Nashville General Hospital at Meharry

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Compliance Plan

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Mission

To improve the health and wellness of Nashville by providing equitable access to coordinated patient-centered care, supporting tomorrow's caregivers, and translating science into clinical practice.

Vision

Leader in exceptional community healthcare-"One neighbor at a time."

Values

1. Compassion to those we serve and each other.
2. Honesty and integrity in all we say and do.
3. Accountability to society, our community, and each other.
4. Respect and dignity for all human kind.
5. Teamwork to achieve our vision, mission and values.

INTRODUCTION & PURPOSE

The Nashville General Hospital is organizationally committed to compliance with all applicable federal, state, local laws and regulations and ethical conduct in all activities.

This Compliance Plan is applicable to the entire organizational community which includes all departments, affiliated providers, medical staff members, allied health professionals, managers, administrators and other employees, agents, representatives, contractors, vendors, consultants and volunteers.

The plan is approved by the Governing Body and serves as a guiding document for activities related to compliance education, prevention and detection of potential or actual criminal conduct or regulatory non-compliance.

The Compliance Plan is distributed to the Hospital Governing Body, Executive Staff, Departmental Directors and Managers and is available to all members of the NASHVILLE GENERAL HOSPITAL community through the online policy database. The plan is also available in paper form from the Compliance Office. Alternative languages and formats are available upon request.

COMPLIANCE PROGRAM OVERSIGHT AND STRUCTURE

The Nashville General Hospital has a designated Compliance Officer reporting to the Chief Executive Officer and the Governing Body, the Hospital Authority Board of Trustees.

The Compliance Committee is charged with the responsibility of operating and monitoring the compliance program. The Compliance Committee meets at least quarterly but may meet more often if business needs require it.

A. **COMPLIANCE OFFICER**

1. **Scope of Authority**

   a. The Compliance Officer will have the authority to review all sources of information (electronic and otherwise) relevant to Compliance activities, including, but not limited to: patient records (as permitted by applicable law), billing records, marketing documents, contracts, and all other arrangements with third parties, including employee payroll, human resource or health records (as permitted by applicable law), and activities of independent contractors, suppliers, agents, and medical staff, residents, and students.

   b. Concerns regarding the behavior of the Compliance Officer should be directed to the CEO, Board of Trustees Chairman or Legal Counsel.

2. **Role of the Compliance Officer**

   a. The Compliance Officer ensures that the organization:

      - Implements the Compliance Plan;
      - Establishes, reviews, updates, and communicates standards and policies as necessary;
      - Responds appropriately to statutory, regulatory and judicial developments relevant to compliance;
      - Maintains effective physician, employee and vendor screening mechanisms;
      - Adequately educates and trains the organizational community regarding compliance, and consistently documents such activities;
      - Implements monitoring and audit procedures in accordance with audit policies, schedules or requirements;
      - Establishes and maintains effective processes for reporting actual or potential violations and clarifying policies;
      - Promptly investigates all complaints and concerns regarding compliance, with involvement of others as appropriate;
      - Makes reasonable attempts to correct identified problems and to prevent recurrence of such problems
      - Executive Leadership, Medical Staff Leaders and the Governing Body receive information regarding compliance activities and education pertaining to compliance issues.

B. The Compliance Officer reports quarterly to the Board of Trustees of the Hospital Authority on the status of adherence to the Compliance Plan. These reports may include recommendations arising from risk assessments, monitoring and audit work plans conducted during the preceding period and other information requested by the Board**.**

C. **COMPLIANCE COMMITTEE (CC)**

1. The Compliance Committee shall be chaired by the Compliance Officer or a designated Board Member as determined by the Governing Body. The remainder of the Compliance Committee is comprised of representatives from relevant areas of operation within the Hospital Authority including at least one member of the medical staff as determined by the Medical Executive Committee and may include legal counsel as appropriate.

2. The CC reviews and monitors the Compliance Program for effectiveness, including, without

limitation, organizational risk assessments and the review of internal controls to provide reasonable assurance of compliance with laws and regulations.

CODE OF CONDUCT (Overview)

NGH has developed a written "Code of Conduct" that is distributed to all employees, medical staff, students, volunteers, business associates and vendors during the onboarding process. During the annual performance evaluation process, supervisors evaluate employees in the area of conformance with the Code of Conduct. The Code of Conduct is reviewed every three years or more frequently as needed by the organization. The Code of Conduct is available to all members of the Nashville General Hospital community through the online policy database.

POLICIES AND PROCEDURES

In addition to the Code of Conduct, the Hospital Authority has adopted several policies and procedures that promote a commitment to compliance activities. (See Attachment 1)

EDUCATION AND TRAINING

Employees, medical staff, volunteers and contractors are provided initial education regarding the compliance program during orientation. In addition, orientees are asked to sign acknowledge receipt of and education regarding the compliance plan and code of conduct. During annual in-service training, employees and medical staff receive additional education. Intermittently, as policies and procedures are adopted, employees are educated about the policies by the department manager or director. Medical staff are educated by their respective chiefs of service who receive updated information during Medical Executive Committee meetings or by other appropriate means of communication.

MANAGEMENT OF INFORMATION (PRIVACY AND SECURITY)

NGH protects the privacy and security of personal information and health information. Employees, medical staff, volunteers and contractors may not share information outside the scope of the job duties or contractual relationship. This prohibition includes financial information, personnel records, employee health records, protected quality information or any other information as protected by law. NGH has a designated Privacy Officer, a designated Information Security Officer and the organization maintains information privacy and security policies as required by law.

NGH recognizes and takes action to protect the rights of our patients to receive notification if the privacy of health information is breached and to provide an accounting of disclosures to patients. Notices of Privacy Practices are available and distributed in accordance with Federal Privacy Regulations.

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

NGH will provide an appropriate medical screening examination (MSE) within our capabilities to determine whether or not an emergency medical condition exists for all individuals who arrive on the premises in accordance with the Emergency Medical Treatment and Labor Act (EMTALA). If an emergency medical condition exists, the hospital will either: (1) provide stabilizing treatment within the hospital's capabilities or (2)

lawfully transfer the patient to another medical facility. (See the policy entitled Emergency Medical Treatment and Labor Act (EMTALA).) Potential EMTALA non-compliance will be investigated and if substantiated, will be self-reported.

BILLING, CODING ACCURACY AND THE FALSE CLAIMS ACT

NGH educates employees, contractors and agents regarding the False Claims Act (FCA) as required by the Deficit Reduction Act of 2005. This education includes an overview of the FCA, rights and protections afforded whistleblowers, and penalties for the violation of the FCA.

NGH takes reasonable action to audit coding, claims and cost-reports prior to submission. NGH requires appropriate documentation to support claims for services and prohibits the coding or billing without complete and accurate documentation. NGH has implemented departmental policies and procedures to support accurate coding and billing.

STARK LAW AND ANTI-KICKBACK STATUTE

NGH maintains a file of all active contracts. Leadership conducts a contract review upon initiation and renewal of all financial arrangements, including compensation arrangements and ownership interests. NGH identifies whether any such arrangements are with persons or entities in a position to make or influence referrals or are with persons or entities to which NGH refers. For each such arrangement with a referral source or with an entity to which patients are referred, NGH determines whether such arrangements pose a material risk of being viewed as violating the Stark or Fraud and Abuse laws, or other applicable law, and, if so, shall terminate or reform the contract. All contracts are subject to review by internal and external auditors. In addition to the Code of Conduct, NGH has adopted Business Courtesies, Employee Gifts and Gratuities Policy. This policy further explores acceptable and prohibited conduct, tracking of compensation that may implicate Stark and mitigation.

CONTRACTOR, MEDICAL STAFF, REFERRAL SOURCE AND EMPLOYEE SCREENING POLICY

NGH will inquire into the background of all individuals who will perform duties that impact patient care, treatment or services. This inquiry will include all applicable registry checks as required by state law and MCO requirements. It is the policy of NGH to inquire reasonably into the background of anyone whose job function or activities may provide them with discretionary authority to make decisions that may involve compliance with the law and/or may materially impact the process of developing and submitting claims to payers. Other inquiries, including inquiries about NGH relationship with physicians and referral patterns between providers also will be made. In addition, in its applicable contractual relationships with vendors, NGH will perform exclusion screenings on contractors and vendors as well.

A. **Non-employment or Retention of Sanctioned Individuals**

1. The Hospital Authority shall not knowingly employ, contract with, accept orders from, or credential any person or entity, who has been convicted of criminal offense related to healthcare or who is listed by federal agency as debarred, excluded, or otherwise ineligible for participation in federally funded healthcare programs. The Hospital Authority will verify non-exclusion on a monthly basis. In addition, until resolution of such criminal charges or proposes debarment or exclusion, any individual who is charged with criminal offense to healthcare or proposed for exclusion or debarment shall be

removed from direct responsibility for or involvement in, debarment, or exclusion of the individual NGH shall terminate its employment or other relationship with such individual.

B. **Billing Agents, Consultants, and Vendors**

1. NGH will obtain commitments from vendors involved directly in furnishing patient care services or in billing agreements that the vendor will not use persons to serve NGH if such persons would not qualify for employment by the Hospital Authority under the preceding paragraph.

IDENTITY THEFT

NGH has a policy and procedure that outlines the organization's practices to prevent and respond to identity theft of our internal or external customers. The organization's procedures align with the Federal Trade Commission's "Red Flag Rules" for creditors. Please see the policy entitled Identity Theft Program for more information.

A. **Covered Accounts**

1. Covered Accounts are any type of account for which a person or the covered entity may be at risk as a result of an identity theft, including financial risk, operational risk, compliance risk, reputation risk or litigation risk. The Hospital Authority maintains the following covered accounts: patient billing accounts, medical records, human resource files and credentialing files for licensed independent practitioners (medical doctors, nurse practitioners, nurse midwives and nurse anesthetists.

B. **Actions**

1. Each facility has a policy that identifies "Red Flags" which trigger further action and/or investigation with regard to whether or not a person may be using an identity other than his/her own. The facility policies address the measures that the facility takes to prevent and detect identity theft, and how the organization responds to the identified "Red Flags."
2. Any employee participating in theft of a patient's or staff member's identity will be terminated. Any employee with knowledge of suspected identity theft by another employee must report the information to his/her supervisor or the Compliance Office.

C. **Program Reporting**

1. The CC and HA Board will receive periodic reports regarding the effectiveness of the Identity Theft Program, significant events involving identity theft including response, and recommendations for material changes to the program. The program will be reviewed and updated every three years as part of the organization's Compliance Plan.

BILLING FOR SERIOUS ADVERSE EVENTS

NGH will implement processes to ensure that billing will not occur for the care provided in response to the following serious adverse events (as recommended by the Tennessee Hospital Association):

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgical procedure
- Unintended retention of a foreign object
- Patient death or serious disability associated with an air embolism
- Patient death or serious disability associated with a medication error
- Patient death or serious disability associated with a hemolytic reaction due to administration of ABO

incompatible blood or blood products
- Artificial insemination with the wrong donor sperm or egg
- Infant discharged to the wrong person
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates
- Patient death or serious disability associated with a burn incurred from any source while being cared for at a healthcare facility

RESEARCH ACTIVITIES

NGH will comply with federal and state laws in any research, investigations and clinical trials. Research studies are approved by Meharry's Institutional Review Board and the Medical Executive Committee. All patients will receive a full explanation of the risks, benefits and alternatives in order for them to give informed consent. Refusal to participate in research will not affect access to services.

OIG WORK PLAN

The NGH Compliance Committee reviews the Office of Inspector General, United States Department of Health & Human Services (OIG) Work Plan and any applicable updates issued by the OIG. The Compliance Committee will include this document as it evaluates ongoing organizational compliance risk. Any changes in the priorities listed below will be brought before the Compliance Committee as well as the Board of Trustees. Please see Attachment 3 for the OIG Work Plan Highlights Applicable to NGH.

USE OF MONITORING AND AUDITS

NGH uses audits and/or other evaluation techniques to monitor compliance with law, regulation, or HA policy. These tools are used to assess of the effectiveness of the Compliance Plan including specifically: (1) whether compliance standards and procedures have been maintained and effectively communicated; and (2) whether effective compliance practices have been implemented to prevent occurrence or recurrence of unethical or illegal conduct. Each audit is executed in accordance with a defined auditing or monitoring tool or protocol. Consistent with the availability of resources and other critical demands on those resources, NGH devotes such resources as are reasonably necessary to ensure that the audits are (1) adequately staffed (2) by persons with appropriate knowledge and experience to conduct the audits (3) utilizing audit tools and protocols which are periodically updated to reflect changes in applicable laws and regulations. In addition, audits are performed as a follow up action in response to deficiencies found during surveys or self-assessments.

REPORTING

In accordance with Office of Inspector General's Compliance Guidance for Hospitals (U.S. Department of Health and Human Services) the Hospital Authority encourages open communication between the Compliance Officer and NGH community by providing a process for bringing issues, questions or concerns to the attention of the Compliance Officer. (Reference: https://oig.hhs.gov/compliance/compliance-guidance/index.asp) NGH has implemented and maintains a process for reporting potential employee safety, patient safety, quality incidents, suspected unethical or illegal behavior (anonymously if the reporting individual wishes). NGH does not permit retaliation against any individual who reports a perceived issue in good faith and to the extent possible, complainants' identity is protected. Complainants may report by phone, electronically, in writing or in person.

Employees who are separating from the Hospital Authority are given an opportunity to disclose any knowledge of violations of the Law, Compliance Plan, Code of Conduct, or policies and procedures during the exit interview process.

INVESTIGATION & REMEDIATION/ RESOLUTION

Violations of the Compliance Plan, failures to comply with applicable federal, state and local laws, and other types of misconduct threaten the organization's status as a high quality, reliable, ethical provider capable of participating in federal and state health care programs. Detected but uncorrected misconduct or patterns of errors can seriously endanger the organization's reputation, tax-exempt status and participation in federal health care programs. In addition, conduct that results in errors must be addressed with appropriate corrective action.

Allegations of improper or illegal activities will be investigated promptly. Priority may be given to some activities over others based on the seriousness of the allegation and resource availability. Investigations will be initiated no later than 14 days in all cases. Investigations may include any personnel required to obtain information necessary to fully evaluate the circumstances.

Investigations will be coordinated by the Compliance Officer or designee with appropriate communication to other executive leadership team members and the Board of Trustees. Legal counsel will be included as appropriate, throughout the process.

During and after investigations, appropriate actions will be taken to mitigate the impact of and resolve the alleged or actual activities. Actions may include: removal of involved employees from the work place, temporary suspension of billing on the involved account(s), and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements. Reporting to outside agencies will be coordinated by the Compliance Officer as required by law or regulation. Voluntary self-disclosure to outside agencies will be considered when appropriate. Appropriate executive leaders and legal counsel will be involved by the Compliance Officer.

ORGANIZATIONAL RESPONSE

1. **Possible Criminal Activity.** If an investigation reveals potentially criminal activity, the Hospital Authority will follow the actions listed below:
    a. **Corrective Action.** NGH immediately stops all potentially unlawful activity related to the problem in the unit(s) where the problem exists and takes appropriate steps to correct the offending conduct. Where appropriate, NGH modifies, or terminates any contract involving questionable activity. NGH will report the criminal activity to appropriate authorities as required by law.
    b. **Disciplinary Action.** NGH initiates appropriate disciplinary action against any person whose conduct appears to have been intentional, willfully indifferent to, or in reckless disregard of applicable laws.
    c. **Billing.** If an investigation reveals overpayments by Medicare/Medicaid, or any other government program or by a private payer, NGH promptly refunds any sums overpaid within 60 days of confirmation and, in consultation with counsel, determines the appropriateness of otherwise reporting the overpayments to the government.
2. **Other Non-Compliance.** In the event the investigation reveals billing or other problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or in reckless disregard of applicable law, NGH undertakes the following steps:
    a. **Improper Billing and Payment Issues.** In the event the problem results in duplicate payments from

a government program or from any private payor, or payments for services not rendered or provided other than as claimed, NGH:

1. Corrects the defective practice or procedure as quickly as possible;
2. Calculates and repays to the appropriate entity duplicate payments or improper payments resulting from the act or omission;
3. Calculates and promptly refunds any sums overpaid within 60 days as established by the federal government;
4. Initiates such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include reprimand, demotion, suspension and discharge for both directly involved personnel as well as supervisors or managers to the extent that their oversight is found to have been lax; and
5. If necessary, promptly undertakes a program of re-education as needed to prevent future similar problems.

b. **Issues Unrelated to Billing and Payment.** In the event the problem has not resulted in an overpayment, NGH:

1. Corrects the defective practice or procedure as quickly as possible;
2. If the activity is required under the terms of a contract, explores ways to revise, reform, amend, or terminate the contract to bring it into compliance with applicable law;
3. Initiates such disciplinary action, if any, as may be appropriate given the facts and circumstances.
4. If necessary, promptly undertakes a program of education as needed to prevent future similar problems

DISCIPLINE

A. **PERFORMANCE REVIEWS**

1. Any employee, contractor or associate is subject to discipline for failing to comply with compliance standards or efforts, including, but not limited to:
   a. Failure to perform any obligation relating to adherence to the Compliance Plan or applicable laws or regulations;
   b. Failure to report suspected violations of the Compliance Plan or applicable laws or regulations to an appropriate person;
   c. Failure of supervisory or managerial employees to implement and maintain policies and procedures reasonably necessary to ensure compliance with the Compliance Plan or applicable laws and regulations; and
   d. Negligently or recklessly failing to detect and report a violation of the Compliance Plan.

B. **Discipline**

1. Disciplinary action will be taken in accordance with NGH policies and procedures on a fair, equitable, and consistent basis. The severity of the discipline will vary with the particular circumstances and may range from oral warnings to termination or revocation of privileges (subject to applicable peer review and fair hearing procedures.)

REFERENCES:

- "OIG Compliance Program Guidance for Hospitals," 63 Fed. Reg. 8987, 1998.
- "Supplemental Compliance Program Guidance for Hospitals," 70 Fed. Reg. 4858, 2005.
- "2016 United States Sentencing Commission Guidelines Manual, Chapter Eight, Part B-Remedying Harm from Criminal Conduct, and Effective Compliance and Ethics Program," United States Sentencing Commission.
- "Health Care Compliance Officer's Manual," Health Care Compliance Association, 2013.
- "Position Description: Chief Compliance Officer," American College of Health Care Executives, Career Resources.

Attachments:

1: Policies that Support Compliant Activities
2: Monitoring/Audit Activities that Support Compliance

Approval Signatures

Step Description	Approver	Date
ELT	Joseph Webb: CEO	11/2017
ELT	Julie Groves: Compliance Office	11/2017
Compliance Officer	Julie Groves: Compliance Office	11/2017