsure about whether or not to report a concern, ask yourself the following questions:

- Does it violate a law, regulation, policy or Standard of Conduct?
- What would my family, friends, our physicians or patients think?
- How would this look if it were in the newspaper tomorrow?
- Is it fair and honest?
- How will I feel about myself afterwards?
- Does it impact quality of care?
- Could it lead to fraud, waste or abuse?

If you are still unsure, speak to a supervisor or contact Corporate Compliance.

Note, all human resources issues, such as discrimination, harassment, unfair treatment, and working conditions should be reported directly to Human Resources.

Sample Compliance Review Process

- **Identification of Potential Issue:** A potential issue is brought to your attention. You promptly conduct an initial review to substantiate the concern.

- **Prompt Notification to Corporate Compliance:** If you substantiate the potential issue or need assistance with the evaluation, promptly report the concern to Corporate Compliance for review.

- **Investigation and Review:** Each report is unique and requires a case by case assessment of what would encompass an appropriate review. Corporate Compliance will collaborate with leadership to obtain pertinent facts and relevant procedures. For example, some reviews require documentation or billing review, while others require the generation of data reports. Your leadership and participation in the review process is critical to successfully addressing the matter.

- **Findings and Corrective Action:** Corporate Compliance will collaborate with leadership to effectuate appropriate corrective action such as process changes, staff education, HR involvement, refunds, or government disclosure as necessary.

Lesson Summary

Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.

To help ensure compliance, behave ethically and follow the Memorial Hermann Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.

Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

Compliance Is Everyone's Responsibility!

Prevent: Operate within the organization's ethical expectations to prevent non-compliance.

Detect & Report: Report detected potential non-compliance.

Correct: Correct non-compliance to protect beneficiaries and patients and save money.

Resources

The following resources contain additional information provided by CMS:

CMS Resources:

- Publications & Multimedia
- Events and Training
- Newsletters and Social Media
- Continuing Education
- Centers for Medicare & Medicaid Services Glossary

Resources

The following resources contain additional information provided by CMS:

CMS Regulatory Guidance & Resources:

- 42 Code of Federal Regulations (CFR) Section 422.503
- 42 CFR Section 423.504
- Chapter 9 of the Medicare Prescription Drug Benefit Manual
- Chapter 21 of the Medicare Managed Care Manual
- CMS Compliance Program Policy and Guidance webpage
- Medicare Parts C and D Compliance Trainings and Answers to Common Questions
- Compliance Education Materials: Compliance 101
- Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
- Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol
- Part C and Part D Compliance and Audits - Overview
- Physician Self-Referral
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
- Safe Harbor Regulations