

University of California Health Sciences Compliance Program Manual

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I. University of California Health Sciences Compliance Program Standards Overview

A. Introduction

Purpose:

The purpose of this manual is to outline the authority and scope of the Health Sciences Compliance Program (“Program”) function within the University of California and to document minimum Standards required at each Campus. The campus Compliance Officer’s judgment is essential in implementing these Systemwide Standards. This manual provides guidance only and it is not intended to inhibit the professional judgment of the Compliance Officer.

Objective:

The overall objective of the Health Sciences Campus Compliance function is to help ensure that the University complies with applicable laws and regulations relating to reimbursement and documentation of patient services, patient confidentiality and to provide recommendations and suggestions for continuous improvements.

Authority:

The UC Board of Regents established the Health Sciences Campus Compliance Program (Program) as one method to help ensure that the University conducts business in accordance with applicable laws and regulations. The Program is endorsed and sponsored by the applicable Chancellor, Dean of the School of Medicine, CEO of the Health System and Chief Executive of the Faculty Practice. The Program has the following essential features:

Incorporation of standards and policies that guide personnel with regard with compliance issues;

- Support of University Administration and the Board of Regents for implementation and ongoing revisions of the Program;
- Ensure that each Health Science campus conducts business in accordance to applicable laws and regulations relating to reimbursement and documentation of patient services.

Training of physicians, residents, clinical staff, billing and coding personnel and others in the applicable laws and regulations relating to reimbursement and documentation of patient services;

- At a minimum, a bi-annual risk assessment and development of an annual Program project plan (work plan). The annual project plan, during the years a risk assessment is not performed, must include the Compliance Officer’s judgment of that year’s risk;
- Regular reviews of billing and supporting documentation to assess compliance and identify issues that require corrective action and/or disclosures;

- Compliance Committee comprised of health care providers and administrators responsible for billing, coding and other areas of compliance risk;
- Mechanism for employees to raise questions or issues about compliance and receive appropriate guidance; and
- Process for implementing corrective action plans to address instances of compliance risk.

B. Mission of the Health Sciences Campus Compliance Program

The Program has been endorsed by the Regents and is administered by the Office of the President. The Program is designed to help ensure compliance with applicable laws, rules and regulations that govern the Medical Enterprise and empower all responsible parties to prevent, detect, respond to, report and resolve conduct that does not conform to applicable laws and regulations, the Code of Conduct and the Program. In addition, the Program is designed to:

- Reinforce the mission of providing quality patient care services, which includes accuracy in documenting, coding and billing of patient and clinical research services;
- Establish, revise, clarify and communicate policies that facilitate the education of all Responsible Parties and promote the importance of adherence to applicable laws and regulations;
- Detect and resolve potential violations of the Program, and applicable federal/state laws and regulations;
- Empower all employees and other responsible parties to report all known or suspected improper governmental activities (IGAs) under the provisions of the University Policy on Reporting and Investigating Allegations of Suspected Improper Governmental Activities (Whistleblower Policy)
<http://ucwhistleblower.ucop.edu/policy.html>;
- Report, disclose and follow-up when potential violations of compliance standards, laws, regulations, or interpretations are detected or other compliance issues are identified;
- Enhance communication with governmental entities with respect to compliance activities;
- Establish mechanisms for employees to raise questions and concerns about compliance issues and ensure those concerns are appropriately addressed; and
- Provide education to promote a culture of compliance with applicable laws and regulations

C. Scope

The Program policies and procedures apply to all University personnel, vendors and contractors involved in the provision of services to the Medical Enterprise (hereinafter referred to as “Responsible Parties”).

University Personnel

University personnel covered by this Program include administrators, directors, managers, faculty, physicians, graduate health professions students, and other health care professionals (including non-salaried faculty), staff and volunteers including those at the University's health sciences campuses, their medical centers and clinics and respective health sciences schools who are responsible for: (1) the direct provision of patient care services; or (2) the provision of clinical support services including staff, business, administrative, or patient care support services.

University Leadership at the Office of the President and Individual Campuses

University leadership with overall delegated responsibility and authority for ensuring that all members of the health sciences clinical enterprise carry out their individual and corporate responsibilities include: the President of the University of California, designated vice presidents within the Office of the President, and chancellors and vice chancellors on campuses with health sciences programs. Within the Office of the President, the Vice President for Clinical Services Development, in consultation with the Office of the General Counsel, the University Auditor, the Executive Vice Presidents, the Senior Vice President for Audit and Compliance, the Vice President for Financial Management, the Executive Vice President Business Operations, and the Vice President for Health Affairs, is responsible for coordinating all compliance activities. At each health sciences campus, the Chancellor has overall responsibility for compliance activities.

Affiliated Individuals and Entities

In the case of entities doing business at either University-owned or leased facilities, the leadership at each campus responsible for negotiating and managing affiliation agreements and provider contracts must inform those entities and individuals about the University's Program. Third-party contractors must comply with the University's Program.

When University personnel work in an affiliated institution or other institutions where the University has a contract, University personnel should continue to follow the University's Program. In addition, if the affiliated institution has a compliance program and University personnel have received a copy of the compliance program, University personnel should also adhere to the respective affiliate's compliance program. University affiliation agreements should contain language which informs affiliated entities and individuals about the University's Program and the University's expectation that all parties to an affiliation agreement will comply with applicable ethical and legal standards.

Vendors Providing Goods or Services to the University

In the case of an outside entity doing business with the University through a contractual agreement, University personnel who negotiate and/or manage the contract shall inform the vendor of the University's Program.

D. Responsibility for Reporting Concerns

Reporting Responsibility

Department Chairs/Chiefs, Medical Center Department Heads, Business Officers and Practice Managers are responsible for enforcing compliance within their own departments and ensuring that employees and vendors are trained in their responsibilities under the Program. Further, it is their responsibility to immediately report to the Compliance Officer any possible noncompliance with, or potential violation of the Program.

University personnel are expected to report all known or suspected improper governmental activities (IGAs) under the provisions of the Policy on Reporting and Investigating Allegations of Suspected Improper Governmental Activities (Whistleblower Policy). Managers and persons in supervisory roles are required to report allegations presented to them and to report suspected IGAs that come to their attention in the ordinary course of performing their supervisory duties. Reporting parties, including managers and supervisors, will be protected from retaliation for making such a report under the Policy for Protection of Whistleblowers from Retaliation and Guidelines for Reviewing Retaliation Complaints (Whistleblower Retaliation Policy).

University personnel are expected to immediately communicate questions and concerns regarding any of the Code standards, the federal regulations, or if a federal or state healthcare insurance carrier's instructions are not clear to a supervisor. The University, federal and/or state government carriers, and other payers should, when necessary, work collaboratively to clarify and revise policies, procedures, and instructions in order to prevent errors or mistakes.

Since unintentional errors can occur in the normal course of doing business, it is the responsibility of both the University, as a health care provider, and the federal government's contracted carrier, to report in a timely manner any errors and to adjust reimbursements accordingly for those errors.

Opportunity to Raise Questions and Concerns

The opportunity for University personnel to ask questions and raise concerns is a cornerstone of a successful compliance program. Each Health Science Compliance Program shall support open discussion of ethical and legal questions and concerns regarding compliance issues and will not tolerate retaliation against any individual who, in good faith, raises questions or reports suspected violations.

Each Health Science campus shall provide instruction to personnel on how to raise compliance concerns

This shall include:

- Communicate with an immediate supervisor or manager
- Talk with higher level management

- Contact the health sciences clinical enterprise Compliance Officer (CO)
- Obtain help from other University resources such as General Counsel, Human Resources, and the Office of Internal Audit
- Call the Campus Compliance Hotline or Helpline. University personnel may want to maintain a personal record of any communications or questions raised.

Reporting Potential Errors or Suspected Violations

All University personnel are expected to report issues, concerns or suspected violations related to the University's Compliance Program. The University Policy on Reporting and Investigating Allegations of Suspected Improper Governmental Activities (Whistleblower Policy) requires reporting and describes the responsibilities and procedures for reporting and investigating known or suspected misuse of University resources by University personnel. <http://ucwhistleblower.ucop.edu/policy.html> .

Chancellors are responsible for implementing the provisions of the Whistleblower Policy by designating an official to be responsible for implementation of local procedures and for general oversight of investigation activities. The University Whistleblower Policy addresses procedures that University personnel should follow to report suspected misuse, including the following:

instances of suspected misuse that come to the attention of University employees as part of the performance of their job responsibilities, for example, through the performance of routine control procedures or as a result of evidence disclosed during the course of an audit, shall be immediately reported to either the Chancellor's designee in accordance with campus procedures or to the person appointed to receive whistleblower reports.

The University's Whistleblower Policy affirms that the University does not tolerate retaliation against University personnel who report suspected violations. For additional information regarding the University's Whistleblower Policy, University personnel can contact the LDO (*Locally Designated Official*), Internal Audit or the local Compliance Office.

E. Compliance Officer Authority and Responsibility

The Compliance Officer (CO) reports at the highest executive levels at the Campus and, as appropriate, has reporting responsibility to the Chancellor, Office of the President and the Board of Regents. The Compliance Officer has free and full access to all University records, personnel and vendors.

The Compliance Officer has responsibility for maintaining a Health Sciences Campus Compliance Program, identifying evolving compliance issues, responding to potential compliance issues, and assuring the effective operation of the Health Sciences Campus Compliance Program. The Compliance Officer's authority and responsibilities includes the following:

- Review, revise, formulate, and communicate appropriate University policies regarding compliance;
- Oversee a bi-annual risk assessment. Results of the risk assessment are communicated to Health Sciences Campus Senior Leadership, such as the Dean of the School of Medicine, the CEO of the Health System and Chief Executive of the Faculty Practice.
- Train workforce and others on applicable laws and regulations relating to the Program and compliance risk areas;
- Conduct reviews to determine the level of compliance;
- Serve as a resource for compliance training materials; and,
- Prepare periodic reports on the results of the Program to appropriate individuals and departments.

Independence

To permit the rendering of impartial and unbiased judgment essential to the proper conduct of the Health Sciences Campus Compliance Program, the Compliance Officer and staff will be independent of the activities they review. In performing the Compliance function, the Compliance Office can not have any direct responsibility for or authority over, any of the activities reviewed. Therefore, Compliance Program review and appraisal process does not in any way relieve other persons in the organization of the responsibilities assigned to them.

F. Health Sciences Campus Compliance Committee

Health Sciences Campus Compliance Committee Charter

The Health Sciences Campus Compliance Committee (the Committee) oversees the Program. The Committee is charged with ensuring that appropriate compliance policies and procedures are in place; approving the annual Compliance Program work plan that provides for the ongoing assessment of compliance with established policies and procedures; reviewing compliance results; endorsing, as needed, corrective actions resulting from compliance reviews; and approving recommendations or other actions for improving the Program effectiveness.

The Committee is advisory to the Compliance Officer and is responsible for: developing and approving the annual compliance work plan; education / training plan; reviewing status reports on ongoing compliance activities; and making other recommendations to the Committee as deemed necessary.

Committee meetings are held, at a minimum, three times per year and additional meetings can be called as needed.

Committee Structure and Composition

The Committee is comprised of leaders from the Medical Enterprise. The CO, Dean, and/or CEO of the Medical Center are responsible for nominating the Compliance Committee members. In addition to the Compliance Officer, the Committee must include

representation from: 1) all Schools that bill clinical professional fees, 2) Medical Center, 3) Office of Campus Counsel, 4) Faculty Medical Group, and 5) Clinical Research.

G. UC Systemwide Health Sciences Compliance Committee

The UC Systemwide Health Sciences Compliance Committee shall have the authority to adopt policies, standards and procedures, consistent with these Standards. The Systemwide Compliance Committee also shall have authority to recommend modifications to these Standards to the Regents. The Office of the President will sponsor the Systemwide Compliance Committee meetings.

H. Risk Assessment Process

Compliance risk is the potential for loss to the Health Sciences Campus due to error, fraud, inefficiency, failure to comply with statutory requirements, or actions that bring disrepute to the entity. The bi-annual risk assessment is a process to develop the annual compliance work plan to focus on significant risk areas first. A variety of sources are utilized to identify compliance risks for the Campus and the University as a whole. The following factors are to be considered in performing the risk assessment:

- Consultations held with “key stakeholders” (leadership) to obtain input about their compliance concerns, suggested areas of compliance emphasis and any significant changes to business operations, programs, systems or controls;
- Results from previous compliance reviews;
- Results from previous Hot Line/Help Line inquiries;
- Published OIG initiatives, including the OIG Annual Work Plan;
- Benchmarking;
- Changes in regulations;
- New interpretations of regulations;
- Major changes in operations, programs, systems and/or controls;
- Opportunities to achieve operating benefits; and,
- Input from the Office of the President and the UC Systemwide Compliance Committee.

I. Repayment / Refunds

A prompt refund will be made to the payer, if any overpayment has occurred including those determined by the Compliance Office. Additionally, any required disclosures will be made by the Compliance Officer, in consultation with others as needed. Corrective actions taken by the departments will be followed-up by the Program personnel to ensure that they are adequate. If a Compliance Office identifies the need for repayment as a result of over-billing, or if another department identifies other significant incorrect receipt of revenue, the Compliance Office will be notified and will receive a copy of the accounting documentation supporting the repayment. The CO will determine if further review is needed. (*Refer to Section II. Types of disclosures and timeframe for investigations.*)

Fines and Penalties Imposed by the Government

The Government may impose fines or penalties upon individuals or institutions because of improper practices. The Health Science Campus Compliance Committee, the Dean, the Chief Executive of the Faculty Practice and/or the CEO of the Health System will determine who bears the cost of fines and penalties.

J. Conflict Resolution (Disputed Compliance Findings)

In the event that there is disagreement with the findings in a Compliance Review every effort will be made to resolve the conflict at the departmental level with assistance from the Dean of the Medical School, CEO of the Health System, Chief Executive of the Faculty Plan or Compliance Officer, as appropriate.

If the conflict is not resolved to the satisfaction of the Department or the Compliance Staff member, the matter will be referred to the Compliance Officer for a final determination. The Department and Compliance Office Staff will be notified of the Compliance Officer's decision and given an opportunity to appeal, in writing, the Compliance Officer's decision within thirty days to the Dean of the School of Medicine, the CEO of the Health System or the Chief Executive of the Faculty Plan. To overturn the Compliance Officer's decision requires the concurrence of the Dean of the School of Medicine or the CEO of the Medical Center and the General Counsel of the University. To protect the independence of the Compliance Officer, the Compliance Officer reserves the right to refer the matter to the Office of the President or the Board of Regents.

K. Disciplinary Action

Disciplinary Action: Faculty, Staff or Vendors

The University reserves the right to take disciplinary action or cause disciplinary action to occur against anyone who fails to comply with the Program. The Compliance Officer will evaluate violations of the Program and refer cases for potential disciplinary action in accordance with the rules set forth in the respective University Faculty Code of Conduct, the Medical Staff Bylaws and Rules and Regulations, and Staff Personnel Policies, as well as any other applicable Medical Center policies and University policies. Disciplinary action up to and including termination, if warranted, will be taken.

NOTE: No action will be taken on the right of the physician to see patients without the prior approval of the Dean and or the Medical Staff; however, suspension of billing privileges can occur at the discretion of the Compliance Officer.

Disciplinary Action: Community-Based Physicians and Volunteer Clinical Faculty

Community based physicians and volunteer clinical faculty are required to adhere to the Program. Failure to comply can lead to discipline up to and including discontinuance of medical staff privileges and/or faculty appointment.

L. Responding to Government and Other Investigations

The CO shall help ensure clear direction to all personnel in the event that there is a government or other investigation, that no employee under any circumstances should:

- Destroy or alter documents in anticipation of a government request;
- Lie or make misleading statements to government investigators; or
- Pressure or advise anyone to hide information or provide false or misleading information.

Instructions to personnel shall at a minimum inform personnel on what they should know about government investigations and refer to campus government investigations policy.

M. Documentation, Coding & Billing Responsibilities

Importance of Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record should chronologically document the care of the patient, who provided the care, the medical necessity, and meet a professionally recognized quality of care. The medical record facilitates:

- the ability to evaluate, plan immediate treatment, and to assess health over time;
- the continuity of care;
- appropriate utilization review and quality of care evaluations;
- data source for research and education;
- legal document for risk management and medical malpractice cases;
- establishes the basis for billing; and
- accurate and timely claims review and justification.

Coding & Billing Staff

Coding and Billing Staff members at the Campus are responsible for correct coding and billing for all patient services. The codes assigned by the coder / billing staff must be supported by medical record documentation in accordance with all Federal and State regulations, payer requirements and the Program.

1. Charge Corrections: In accordance with review findings, Coding and Billing Staff are required to make the necessary charge corrections as directed by the Compliance Officer. Charge corrections must be made in a timely basis and documentation of the correction provided to the Compliance Officer.
2. Suspension of Billing Privileges: Coding and Billing Staff are required to act upon directives from the Compliance Officer to suspend billing privileges. Reactivation of billing privileges can occur only with written approval of the Compliance Officer.
3. Reporting: Coders and Billing Staff are responsible for reporting any encounter of potential billing irregularities that indicate possible noncompliance with, or violation of, the Program to report to the Compliance Officer.

Billing Agents - Including External Billing Vendors, Contractors, Consultants

All “Billing Agents” (including vendors, contractors, third-party billing vendors and/or consultants) who enter into contract with the University must agree to comply with all Federal and State regulations, payer requirements and the Program. As a contract condition, Billing Agents are required to assist the Compliance Program with all requests for information relating to billing and documentation.

1. Charge Corrections: In accordance with review findings, Billing Agents are required to make the necessary charge corrections as directed by the Compliance Officer. Charge corrections must be made in a timely basis and documentation of the correction provided to the Compliance Officer.
2. Suspension of Billing Privileges: Billing Agents are required to act upon directives from the Compliance Officer to suspend billing privileges. Reactivation of billing privileges can occur only with written approval of the Compliance Officer.
3. Reporting: Billing Agents are responsible for reporting any encounter of potential billing irregularities that indicate possible noncompliance with, or violation of, the Program to report to the Compliance Officer.

II. Health Sciences Campus Compliance Program Activities

A. Compliance Oversight and Focus

The Compliance Officer’s (CO) primary focus involves ensuring compliance with applicable laws, regulations and other binding obligations relating to claims for health care services

The CO, in conjunction with various other components within the health care enterprise (e.g., Office of General Counsel, contracts office, purchasing department, medical staff, finance and administration), also focuses on the compliance implications of financial arrangements, including issues arising under the anti-kickback statute, the physician self-referral statute (a.k.a., “Stark”) and gain-sharing.

B. Compliance Monitoring Methodologies

Claims for Payment: Routine Monitoring

The CO is responsible for conducting Routine Monitoring of health care claims practices throughout the health care enterprise. The Compliance Officer will determine the specific methodology for pursuing Routine Monitoring. When the magnitude of the overpayment (actual or potential) is significant, or where the facts suggest that the noncompliance may be widespread, the CO shall initiate an Expanded Review. An Expanded Review is required when the results of Routine Monitoring identify high-risk billing errors, such as the existence of any of the following conditions:

- No documentation for services billed;
- Co-signed notes that do not support teaching physician presence / involvement; or

- Other potential systemic issues, such as incorrect assignment of codes in charge documents, unbundling, and repeated instances of the same billing or coding error.

When Routine Monitoring demonstrates that an overpayment has occurred, a refund shall be made to the appropriate payor/contractor with reasonable promptness, except in cases where self-disclosure to the Health and Human Services Office of Inspector General (OIG) is warranted, as described below.

Expanded Review

An Expanded Review shall be conducted either following Routine Monitoring as outlined above, or in response to a complaint or other specific information indicating potential noncompliance. The CO shall exercise their professional judgment as to the scope of the Expanded Review (e.g., number of charts/claims to be reviewed; time period to be examined).

When the Expanded Review indicates that the noncompliance is widespread (is equal to or exceeds 10%), the CO shall conduct an Investigation (as outlined below) unless, after consultation with the Compliance Committee and the Office of General Counsel, the CO determines that an investigation is not warranted under the circumstances. When the Expanded Review indicates that the noncompliance is not widespread (is less than 10%), the CO, in the exercise of their professional judgment, still may conduct an Investigation.

When the Expanded Review demonstrates that an overpayment has occurred, a refund shall be made to the appropriate payor/contractor with reasonable promptness.

Investigations

Where the circumstances require an Investigation, or where the CO, in his or her discretion, determines that an Investigation is warranted, the Investigation shall be undertaken with reasonable promptness, except in cases where self-disclosure to the OIG is warranted, as described subsection (d) below.

The CO shall develop and Investigation plan, which shall address such matters as the population to be examined, sampling methodology, payor(s) and codes at issue. The Investigation shall cover a two-year retrospective period unless the Investigation involves a “Defining Event” (as defined below), in which case, the time period shall be based on the Defining Event.

Voluntary Disclosure to the OIG

If the CO determines, after consultation with the Office of General Counsel (OGC), that the facts and circumstances indicate a potential violation of Federal criminal, civil or administrative laws, the CO shall proceed in accordance with the OIG’s “Self-Disclosure Protocol.”¹ The Office of General Counsel shall review and approve, in advance, all

¹ *Matters exclusively involving overpayments or errors that do not suggest that violations of law have occurred should be brought directly to the attention of the entity (e.g., a contractor such as a carrier or*

potential submissions to the OIG, and shall be actively involved in the disclosure process until its conclusion.

C. Communicating Results to Responsible Parties

It is the responsibility of the Compliance Officer to communicate results of the monitoring reviews and investigations to the appropriate persons in a written report supported by work papers. The purpose of this feedback is to ensure that Responsible Parties are advised of the results and corrective action can be taken, as necessary.

- Compliance reports should be addressed to the director, chairperson or department head directly responsible for the audited activity or activities.
- Reports for projects conducted under attorney-client privilege should be addressed to the person(s) directed by Counsel.

D. Corrective Actions

Potential noncompliance issues may arise from various sources including compliance reviews, hotline referrals, external audits, patient complaints, etc. The Compliance Office and the Compliance Committee are responsible for providing direction for the implementation of corrective action plans to be carried out by the appropriate responsible individual(s), and will work in conjunction with management to ensure corrective action is meaningful and effective. Development of the Corrective Action Plan is the responsibility of management.

Corrective actions may include additional training, implementation of a specific billing process, or other specific actions to be taken to prevent inappropriate billing practices. The corrective action plan may also require suspension of billing privileges for a provider, repayment or charge adjustment, or that the matter be reported to the appropriate external agency by the Compliance Officer.

Consistent with University personnel policy, corrective actions shall be implemented whenever Responsible Parties are found to have not fully complied with the compliance policies and procedures of the University. The Departments are responsible for immediate implementation of corrective actions, and the Compliance Program is responsible for follow-up to ensure that corrective action is properly taken. The Compliance Officer will keep the Compliance Committee advised of the implementation of corrective action plans.

E. Work Papers & Record Retention

Compliance work papers document what the Compliance Office has done. The working papers serve as the connecting link between the compliance assignment, the fieldwork and the final report. Working papers contain the records of planning and preliminary surveys, the monitoring program/procedures, fieldwork and other documents relating to the compliance project and support the final report conclusions and the reasons those

fiscal intermediary) that processes claims and issues payment on behalf of the particular Federal health care program, as described in subsections (a), (b) and (c) above.

conclusions were reached. Compliance working papers may be in any form prescribed by the Compliance Officer (paper, electronic or a combination, etc.). If work papers are in a form other than paper, appropriate backup procedures should be developed and followed.

Record Retention. Compliance work papers and reports will be retained for six years unless the work papers and report relate to a settlement agreement (10 years).

F. Training and Education

Conducting Effective Training and Education

Education is an integral part of the Compliance Program. It is an ongoing process to educate faculty and staff about compliance responsibilities and changes in regulations or interpretations of compliance regulations. Our highest priority is the education of physicians, coders, billers, hospital departments and healthcare providers on their compliance responsibilities. In addition to general compliance training, education programs are often tailored to physician practices' or hospital departments' specific needs.

General Compliance Training

General compliance training in the Program is the responsibility of management. A key training objective is to ensure that employees receive training on how to perform their jobs in compliance with the University standards and applicable regulations. General Compliance Training centers on explaining: why the Compliance Program was developed; what each employee's responsibilities are; the Code of Conduct; how to access the University's written policies and procedures; and how employees can contact the Compliance Office for information or to report potential concerns related to non-compliance, e.g., hotline, whistleblowing policies.

Practice, Department and/or Provider Specific Training

Items covered in practice / provider specific training may include:

- Appropriate documentation of services rendered
- Documentation guidelines for teaching physicians and mid-level providers
- Coding and billing standards and procedures for the submission of accurate bills for reimbursement of services or items rendered
- Targeted education topics based on identified areas of weakness or coding advisory alerts
- Focused education for physician medical specialty and/or coding staff

New Faculty, New Residents and Other New Employees Training

All new faculty, residents, managers and employees should receive a general orientation about the Health Sciences Campus Compliance Program, the Code of Conduct and their compliance responsibilities, and how to report concerns.

Consultations

The Compliance Office provides consultative services to requesting departments for clarification of coding, documentation and billing requirements for areas of specific concern. Consultation request may require extensive research utilizing the Federal Register, Code of Federal Regulations, California Code of Regulations, Centers for Medicare and Medicaid Services, Medi-Cal Manuals, and other information sources that may assist in the analysis for final determination.

G. Exclusion Screening

The CO is responsible for assuring that policies and procedures are in place to, at least annually, screen all Responsible Parties (including vendors and contractors) against the exclusion/debarment lists of the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA)). In addition, newly hired or contracted Responsible Parties will be screened, either before first providing services or soon after.

When a Responsible Party is identified as excluded, the Medical Enterprise shall refund any payments made under Medicare (Title XVIII), Medicaid (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and State Children's Health Insurance (Title XXI) programs during the period of exclusion for any items or services (including administrative and management services) furnished, ordered, or prescribed by the excluded individual or entity

H. Compliance Officer's Annual Report

Minimum criteria for the Annual Report will be distributed annually by the systemwide Compliance Officer. The annual report will include an executive summary of significant changes and new policies, as well as voluntary disclosures and material deficiency errors. The annual report will be distributed to senior leadership at each health science campus and to the Systemwide Compliance Officer.

III. Health Sciences Code of Business Conduct

In a separate document