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		Retires Policy Dated:	
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I. SCOPE:

This policy applies to Tenet Healthcare Corporation (“Tenet”), its consolidated subsidiaries and all hospital and other healthcare operations owned or operated by Tenet’s consolidated subsidiaries where patients are admitted to a bed (each, a “Tenet Facility”).

II. PURPOSE:

To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges. A comprehensive medical billing audit program serves to:

- Provide the structure by which hospitals may realize organizational benefits through improvements in internal processes;
- Improve the customer service relationship by prompt response to patients’ billing questions;
- Perform reasonable third-party payer audits in accordance with the provisions set forth herein and as identified in the Third-Party Audit Policy Statement;
- Identify deficiencies in charge pathways and processes to strengthen the controls necessary for high-quality fiscal and clinical data.


III. DEFINITIONS:

A. “Concurrent Audit” means a complete audit of an account accomplished within 30 days of patient discharge.

B. “Focus Audit” means an audit performed on a select group of accounts. Focus Audits may be self-prompted by the Medical Billing Auditor or may come from a committee, group, or entity within the Tenet Facility or Tenet corporate offices. Focus audits are designed to address a variety of issues, including, but not limited to:

- Validate or quantify a trend or pattern of billing errors noticed during routine/concurrent audits.
- Validate charge capture mechanisms on new service lines or new products/items.

¹Retires Revenue Cycle Procedure Manual Policies 04.01.09 Medical Billing Audit and 04.01.10 Chart Audit Committee

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- Validate the effectiveness of a previously implemented corrective action plan.
- Validate and correct accounts in which a specific billing error has been previously identified and may have re-occurred.
- Validate documentation and billing for high dollar/high risk accounts and/or in response to Office of Inspector General (OIG) directives.

C. “Late charge” means a charge posted to the billing system greater than three days post discharge.

D. “Physician” means, for the purpose of this policy, a physician or other licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis and is authorized by state licensure law and the Tenet Facility’s medical staff by-laws to admit patients or order outpatient services.

E. “Physician Order” means an order from the Physician who is either the Physician admitting the patient to the Tenet Facility or the Physician responsible for the patient’s general medical management during the admission/encounter. The order may be in writing or be a telephone/verbal order as allowed by the Tenet Facility’s medical staff by-laws.


F. “Third Party (Defense) Audit” means an audit performed by a third party on behalf of a specific payer.

IV. POLICY:

Each Tenet Facility will establish and maintain a medical billing audit program as an objective means to review and correct individual patient accounts, as well as gather fundamental data to measure the effectiveness and accuracy of charge processes and pathways. All Tenet Facilities will utilize Tenet’s online Medical Audit Software System (MASS) to document, report, and maintain their medical billing audit activities.

The scope of a medical billing audit is limited and is intended to verify charges on the detailed claim are accurate, represent services rendered to the patient, and are ordered by a Physician. However, services and items may be provided based upon standard hospital practices and/or medical/clinical protocols and procedures. The audit does not assess the “reasonableness” of the charges, or medical necessity related to services provided.

In concert with the position taken by the American Hospital Association’s (AHA) publication Billing Audit Guidelines (1992), the Tenet Facility does not attempt to make the patient’s Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by

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medical/clinical protocols and/or standard hospital practices which are not reflected in the Medical Records. Furthermore, ancillary departments may have information or documentation not contained in the Medical Record which may be used to substantiate charges. In a business relationship, the Tenet Facility will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient/payer.

V. PROCEDURE:

A. Medical Billing Auditor Responsibilities


The Tenet Facility will designate at least one individual to be responsible for coordinating all medical billing audit activities; at the discretion of the Tenet Facility Chief Financial Officer (CFO) this function may be contracted to an individual supplier. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits), the Medical Billing Auditor (or designee) will serve as the primary liaison between the Tenet Facility and all outside parties requesting patient account audits.

B. Medical Audit Software System (MASS)

MASS is an electronic audit tool designed to facilitate, streamline and enhance the medical audit workflow and to strengthen appropriate charge capture. By utilizing MASS, standardized statistical data may be generated for each facility and region. MASS automatically generates action plans based on defined criteria; this allows users to review, distribute, respond, resolve, approve, and complete action plans electronically through a workflow product. Use of MASS is required in completing monthly medical audit reviews. Criteria for account selection are programmed into MASS and generated monthly or more frequently as defined by audit requirements.

C. Concurrent Account Audits

1. The Medical Billing Auditor (or designee) will perform concurrent account audits on a monthly basis to identify charge issues which may indicate deficiencies in charge pathways and processes. Concurrent audit samples must be randomly selected, must include a minimum of ten patient accounts representing at least one-third of a single day's hospital acute care revenue, and must not previously have been selected/identified for audit. Additionally, audits should reflect a 1:3 inpatient to outpatient ratio. All facilities are required to finalize accounts generated by MASS in their concurrent audit sample each month.

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2. Acute care facilities with psychiatric, rehabilitation, skilled nursing, or other exempt units are required to perform additional concurrent account audits. A monthly sample of not less than two inpatient accounts representing a minimum of one-third of a single day's revenue for each unit, and not less than three outpatient accounts representing a minimum of one-sixth of a single day's revenue for each unit is required. All facilities are required to finalize accounts generated by MASS, as applicable.

3. The Tenet Facility may substitute "focused" reviews for concurrent reviews up to 25% of revenue threshold or 10% of the account number threshold. In order to maintain the integrity of the audit sample and to ensure audit results are not biased or skewed through substitution, approval is required by the Hospital Compliance Officer or the CFO. Complete substitution of concurrent audits (100% substitution) requires approval of the Regional Vice-President of Finance. Additionally, the Tenet Senior Vice-President of Operations Finance may direct 100% substitution of concurrent audit accounts for special projects (such as OIG audits; Emergency Department audits; etc.). Substitution of concurrent accounts should be on an *exception* basis and should not routinely occur. Defense audits and Patient Request Audits may not be substituted for Concurrent Audits.


D. Focus Audits

1. Focus audits, performed on a select group of accounts, may be self-prompted by the Medical Billing Auditor, may come from a committee, group or other entity within the Tenet Facility or Tenet corporate offices or may be high dollar/high risk accounts as identified by the OIG.

2. The Medical Billing Auditor will perform audits on identified accounts to target a specific departmental issue or concern. Focus audits take an in-depth look at small segments of the Tenet Facility's charging structure to make a determination, decision, or conclusion about specific billing or charging practices. The Medical Billing Auditor must define and document the impetus, scope, approach, timeframe, and extent of the Focused review.

E. Miscellaneous Audits

Internal requests for single account audits from various individuals or departments within the Tenet Facility are processed at the discretion of the Tenet Facility's administration. These single account audit requests originate from, but are not limited to, clinical departments, National Insurance Center (NIC), National Medicare/Medicaid Center (NMC), Health Information Management (HIM), and/or Finance. A clearly defined internal process for these requests is the responsibility of the Medical Billing Auditor at the direction of the Tenet Facility's administration.

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F. Patient Request Audits

1. Each Tenet Facility will establish and maintain internal guidelines for processing patients' questions regarding the validity of itemized charges. The guidelines must address the following issues:

- a. Procedure for referring requests to the Medical Billing Auditor;
- b. Procedure for communicating audit information to NIC or NMC;
- c. Procedure for communicating audit results to the patient
- d. Audit fees (if any).


2. In the event a patient's questions may be answered without auditing the account, account notes must be entered into appropriate patient accounting, follow-up, or other hospital system(s) (i.e., a patient may want to know when or why a particular item or service was provided and has no further billing questions). If the patient requests a complete bill audit, the following points must be discussed with the patient and appropriate account notes made in the system(s):

- a. The entire bill will be audited, not just one department or one section.
- b. The bill will be audited for both overcharges and undercharges, and the claim will be corrected to reflect all billing errors as a result.
- c. Debits and credits will affect the total charges, but depending on reimbursement methodology, the patient's out-of-pocket liability may or may not be impacted.

G. Third-Party Payer (Insurance Defense) Audits

1. Third party payer audits will follow the policies set out in the Tenet Third-Party Audit Policy Statement (see Attachment A). All facilities must have a person assigned the responsibility to properly conduct third-party payer audits and to serve as the primary liaison between the facility and any outside audit party.

2. Upon receipt of a written request for a Third-Party Audit, the Medical Billing Auditor must send the audit representative a copy of the Tenet Third-Party Audit Policy Statement. The Medical Billing Auditor must document dates and recipients of all audit policy statements sent to outside parties in the account notes of appropriate hospital system(s).

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3. All accounts, without exception, are to be pre-audited in their entirety by the Medical Billing Auditor prior to the scheduled audit date. The Medical Record must be complete prior to conducting the audit. The Medical Billing Auditor must also identify any portions of the medical record containing sensitive information and subject to additional protections (consult HIM policies for handling of these records).

H. Adjustments


All audit-related account adjustments are to be processed only after appropriate facility-level sign-off approval has been obtained. All audit-related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with [Administrative Policy AD 1.11, Records Management](#). For Third-Party defense audits, the NIC representative should be notified of the audit and the amount of adjustments by the next business day after the audit is finalized.

I. Medical Audit Committee

All Tenet Facilities will have a Medical Audit Committee. The purpose of the Medical Audit Committee is to provide a forum for communicating audit results, discussing problematic charge practices, and identifying, initiating, and monitoring corrective actions. The Medical Audit Committee will meet at least nine times annually.

1. The Medical Audit Committee will include at a minimum: CFO, Director of Patient Services, Medical Billing Auditor, HIM director or representative, Nursing director(s), and department directors/managers from Central Supply, Pharmacy, Radiology, Laboratory, and Surgery, as determined necessary by facility. The Medical Audit Committee must be comprised of appropriate representation at a level which ensures problem resolution and decision making. Department directors/managers are required to attend based on identified error rates:

- 0 % - 4.99 % error rate: department director/manager is not required to attend Medical Audit Committee meeting
- 5% or greater error rate: department director/manager attends Medical Audit Committee meeting until all action items are resolved. Director/Manager provides an explanation of the source of errors, how errors may be corrected and presents a detailed corrective action plan addressing root causes; corrective action plans shall include education to prevent recurrence. MASS generates detailed corrective action plans for error rates greater than 5%

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2. The Medical Audit Committee shall:


a. Analyze the summarized concurrent audit findings presented by the Medical Billing Auditor. The analysis should:

- (1) Identify departments demonstrating an error rate of greater than 5% in overcharges and undercharges.
- (2) Discuss possible reasons why overcharges and undercharges are occurring; i.e., failure to properly document services, failure to process credits, failure to accurately capture charges, incomplete documentation on Medication Administration Record, inaccurate charge sheets, lack of departmental charge reconciliation, etc.
- (3) Discuss corrective action plans electronically generated by MASS. Action plans are designed to assist the departments in moving progressively toward a 0% error rate. Department directors/managers are responsible for establishing control mechanisms to ensure timely, accurate charging and documentation of services rendered.
- (4) Ensure corrective action plans are implemented no later than 30 days from the date the error rate was identified.
- (5) Monitor and evaluate the effectiveness of all open action plans. Corrective action plans are considered closed when the error rate is below 5% for two consecutive months.

Note: The CFO is responsible for ensuring corrective action plans address charge error issues.

b. Analyze the Monthly Late Charge Summary Report. The analysis should:

- (1) Identify departments showing a trend of late charges. Evaluate departments exhibiting late charges greater than 2% of monthly department gross charges.

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- (2) Discuss possible reasons why charges are not processed on a timely basis; i.e., charges not submitted on weekends, failure to batch charges regularly, failure to cross-train personnel on charging practices, incomplete charge information sent to Data Processing, charges generated by the NIC/NMC, lack of departmental reconciliation, etc.
- (3) Discuss ideas for corrective action by departments exhibiting late charges.
- (4) Ensure corrective actions are implemented no later than 30 days from the date the late charge rate was reported.
- (5) Monitor and evaluate the effectiveness of all open action items. Corrective actions are considered closed when the applicable department late charge rate is less than 2% for two consecutive months.

Note: The CFO is responsible for ensuring departmental corrective action plans address late charge issues.

- c. Analyze summarized focus, patient request, miscellaneous, and insurance defense audit findings.

4. Medical Audit Committee Documentation

- a. The CFO must review and sign all documented Medical Audit Committee activity, which shall include the following:
 - (1) Medical Audit Committee meeting agenda and minutes;
 - (2) Signed roster of Medical Audit Committee meeting attendees;
 - (3) Corrective action plans;
 - (4) Summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party-defense) completed during the month.
- b. Tenet Facilities must submit all required documentation electronically via MASS.

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5. Reporting to Compliance Committee

The Medical Audit Committee shall provide monthly reports to the facility's Compliance Committee, including Medical Audit Committee meeting minutes, overall facility error rate trended over 12 months, department error rates trended over 12 months and corrective action plans for any department with an error rate of 10 % or greater. The facility Compliance Officer or the Compliance Committee shall follow [Regulatory Compliance Policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues](#) for compliance-related issues identified through the Medical Billing Audit process. The Compliance Officer or the Compliance Committee shall determine if further audits are required for evaluation and will coordinate this through appropriate channels.

J. Enforcement

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 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.

VI. REFERENCES:

- [Administration Policy AD 1.11 Records Management](#)

- [Regulatory Compliance Policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues](#)

VII. ATTACHMENTS:

Attachment A: Third-Party Audit Policy Statement

THIRD-PARTY AUDIT POLICY STATEMENT

The facility wishes to cooperate with any reasonable commercial requests for audit of patient accounts and which are performed in accordance with the provisions set forth herein. These policies and procedures, along with the associated fees and charges, are necessary so all audits may be performed efficiently, and the costs imposed on the hospital, in connection with such audits, will not be unduly borne by other patients. In concert with the position taken by the American Hospital Association, the facility does not attempt to make the patient's Medical Record a duplicate patient bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by medical/clinical protocols and/or standard hospital practices, which are not reflected in the Medical Record. Furthermore, ancillary departments may have information or documentation not contained in the Medical Record which may be used to substantiate charges. Questions concerning level/scope of care, medical necessity, charge structure, and/or issues relating to the cost of particular items or services will not be addressed in a medical billing audit, as defined by the joint guidelines for billing audits.

Policy	Description
Policy 1	The facility requires written receipt of "Notice of Intent to Audit" within four months from the date of discharge. Audit requests received after 120 days from the discharge date will not be considered. Onsite audits will be scheduled and completed within 60 days of receipt of intent to audit.
Policy 2	Written notice of intent to audit must state the reason for audit; clearly identify the name of the patient; provide the patient account number; include dates of service; state the carrier requesting audit, name of firm and name of person, if known, who will perform the audit; and state total charges to be audited.
Policy 3	Audits requested by Third-Party Audit representatives on behalf of an insurance carrier will not be scheduled or conducted until the Medical Billing Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit firm. Auditors who contractually represent Third-Party Audit firms must provide written proof of their contractual relationship before an audit will be scheduled or conducted.
Policy 4	Upon receipt of written notice, the facility will ensure the Tenet Third-Party Audit Policy Statement is provided to the audit firm. The Third Party Audit Representative must agree to abide by the Third Party Audit Policy Statement before the facility will schedule an audit.
Policy 5	No offsite audits will be allowed. All audits will be conducted onsite under the direction and coordination of the Medical Billing Auditor or designee. Offsite reviews of photocopied records are not permitted. Facility Health Information Management personnel/NIC staff will direct all such requests to the Medical Billing Auditor. Only the portion of a patient's Medical Record pertaining to the dates of service for the designated account will be provided to the Third-Party Audit representative unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit representative shall be required to furnish to the Medical Billing Auditor written evidence proving the exceptions referred to in clauses (a) and (b) apply to the account under audit, or such exceptions will not apply to the audit.

- Policy 6 A single account may not be audited by a third party more than once. Any additional third-party requests for audit will be denied. The findings of the first audit shall apply to any subsequent requests.
- Policy 7 Copies of the discharge bill will not be provided by Tenet personnel. All requests for itemized statements and UB-04s will be denied. The insurance carrier must provide this information.
- Policy 8 Payment of 95% of policy benefits must be received prior to scheduling the audit. Audits will not be performed on interim bill accounts.
- Policy 9 Audit fees will be imposed in the absence of complete pre-audit payment of policy benefits. A minimum fee of \$150.00 may be required by the Tenet facility. This fee is in addition to any pre-audit payment of policy benefits and must be received prior to or at the time of the audit.
- Policy 10 Audits will not be conducted with Third-Party Audit representatives currently providing contracted audit services at any Tenet facility.
- Policy 11 All requests by Third-Party Audit representatives to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the Medical Billing Auditor and are subject to a minimum re-schedule fee of \$100.00. This fee may be charged to the carrier or its agent if notice is not received within ten (10) days of the originally scheduled audit date. An audit may be rescheduled only once. No-shows will not be rescheduled.
- Policy 12 Third-Party Audit representatives will report to the Medical Billing Auditor upon arrival at the facility. To prevent disruption of facility operations, Third-Party Audit representatives are prohibited from making direct contact with facility department personnel. All questions regarding clarification of charging practices and/or protocols are to be directed exclusively to the Medical Billing Auditor.
- Policy 13 The entire bill will be audited, not just one department or one section. Both overcharges and undercharges will be identified and the claim corrected to reflect all billing errors as a result of the audit. Debits and credits will affect total charges, but depending on reimbursement methodologies, the patient's out-of-pocket expenses may or may not be impacted.
- Policy 14 An itemization of undercharges (unbilled) and overcharges (unsupported) must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.
- Policy 15 An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final. A final written report of the audit findings will be submitted to the facility by the Third-Party Audit representative within ten (10) business days of the exit conference. Both unbilled and unsupported charges must be identified in the final report and must be detailed by description and price, and summarized by department.
- Policy 16 Upon receipt and review of the written report, the Medical Billing Auditor or facility representative will determine if the results will be accepted or contested and advise the payer.

- Policy 17 If necessary, the facility will submit an additional bill itemizing previously unbilled charges identified in the audit. If indicated, a net refund or adjustment of charges will be completed within the regular course of business.
- Policy 18 Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payer and the facility. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless stipulated by contract.