TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE AUDIT, COMPLIANCE AND ETHICS COMMITTEE
April 19, 2018
8:30 a.m. – 10:30 a.m.
Assembly Rm. 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Action/ Recommendation	Requestor/ Presenter
1.	Call to order	5 min.		Chair
2.	Approval of Agenda	2 min.		Chair
3.	Public Comments – Announcement Comments may be made at this time by members of the public and Committee members on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee. NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.	1 min.		Standard
4.	Ratification of Minutes- January 18, 2018	3 min.	Action	Chair
5.	Old Business – a) Fiscal Year 2018 – Financial Statement Audit Proposal	10 min.	Discussion/ Possible Action	CFO
6.	New Business – **Discussion and Possible Action** a) **<u>Administrative Policies & Procedures:</u>** 1) Fraud Recognition Response #395 2) Hospital Issued Notice of Non-coverage of Medicare-Covered Services (HINN) #398 3) Important Message from Medicare & Notification of Hospital Discharge Appeal Rights - #392 4) Medical Directorships - #572 5) Monitoring Compliance – Auditing & Reporting – Annual Compliance Work Plan - #552 6) Monitoring Compliance Auditing & Reporting – Compliance Reviews and Audits - #553 7) Physician & Allied Health Professional Service Contracts - #580 8) Sales of Items or Services to Physicians and Other Potential Referral Sources - #575 b) Chief Compliance Officer Report 1) Dashboard Update 2) Work Plan Update 3) Government Audit Trends	30 min. 30 min.	Discussion/ Possible Action Information Only	CCO/P. Guerra CCO
7.	Motion to go into Closed Session			

	Agenda Item	Time Allotted	Action/ Recommendation	Requestor/ Presenter
8.	Closed Session			
	a) Approval of Audit, Compliance & Ethics Closed Session Minutes of January 18, 2018 (Authority: Government Code Section 54957.2)	5 min.	Action	Chair
	b) Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matter)	10 min.	Action	Chair
9.	c) Motion to go into Open Session	2 min.	Action	Chair
10.	Open Session			
11.	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1).	1 min.		
12.	Committee Communications	5 min.		All
13.	Committee Openings – None	3 min.		Chair
14.	Date of Next Meeting: May 17, 2018	1 min.		Chair
15.	Adjournment			Chair
16.	Total Time Budgeted for Meeting	1.5 hours		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations

Tri-City Medical Center
Audit, Compliance & Ethics Committee
January 18, 2018
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Julie Nygaard; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member
Non-Voting Members:	Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO; Carlos Cruz, CCO, Susan Bond, General Counsel
Others Present:,	Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Contract Analyst - Paralegal
Absent:	Cary Mells, M.D.; Physician Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. Chairman Schallock welcomed Board Member Julie Nygaard and introduced Scott Livingstone, newly appointed Chief Operations Officer.		
2. Approval of Agenda	**It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – September 21, 2017	Chairman Schallock noted an additional page 8 was inadvertently included in the minutes which should be omitted. **It was moved by Director Dagostino and seconded Mr. Leslie Schwartz to approve the minutes with the omitted page as described. The motion passed with Director**	**Minutes ratified.**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Nygaard abstaining from the vote.		
5. Old Business a) Discussion regarding Fy2018 Financial Statement Audit	Mr. Ray Rivas, CFO stated at the direction of the committee he contacted Moss Adams to seek an audit proposal to conduct the FY2018 Financial Statement Audit with no increase in fees. Mr. Rivas stated Moss Adams has verbally stated the fees would not only remain the same but may actually come down slightly from last year. He explained there was a slight increase last year due to the single audit required in connection with the HUD loan. The committee directed Mr. Rivas to seek a letter of engagement with Moss Adams to perform the FY2018 Financial Statement Audit and bring forward at the April 19th meeting.	**Mr. Rivas to seek letter of engagement with Moss Adams to perform the FY2018 Financial Statement Audit. Letter of Engagement to be presented to Committee at the April meeting.**	Mr. Rivas
6. New Business a) Administrative Policies & Procedures: 1. Medical Procedures & Interrogations Requested by Law Enforcement	Ms. Susan Bond requested that the Medical Procedures & Interrogations Requested by Law Enforcement Policy be pulled for further review. She noted this policy is based on implied consent laws stemming from an incident in Utah.	Medical Procedures & Interrogations Requested by Law Enforcement Policy to be presented at a future meeting.	Ms. Bond
b) FY2019-2019 Compliance Program Work)Plan	Mr. Carlos Cruz, CCO presented a comprehensive overview of the FY18-19 Work Plan. Key focus areas and goals were discussed including the following: 1) Compliance Office Structure **Goal:** To ensure that TCHD Compliance Office has the appropriate infrastructure and staffing in place to support an effective compliance program. Mr. Cruz introduced his staff Ms. Kristy Larkin, Director of Director of Compliance, Audit & Monitoring and Maria Carapia, Contract Analyst – Paralegal. Each staff member	**Information Only.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	gave a brief summary of their background and experience. 2) Compliance Program Marketing **Goal**: To ensure that there is awareness of the Compliance Program by TCHD staff members 3) Compliance Program Oversight **Goal:** To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the District and ongoing mitigation efforts. Director Nygaard questioned the location of Mr. Cruz's office and staff accessibility. Mr. Cruz stated he is located in the Administrative suite. He presented a flyer that will be distributed to staff regarding how to report a concern. Director Nygaard suggested the flyer also include a map that reflects Mr. Cruz's office location. Mr. Cruz stated he will be creating a business type card that can be attached to the employee badge with information on accessing Compliance staff and the Values Line. In addition a Compliance Newsletter will be developed and distributed on a monthly basis. Chairman Schallock requested that the Board also receive a copy of the Newsletter. Mr. Cruz reported that all staff will be receiving Fraud, Waste and Abuse training as required by Medicare. He explained the training will be in the form of a Net Learning module. Mr. Cruz stated he also intends to provide 30 minute Board of Directors training in February. He explained the importance of highlighting the trends in regulatory and case law on a yearly basis. 4) Compliance Policies & Procedure **Goal**: To ensure that the appropriate compliance policies and procedures are implemented.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	5) Compliance Training and Education **Goal:** To ensure compliance training and education is up to date and meets CMS requirements. 6) Auditing and Monitoring **Goal**: To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks to the District Mr. Cruz discussed the Meditract software that is utilized to upload contracts. He stated it has been very effective in making sure we have agreements in place and triggers to renew contracts prior to expiration. Ms. Fitzwilliam suggested Meditract be added to the Compliance Work Plan to ensure it meets controls. Mr. Cruz discussed the Compliance team is also looking at claims data and denials. He stated he may bring in external auditors from time to time to do auditing as well. Ms. Fitzwilliam Kathryn requested clarification on the monthly employee exclusions screening process. Mr. Cruz explained it is recommended that this screening be done on a monthly basis to determine if there is any staff on the exclusion list. He stated he is working with Human Resources to bring in a vendor to do conduct that screening. 7) Open Lines of Communication **Goal**: To ensure that the TCHD Values Line is being utilized appropriately by staff members. At Chairman Schallock's request Mr. Cruz commented on the development of a "speak up culture" where staff will be educated on "speaking up" and non-retaliation. 8) HIPAA Privacy & Security **Goal**: To ensure that TCHD has adequate controls in place		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	to protect patient's protected health information (PHI). Mr. Cruz stated in the past there has been a separate Privacy Officer however the Privacy component will be transitioned to Mr. Cruz where HIPAA, Privacy & Security will be centralized. Discussion was held regarding privacy related to physicians and texting of patient information. Mr. Livingstone stated in Cerner there is an application for secured texting however it is not up and running at this time. Discussion was held regarding a patient portal. Mr. Livingstone stated each facility makes the determination of data they wish to make available to the patient on their institution's portal. At Ms. Devine's request, Mr. Cruz reviewed the processes in place for investigation of Values line complaints. 9) Operational Support **Goal:** To provide support to operational units and address critical risk areas as specified by leadership. Discussion was held regarding the Pension Plan and whether the Employee Fiduciary Subcommittee was the appropriate committee to provide oversight of the plan. Mr. Cruz stated compliance does not get involved in the day to day operations of the plan. Mr. Dietlin stated it is a highly regulated area. He explained the district has a fully funded plan that is managed by a third party. Mr. Livingstone commented that the third party that manages the plan is highly regulated as well and possibly even more so than us. Chairman Schallock expressed his appreciation to Mr. Cruz for presenting such a thorough Work Plan.		
c) Approval of Committee Charter	Chairman Schallock reported the Committee Charter was	**Recommendation to be**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	revised to reflect the changes made to the committee structure and meeting schedule. Ms. Fitzwilliam inquired as to whether the physician member has voting rights as the voting members should be an odd number. Chairman Schallock confirmed that the physician member has voting rights however Administrative members do not have voting rights. **It was moved by Director Dagostino to approve the Charter as presented. Mr. Leslie Schwartz seconded the motion. The motion passed unanimously.**	**sent to the Board of Directors to approve the committee Charter as presented; item to be placed on Board agenda and included in packet.**	
7. Motion to go into Closed Session	It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to go into closed session at 9:40 a.m.		
11. Open Session	The committee returned to open session at 9:56 a.m. with attendance as previously noted.		
12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
13. Comments from Committee Members	There were no comments from members of the committee.		
14. Committee Openings	There are no committee openings.	**None**	
15. Date of Next Meeting	Chairman Schallock stated the next meeting will be held on April 19, 2018.	**The Committee's next meeting is scheduled for April 19, 2018.**	
16. Adjournment	Chairman Schallock adjourned the meeting at 10:00 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
April 19th, 2018

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Fraud Recognition Response	395	3 year review, practice change	
2. Hospital Issued Notice of Noncoverage of Medicare-Covered Services (HINN)	398	NEW	
3. Important Message From Medicare and Notification of Hospital Discharge Appeal Rights	392	3 year review, practice change	
4. Medical Directorships	572	practice change	
5. Monitoring Compliance - Auditing & Reporting - Annual Compliance Workplan	552	3 year review, practice change	
6. Monitoring Compliance Auditing and Reporting - Compliance Reviews and Audits	553	DELETE	
7. Physician and Allied Health Professional Service Contracts	580	3 year review, practice change	
8. Sales of Items or Services to Physicians and Other Potential Referral Sources	575	3 year review, practice change	

Tri-City Health Care District
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: 03/11 **SUBJECT:** Fraud Recognition and Response

REVISION DATE: **POLICY NUMBER:** 8610-395

Department Approval:	01/18
Administrative Policies & Procedures Committee Approval:	~~01/11~~01/18
Organization Compliance Committee:	02/18
Medical Executive Committee Approval:	~~02/11~~03/18
Audit, Compliance and Ethics Committee:	
Board of Directors Approval:	03/11

A. **PURPOSE:**

To describe the measures to be followed when health care is obtained under a fictitious name or in another person's name. This includes situations when a person intentionally misrepresents himself/herself and when a person gives his/her real name, but the hospital or other facility accesses the wrong medical record so that the medical records of two patients are commingled.

B. **DEFINITION(S):**

1. Identity ~~t~~Theft:~~ means~~ the act of~~:~~ knowingly obtaining, possessing, buying, or using, the personal identifying information of another:
   a. ~~(1)~~ with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain credit, goods, services or medical information in the name of such other person; and
   b. ~~(2) (a)~~ without the consent of such other person~~;~~ or ~~(b)~~ without the lawful authority to obtain, possess, buy or use such identifying information.
2. **Theft of Services:**
   a. ~~means (1)~~ **intentionally obtaining services by deception, fraud, coercion, false pretense or any other means to avoid payment for the services; and**
   ~~1.~~b. ~~(2)~~ **having control over the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another not entitled thereto.**

C. **POLICY:**

Tri-City Healthcare District (TCHD) strives to prevent the intentional or inadvertent misuse of patient names, identities, and medical records; to report criminal activity relating to identity theft and theft of services to appropriate authorities; and to take steps to correct and/or prevent further harm to any person whose name or other identifying information is used unlawfully or inappropriately.

D. **PROCEDURE:**

1. ~~Request~~ Identification at Registration/~~i~~Intake ~~p~~Points - Hospital emergency department and all other registration/intake ~~areas~~ **staff** should **request,** review and include in each patient's file a copy of the patients photo identification (ID) issued by a local, state, or federal government agency (i.e., driver's license, passport, military ID, etc.). In the event the patient does not have a photo ID, ask for two forms of non-photo ID, one of which has been issued by a state or federal agency (i.e., Social Security card and utility bill or company or school ID). When the patient is under 18 or if the patient is unable due to their condition to produce ID, the responsible party's ID shall be requested.

2. **Identification at Subsequent Patient Visits -** Each time a patient visits, **TCHD staff should** check whether the ID provided is valid, and matches any photo in the patient's medical record to the ID provided for visit. During the registration process, if an identity alert flag appears in the TCHD Master Patient Index (MPI), **the staff member should** call the Registration Supervisor.
   a. Special Considerations:
      i. Emergency Care – no delay. Providing ID is not a condition for obtaining emergency care. The process of confirming a patient's identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.
      ii. Responding to Questions – If asked the reason for the identifying procedures, **TCHD staff should** explain that the procedures are "for patient protection to prevent identity theft and theft of services."

2. Refusal to Provide or Lack of ID – No one should be refused care because they do not have acceptable ID with them. Patients should be asked to bring appropriate documents to their next visit. ~~and registration staff may offer to take a photograph of the patient in accordance with any approved registration staff photograph policy. Refer to Photo Identification of Patients Policy.~~

3. Signs of Possible Identify Theft – Employees should be alert for cases of possible identity theft. Potential signs of identity theft include, but are not limited to, the following: (refer to **Administrative Policy: Identity Theft [**Red Flag Rules] 596):
   a. Any patient appearing and giving an identity that has been flagged in TCHD's MPI or Identity Theft Database.
   b. A patient providing photo ID that does not match patient.
   c. A patient giving a Social Security number different than one used on a previous visit.
   d. A patient giving information that conflicts with information in the patient's file or received from third parties, such as insurance companies.
   e. Family members/friends calling the patient by a name different than that provided by the patient at registration.

~~e.~~4. ~~TCHD~~**Administrative Policy: Identity Theft (Red Flag Rules) 8610-596 sets forth the TCHD Identity Theft Prevention Program (ITPP).**

5. Identity Theft Investigation/Follow-Up:
   a. If ~~an employee~~ **TCHD staff member** reasonably believes identity theft has occurred or may be occurring, **he/she must** immediately notify the Registration Supervisor. The Registration Supervisor will notify the **Chief Compliance and** Privacy Officer. ~~TCMC will be informed of the suspected identity on an as needed basis.~~
   ~~4.~~b. When Identity Theft is alleged by a Patient – Advise the patient to report the identity theft incident to law enforcement and to the **Federal Trade Commission** (FTC) and complete the Identity theft report. A unique number will be generated to track this report. Use of these two reports should substantiate that identity theft did in fact occur. Once the identity theft allegation is supported by an FTC Identity report, the facility must flag the account of the patient alleging identity theft so that medical personnel are alert to the issue that the medical record may contain inaccurate information about the patient.
   ~~a.~~c. When Identity Theft Occurs – A person obtains or uses the personal identifying information of another to obtain (or to attempt to obtain) medical services or information in the name of such other person, TC~~MC~~**HD** will take the following steps:
      i. Notifications – When identity theft is reasonably suspected or is known to have occurred as soon as possible, report the theft to the Compliance Officer. The Compliance Officer will make decisions on the findings, external reporting law enforcement agency and make necessary notifications.
         1. Reporting Medicaid Fraud – If Medicaid fraud (i.e., a patient uses another person's Medicaid information to obtain medical care), the fraud must be reported immediately to the Medicaid OIG at 800-447-8477.
         2. Mail theft – For incidents involving mail theft, the United States Postal Inspection Service will be contacted.

3. Security Breach – If the identity theft involves unauthorized access of unencrypted computerized data would permit access to an individual's financial account, the Compliance Officer will direct reporting in accordance with California laws to any resident of California whose unencrypted personal information was or is reasonably believed to have been acquired by an unauthorized person. Such reporting will be made in the most expedient time possible and without unreasonable delay, consistent with the legitimate needs of law enforcement.

~~b.~~**d.** Accounts on Hold – The Director of Patient Financial Services will put all patient accounts affected by the **suspected** identity theft on hold pending the outcome of the investigation.

~~c.~~**e.** Reporting of **Identity** ~~t~~Theft -Victims of identity theft should be encouraged to cooperate with law enforcement in identifying and prosecuting the suspected identity thief. They also should report the theft to the FTC using the link provided https://www.identitytheft.gov. The FTC process for helping victims of identity theft.

f. Correcting medical and payment records - ~~of identity theft victims—~~**If a case of identity theft is confirmed** after appropriate investigation and review**, TC~~~~M~~~~G~~**HD will ensure** ~~and it has been determined that identify thief did in fact occur ensure~~ that:

i. ~~(1)~~ Inaccurate health information is not inadvertently relied upon in treating a patient.~~,~~

ii. ~~(2) a~~ Patient or a third-party payer is not billed for services the patient did not receive~~, and (3)~~.

~~d.~~**iii.** PHI is protected from inappropriate disclosure, patient medical and payment records must be corrected when a case of identity theft occurs.

~~i.~~**1.** Medical records - ~~t~~The HIM department will make appropriate corrections to the patient's medical record. Corrections shall be made in accordance with ~~TCMC~~ Medical Record **Policy: Making** Corrections **to Supplemental Dictionary** Policy and ~~TCMC HIPAA~~**Administrative** Policy:~~,~~ Amendment of **Protected** Health Information **520**. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. Pursuant to **Administrative Policy: Amendment of Protected Health Information 520**~~TCHD HIPAA Policy~~, the HIM department may need to send amended information to persons who have received incorrect or incomplete information. The HIM department shall remove all related documents from Cerner and make replacements with appropriately revised documents. The patient's verification of the corrected medical record shall be documented and included as part of the case file forwarded to the Compliance Officer.

~~ii.~~**2.** Payment records – The billing department will make appropriate corrections to the patient's billing information, inform and provide documentation to any third-party payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for services actually provided to the patient. Corrections shall be made in accordance with TC~~M~~~~G~~**HD** billing record corrections policy. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. The patient's verification of the corrected billing records shall be documented and included as part of the case file forwarded to the Compliance Officer.

~~iii.~~**3.** Flagging – The Registration Supervisor will add an MPI Alert Flag of "Identity issue/call Security" to each MPI record affected by the identity theft event.

~~iv.~~**4.** Release of Hold – The Registration Supervisor will verify that all demographic and insurance information is correct after the visit is

transferred to the appropriate MPI record. Once all medical and billing records have been corrected, Patient Financial Services Director will release the bill hold and bill appropriately.

~~e.~~**g.** Assisting Identity Theft Victims:

i. Copies of Records on Written Request – Identity theft victims are entitled to obtain a copy of the billing and medical record relating to the identity theft free of charge. The facility must provide these records within **thirty** (30) days of receipt of the victim's written request. The facility also must provide these records to any law enforcement agency which the victim authorizes. Document receipt of and copy all such information. The facility may refuse to provide business transaction records if the facility determines in good faith that:

1. ~~(1)~~ the true identity of the person asking for the information cannot be verified;

2. ~~(2)~~ the request for the information is based on a misrepresentation; or

~~i.~~**3.** ~~(3)~~ state or federal law prohibits the facility from disclosing such information.

ii. Mitigation – The hospital should mitigate, to the extent practicable, any harmful effect that is known as a result of unlawful use or disclosure of **protected health information** (PHI) in connection with a case of identity theft.

~~f.~~**h.** Recoveries from Suspect – If known, the hospital may bill the identity theft suspect for unlawfully obtained services. ~~Consult with t~~**The Chief** Compliance Officer **should be consulted** for further guidance.

~~g.~~**i.** Accounting for Disclosures – The entity's Privacy Officer should determine whether, as result of identity theft, PHI was inappropriately disclosed. If PHI was inappropriately disclosed, the entity's HIM department must account for such disclosures in accordance with the ~~TCHD HIPAA~~**Administrative** Policy:~~,~~ Accounting ~~for~~**of** Disclosures **of Protected Health Information (PHI) 528**.

~~5.~~**6.** When Patient Misidentification Occurs – If it is determined that patient misidentification, has occurred (for example, when a patient gives his or her real name, but the incorrect medical record is pulled up and the medical information of two patients is subsequently intermingled), the hospital shall take the following steps:

a. Notifications – When patient misidentification has occurred, notify the appropriate Director' needed to remedy the situation. For example: Privacy Officer, HIM Director, Patient Financial Services Director, and the Compliance Officer. The Compliance Officer will review and make decisions on the findings and make all external reporting and notification decisions.

b. Accounts on Hold – The Patient Financial Services Director will put all patient accounts affected by the patient misidentification on hold pending the outcome of the investigation.

c. Notifying Affected Patients - Directed by the **Chief** Compliance Officer, notify– Patients affected by the misidentification.

d. Correcting Medical and Payment Records- Patient medical and payment records must be corrected when a case of patient misidentification occurs.

i. Medical Records – the HIM department will make appropriate corrections to the patient's medical record. Corrections shall be made in accordance with ~~TCMC~~ **Patient Care Services Policy:** Medical Record, **Making** Corrections **to Documentation** ~~policy~~**Procedure** and ~~TCMC HIPAA~~ **Administrative** Policy:~~,~~ Amendment of **Protected** Health Information **520**, A detailed explanation of the corrections shall be generated by the entity and verified by the patient. Pursuant to ~~TCHD HIPAA~~ policy, the HIM department may need to send amended information to persons who have received in correct or incomplete information. The HIM department shall remove all related documents from Cerner and make replacements with appropriately revised documents. The patient's verification of

the corrected medical record shall be documented and included as part of the case file forwarded to the **Chief** Compliance Officer

ii. Payment Records — the billing department will make appropriate corrections to the patient's billing information, inform and provide documentation to any third-party payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for services actually provided to the patient. Corrections shall be made in accordance with TCM~~C~~**HD** billing record corrections policy. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. The patient's verification of the corrected billing records shall be documented and included as part of the case file forwarded to the Compliance Officer.

iii. -Release of Hold – The Registration Supervisor will verify that all demographic and insurance information is correct after the visit is transferred to the appropriate record. Once all medical and billing records have been corrected, Patient Financial Services Director will release the bill hold and bill appropriately.

e. Accounting for Disclosures – The entity's Privacy Officer should determine whether PHI was inappropriately disclosed. If PHI was inappropriately disclosed, the HIM department must account for such disclosures in accordance with **Administrative**~~TCHD HIPAA~~ Policy:~~,~~ Accounting for Disclosures **of Protected Health Information (PHI) 528**.

~~6. Definitions~~

~~a. Identity theft means the act of: knowingly obtaining, possessing, buying, or using, the personal identifying information of another: (1) with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain credit, goods, services or medical information in the name of such other person; and (2) (a) without the consent of such other person; or (b) without the lawful authority to obtain, possess, buy or use such identifying information.~~

~~b.~~f. ~~Theft of services includes: (1) intentionally obtaining services by deception, fraud, coercion, false pretense or any other means to avoid payment for the services; and (2) having control over the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another not entitled thereto.~~

E. EXTERNAL LINK(S):

~~c.~~1. **Federal Trade Commission: https://www.identitytheft.gov**

F. RELATED DOCUMENT(S):

1. **Administrative Policy: Accounting of Disclosures of Protected Health Information (PHI) 528**
2. **Administrative Policy: Amendment of Protected Health Information 520**
~~d.~~3. **Administrative Policy: Identity Theft (Red Flag Rule) 596**
4. **Medical Record Policy: Making Corrections to Supplemental Dictionary Policy**
5. **Patient Care Services Policy: Medical Record, Making Corrections to Documentation Procedure**

~~E.~~G. REFERENCE(S):

1. HHS.GOV - Uses and Disclosures for Treatment, Payment, and Health Care Operations 45 CFR
~~1.~~2. https://www.consumer.ftc.
~~2.~~3. Identity Theft Rule, 16 C.F.R. 681.I

Tri-City Medical Center
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: NEW

SUBJECT: Hospital Issued Notice of Noncoverage of Medicare-Covered Services (HINN)

REVISION DATE: NEW

POLICY NUMBER: 8610-498

Department Review:	**10/17**
Administrative Policies & procedures Committee Approval:	**10/17**
Organizational Compliance Committee Approval:	**2/18**
Finance, Operations and Planning Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To explain the CMS ruling regarding the Notice of Medicare Provider Non-Coverage for the Medicare beneficiaries.

B. **POLICY:**
1. It is the policy of the hospital to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with Hospital Issued Notice of Noncoverage of Medicare-covered services (HINN).

C. **PROCEDURE:**
1. Hospitals give HINNs to beneficiaries when issues of noncoverage arise for hospital-level inpatient care. The HINN may be given prior to admission, at admission, or at any point during the inpatient stay. It may be issued by hospital staff or utilization review committees based on Medicare instructions, including: coverage guidelines, notices, bulletins, or other written guides or directives from intermediaries or QIOs. After the hospital issues a notice of noncoverage, the beneficiary or his/her representative is considered to have knowledge that services are not covered and is liable for customary charges. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or his/her representative. Potential liability may arise when the hospital determines that certain inpatient services are never covered by Medicare. It may also arise when an inpatient stay, either in whole or in part, or a specific, severable service during an otherwise covered stay: Is not considered reasonable and necessary, Can be provided safely in another setting is custodial in nature.
2. Types of HINNS:
    a. HINN 1 – Preadmission/Admission HINN: the hospital may issue a preadmission/admission HINN when the hospital has determined at the time of preadmission or admission that a beneficiary's stay will be a non-covered stay.
        i. Preadmission HINN -- The beneficiary or his/her representative is liable for customary charges for all services furnished if he/she enters the hospital after receipt of a preadmission HINN.
        ii. Admission HINN -- Determine liability as follows:
            1) *HINN Issued on the Day of Admission* – The beneficiary or his/her representative is liable for customary charges for all services furnished after the admission HINN is received. However, to hold a beneficiary or his/her representative liable for charges on the day of admission, the

hospital must issue the admission HINN no later than 3:00 p.m. on the day of admission. If the hospital does not meet these requirements, the beneficiary or his/her representative is protected from liability until the day following receipt of the admission HINN (e.g., a HINN issued for an admission after 3:00 p.m. or a late evening admission).

2) *HINN Issued After the Day of Admission* – The beneficiary or his/her representative is liable for customary charges for all services furnished beginning the day following the date of receipt of the admission HINN.
   a) Timing for Preadmission/Admission HINN Request & Review- When a beneficiary or his/her representative requests review of a preadmission or an admission HINN, the QIO will review any records pertaining to health care services furnished. This includes records pertaining to any inpatient hospital services provided or proposed to be provided to the Medicare beneficiary whether or not, in the hospital's view, the services are covered.
      i) Immediate Review – If the beneficiary or his/her representative disagrees with the hospital preadmission notice, he/she may request your review, by telephone or in writing, within 3 calendar days of receipt of the HINN. If admitted, the beneficiary or his/her representative may request your review at any point during the stay. In either situation, the QIO will review the case within 2 working days following the beneficiary's or his/her representative's request, and issue either a denial notice or a notice explaining that the care would be, or is, covered.
      ii) Review after Discharge or When Beneficiary Was Not Admitted to Hospital – The beneficiary or his/her representative may request review within 30 calendar days after receipt of the notice. The QIO completes this review within the timeframe specified for any retrospective review – 30 calendar days. Once the QIO review is completed, either a denial notice or a notice explaining that the care would be, or is, covered is issued. In all cases of appropriately requested reviews, QIOs will formally determine if the hospital notification was valid, if the hospital's findings were valid, and if beneficiaries will be liable should they remain in the hospital. If the right to reconsideration is exercised, final notification does not occur until the reconsideration is complete.

b. HINN 10 – Hospital Requested Review (HRR): When a hospital determines that a beneficiary no longer requires an acute level of inpatient care, but the attending physician does not agree, the hospital may request a QIO review of the medical record—known as a hospital requested review (HRR). Hospitals must notify the beneficiary that the review has been requested. The QIO review of the hospital's determination considers whether or not continued inpatient care is needed (42 CFR 405.1208(b)(1), effective July 1, 2005).

c. HINN 11 is used for non-covered items or services provided during an otherwise covered inpatient stay. The notice may be used to hold beneficiaries liable for certain non-covered services. The item or service at issue must be a diagnostic or therapeutic service excluded from Medicare coverage as medically unnecessary and the beneficiary must require continued inpatient hospital care.

d. HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay after the appeal is completed or the time frame for requesting an expedited review is

past. The compliance with this notice does not fall under the review authority of the QIO. (Refer to IMFM Policy)

i. HINN 12 is designed to inform patients who remain in the hospital without seeking timely review of their liability for services provided after the date of the proposed discharge. Timely review (by midnight of the date of the proposed discharge) would limit the patient's liability to applicable deductibles and coinsurance until noon of the day after the discharge date on which the QIO notifies the patient of its agreement with the hospital. Failure to seek timely review appears to subject patients who remain in the hospital to liability for all Part A inpatient services provided after the date of the proposed discharge, unless the QIO determines otherwise.

e. Beneficiary Payment Responsibility

i. HINNs do not address every aspect of beneficiary responsibility for payment. Beneficiaries remain liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services never covered by Medicare, even in periods where covered care is also delivered. Hospitals are not required to issue HINNs when the beneficiary will not be billed/liable.

D. **RELATED DOCUMENT(S):**

1. Administrative Policy: Important Message From Medicare and Notification of Hospital Discharge Appeal Rights 392

E. **REFERENCE(S):**

1. Center for Medicare & Medicaid Services (2017, April 13). Beneficiary Notices Initiative (BNI). Retrieved from https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/
2. Center for Medicare & Medicaid Services. Details for Title 100-04: Medicare Claims Processing Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending
3. Center for Medicare & Medicaid Services. Details for Title 100-10: Quality Improvement Organization Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019035.html?DLPage=2&DLSort=0&DLSortDir=ascending
4. CMS Manual System (2005, October 14). Correction to Change Request 3949, Section 50.3.3 in IOM to Add 23x Type of Bill. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R712CP.pdf
5. Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary, Title 42 CFR 411.404 (1989).
6. Preadmission/Admission HINN. Medicare Claims Processing Manual, Transmittal 982

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Patient Care

ISSUE DATE: 03/10 **SUBJECT:** Important Message from Medicare and Notification of Hospital Discharge Appeal Rights

REVISION DATE: 03/10 **POLICY NUMBER:** 8610-392

Department Review:	09/17
Administrative Policies & Procedures Committee Approval:	~~01/10~~09/17
Organizational Compliance Committee Approval:	~~02/10~~02/18
Finance, Operations and Planning Committee Approval:	03/10
Board of Directors Approval:	03/10

A. PURPOSE:

1. To comply with ~~new~~ **the Centers for Medicare and Medicaid Services** (CMS) ~~regulations~~ **regulatory requirements that hospitals notify**~~regarding discharge appeal notices to all patients enrolled in~~ Medicare or Medicare Advantage ~~insurance~~ plans **beneficiaries who are hospital inpatients about their hospital discharge rights.** ~~Applies to acute care inpatients only.~~

~~2. All Medicare and Medicare Advantage plan members will be presented with the CMS-R-193 upon admission to the hospital or within two calendar days of admission. This will be performed by the registration staff as part of the admission paperwork.~~

B. DEFINITION(S):

~~1. CMS-R-193 Form Rev 5-07:~~

~~a.~~**1.** Important ~~Notice~~ **Message** from Medicare **(IMFM) CMS-R-193: A hospital inpatient admission notice given to all beneficiaries with Medicare, Medicare and Medicaid (dual-eligible), Medicare and another insurance program, Medicare as a secondary payer.** ~~The newest version replaces all previously issued revisions of the same form number, as well as the former Notice of Discharge and Medicare Appeal Rights (NODMAR) form.~~

~~i. Notice provides patient with information and directions on how to appeal their hospital discharge if they feel it is inappropriate.~~

~~2. CMS-10066 form:~~

~~a. Detailed Notice of Discharge. New form that explains in writing the reasons for a patient's discharge. To be completed by Case Manager or House Supervisor.~~

~~3.~~**2.** Quality Improvement Organization (QIO):

a. ~~Organization that reviews all patient appeals.~~**QIO enacted by Federal statute "to improve the efficiency, effectiveness, economy and quality or services delivered to Medicare Beneficiaries".**

~~b. Health Services Advisory Group (HSAG) is the local QIO for TCMC.~~

3. Representative:

a. A representative is defined broadly to include individuals authorized to act on behalf of the beneficiary; someone acting responsibly on behalf of an incapacitated or incompetent beneficiary; or someone requested by the beneficiary to act as his or her agent.

4. Detailed Notice of Discharge (CMS-10066):

a. Hospitals must deliver the Important Message from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal

rights. Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice.

C. POLICY:

1. Tri-City Healthcare District (TCHD) must issue the IMFM within two (2) days of admission and must obtain the signature of the beneficiary or his/her representative. TCHD must deliver a copy of the signed notice to each beneficiary not more than two (2) days before the day of discharge. Follow-up notice is not required if delivery of the initial IMFM falls within two (2) calendar days of discharge, if the beneficiary is being transferred from one inpatient hospital setting to another inpatient hospital setting, or when a beneficiary exhausts Part A hospital days. TCHD must retain a copy of the signed notice.

D. PROCEDURE:

1. Initial Notice:
   a. TCHD personnel must provide the IMFM at or near admission but no later than two (2) calendar days from the day of admission or at preadmission, but not more than seven (7) calendar days before admission, and obtain the signature and signature date of the patient or representative to indicate receipt of notice.
   ~~C.~~b. The original is given to the patient with a copy retained by the hospital.

~~1. The patient or representative will sign and date the form to acknowledge understanding of the contents.~~
   ~~a. The original will stay with the patient chart, the second copy will be kept with the financial paperwork, and the third will be given to the patient.~~
   ~~b. If the patient refuses to sign the form, it will be noted on the form by the registrar.~~
   ~~c. The floor unit secretaries will monitor appropriate charts for compliance at set intervals. These charts that do not have a form attached at the time of admission will have the form placed on the chart. Case management will obtain signatures as needed.~~
      ~~i. The business office copy will be placed in a designated area for daily pickup.~~

2. Follow-Up Notice:
   a. The follow-up IMFM must also be provided to the patient as soon as possible prior to discharge, but no more than two (2) days before.
      i. When a discharge seems likely in one (1) to two (2) days, the follow-up notice should be given to the patient, so the patient has ample time to review and act on it.
      ii. If the follow up notice is delivered on the day of discharge, the patient must be given at least four (4) hours prior to discharge to consider their rights.
   b. TCHD must document delivery of the notice in order to demonstrate compliance with this requirement.
   c. If TCHD delivers the follow-up notice, and the beneficiary status subsequently changes, so that the discharge is beyond the two (2) day timeframe, TCHD must deliver another copy of the signed notice again within two (2) calendar days of the new planned discharge date.

~~d. Follow up notification will be performed within 48 hours of discharge from acute care. The patient will be presented with a second form CMS-R-193. The patient will sign the form to capture the date of notification. This will be coordinated through the patient's nurse or case management.~~
      ~~i. Patient should be presented the form as soon as possible, if discharge is less than 48 hours away.~~
      ~~ii. If the patient stay is less than 48 hours, follow up notification is not required.~~

~~2. If the patient does not want to appeal their discharge, no further action is required.~~

3. Beneficiary Refusal to Sign:
   a. If the beneficiary refuses to sign the notice, the hospital should note the refusal and date of refusal on the form and this will be considered the date of notice.

~~3. If the patient wants to appeal their discharge:~~

~~a. Patient will be required to call Health Services Advisory Group (HSAG) at (800) 841-1602 to file their appeal.~~
~~b. Patient must call HSAG no later than the day of discharge.~~
~~i. Hospital staff should assist patient with the filing process if needed.~~
~~c. Case Management (weekdays 0800-1630) or the House Supervisor (Weekends and after hours) will be notified of the appeal.~~
~~d. Upon notification of the appeal, the Case Manager or House Supervisor will provide the patient with a completed CMS-10066.~~
~~i. Form provides detailed reason(s) for discharge.~~
~~ii. Form copy will be provided to HSAG by the hospital.~~
~~e. Appeal should take no more than one day after HSAG receives the necessary information.~~
~~f. During the appeal process, patient will continue stay in present accommodations.~~
~~g. If patient appeal is successful, Medicare will continue to cover the patient's acute care.~~
~~h. If the QIO finds the patient is ready for discharge, the Medicare will continue to cover patient's stay until noon of the day following the QIO notification.~~

~~4. If the patient misses the appeal deadline, they may still ask for a review by contacting either the QIO (for traditional Medicare) or their health plan (if Medicare Advantage).~~
~~a. Patient may be charged for services provided after planned discharge date.~~

4. Medical Record Documentation:
   a. TCHD should place a copy of the initial notice in the patient's medical record.
   b. TCHD must document timely delivery of the follow-up copy of the IMFM in the patient records, when applicable.
   c. TCHD should also document any attempted contact with beneficiary representatives, including telephone calls, messages and subsequent certified mail.
5. Copies:
   a. IMFM form (Initial Notice):
      i. 2 Copies:
         1. Original notice for patient is in the medical record
         2. Patient's copy
   b. IMFM form (Follow up Notice):
      i. 2 copies:
         1. Original notice for patient is in the medical record
         2. Patient's copy
   c. Detailed Notice:
      i. 2 copies:
         1. Original notice for hospital
         2. Patient's copy
      ii. Additional copies may be needed if the patient requests a review, as the QIO will require a copy.
   d. Prior to the patient signing and dating an IMFM and/or Detailed Notice of Discharge, TCHD must ensure the patient comprehends the contents of the notice.
   e. Notices should not be delivered in an emergency medical situation.
6. Expedited Reviews:
   a. A patient has a right to request a review of the discharge decision, by asking for an expedited review by the QIO when the hospital, with physician/Allied Health Professional (AHP) concurrence, determines that inpatient care is no longer necessary. The process is as follows:
      i. The patient submits a request for review to the QIO no later than midnight of the day of discharge that has been ordered by the physician/AHP.
      ii. The request may be in writing or by telephone and must be before the patient leaves the hospital.

1. **If the request is not in this timeframe, and the patient remains in the hospital, he or she may request a review at any time, but will be held responsible for the charges incurred after the date of discharge ordered.**

iii. **When the patient requests a review prior to midnight the day of discharge, the patient is not financially responsible for inpatient hospital services (except coinsurance and deductibles) furnished before noon the day after the patient receives notification of the determination from the QIO.**

iv. **If the QIO does not agree with the patient, the liability for continued services begins at noon of the day after the QIO notifies the patient.**

v. **If the QIO does agree with the patient, the patient is not financially responsible for continued care, until the hospital once again determines that the patient no longer requires inpatient care, secures the concurrence of the physician responsible for the patient or the QIO and notifies the patient with a follow-up copy of the IMFM.**

~~D.~~E. ~~FORM~~RELATED DOCUMENT(S) ~~REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~

~~1. Important Message from Medicare (IMFM)~~

~~2.~~1. CMS-R-193 **An Important Message From Medicare About Your Rights**

~~3.~~2. CMS-10066 **Detailed Notice of Discharge**

F. REFERENCE(S):

~~4.~~1. **CMS Transmittal 1257, May 2007, CR 5622**

Important Message from Medicare (IMFM)

IMPORTANT MESSAGE FROM MEDICARE

Important Message From Medicare (IMFM)

- Is a CMS requirement that is about patient's discharge rights.
- The purpose of this letter is to inform the patient that he/she will be discharged in 1–2 days and have the right to:
  - Evaluate the appropriateness of the discharge plans
  - Communicate with their physicians, care manager, and family, and decide if he/she agrees with the discharge
- If the patient does not agree with the discharge plan, then the patient has a right to appeal the discharge plans.
- At the time of providing the IMFM to the patient and/or family member, it is important to highlight the telephone number (877) 588-1123.

Process Review:

REGISTRATION

- Obtains patient signature on the initial IMFM at admission and gives patient a signed copy. Registration scans the original copy in the patient's medical chart.
- If a patient appeals their discharge and the QIO upholds their decision for discharge, then the financial counselor will explain financial liability to the patient/representative.

CASE MANAGEMENT DEPARTMENT

- Obtains the patient signature on the follow up notice IMFM and gives the patient a signed copy. This is done on Mondays-Wednesdays-Fridays. Place the IMFM into the chart so Medical Records can scan it in once the patient discharges.
- If the QIO notifies TCMC that the patient has appealed their discharge, the Case Manager will issue a Detailed Notice of Discharge. Once the form is completed and delivered to the patient, the original form will be placed in the chart and the RN CM will email the IMFM to Registration to scan into the chart in preparation for the appeal. Email to: Jessica Ruh, David Benitez, Nina Luna, and Elizabeth Atiga.

NURSING

- At the time of discharge, if the patient indicates they do not feel they are ready for discharge, or disagree with the discharge plan, contact/consult the Case Management Department.
- If patient appeals his/her discharge, contact the Case Management Department to notify the physician of the Appeal.

The IMFM form has been revised 8/17and is available in both English and Spanish. Order form CMS-R-193.

CMS-R-193 An Important Message From Medicare About Your Rights

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date Time

Form CMS-R-193 (Exp. 03 31 2020)

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO (in bold)

    Telephone Number of QIO
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name	Provider ID Number

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4**: The QIO will review your medical records and other important information about your case.
- **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Additional Information:

CMS-10066 Detailed Notice of Discharge

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

{Insert Hospital or Plan Logo here}

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: _____ _____ {insert specific managed care policies}

  _____ Other _____ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____{insert hospital and or plan telephone number}.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (Exp. 10/31/2019)

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

ISSUE DATE: 01/13	**SUBJECT: Medical Directorships**
REVISION DATE(S): 07/17	**POLICY NUMBER: 8750-572**

Department Approval:	**~~03/16~~07/17**
Administrative Policies and Procedures Approval:	**07/17**
Medical Executive Committee Approval:	**08/17**
Organizational Compliance Committee Approval:	**02/18**
Audit, Compliance and Ethics Committee Approval:	**02/13**
Board of Directors Approval:	**02/13**

A. **PURPOSE:**

1. The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that:
   a. All medical directorship arrangements are undertaken only when Tri-City Healthcare District (TCHD) has a legitimate need for a physician to provide the type and quantity of medical directorship services contemplated to promote quality, cost-effective care, or to fulfill other legitimate needs of ~~the District~~**TCHD**;
   b. The remuneration paid pursuant to all medical directorship arrangements is commercially reasonable and consistent with fair market value for the medical directorship services furnished;
   c. All medical directorship services furnished pursuant to a medical directorship arrangement are adequately and timely documented by the medical director;
   d. All medical directorship arrangements comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law; and
   e. Under no circumstance will a directorship arrangement involve TCHD paying remuneration to a physician, directly or indirectly, with the intent to induce the referral of patients or generation of business.

B. **GENERAL POLICIES:**

1. TCHD may not enter into a medical directorship arrangement without an objectively determined, legitimate need for the medical directorship services contemplated by the medical directorship arrangement.

C. **DEFINITION(S):**

1. Medical Directorship Arrangement: means an arrangement pursuant to which a provider provides remuneration to a physician for the performance of medico-administrative services furnished by the physician on behalf of the provider.
2. Physician: means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.
3. Medical Directorship Services or Services: mean medico-administrative services furnished by a physician on behalf of a provider, consistent with this policy
4. Remuneration: means anything of value, including, but not limited to, cash, items, or services.
5. Fair Market Value: means the value in arm's-length transactions, consistent with the compensation that would be included in a service agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position

to generate business for the other party at the time of the service agreement.

6. Medical Director: means a physician performing medical director services as an independent contractor of a provider pursuant to a medical director agreement.
7. Federal health care program: means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, Tri-Care/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corps Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs), and Section 1011 Requests.

D. **SCOPE OF POLICY:**

1. This policy applies to
   a. ~~Tri-City Healthcare District~~**TCHD** and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
   b. Any other entity or organization in which ~~Tri-City Healthcare District~~**TCHD** or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which ~~Tri-City Healthcare District~~**TCHD** or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tri-City Healthcare District Facility") (collectively, "Tri-City Healthcare District").

E. **PROCEDURES**

1. Hospital Implementation: TCHD shall ensure that this policy is adhered to by following all of the steps set forth in this policy.
   a. Step 1 - Identify the Need for the Services
      i. TCHD's clinical and/or administrative staff shall identify any mandates or recommendations from legal authorities (e.g., Medicare requirement for a director of a rehabilitation unit, 42 C.F.R. § 412.29(f), inpatient psychiatric services, 42 C.F.R. § 412.27(d), nuclear medicine services, 42 C.F.R § 482.53(a), respiratory care services, 42 C.F.R. § 482.57(a), skilled nursing facility, etc.), government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the provider's medical staff or governing board, and any other evidence, indicating that one or more physicians should be retained to furnish the medical directorship services contemplated by the medical directorship arrangement in order to promote quality, cost-effective care or fulfill other legitimate needs.
   b. Step 2 - Project the Number of Hours Required
      i. TCHD's clinical and/or administrative shall make an objective determination that the number of hours of medical directorship services contemplated by the medical directorship arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the medical directorship services. TCHD must prepare a written projection of the number of hours reasonably necessary to discharge the medical directorship services based on:
         1) any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or TCHD's medical staff or governing board;
         2) data from time logs; and/or
         3) other factors, such as the number of physicians with medical staff privileges in the applicable specialty, the size of the applicable department, unit or service line, the average daily census of the applicable department, unit or service line, and the medical acuity and needs of the patients in the applicable department, unit or service line.
   c. Step 3 - Demonstrate the Professional Qualifications of the Proposed Medical Director

i. TCHD shall objectively determine that the medical director is qualified and capable of performing the medical directorship services. To demonstrate each medical director's qualifications, TCHD must:
   1) Verify that each medical director is qualified and capable of furnishing the medical directorship services (i.e., the medical director must confirm that he/she does not have other preexisting obligations which would limit or restrict the medical director from fully performing the medical directorship services);
   2) Obtain a copy of each proposed medical director's curriculum vitae;
   3) Verify, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General's (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that each medical director (and, in the context of a medical directorship agreement with a group practice, the group) has no exclusions, suspensions or debarments from participation in any Federal health care program.

d. Step 4 - Calculate Fair Market Value Compensation
   i. TCHD must objectively determine and document that the remuneration being offered to the physician for the medical directorship services is consistent with fair market value. In order to ensure that the remuneration is consistent with fair market value, TCHD shall derive an hourly rate to be utilized in calculating the remuneration by **obtaining a fair market value opinion from a reputable and qualified fair market value consultant**~~taking the average salary, not to exceed fair market value, for the physician's specialty of the most recent publications of two national salary surveys and dividing the resulting figure by 2,000 hours (the "Hourly Rate")~~.
   ii. Notwithstanding the foregoing, in exceptional cases, if TCHD's administrative or clinical staff believes that a compensation amount that differs from and exceeds the average hourly compensation derived above is fair market value, and all other requirements of this policy are met, they may seek approval of the proposed hourly compensation from TCHD's **Chief** Compliance Officer or legal counsel.

e. Step 5 - Review the Requirements of the Medical Directorship Agreement
   i. TCHD shall confirm that the proposed medical directorship arrangement will meet all of the following terms:
      1) The medical directorship arrangement shall be evidenced by a written medical directorship agreement contained in the Contract Database signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. In the event TCHD desires for a physician to serve as a medical director of more than one department, TCHD shall prepare separate agreements, require separate logs and make separate payments to the physician to ensure that expenses are appropriately allocated for cost reporting purposes.
      2) The medical directorship agreement shall require that the medical director contemporaneously record his or her medical directorship services on the medical director activity log/timesheet.
      3) Prior to TCHD's entrance into an agreement with a physician group for medical director services, the group practice must furnish a written representation and warranty that (1) the compensation of each physician affiliated with the group including, without limitation, shareholders, members, partners, employees and independent contractors (a) will be

commercially reasonable and consistent with fair market value; and (b) will not vary with, or reflect or relate to – either directly or indirectly – the volume or value of patient referrals (actual or anticipated) to, or other business generated for, the hospital; and (2) that the group practice agrees to comply with all relevant claims submission and billing laws and regulations.

4) The medical directorship agreement shall set forth with specificity all of the medical directorship services to be furnished by each medical director.

5) The designated duties shall not include:

a) ~~(1) advertising~~ **Advertising** or marketing on behalf of TCHD, ~~(2)~~

b) ~~clinical~~ **Clinical** duties for which a proposed medical director or an affiliated group practice is permitted to bill and retain payment from patients or third party payers, ~~(3)~~

c) ~~duties~~ **Duties** which a proposed medical director is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the proposed medical director is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings, ~~(4) c~~

d) Continuing medical education (unless approved by TCHD's Compliance Officer or legal counsel), ~~(5) r~~

e) Review of medical journals and periodicals, ~~(6) a~~

f) Any entertainment activities, ~~(7) c~~

g) Completing time logs, including, without limitation, activity logs, or ~~(8) d~~

~~4)~~h) Duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the medical directorship arrangement in question.

~~5)~~6) The term of the medical directorship agreement shall be at least one year, but shall not exceed five years. The medical directorship agreement may contain an automatic month-to-month renewal provision for up to six (6) months provided the arrangement is on the same terms and conditions as the immediately preceding agreement but shall otherwise require affirmative renewal by mutual written agreement of the parties.

~~6)~~7) The medical directorship agreement shall provide that, in the event the agreement is terminated during the first year of the term, then neither the provider and any medical director, nor the provider and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first twelve months of the intended term of the agreement. Notwithstanding, if the agreement does not contain similar language and the agreement is terminated during the first twelve months of the term, then neither the provider and any medical director, nor the provider and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.

~~7)~~8) The medical directorship arrangement shall not be conditioned on any proposed medical director or, in the event of a group agreement, the group practice or any physician affiliated with the group practice, (a) making referrals to TCHD, (b) being in a position to make or influence referrals to TCHD, or (c) otherwise generating business for TCHD; provided, however, that the medical directorship agreement shall require that the proposed medical director obtain and maintain active staff

privileges at TCHD.

~~8)~~**9)** The remuneration paid to any medical director and/or affiliated group practice under the medical directorship agreement shall not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or expected referrals to, or business otherwise generated for, TCHD by any medical director or, in the event of a group agreement, by the group practice or any individual or entity affiliated with the group practice.

~~9)~~**10)** No medical director, or, in the event of a group agreement, physician affiliated with the group practice, shall be precluded or restricted in any way from (a) establishing staff privileges at any other hospital or facility, (b) referring patients to or utilizing the services of any other hospital or facility, or (c) otherwise generating business for any other hospital or facility.

~~10)~~**11)** The medical directorship agreement shall provide that remuneration shall not be paid to a medical director and/or affiliated group practice (as appropriate) for a given payment period unless the medical director furnishes adequate, contemporaneous documentation indicating he or she fully discharged all designated duties during the payment period.

~~11)~~**12)** Except for terminations permitted by the medical directorship agreement, or unless otherwise approved by legal counsel, the remuneration set forth in the medical directorship arrangement shall not be renegotiated, renewed, extended or amended after the medical directorship agreement is executed by the parties.

~~12)~~**13)** Each medical director and any affiliated group practice shall agree to treat in a nondiscriminatory manner patients receiving medical benefits or assistance under any federal health care program.

~~13)~~**14)** Other than as specifically provided for in this policy, the remuneration shall not directly or indirectly benefit any individual or entity in a position to make or influence patient referrals to, or otherwise generate business for, the provider.

~~14)~~**15)** The directorship agreement will require the physician and the group practice, if applicable, to abide by TCHD's Code of Conduct and Compliance Program. The physician and group, if applicable, shall complete any training required under Compliance Program.

f. Step 6 – Complete TCHD's Contract Review Process
   i. No medical directorship agreement shall be executed until completion of TCHD's Contract Review Process as defined in the Contracting Manual.

g. Step 7 – Documenting the Medical Director's Completion of Duties Prior to Payment
   i. Each medical director shall be required to contemporaneously document his or her time spent performing his or her designated duties under a medical director agreement. Such documentation shall be submitted to Accounts Payable on a monthly basis, in the form of the activity log/time sheet attached to the medical directorship agreement. Each medical director shall personally complete, sign and date his or her activity log. Only time that a medical director spends on his or her designated duties under a medical directorship agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the medical director's private practice, shall not be reimbursable.
   ii. TCHD shall not furnish remuneration to a medical director for a given month unless and until:
      1) The medical director legibly completes in all material respects the activity log/time sheet applicable to such month;
      2) The medical director signs, dates and submits the activity log/time sheet applicable to a given month by the date set forth in the directorship

agreement;

3) The Department/Unit Director/Supervisor shall review and sign the logs for applicability of reported activities;

iii. A medical director's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a forfeiture of compensation due for that particular month.

iv. If in any given month while a medical directorship agreement is in effect, a medical director provides fewer hours of medical director services than the projected number of hours, then the medical director or group practice (as appropriate) shall be compensated at the hourly rate for each hour of medical directorship services actually provided as set forth in the medical directorship agreement.

v. The Chief Financial Officer (CFO) is responsible for ensuring that medical directorship payments are recorded in accordance with accounting policies and are charged only to accounts designated for such arrangements.

2. Renewal/Amendment
   a. Renewal or amendment of the agreement is permitted only through a full review of the entire arrangement through the process as provided above.
3. Documentation Retention
   a. ~~The Contracts Manager shall retain all documents, packages, agreements, and other documentation relating to each medical director agreement in accordance with TCHD's document management policies.~~**All Medical Director Contracts and associated documents will be entered into the appropriate TCHD Contract Retention System (such as MediTract).**
4. Enforcement
   a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject the employee to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination. Such disciplinary action may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

B. **REFERENCE(S):**

1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
2. Definition of Immediate Family Member, 42 C.F.R. § 411.351
3. Fair Market Value exception, 42 C.F.R. § 411.357(l)
4. **Inpatient psychiatric services , 42 C.F.R § 412.29(f)**
5. **Nuclear medicine services, 42 C.F.R § 412.27(d)**
6. **Personal services and management contracts** 42 C.F.R. § 1001.952(d)
7. Personal Services Arrangements exception, 42 U.S.C. § 1395nn(e)(3); 42 C.F.R. § 411.357(d)
8. **Respiratory care services, 42 C.F.R § 482.53(a)**
9. Safe Harbor for Personal Services and Management Contracts
10. **Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens**
11. **Skilled nursing facility, 42 C.F.R § 482.57(a)**
12. Stark Law, 42 U.S.C. § 1395nn, and implementing regulations
13. **TC~~M~~CHD Handbook for Contracting ~~Handbook~~**

Tri-City Medical Center
Oceanside, California

Administrative Policy
Compliance

ISSUE DATE: ~~May 31, 2003~~/12	SUBJECT: Monitoring Compliance/ Auditing and Reporting; Annual Compliance Work Plan
REVISION DATE(S):	POLICY NUMBER: 8750-552
Department Approval:	11/17
Administrative Policies and Procedures Approval:	11/17
Organizational Compliance Committee Approval	02/18
Audit, Compliance and Ethics Committee Approval:	
Board of Directors Approval:	03/12

A. **PURPOSE:**

1. ~~Policy 8750-552~~To provides (1) a statement of Tri-City Healthcare District's (**~~District~~TCHD**) policy with respect to the development of an annual compliance work plan ("Work Plan"), and (2) ~~to ensure that the District's practices are consistent with its stated policy.~~ **a statement of ~~the District~~TCHD's policy of conducting periodic and ad hoc compliance reviews and audits of the compliance program and ~~the District~~TCHD's performance under the compliance program.**

B. **INTRODUCTION:**

1. **Ongoing monitoring and evaluation is essential to the development and maintenance of an effective compliance program. By developing annual work plans and conducting audits and reviews in response to reported concerns, the compliance program ensures that ~~the District~~TCHD meets its commitment to conduct business consistent with fundamental ethical standards and to comply with all applicable laws and regulations.** ~~Tri-City Healthcare District's Chief Compliance Officer (with the assistance of the Compliance Committee, outside consultants and counsel, as necessary) will recommend and facilitate, as appropriate, the identification of compliance-related risk areas of relevance to hospitals, health systems, and the health care industry in general. These risk areas will be documented in an annual Work Plan.~~

C. **~~GENERAL POLICY~~ANNUAL COMPLIANCE WORK PLAN:**

~~a.~~1. **~~The District~~TCHD's Chief Compliance Officer (CCO) (with the assistance of the Director of Compliance Audit &and Monitoring, Compliance Committee, outside consultants and counsel, as necessary) will recommend and facilitate, as appropriate, the identification of compliance-related risk areas of relevance to hospitals, health systems, and the health care industry in general. These risk areas will be documented in an annual work plan.**

~~1.~~2. Risk areas may be identified through any number of channels including, by way of example:

a. the Office of Inspector General's (**OIG**) annual work plan;
b. recent OIG and/or Department of Justice ("DOJ") enforcement actions and settlements;
c. audit reports published by the OIG;
d. health care news reports on recent or ongoing government investigations in the health care space;
e. payor denial reports;
f. internal District reviews;
g. exit surveys/interviews with employees and contractors; and

h. Confidential Reporting Line (Values Line) reports.

~~2.~~3. The work plan shall be developed **by the Director of Compliance Audit and Monitoring** under the supervision of the ~~Chief Compliance Officer~~**CCO**, who shall:

a. implement processes with the assistance of various ~~District~~ **TCHD** departments (such as the Finance Department, by way of example) for assessing ~~the District~~**TCHD**'s compliance with respect to the risk areas identified in the work plan;

b. supervise the reviews and assessments related to each risk area;

c. based on the reviews and assessments, determine whether to develop or enhance training and/or policies related to the risk areas; and

d. where appropriate, identify and implement corrective actions.

~~3.~~4. Approval

a. The annual work plan will be presented to and be approved by senior management and ~~the District~~**TCHD** Board **of Directors (Board)**.

b. ~~The Board will ensure that t~~The ~~Chief Compliance Officer~~**CCO is will be** afforded a budget that will enable him or her to implement the work plan.

~~a.~~D. **COMPLIANCE PROGRAM EFFECTIVENESS REVIEWS:**

1. **The ~~Chief Compliance Officer~~CCO and Director of Compliance Auditing and Monitoring (with the assistance, as appropriate, of outside independent review consultants and/or counsel, as described ~~in Section 3.C~~ below) shall develop a protocol for performing periodic reviews of ~~the District~~TCHD's policies and practices to determine the effectiveness of the compliance program. The protocol shall assist in the assessment of the following elements of the compliance program:**

a. **Compliance program policies (including any requirements relating to documentation)**

b. **Effectiveness of compliance training and education provided to all ~~District~~ TCHD employees**

c. **Appropriateness of the monitoring and auditing conducted by the compliance program**

d. **Awareness of the compliance program reporting mechanisms, including use of ~~the District~~TCHD's values line**

e. **Promptness of investigations of reported compliance concerns**

~~c.~~f. Process for the development of corrective actions in response to reported concerns

E. **FOCUSED REVIEWS AND AUDITS:**

1. **When suspected noncompliance with laws and/or policies is reported, the ~~Chief Compliance Officer~~CCO and/or the Director of Compliance Auditing &and Monitoring shall initiate a formal review and/or audit of the conduct in question.**

a. **Technique:**

i. **The protocol developed by the ~~Chief Compliance Officer~~CCO may provide for sampling, full claim review, contract review, pre-billing reviews, email and other correspondence review or other appropriate measures.**

b. **Review Assistance:**

i. **The compliance program reviews and audits shall be conducted under the supervision of the ~~Chief Compliance Officer~~CCO, Director of Compliance Audit and Monitoring and/or legal counsel, as appropriate. In addition to, or in lieu of, internal reviewers, outside independent review consultants and/or counsel may be used to assist, as appropriate.**

c. **Reviewer Qualifications and Independence:**

i. **The entity or individual(s) conducting the compliance program reviews and audits (whether internal or external to ~~the District~~TCHD) shall be independent insofar as they must be able to review ~~the District~~TCHD's practices and make objective, independent determinations as to the accuracy or effectiveness of those practices.**

ii. **The reviewers/auditors shall have the qualifications and experience necessary to adequately identify potential issues related to the subject they are reviewing.**

iii. **The reviewers/auditors shall have access to the resources and information necessary to conduct the compliance program reviews and audits, including full access to documents and employees.**

~~b.~~F. **DOCUMENTATION:**

~~c.~~1. ~~In conformity with generally accepted compliance review procedures,~~ **The** final version of work papers, notes and other documentation generated in connection with every review shall be maintained in the compliance program files.

~~d.~~2. After completing each annual work plan, the ~~Chief Compliance Officer~~**CCO** shall furnish **senior management and** the Board ~~of Directors~~ with a written report of principal findings, conclusions and recommendations.

~~e.~~3. The review findings, conclusions and recommendations (including the written report) shall be documented in the compliance program files.

~~b.~~G. ~~**DOCUMENTATION**~~**RELATED DOCUMENT(S):**

1. **Administrative Policy: Compliance Program Overview 8750-532**
2. **Administrative Policy: Monitoring Compliance Auditing & Reporting – Exit Interviews 8750-554**
3. **Tri-City Healthcare District Code of Conduct**

H. **REFERENCE(S):**

1. **Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.**

~~4.~~2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.

Tri-City Medical Center
Oceanside, California

Administrative Policy
Compliance

DELETE: Incorporated into Administrative Policy: 552 Monitoring Compliance/ Auditing and Reporting; Annual Compliance Work Plan

ISSUE DATE: May 31, 2012

SUBJECT: Monitoring Compliance/Auditing and Reporting; Compliance Reviews and Audits

REVISION DATE:

POLICY NUMBER: 8750-553

Department Approval:	11/17
Administrative Policies and Procedures Approval:	11/17
Organizational Compliance Committee Approval	02/18
Audit, Compliance and Ethics Committee Approval:	
Board of Directors Approval:	03/12

~~A. **PURPOSE:**~~

~~1. Policy 8750-553 provides (1) a statement of Tri-City Healthcare District's policy with respect to conducting periodic and *ad hoc* compliance reviews and audits of the Compliance Program and the District's performance under the Compliance Program.~~

~~B. **COMPLIANCE PROGRAM REVIEWS:**~~

~~1. Subject Matter Areas. The Chief Compliance Officer (with the assistance, as appropriate, of outside independent review consultants and/or counsel, as described in Section 3.C below) shall develop a protocol for performing periodic and *ad hoc* reviews and audits of the District's policies and practices. This protocol shall provide for reviews/audits of at least the following areas:~~

~~a. Compliance with the following Compliance Program Policies (including any requirements relating to documentation):~~

~~i. Chief Compliance Officer: CCO Policies~~

~~ii. Hiring and Employment: HE Policies~~

~~iii. Education and Training: ET Policies~~

~~iv. Monitoring Compliance: MCA Policies~~

~~v. Communicating and Reporting Misconduct/Irregularities: CRCC Policies~~

~~vi. Responding to Compliance Issues/Corrective Action: RCI Policies~~

~~2. Compliance with the Policies developed for specific risk areas identified by the Chief Compliance Officer.~~

~~3. Compliance with particular laws and regulations with respect to compliance matters or concerns that may arise from time to time.~~

~~a. Technique. The protocol developed by the Chief Compliance Officer may provide for sampling, full claim review, contract review, pre-billing reviews, email and other correspondence review or other appropriate measures.~~

~~b. Review Assistance. The Compliance Program reviews and audits shall be conducted under the supervision of the Chief Compliance Officer and/or legal counsel, as appropriate. In addition to, or in lieu of, internal reviewers, outside independent review consultants and/or counsel may be used to assist, as appropriate.~~

~~c. Reviewer Qualifications and Independence.~~

~~i. The entity or individual(s) conducting the Compliance Program reviews and audits (whether internal or external to the District) shall be independent~~

~~insofar as they must be able to review the District's practices and make objective, independent determinations as to the accuracy or effectiveness of those practices.~~

~~ii. The reviewers/auditors shall have the qualifications and experience necessary to adequately identify potential issues related to the subject they are reviewing.~~

~~iii. The reviewers/auditors shall have access to the resources and information necessary to conduct the Compliance Program reviews and audits, including full access to documents and employees.~~

~~C. **DOCUMENTATION:**~~

~~1. The reviewers/auditors shall document their findings and share them with the Chief Compliance Officer. The Chief Compliance Officer shall then consider appropriate next steps, including additional reviews and/or any corrective action needed to achieve compliance with the Compliance Program Policies or Code of Conduct. The Chief Compliance Officer shall report his/her conclusions to the Compliance Committee, the Board of Directors and the CEO.~~

~~2.~~1. ~~In conformity with generally accepted compliance review and audit procedures, final copies of work papers, notes and other documentation generated in connection with every Compliance Review and the findings and conclusions shall be maintained in the Compliance Program files, consistent with the District's document retention policies.~~

Tri-City Medical Center
Oceanside, California

Administrative Policy
Compliance

ISSUE DATE: 04/13

SUBJECT: Physician and Allied Health Professional Service Contracts

REVISION DATE(S): 04/13

POLICY NUMBER: 8750-580

Department Approval:	07/17
Administrative Policies and Procedures Approval:	07/17
Medical Executive Committee Approval:	08/17
Organizational Compliance Committee Approval:	02/18
Audit, Compliance and Ethics Committee Approval:	
Board of Directors Approval:	.04/13

A. **PURPOSE:**

1. The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls:
   a. all ~~personal~~ **professional** services ~~arrangements~~**contracts** are undertaken only when **Tri-City Healthcare District** (TCHD) has a legitimate need for a physician or allied health professional to provide the type and quantity of services contemplated to promote quality, cost-effective care or to fulfill other legitimate needs of the District;
   b. the remuneration paid per all ~~personal~~**professional** services ~~arrangements~~**contracts** is commercially reasonable and consistent with fair market value for the services furnished;
   c. all services furnished per a ~~personal~~**professional** services arrangement are adequately and contemporaneously documented by the physician or allied health professional;
   d. all ~~personal~~**professional** services ~~arrangements~~**contracts** comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law; and
   e. under no circumstance will a ~~personal~~**professional** services arrangement involve paying remuneration to a physician, directly or indirectly, with the intent to induce the physician to refer patients to, or otherwise generate business for, TCHD.

B. **GENERAL POLICIES:**

1. TCHD may not enter into a professional services arrangement without an objectively determined, legitimate need for the services contemplated by the professional services arrangement. Prior to entry into, or renewal of, a professional services arrangement, the TCHD Department requesting such arrangement follow TCHD's Contracting Manual, and provide an explanation regarding the need for the services, the need for payment from TCHD rather than having the physician bill third party payers, and the number of hours contemplated under the agreement. These contracts are subject to Board approval.

C. **DEFINITION(S):**

1. "Professional Services Arrangement": ~~means~~ an arrangement pursuant to which TCHD provides remuneration to a physician for the performance of professional medical, medico-administrative, or consulting services furnished by the physician on behalf of TCHD, but does not include services otherwise covered by other policies, such as Medical Directorships.
2. "Physician": ~~means~~ a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor. For purposes of this policy, "physician" also includes allied health professionals.
3. "Remuneration": ~~means~~ anything of value, including, but not limited to, cash, items, or services.

4. "Fair Market Value": ~~means~~ the value in arm's-length transactions, consistent with the compensation that would be included in a services agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party at the time of the service agreement
5. "Federal health care program": ~~means~~ any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, TRICARE/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.
6. "Group Practice": ~~means~~ two or more Physicians who practice medicine through a single legal entity, using a common trade name and a common tax identification number, including a faculty practice plan or other physician group practice organization affiliated with an academic medical center.

D. **SCOPE OF POLICY:**

1. This policy applies to
   a. ~~(1)~~ TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
   b. ~~(2)~~ any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and
   ~~E.~~c. ~~(3)~~ any hospital or healthcare facility in which Tri-City Healthcare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

E. **PROCEDURES:**

1. **Step 1 - Identify the Need for the Services**
   a. **The TCHD Department shall identify why the services are best contracted for and compensated by TCHD rather than having the physician bill a payor independently for the service.**
   b. **In the case of on-call services, the Department**
      i. **shall identify any mandates or recommendations from legal or regulatory authorities (*e.g.*, EMTALA, Joint Commission, other state regulations), and any other evidence, that on-call coverage in the particular specialty or subspecialty should be secured,**
      ii. **shall also document whether such on-call services are required without compensation under the medical staff bylaws or rules and regulations; and**
      iii. **shall also document prior efforts to obtain such services on a voluntary basis.**
2. **Step 2 - Project the Number of Hours/Specific Services Required**
   a. **Medico-administrative and consulting services should generally be contracted for based on a fixed number of hours per week or month. TCHD shall not enter such contracts until after having determined that the number of hours of medico-administrative or consulting services contemplated by the personal services arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the services. The requesting Department must prepare a projection of the number of hours reasonably necessary to discharge the medico-administrative or consulting services based on:**
      i. **any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the Tri-City Health Care District entity's medical staff or governing board;**

ii. data from time logs; and/or
iii. other factors, such as a detailed description of the scope of the consulting project.

b. Professional medical services should be contracted for either on an hourly basis or on a per unit of service basis. Hourly services must meet the requirements above. Services rendered on a per unit of service basis should be identified by Physician using a CPT code number and descriptor.

c. On-call services should be contracted for on the basis of 24-hour coverage.

3. Step 3 - Demonstrate the Qualifications of the Physician

a. TCHD must determine that the physician is qualified and capable of performing the services by:

i. verifying that the physician is capable of furnishing the services (i.e., the physician must confirm that he/she does not have other preexisting obligations which would limit or restrict the physician from fully performing the services);
ii. obtaining a copy of the physician's curriculum vitae;
iii. verifying, if not evident from existing information, that Physician is currently licensed in California; verifying that the physician is qualified to provide the services (e.g., that the physician possesses relevant training and/or experience in the area); and
iv. verifying, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that the physician (and, in the context of a personal services agreement with a group practice, the group) has no exclusions, suspensions or debarments from participation in any federal health care program.

4. Step 4 - Calculate Fair Market Value Compensation

a. TCHD may not enter into a personal services arrangement without first objectively determining and documenting that the remuneration being offered to the physician for the services is consistent with fair market value.

i. TCHD shall identify the basis for selection of the benchmark(s) utilized as most appropriate for the service in question.
ii. Both monetary and any other compensation will be taken into consideration in determining fair market value.

5. Step 5 - Review the Requirements of the Personal Services Agreement

a. TCHD shall confirm that the proposed personal services arrangement will meet all of the following terms to be included in the personal services agreement:

i. The personal services arrangement shall be evidenced by a written agreement signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. If the physician is not affiliated with a group practice, the agreement shall be between TCHD and the physician who will provide the services (the individual agreement). If the physician is an employee, independent contractor, partner, member or is otherwise affiliated with a group practice (or practices through a sole shareholder PC), the agreement shall be among TCHD and the group practice (the group agreement) or the sole shareholder PC (the sole shareholder PC agreement) and the agreement shall identify the physician who will provide the personal services.
ii. The personal services agreement shall require that the physician contemporaneously record any medico-administrative or consulting services, or professional medical services furnished on an hourly basis, on a physician activity log or timesheet. The personal services agreement

shall require that any professional medical services paid on a per-procedure basis be documented by the physician contemporaneously on a per-procedure basis. On-call agreements paid on a per-diem basis may be documented by reference to monthly panel schedules which are verified by TCHD. Physician Governing Board members shall not be required to submit logs for Governing Board duties, but attendance may be verified by referencing the Governing Board minutes.

iii. The personal services agreement shall set forth with specificity all of the services to be furnished by the physician. The designated duties shall not include
   1) advertising or marketing on behalf of TCHD,
   2) duties which the physician is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the physician is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings (unless the physician is also a Governing Board member and has signed a separate appointment letter),
   3) continuing medical education,
   4) review of medical journals and periodicals,
   5) any entertainment activities,
   6) completing time logs, including, without limitation, activity logs, or
   7) duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the personal services arrangement in question.

iv. If the personal services agreement is terminated during the first year of the term, then neither TCHD and the physician, nor TCHD and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.

v. The personal services arrangement shall not be conditioned on the physician, or, in the event of a group agreement, the group practice or any physician affiliated with the group practice,
   1) making referrals to TCHD,
   2) being in a position to make or influence referrals to TCHD, or
   3) otherwise generating business for TCHD; provided, however, that the agreement may require that the physician obtain and maintain active staff privileges at TCHD if appropriate for the services in question.

vi. The remuneration paid to the physician and/or affiliated group practice under the personal services agreement (which may include per unit of service-based compensation) shall not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or expected referrals to, or business otherwise generated for, TCHD by the physician or, in the event of a group agreement, by the group practice or any individual or entity affiliated with the group practice.

vii. No physician, or, in the event of a group agreement, any physician affiliated with the group practice, shall be precluded or restricted in any way from
   1) establishing staff privileges at any other hospital,
   2) referring patients to or utilizing the services of any other hospital, or
   3) otherwise generating business for any other hospital.

viii. The physician and any affiliated group practice shall agree to treat in a nondiscriminatory manner patients receiving medical benefits or assistance under any federal health care program.
ix. The personal services agreement will require the physician and the group practice, if applicable, to abide by TCHD's Compliance Program, including its Code of Conduct.

6. Step 6 - Prepare the Contractual Arrangements
   a. For each proposed professional services contracts, the TCHD department director shall prepare all of the following documentation for submission with the Contract Request Form (CRF) package and associated documents will be entered into the appropriate TCHD Contract Retention System (such as MediTract) :
      i. A fully completed CRF, signed by a Chief Officer, setting forth the total dollar value (or, as applicable, the estimated maximum total dollar value) of the remuneration that may be furnished by TCHD under the professional services contract, and any other agreement, during the term;
      ii. Copies of all internal and external correspondence (including e-mails, memos or other like materials) that have been generated in connection with the proposed professional services contracts;
      iii. A copy of the physician's current curriculum vitae;
      iv. The results of an OIG/GSA and applicable state healthcare exclusion list search noting no exclusions, suspensions or debarments of the physician (in the case of an individual agreement), or of the physician and the group practice (in the case of a group agreement), from participation in any Federal health care program; http://exclusions.oig.hhs.gov
      v. Physician's Certificate of Insurance (COI)
      vi. If furnishing professional medical services, a copy of the physician's current medical license; http://www2.mbc.ca.gov/LicenseLookupSystem/PhysicianSurgeon/Search.aspx
      vii. Any original source or other documentation required to support the statements included in the cover memorandum; and
      viii. Any other information required by TCHD's Legal and Compliance Department.

7. Step 7 - Obtain Legal Review and Approval
   a. No professional services contract shall be executed or renewed without properly completing the steps detailed in TCHD's Contracts Manual.

8. Step 8 - Documenting the Physician's Completion of Duties Prior to Payment
   a. The physician shall be required to contemporaneously document his or her time spent performing his or her designated duties under the personal services agreement. Such documentation shall be submitted to TCHD on a monthly basis, in the form of the activity log attached to the personal services agreement. The physician shall personally complete, sign and date his or her activity log. Professional medical services paid on a per-service basis may be documented by (a) a monthly invoice that identifies each service by patient name or number, date of service and CPT code(s), or (b) individual Form 1500s. On-call services paid on a per diem basis may be documented by the monthly call schedule as verified at month-end by TCHD.
   b. Only time that a physician spends on his or her designated duties under a personal services agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the physician's private practice, shall not be reimbursable.
   c. Except for on-call services paid on a per-diem basis, and personal medical services paid on a unit of service basis and invoiced to TCHD, TCHD shall not furnish remuneration to a physician for a given month unless and until:

i. the physician legibly completes in all material respects the activity log applicable to such month;
ii. the physician signs, dates and submits the activity log applicable to a given month by the date set forth in the personal services agreement;
iii. the Department Director shall review and sign the logs for applicability of reported activities.
1) A physician's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a forfeiture of compensation due for that particular month.
2) For professional services contracts where the compensation is fixed in the aggregate and based on an hourly rate times a projected number of hours, if, in any given month while a professional services contract is in effect, a physician provides fewer hours of professional services than the projected number of hours, then the physician or group practice (as appropriate) shall be compensated at the hourly rate for each hour of services actually provided as set forth in the professional services contract.

9. Document Retention
a. TCHD shall retain all documentation relating to the contract, including the Contract Request Form and documentation of fair market value will be entered into the appropriate TCHD Contract Retention System (such as MediTract) in accordance with the CHA document retention recommendations in existence at the time of document execution.
10. Responsible Person
a. The Compliance Officer and CFO are responsible for assuring adherence to the contracting and payment portions of this policy, respectively.
11. Auditing and Monitoring
a. TCHD's Audit, Compliance & Ethics Committee will audit compliance with this policy as part of its routine audits.
12. Enforcement
a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **REFERENCE(S):**
1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b):
2. Definition of Immediate Family Member, 42 C.F.R. § 411.351. CAM Standard Form Non-Invasive Cardiology Panel Agreement [Direct Pay]
3. Fair Market Value exception, 42 C.F.R. § 411.357(l).
4. Personal Services Arrangements exception, 42 U.S.C. § 1395nn(e)(3); 42 C.F.R. § 411.357(d).
5. Safe Harbor for Personal Services and Management Contracts, 42 C.F.R. § 1001.952(d).
6. Stark Law, 42 U.S.C. § 1395nn, and implementing regulations
7. Tri-City Health Care District Code of Conduct
8. Tri-City Health Care District Contractual Arrangements Manual

ATTACHMENT 1

A. **PROCEDURES:**

1. **Step 1 - Identify the Need for the Services**
   a. The TCHD Department shall identify why the services are best contracted for and compensated by TCHD rather than having the physician bill a payor independently for the service.
      b. In the case of on-call services, the Department (a) shall identify any mandates or recommendations from legal or regulatory authorities (*e.g.*, EMTALA, Joint Commission, other state regulations), and any other evidence, that on-call coverage in the particular specialty or subspecialty should be secured, (b) shall also document whether such on-call services are required without compensation under the medical staff bylaws or rules and regulations; and (c) shall also document prior efforts to obtain such services on a voluntary basis.
2. Step 2 - Project the Number of Hours/Specific Services Required
   a. Medico-administrative and consulting services should generally be contracted for based on a fixed number of hours per week or month. TCHD shall not enter such contracts until after having determined that the number of hours of medico-administrative or consulting services contemplated by the personal services arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the services. The requesting Department must prepare a projection of the number of hours reasonably necessary to discharge the medico-administrative or consulting services based on:
      i. any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the Tri-City Health Care District entity's medical staff or governing board;
      ii. data from time logs; and/or
      iii. other factors, such as a detailed description of the scope of the consulting project.
   b. Professional medical services should be contracted for either on an hourly basis or on a per unit of service basis. Hourly services must meet the requirements of Paragraph (1) above. Services rendered on a per unit of service basis should be identified by Physician using a CPT code number and descriptor.
   c. On-call services should be contracted for on the basis of 24-hour coverage.
3. Step 3 - Demonstrate the Qualifications of the Physician
   a. TCHD must determine that the physician is qualified and capable of performing the services by: (1) verifying that the physician is capable of furnishing the services (i.e., the physician must confirm that he/she does not have other preexisting obligations which would limit or restrict the physician from fully performing the services); (2) obtaining a copy of the physician's curriculum vitae; (3) verifying, if not evident from existing information, that Physician is currently licensed in California; verifying that the physician is qualified to provide the services (e.g., that the physician possesses relevant training and/or experience in the area); and (4)verifying, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that the physician (and, in the context of a personal services agreement with a group practice, the group) has no exclusions, suspensions or debarments from participation in any federal health care program.
4. Step 4 - Calculate Fair Market Value Compensation

a. TCHD may not enter into a personal services arrangement without first objectively determining and documenting that the remuneration being offered to the physician for the services is consistent with fair market value. (1) TCHD shall identify the basis for selection of the benchmark(s) utilized as most appropriate for the service in question. (2) Both monetary and any other compensation will be taken into consideration in determining fair market value.

5. Step 5 – Review the Requirements of the Personal Services Agreement

a. TCHD shall confirm that the proposed personal services arrangement will meet all of the following terms to be included in the personal services agreement:

b. (1) The personal services arrangement shall be evidenced by a written agreement signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. If the physician is not affiliated with a group practice, the agreement shall be between TCHD and the physician who will provide the services (the individual agreement). If the physician is an employee, independent contractor, partner, member or is otherwise affiliated with a group practice (or practices through a sole shareholder PC), the agreement shall be among TCHD and the group practice (the group agreement) or the sole shareholder PC (the sole shareholder PC agreement) and the agreement shall identify the physician who will provide the personal services.

c. (2) The personal services agreement shall require that the physician contemporaneously record any medico-administrative or consulting services, or professional medical services furnished on an hourly basis, on a physician activity log or timesheet. The personal services agreement shall require that any professional medical services paid on a per-procedure basis be documented by the physician contemporaneously on a per-procedure basis. On-call agreements paid on a per-diem basis may be documented by reference to monthly panel schedules which are verified by TCHD. Physician Governing Board members shall not be required to submit logs for Governing Board duties, but attendance may be verified by referencing the Governing Board minutes.

d. (3) The personal services agreement shall set forth with specificity all of the services to be furnished by the physician. The designated duties shall not include (1) advertising or marketing on behalf of TCHD, (2) duties which the physician is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the physician is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings (unless the physician is also a Governing Board member and has signed a separate appointment letter), (3) continuing medical education, (4) review of medical journals and periodicals, (5) any entertainment activities, (6) completing time logs, including, without limitation, activity logs, or (7) duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the personal services arrangement in question.

i. If the personal services agreement is terminated during the first year of the term, then neither TCHD and the physician, nor TCHD and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.

ii. The personal services arrangement shall not be conditioned on the physician, or, in the event of a group agreement, the group practice or any physician affiliated with the group practice, (a) making referrals to TCHD, (b) being in a position to make or influence referrals to TCHD, or (c) otherwise generating business for TCHD; provided, however, that the

~~agreement may require that the physician obtain and maintain active staff privileges at TCHD if appropriate for the services in question.~~

~~iii. The remuneration paid to the physician and/or affiliated group practice under the personal services agreement (which may include per unit of service-based compensation) shall not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or expected referrals to, or business otherwise generated for, TCHD by the physician or, in the event of a group agreement, by the group practice or any individual or entity affiliated with the group practice.~~

~~iv. No physician, or, in the event of a group agreement, any physician affiliated with the group practice, shall be precluded or restricted in any way from (a) establishing staff privileges at any other hospital, (b) referring patients to or utilizing the services of any other hospital, or (c) otherwise generating business for any other hospital.~~

~~v. The physician and any affiliated group practice shall agree to treat in a nondiscriminatory manner patients receiving medical benefits or assistance under any federal health care program.~~

~~vi. The personal services agreement will require the physician and the group practice, if applicable, to abide by TCHD's Compliance Program, including its Code of Conduct.~~

~~6. Step 6 - Prepare the Contractual Arrangements~~

~~a. For each proposed personal~~ **~~professional~~** ~~services arrangement~~**~~contracts~~**~~, the TCHD department director shall prepare all of the following documentation for submission with the~~ **~~Contract Request Form~~** ~~(CRF) package~~ **~~and associated documents will be entered into the appropriate TCHD Contract Retention System (such as MediTract)~~** ~~into Meditract:~~

~~i. (1) A fully completed Contract Request Form~~**~~CRF~~**~~, signed by a Chief Officer, setting forth the total dollar value (or, as applicable, the estimated maximum total dollar value) of the remuneration that may be furnished by TCHD under the personal~~ **~~professional~~** ~~services agreement~~**~~contract~~**~~, and any other agreement, during the term;~~

~~b. (2) Copies of all internal and external correspondence (including e-mails, memos or other like materials) that have been generated in connection with the proposed personal~~ **~~professional~~** ~~services arrangement~~**~~contracts~~**~~;~~

~~c. (3) A copy of the physician's current curriculum vitae;~~

~~(4) The results of an OIG/GSA and applicable state healthcare exclusion list search noting no exclusions, suspensions or debarments of the physician (in the case of an individual agreement), or of the physician and the group practice (in the case of a group agreement), from participation in any Federal health care program; http://exclusions.oig.hhs.gov~~

~~d.~~ **~~(5) Physiain's Certificate of Insurance (COI)~~**

~~e. (56) If furnishing professional medical services, a copy of the physician's current medical license; http://www2.mbc.ca.gov/LicenseLookupSystem/PhysicianSurgeon/Search.aspx~~

~~f. (67) Any original source or other documentation required to support the statements included in the cover memorandum; and~~

~~g. (78) Any other information required by TCHD's Legal and Compliance Department.~~

~~7. Step 7 - Obtain Legal Review and Approval~~

~~a. No personal~~ **~~professional~~** ~~services~~ **~~contract~~**~~agreement shall be executed or renewed without properly completing the steps detailed in TCHD's Contracts Manual.~~

~~8. Step 8 - Documenting the Physician's Completion of Duties Prior to Payment~~

~~i. The physician shall be required to contemporaneously document his or her time spent performing his or her designated duties under the personal services agreement. Such~~

documentation shall be submitted to TCHD on a monthly basis, in the form of the activity log attached to the personal services agreement. The physician shall personally complete, sign and date his or her activity log. Professional medical services paid on a per-service basis may be documented by (a) a monthly invoice that identifies each service by patient name or number, date of service and CPT code(s), or (b) individual Form 1500s. On-call services paid on a per diem basis may be documented by the monthly call schedule as verified at month-end by TCHD.

ii. Only time that a physician spends on his or her designated duties under a personal services agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the physician's private practice, shall not be reimbursable.

iii. Except for on-call services paid on a per-diem basis, and personal medical services paid on a unit of service basis and invoiced to TCHD, TCHD shall not furnish remuneration to a physician for a given month unless and until:

b. (1) the physician legibly completes in all material respects the activity log applicable to such month;

c. (2) the physician signs, dates and submits the activity log applicable to a given month by the date set forth in the personal services agreement;

d. (3) the Department Director shall review and sign the logs for applicability of reported activities.

A physician's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a forfeiture of compensation due for that particular month.

For personal **professional** services agreements **contracts** where the compensation is fixed in the aggregate and based on an hourly rate times a projected number of hours, if, in any given month while a personal **professional** services **contract**agreement is in effect, a physician provides fewer hours of personal **professional** services than the projected number of hours, then the physician or group practice (as appropriate) shall be compensated at the hourly rate for each hour of services actually provided as set forth in the personal **professional** services agreement**contract**.

9. Document Retention

a. TCHD shall retain all documentation relating to the contract, including the Contract Request Form and documentation of fair market value **will be entered into the appropriate TCHD Contract Retention System (such as MediTract)** in accordance with the CHA document retention recommendations in existence at the time of document execution.

10. Responsible Person

a. The Compliance Officer and CFO are responsible for assuring adherence to the contracting and payment portions of this policy, respectively.

11. Auditing and Monitoring

a. TCHD's Audit, Compliance & Ethics Committee will audit compliance with this policy as part of its routine audits.

12. Enforcement

a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

ISSUE DATE: 04/13	**SUBJECT:** Sales of Items or Services to Physicians and Other Potential Referral Sources
REVISION DATE(S): 04/13	**POLICY NUMBER:** 8750-575

Department Approval:	~~06/16~~07/17
Administrative Policies and Procedures Approval:	07/17
Medical Executive Committee Approval:	08/17
Organizational Compliance Committee Approval:	02/18
Audit, Compliance and Ethics Committee Approval:	04/13
Board of Directors Approval:	04/13

A. **PURPOSE**

1. ~~The purpose of this policy is t~~To ensure, through the implementation of prudent and reasonable controls that purchase arrangements and payments comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law.

B. **GENERAL POLICIES:**

1. **Tri-City Healthcare District** (TCHD) shall only enter into purchase arrangements with physicians, allied health professionals, or other potential referral sources that comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law. TCHD does not sell or provide medical malpractice insurance to physicians. TCHD Departments shall follow the steps set forth in this policy and the attached procedures when entering into purchase arrangements with physicians, allied health professionals, or other potential referral sources. Examples include management services, staffing services, sales of laboratory-related services, drugs or pharmaceuticals, instrument sterilization services, private practice transcription services, and joint marketing arrangements.

C. **DEFINITION(S):**

1. Purchase Arrangement - ~~means~~ an arrangement pursuant to which TCHD sells an item or service to a physician, allied health professional, or other potential referral source.
2. Remuneration - ~~means~~ anything of value, including, but not limited to, cash, items or services.
3. Physician ~~means~~ a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.
4. Other Potential Referral Source - ~~means~~ any individual (other than a physician) or entity in a position to make or influence referrals to, or otherwise generate business for, TCHD.
5. Group Practice - ~~means~~ two or more physicians who practice through a single legal entity, using a common trade name and a common tax identification number, including a faculty practice plan or other physician group practice organization affiliated with an academic medical center.
6. Fair Market Value - ~~means~~ the value that would be ascribed to the item or service in an arms-length transaction, as the result of bona-fide bargaining between well-informed parties who are not otherwise in a position to generate business for the other party.
7. Director - as used in this policy means Department Director, or an employee with the level of authority and responsibility associated with that of a Department Director.

D. **SCOPE OF POLICY:**

1. This policy applies to:
   a. TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
   b. Any other any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and
   c. Any hospital or healthcare facility in which ~~Tri-City Healthcare District~~**TCHD** or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

E. **PROCEDURE:**

1. Step 1 – Determine that Purchase is Reasonable and Necessary
   a. When a department proposes to sell items or services to a Physician, group practice or other potential referral source, the items and services, as applicable, shall not exceed that which is reasonable and necessary for the legitimate business purposes of the arrangement. The department director shall make reasonable inquiry into whether the items and services will be used for the legitimate business purposes of the purchaser.
2. Step 2 – Determine Fair Market Value of Items or Services
   a. No purchase arrangement with a referral source may be entered unless (a) the purchase price (which may include a fixed aggregate price or a fixed per-item or unit of service based price) is set in advance and (b) TCHD has determined that the purchase price is consistent with fair market value for the item(s) or service(s) purchased **and has obtained approval from the Chief Compliance Officer**.
   b. For services to be compensated on a per-unit of service basis, documentation of fair market value must be demonstrated by reference to benchmarks relevant to the service being contracted for. Such benchmarks may include applicable Medicare and Medicaid rates, prevailing managed care rates in the relevant market, amounts received by the hospital from third party payors for the specific contracted services in question, weighted averages of the above benchmarks based on historical or anticipated case mix and payor mix, or independent valuations. TCHD shall identify and document the basis for selection of the benchmark(s) utilized as most appropriate for the service in question.
3. Step 3 – Review the Terms of the Purchase Agreement
   a. The director requesting the arrangement shall ensure the purchase agreement is commercially reasonable without regard to any referrals made between the parties.
   b. No Physician, allied health professional, or other potential referral source shall be precluded or restricted in any way by a purchase agreement from (a) establishing staff privileges at any non-TCHD hospital or facility, (b) referring patients or utilizing the services of any non-TCHD hospital or facility, or (c) otherwise generating business for any non-TCHD hospital or facility.
   c. **The above steps shall be confirmed by the Chief Compliance Officer.**
4. Step 4 – Obtain Legal Review and Approval
   a. The director requesting the arrangement shall comply with TCHD's Contracting Manual, obtaining appropriate review and approval of business terms from **thea** Chief Compliance Officer followed by approval of the Legal Department **as needed on a case by case basis**.
5. Step 5 – Collect Amounts Due to ~~Tri-City Healthcare District~~**TCHD** Entities
   a. The director requesting the arrangement is responsible for ensuring that diligent efforts are made to collect any and all money due from the Physician, group practice, or referral source in accordance with the terms of the underlying purchase arrangement.
   b. The director is responsible to promptly report any noncompliance with the arrangement to the Compliance Officer. TCHD shall maintain all documentation of its efforts to collect delinquent receivables.
   c. The hospital shall not write off a referral source's receivable without the prior approval of Legal & Compliance.
6. Document Retention:

a. TCHD shall retain all Contract Request Form Packages, agreements and other documentation relating to each lease / **purchase** arrangement ~~according to the requirements of Records Management~~ **and associated documents will be entered into the appropriate Contract Retention System (such as MediTract)**.

7. Responsible Person:
   a. The requesting director is responsible for compliance with this policy and procedures. The **Chief** Compliance Officer and CFO are responsible to ensure reasonable measures are in place to detect noncompliance.
8. Auditing and Monitoring:
   a. The Audit, Compliance **&and** Ethics Committee will monitor compliance with this policy as part of its routine audits.
9. Enforcement:
   a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law

F. **REFERENCE(S) ~~LIST~~:**

1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
2. Payments by a Physician for Items and Services, 42 U.S.C. § 1395nn(e)(8); 42 C.F.R. § 411.357(i). - Definition of Immediate Family Member, 42 C.F.R. § 411.351
3. Safe Harbor for Personal Services and Management Contracts, 42 C.F.R. § 1001.952(d)
4. Stark Law, 42 U.S.C. § 1395nn and implementing regulations
5. TCHD Contract Manual

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
1	***Department Structure***	***Goal: To ensure appropriate infrastructure and staffing in place***					
A		Compliance Issue/Consult Tracking	1) Develop compliance issue/consult tracking database/spreadsheet	CCO	10/2/17	Completed	
B		Reorganize Department Staffing	1) Transition Contracts Specialist into Compliance Manager role	CCO	1/8/18	In progress	Contracts responsibility transitioning from Compliance to Legal Department.
C		Investigation Process	1) Develop and implement formal investigation process	CCO	12/4/17	In progress	
D		Investigation Reports	1) Develop and implement formal investigations report format	CCO	1/29/18	In progress	
2	***Program Marketing***	***Goal: To ensure that there is awareness of the Compliance Program by TCHD staff members***					
A		Compliance Program Materials	1) Create and distribute Values Line posters/business cards	CCO/Marketing	1/10/18	Completed	
			2) Distribute posters to all hospital and 1206(b) clinics	CCO	2/26/18	In progress	
B		Compliance Webpage	1) Create Compliance Program webpage on TCHD intranet site	CCO/Marketing	1/10/18	In progress	
C		Compliance Newsletter	1) Develop and implement monthly compliance newsletter called "The Compliance Corner".	CCO	2/8/18	In progress	
D		Staff Rounding	1) Initiate routine monitoring of staff at hospital and 1206(b) clinics	CCO	2/5/18	In progress	
3	***Program Oversight***	***Goal: To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the District and ongoing mitigation efforts***					
A		Compliance Program Dashboard	1) Develop compliance dashboard for Board and Senior Leadership	CCO	10/19/17	Completed	Dashboard presented to Audit, Compliance and Ethic ("ACE") Committee at January ACE meeting.
B		Internal Compliance Committee	1) Re-initiate meeting of Organizational Compliance Committee	CCO	2/12/18	Completed	Meeting held on February 14, 2018.
			2) Draft Organizational Compliance Committee Charter	CCO	1/8/18	Completed	New charter approved at February 14th meeting.
C		TCHD Board of Directors Training	1) Conduct Board of Directors Training on Compliance Program oversight role	CCO	1/8/18	Completed	Training conducted at January Board meeting.
4	***Compliance Policies and Procedures***	***Goal: To ensure that the appropriate compliance policies and procedures are implemented***					
A		Policy Gap Analysis	1) Conduct compliance policy gap analysis and identify additional policies needed (if applicable)	CCO	11/1/17	Completed	

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			2) Draft and implement needed policies (if applicable)	CCO	1/8/18	In progress	Overpayment Refund Policy; False Claims Act; Gifts to and from Patients.
B		Code of Conduct	1) Review current Code of Conduct and revise (if necessary)	CCO	5/7/18	Not yet started	
5	***Compliance Training and Education***	***Goal: To ensure compliance training and education is up-to-date and meets CMS requirements***					
A		New Employee Training	1) Review and update new employee training module	CCO	10/2/17	Completed	
B		Annual Training	1) Develop and implement CMS-approved Fraud, Waste and Abuse Training module	CCO[1]/HR[2]	10/16/17	Completed	
C		Targeted Training	1) Develop new targeted training to address specific risk areas	CCO	ongoing	ongoing	
			2) Track ad hoc training provided to employees	CCO	11/6/17	ongoing	
6	***Auditing and Monitoring***	***Goal: To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks to the District***					
A		Monthly Exclusions Screening	1) Identify vendor to conduct monthly exclusions screening and implement process	CCO/HR	1/22/18	N/A	HR confirmed that OIG exclusions screenings are conducted on a monthly basis.
B		OIG Work Plan	1) Review areas noted on the OIG[3] Work Plan for fiscal year 2018/2019 and identify risks relevant to TCHD	CCO	1/2/18	In progress	
C		Coding and Documentation	1) Evaluate current coding and documentation audits	CCO/AMD[4]/HIM[5]	1/16/18	Completed	
			2) Assess coding and documentation high risk areas and develop audit schedule	CCO/AMD/HIM	3/12/18	In progress	
			3) Implement coding and documentation audit plan	CCO/AMD /HIM	4/16/18	Not yet started	
D		Physician Agreements	1) Develop and implement audit of	CCO/AMD	4/2/18	In progress	

[1] Chief Compliance Officer
[2] Human Resources
[3] Office of Inspector General
[4] Director of Audit & Monitoring
[5] Health Information Management

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			current physician agreements				
7	***Open Lines of Communication***	***Goal: To ensure that the TCHD Values Line is being utilized appropriately by staff members***					
A		Reporting	1) Assess current utilization of Values Line by TCHD staff	CCO/HR	10/30/17	Completed	
B		Education	1) Re-educate staff on purpose of Values Line	CCO	12/4/17	In progress	
			2) Educate staff on "speaking up" and non-retaliation (Development of a "speak up culture")	CCO/HR	4/30/18	Not yet started	
C		Values Line Management	3) Evaluate current Values Line work flow and make changes, as needed	CCO/HR	1/8/18	In progress	
8	***HIPAA Privacy Program***	***Goal: To ensure that TCHD has adequate controls in place to protect patients' protected health information ("PHI")***					
A		Program Reporting	1) Move Privacy Program from HIM to Compliance Department	CCO	1/8/18	Completed	
			2) Evaluate investigation and state/Federal reporting process and implement any required changes	CCO	1/22/18	Completed	
B		Policies and Procedures	1) Conduct HIPAA policy gap analysis and identify additional policies need (if applicable)	CCO	2/4/18	Completed	
			2) Draft and implement needed policies (if applicable)	CCO	3/5/18	In progress	
C		Electronic Medical Record ("EMR") Access	1) Determine feasibility of conducting proactive/ongoing EMR access monitoring	CCO/VP of Information Technology[6]	4/2/18	Not yet started	
			2) Initiate proactive monitoring of EMR access by TCHD staff	CCO/VP of IS	7/1/18	Not yet started	
D		Business Associate Agreement Tracking	1) Identify all current business associate agreements in place and ensure that all information required by the Office of Civil Rights is included in the MediTract	CCO/AMD	6/2/18	Not yet started	

[6] Information Technology

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			contracts database.				
9	***Operational Support***	***Goal: Provide support to operational units and address critical risk areas as specified by leadership***					
A		1206(b) Clinics	1) Provide compliance support to 1206(b) clinic leadership, as needed	CCO	Ongoing	Ongoing	
B		TCHD Strategic Plan	1) Provide compliance support on relevant items in current and future strategic plan	CCO	Ongoing	Ongoing	