



City and County of San Francisco
Edwin M. Lee, Mayor

San Francisco Department of Public Health

Barbara A. Garcia, MPA
Director of Health

San Francisco Department of Public Health

*Policy & Procedure Detail**

Policy & Procedure Title: Compliance Policy – Operation of a Compliance Program (COM6)	
Category: Compliance	
Effective Date: April 6, 2007	Last Reissue/Revision Date: March 25, 2013
DPH Unit of Origin: Compliance	
Policy Contact - Employee Name and Title; and/or DPH Division: Yvonne Lowe, Compliance	
Contact Phone Number(s): 206-4104	
Distribution: DPH-wide <input checked="" type="checkbox"/>	If not DPH-wide, other distribution:

**All sections in table required.*

1. Purpose of Policy

It is the policy of the San Francisco Department of Public Health (DPH) to maintain and operate a Compliance Program in accordance with Federal and State regulations and guidance to address the increasing complexity of properly and accurately documenting, coding and billing for health care services. This policy applies to all DPH employees and to all contractors and agents who, on behalf of DPH, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, or monitor the health care provided by DPH.

A. DPH Compliance Program Mission and Goals

The mission of the DPH Compliance Program is to ensure integrity in DPH clinical and business activities. This mission is carried out through a Compliance Office that is dedicated to the following goals:

1. To promote an understanding of and compliance with Medicare, Medi-Cal, and other applicable federal and state laws and regulations;
2. To use education and training to improve compliance with documentation, coding, billing, and reimbursement rules and regulations; and
3. To work with providers, managers, and staff to integrate compliance into the daily operations of DPH.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

We shall ~ Assess and research the health of the community ~ Develop and enforce health policy ~ Prevent disease and injury ~
~ Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

2. Procedures

Compliance Program

DPH is committed to avoiding potential problems by fully complying with all applicable federal and state statutes and regulations related to billing for services. To this end, the Compliance Office oversees a program designed to prevent and detect fraud and abuse.

The basic elements of the DPH Compliance Program are as follows:

1. The commitment of leadership and the allocation of resources to staff the Compliance Office.
2. Development and maintenance of a Compliance Program, including a Code of Conduct, written policies and procedures, a coding compliance plan, and an annual work plan.
3. Providing an annual training tool for DPH employees and contractors regarding compliance matters, including the federal False Claims Act and California's False Claims Act.
4. Making lines of communication available for employees to report fraud and compliance concerns, with the option of remaining anonymous. This includes a confidential Compliance Hotline at 415-642-5790. DPH also has a strict non-retaliation policy for employees who report compliance violations.
5. Promptly investigating reports of violations of the DPH Compliance Program or federal or state laws and regulations related to billing for health care services.
6. Rendering appropriate discipline for the failure of any DPH employee to comply with the DPH Compliance Program or any federal or state law related to billing for health care services.
7. Auditing potential risk areas periodically.



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Policy & Procedure Detail*

Policy & Procedure Title: Compliance Program - Mission, Elements, and Responsibilities (COM7)	
Category: Compliance	
Effective Date: November 29, 2005	Last Reissue/Revision Date: March 25, 2013
DPH Unit of Origin: Compliance	
Policy Contact - Employee Name and Title; and/or DPH Division: Yvonne Lowe, Compliance	
Contact Phone Number(s): 206-4104	
Distribution: DPH-wide <input checked="" type="checkbox"/>	If not DPH-wide, other distribution:

**All sections in table required.*

1. Purpose of Policy

The purpose of this policy is to inform DPH staff, contractors, and agents of the elements of the department's compliance program. DPH maintains a compliance program in accordance with Federal and State regulations and guidelines to address the complexity of properly and accurately documenting, coding, and billing for health care services. All staff, contractors, and agents who, on behalf of DPH, furnish or authorize the furnishing of Medicare and Medi-Cal services, bill or code services, or monitor the health care provided by the department are subject to this policy and expected to ensure a culture of compliance.

2. Policy

A. DPH Compliance Program Mission and Goals

The mission of the DPH Compliance Program is to ensure integrity in DPH clinical and business activities. This mission is carried out through a Compliance Office that is dedicated to the following goals:

1. To promote an understanding of and compliance with Medicare, Medi-Cal, and other applicable federal and state laws and regulations;
2. To use education and training to improve compliance with billing and reimbursement rules and regulations; and
3. To work with providers, managers, and staff to integrate compliance into the daily operations of DPH.

DPH is committed to fully complying with federal and state laws and guidance for the operation of an effective compliance program.

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B. Elements of the DPH Compliance Program

The structure of the Compliance Program is laid out by the seven elements and DPH policies guide activities for detecting and preventing fraud, waste, and abuse.

Element 1: Leadership Commitment and Resource Allocation

Reporting Relationship: The Compliance Program reports directly to the Director of Health and the DPH Compliance Council. The Compliance Council consists of the following DPH leadership: Director of Health, Chief Financial Officer, Director of Human Resources, Director of Community Programs, and the Executive Administrators for San Francisco General Hospital and Laguna Honda Hospital. The Compliance Office makes quarterly reports and obtains direction and feedback from the Council. The Compliance Program also includes periodic reporting to the Health Commission through Compliance Officer reports to the Joint Conference Committees.

Compliance Officer Role and Responsibilities:

DPH Compliance Officers are assigned to areas that bill Medicare, Medi-Cal, and other third party payers.

The officers' responsibilities include the following:

- a. Conducting risk assessments to prioritize compliance monitoring and auditing activities;
- b. Directing compliance monitoring and auditing activities and presenting findings and recommendations to senior administrators and managers;
- c. Maintaining a system for staff to report compliance concerns in a confidential or anonymous manner, and ensuring a culture of non-retaliation;
- d. Conducting investigations of reported compliance incidents and developing corrective action plans;
- e. Communicating with external auditors and regulatory bodies and coordinating responses to inquiries; and
- f. Developing the annual training program, as well as targeted training activities.

The Compliance Office includes additional staff, such as Compliance Managers and Auditors that are appointed to the office to assist in carrying out a wide range of compliance responsibilities. These responsibilities include training, maintaining a mechanism for staff to report compliance concerns, and responding to compliance issues for the entire department, including public health functions. In some instances, staff from other departments are called upon to assist with investigating and resolving compliance matters.

Element 2: Development and Maintenance of the Compliance Program

An effective Compliance Program includes a department code of conduct, written policies and procedures, a coding compliance plan, and an annual work plan.

DPH Code of Conduct: The DPH Code of Conduct is the foundation of the department’s compliance program. The purpose of the Code of Conduct is to provide direction to all DPH employees. All employees are expected to be familiar with the federal, state, and local laws, regulations, or policies that apply to their duties. Supervisors and Managers are responsible for overseeing the quality of their employees’ work. All employees must avoid policy violations and activities that may be construed as deceitful, false, or fraudulent. It is the responsibility of each employee to seek assistance for clarification or application of a particular rule, law, or regulation.

DPH Statement of Incompatible Activities: The DPH Statement of Incompatible Activities provides guidance to DPH officers and employees and the Health Commission about the types of activities that are incompatible with public duties and prohibited. The Statement is adopted under the provisions of the San Francisco Campaign and Governmental Conduct Code section 3.218.

Consultants and contractors are expected to abide by the terms of their contract(s) with the City and by all applicable laws and regulations, especially those related to privacy, billing, coding, and documentation.

Written Policies and Procedures: DPH has written policies and procedures that address the Compliance Hotline, Non-Retaliation, False Claims Act education as required by the Deficit Reduction Act (DRA) of 2005, and guides to government interviews and investigations.

Coding Compliance Plan: The department has a written Coding Compliance Plan developed to foster the correct application of the coding structure to diagnosis and procedures and to guard against upcoding.

Annual Compliance Work Plan: Each year the Compliance Office develops a Compliance Work Plan, detailing the priority work tasks for the following year. It is reviewed and approved by the Director of Health and the Compliance Council.

The Work Plan is developed based on risk assessment results and focuses on DPH activities that address the following:

- a. Training on documentation, coding, and billing;
- b. Auditing medical records and conducting chart reviews;
- c. Software and hardware upgrades that improve documentation, coding, and billing accuracy;
- d. Improvement to forms, such as encounter forms and requisitions, that facilitate more accurate documentation, coding, and billing;
- e. Licensure verification;
- f. Documentation efforts such as “Do Not Use Abbreviations” and “Write Legibly”;
- g. Efforts to better understanding billing requirements and regulations;
- h. Systems to minimize, detect, or correct billing and coding errors;
- i. Regulatory changes and major initiatives, such as Health Care Reform.

An assessment of the Compliance Program and Work Plan is performed by the Compliance Office at the end of each calendar year and presented to the Director of Health and the Compliance Council for approval.

Element 3: Training and Education

DPH requires annual compliance training for all employees. The Compliance Office updates the training materials annually to reflect changes in regulations and to address specific areas of risk. In addition to changes in regulations and risk, the annual training covers the DPH Code of Conduct and Statement of Incompatible Activities.

DPH Training and Education Tools: DPH incorporates various training methods to assist employees in meeting the annual compliance training requirement. These methods include computer based training modules and live trainings.

Element 4: Lines of Communication to Report Compliance Concerns

DPH provide various methods for employees to communicate compliance concerns or to report fraud, with the option of remaining anonymous. The methods are briefly described below.

Compliance Hotline: The Compliance Office maintains a Hotline so that employees may report concerns regarding non-compliance with federal, state or local laws in a confidential manner. These calls may also be made anonymously. DPH policy protects employees who report compliance concerns from any form of discrimination, harassment or retaliation within DPH. Posters advertising the Hotline number are displayed throughout DPH. Additionally, the Office coordinates with the Office of the Controller, Whistleblower Program when complaints are submitted through the Citywide Whistleblower reporting system.

Formal Communication: Every year the Compliance Office prepares a calendar to ensure that face-to-face communication occurs with each of the divisions within DPH that bill Medicare, Medi-Cal and other third party payers. This is generally done through regular meetings with the Executive Staffs at San Francisco General Hospital, Community Primary Care, Laguna Honda Hospital, and the Community Behavioral Health Service. At these meetings, the Compliance Office may review specific investigations or areas of concern, recent developments or new regulations, status of the Work Plan, and answer questions.

Compliance Website: The Compliance Office also maintains a website which can be accessed through the DPH, San Francisco General Hospital or Laguna Honda Hospital intranet sites. The website includes the DPH Code of Conduct, DPH Statement of Incompatible Activities, and DPH Compliance Policies.

Element 5: Prompt Response to Detected Offenses including Development of Corrective Action Plans

Compliance concerns are generally discovered by the Compliance Office during the auditing and monitoring process; self-reported by providers, managers or staff; or reported through the Hotline. It is the responsibility of the Compliance Office to take the lead in assessing actual or possible offenses, pulling the right group of people together, determining the extent of the problem, and developing a corrective action plan. If appropriate, the plan may include recommendations for disciplinary action, refunding of monies, or self-disclosure. It is also the responsibility of the Compliance Office to ensure that information is communicated to the Director of Health, the Deputy City Attorney, and the appropriate members of the Compliance Council in a timely manner.

Element 6: Standards Enforcement Through Well Publicized Disciplinary Guidelines

In addition to ongoing efforts by the Compliance Office to generate and increase awareness of compliance issues, employees regularly come into contact with compliance standards and disciplinary guidelines through the Civil Service or City and County of San Francisco Personnel System. DPH strives to incorporate compliance elements (such as annual training, maintaining a current license, and enrolling in Medicare) into its employee recruiting, hiring, orienting and performance appraisal process. At San Francisco General Hospital and Laguna Honda Hospital, physicians, dentists, podiatrists, clinical psychologists and affiliated professionals are also subject to ethical and professional standards set forth in the Medical Staff Bylaws for each hospital. These Bylaws clearly delineate the consequences for failing to meet these standards.

Element 7: Internal Monitoring and Auditing

Each year the Compliance Office develops an audit schedule and audit tools. These audits and reviews are used to proactively identify issues and to give feedback to providers, coding and billing staff. Audits and reviews are also conducted when there are concerns regarding potential compliance violations.

Review of employee annual compliance training occurs as part of the annual performance appraisal process. Additionally, credentialing verification is performed every two years for physicians, dentists, podiatrists, psychologists, and affiliated professionals at San Francisco General Hospital and Laguna Honda Hospital. Finally, the Office of Inspector General Exclusion List is checked for each billable provider at least every two years.

C. Federal and State False Claim Acts

All DPH employees, agents, and contractors should be familiar with the Federal and State False Claim Acts, including the qui tam provisions and other applicable laws and regulations.

Federal False Claims Act (FCA 31 U.S.C. Section 3729(a)):

The FCA authorizes federal prosecutors to file a civil action against any person or entity that knowingly files a false claim with a federal health care program, including the Medicare or Medicaid programs. The FCA applies to providers, beneficiaries, and health plans doing business with the federal government as well as billing companies, contractors, and other persons or entities connected with the submission of claims to the government. The government can use the FCA against both organizations and individuals who commit billing fraud.

The FCA applies to any person who does any of the following:

1. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to an officer or employee of the United States government.
2. Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
3. Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.

4. Knowingly makes, uses or causes to be made or used, a false record or statement or to conceal, avoid, or decrease an obligation to pay or transmit property to the government.

A party that commits any prohibited act under the FCA is liable to the government for a civil penalty of not less than \$5,500 and not more than \$11,000 per claim, plus three times the amount of the damages the government sustains. Parties that submit false claims may also be subject to criminal prosecution, other monetary penalties and exclusion from federal and state healthcare programs (Medicare and Medi-Cal).

Qui Tam Actions:

The FCA authorizes what is known as qui tam actions (commonly referred to as “whistleblower” actions). The FCA’s qui tam provision permits private persons to: (1) sue, on behalf of the government, persons or entities who knowingly have presented the government with false or fraudulent claims; and (2) share in any proceeds ultimately recovered as a result of the suit.

The FCA includes provisions to discourage employers from retaliating against employees for initiating qui tam lawsuits. Any employee who is terminated, demoted, suspended or in any way discriminated against because of acts in support of an action under the FCA has a right to sue the employer for reinstatement, back pay and other damages.

California False Claims Act (California Government Code Sections 12650-555)

In addition to the federal FCA, California has its own False Claims Act that is focused on claims for payment submitted to the state and its agencies. The California False Claims Act is very similar to the FCA in terms of the types of acts that give rise to liability. Like the FCA, the California False Claims Act allows private parties to sue on behalf of the state as qui tam plaintiffs.

3. Definitions

- A. Centers for Medicare and Medicaid Services (CMS) – CMS administers the Medicare program and works in partnership with state governments to administer the Medicaid program. CMS was formerly known as the Health Care Financing Administration (HCFA).
- B. Fraud (per CMS) - Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
- C. Abuse (per CMS) - Actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program or the improper payment for services that fail to meet professionally recognized standards of care or that are medically unnecessary.
- D. Waste (per Controller’s Office) - The needless, careless, or extravagant expenditure of City funds, incurring of unnecessary expenses or mismanagement of City resources or property. Waste does not necessarily involve private use or personal gain, but almost always signifies poor management decisions, practices or controls.
- E. Department of Justice (DOJ) – DOJ is a federal law enforcement agency. One of DOJ’s functions is to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse.

- F. Office of Inspector General (OIG) - The OIG is mandated to protect the integrity of Department of Health and Human Services programs, as well as the health and welfare of the beneficiaries of those programs. The OIG's duties are carried out through a nationwide network of audits, investigations, and inspections.
- G. Coding/Documentation - The purpose of coding and documentation is to accurately reflect clinical effort, demonstrate medical necessity and obtain appropriate reimbursement. There are two sets of nationally recognized codes: Healthcare Common Procedural Coding System and International Classification of Diseases.
- H. Upcoding – Consistently using procedure/revenue codes that describe more extensive services than those actually performed. Consistent upcoding may be found to constitute fraud.
- I. Healthcare Common Procedural Coding System (HCPCS) – HCPCS was established to standardize medical services, supplies, and equipment. There are two levels of HCPCS codes.
 - H1. HCPCS Level 1 or Current Procedural Terminology (CPT) Codes: The five digit codes are used for outpatient services and are divided into six categories. The categories are a) Evaluation and Management (E&M); b) Anesthesia; c) Surgery; d) Radiology; e) Pathology and Laboratory; and f) Medicine.
 - H2. HCPCS Level II Codes: Level II HCPCS codes are a mixture of durable medical equipment (DME) codes, dentistry codes, Medi-Cal surgical supply codes, alcohol and drug treatment codes, and other material and services codes.
- J. Modifiers - Modifiers are two digit numbers that can be added to a CPT code to provide more specific information on some aspect of the service provided.
- K. International Classification of Diseases , Ninth Edition, Clinical Modification (ICD-9-CM) Codes – ICD-9-CM codes are three to five digit numeric codes that describe a particular illness, medical condition or disease, and signs and symptoms. They can also reflect preventative circumstances
- L. The Diagnostic and Statistical Manual of Mental Disorders (DSM) – DSM is published by the American Psychiatric Association. The DSM provides standard criteria for the classification of mental health disorders. DSM diagnoses are linked to diagnostic codes listed in the International Classification of Diseases (ICD) to report diagnosis to insurers for reimbursement and to public health authorities for causes of illness and death. DSM-IV TR is the current version used by clinicians.

4. Procedures

DPH staff, contractors, and agents are expected to carry out their duties in accordance with all Federal and State regulations. It is the responsibility of staff, contractors, and agents to be familiar with the Federal and State False Claims Acts, including qui tam provisions and other applicable laws and regulations.

DPH staff, contractors, and agents are expected to report concerns related to the compliance program to their supervisors, and/or other appropriate parties. Staff, contractors, and agents should use the Compliance Hotline if they prefer to report concerns in a confidential manner.

5. References/Attachments

A. Relevant Federal and State Compliance Related Statutes



City and County of San Francisco

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Attachment A

San Francisco Department of Public Health Compliance Program Relevant Federal and State Compliance Related Statutes

Federal Compliance Related Statutes and Regulations

Civil Monetary Penalties Act (CMPL) (42 U.S.C. Section 1320a-7a)

Prohibit providers from knowingly, or through negligence or reckless disregard, presenting or causing a claim under a government program that is:

- For a medical or other items or services that the party knows or should know was not provided as claimed (e.g. "upcoding");
- For a medical or other service and the party knows or should know the claim is false or fraudulent;
- Presented for a physician's service (or an item or service incident to a physician's service) by a party who knows or should know that the individual who furnished (or supervised the furnishing of) the service was not properly licensed as a physician or represented to the patient at the time the service was furnished that the physician was certified in a medical specialty when the individual was not so certified;
- For a medical or other item or service furnished during a period in which the party was excluded from the program under which the claim was made;
- For a pattern of medical or other items or services that a party knows or should know are not medically necessary; or
- In violation of an assignment, a Medicare or Medicaid provider agreement, or an agreement to be a Medicare participating physician or supplier.

For purposes of these prohibitions, the term "should know" means that providers or persons, who, with respect to information, act:

- In deliberate ignorance of the truth or falsity of the information, or
- In reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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Program Exclusion (42 U.S.C. Section 1320a-7)

The Social Security Act provides for mandatory and permissive exclusion from government health care programs, including Medicare and Medicaid, of individual providers and health care entities convicted of program-related crimes, crimes relating to patient abuse or neglect, and other convictions relating to health care fraud. Program exclusion is also authorized for convictions relating to obstruction of an investigation.

False Statement and Representations (42 U.S.C. Section 1320a – 7b (a))

Prohibits providers and staff from knowingly and willfully making or causing false statements or representations of material fact in applications for benefits or for the determination of benefits under government health care programs and for concealing or failing to disclose events effecting initial or continued right to such benefits or payments “with intent to fraudulently secure such benefit or payment either in greater amount or quantity than is due or when no benefit or payment is authorized.”

Program Fraud Civil Remedies Act (31 U.S.C. Sections 3801-3812)

Prohibits providers and staff from:

- Submitting a claim that the party knows or has reason to know is false, fictitious, or fraudulent or that includes or is supported by any written statement that is false, factitious, or fraudulent; and
- Making written statements that the party knows or has reason to know is false, factitious or fraudulent, or omits a material fact that the person has a duty to include and that is accompanied by an express certification of the statement’s accuracy and truthfulness. The HCFA-1500 claim form includes such a certification.

Health Care Fraud (18 U.S.C. Section 669)

Prohibits providers and staff from knowing and willful execution or attempt to execute a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretense, representation, or promises, any of the money or property owned by, or under the custody or control of, any governmental health benefit program

Federal False Claims Act (FCA 31 U.S.C. Section 3729(a))

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government can use the FCA against both organizations and individuals who commit billing fraud.

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