I. SCOPE:

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

II. PURPOSE:

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

A. Provide the structure by which Tenet Entities may realize organizational benefits through improvements in internal processes;

B. Improve the customer service relationship by prompt response to patients’ billing questions;

C. Perform reasonable third-party payer audits in accordance with the provisions set forth herein and as identified in the Third-Party Audit Policy Statement;

D. 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 60 days of patient discharge, normally performed in the calendar month that follows the month of discharge date.

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 Entity or Tenet corporate offices. Focus audits are designed to address a variety of issues, including, but not limited to:

1. Validate or quantify a trend or pattern of billing errors noticed during routine/concurrent audits.

2. Validate charge capture mechanisms on new service lines or new products/items.

3. Validate the effectiveness of a previously implemented corrective action plan.

4. Validate and correct accounts in which a specific billing error has been previously identified and may have re-occurred.
5. 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 Entity’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 Entity or the Physician responsible for the patient’s general medical management during the admission/encounter. The order may be electronic, in writing or be a telephone/verbal order as allowed by the Tenet Entity’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 Entity 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 Entities will utilize Tenet’s online Medical Audit Software System (MASS) to document, report, and maintain their medical billing audit activities, as technology permits.

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, revised 2009), the Tenet Entity 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 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 Entity 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 Entity will designate at least one individual to be responsible for coordinating all medical billing audit activities; at the discretion of the Tenet Entity 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 Entity 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 Entity and region. MASS automatically generates the requirement of 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-sixth of a single day’s hospital acute care revenue, and must not previously have been selected/identified for audit. Additionally, the initial 10 accounts (minimum) identified for 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.

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-sixth of a single day’s revenue for each unit, and not less than three outpatient accounts representing a minimum of one-twelfth of a single day’s revenue for each unit is required. All facilities are required to finalize accounts generated by MASS, as applicable. *In the event MASS
technology is not available for an entity, these audits should be performed manually.

3. The Tenet Entity 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 Tenet Entity CFO. Complete substitution of concurrent audits (100% substitution) requires approval of the Tenet Vice-President of Operations Finance. Additionally, the Tenet 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. All substitution approvals require submission to Tenet Billing Compliance.

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 Entity 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 Entity’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 Entity are processed at the discretion of the Tenet Entity’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 Entity’s administration.
F. Patient Request Audits

1. Each Tenet Entity 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 charging 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 Tenet Entities must have a person assigned the responsibility to properly conduct third-party payer audits and to serve as the primary liaison between the Tenet Entity 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).
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 Entity-level approval has been obtained, meaning that the Medical Billing Auditor and the Department Director are in agreement. All audit-related account adjustments are to be signed and dated by the requestor. For most PBAR entities, this will be accomplished via electronic submission of corrected charges within MASS. For all other facilities, the charge corrections must be printed out, signed and dated by the Medical Billing Auditor and handed off for manual charge entry. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. This pertains to manually entry. All audit-related account adjustment documents are to be maintained in accordance with Administrative Policy AD 1.11, Records Management and its Record Retention Schedule. 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 Entities 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 and will be chaired by the Tenet Entity CFO.

1. The Medical Audit Committee will include at a minimum: CFO - Chair, Director of Revenue Analysis, Medical Billing Auditor, HIM Director or representative, Nursing director(s), and department directors/managers from Materials Management/Central Supply, Pharmacy, Radiology, Laboratory, and Surgery, as determined necessary by the Entity. 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 departmental error rates:

a. 0 % - 4.99 % error rate: department director/manager is not required to attend Medical Audit Committee meeting
b. 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 that are 5% or greater.

c. CFO should also give consideration to a department’s late charges, daily/monthly charge reconciliation, and Midnight Census reconciliation when considering a department director/manager required attendance.

2. The Medical Audit Committee shall:

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

      i. Identify departments demonstrating an error rate of greater than 5% in overcharges and undercharges.
      
      ii. 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.
      
      iii. Discuss completed corrective action plans electronically generated by MASS when the department’s error rate is 5% or greater. Action plans are designed to assist the departments in moving progressively toward a 0% error rate. Department directors/managers are responsible for completing the corrective action plans and establishing control mechanisms to ensure timely, accurate charging and documentation of services rendered.

      iv. Ensure corrective action plans are implemented no later than 30 days from the date the error rate was identified.
      
      v. 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 and provide final approval of action plan within MASS.
b. Analyze the Monthly Late Charge Summary Report. The analysis should:

   i. Identify departments showing a trend of late charges. Evaluate departments exhibiting late charges greater than 2% of monthly department gross charges.
   
   ii. 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 charge reconciliation performed daily/monthly, lack of midnight patient census daily reconciliation that includes verification of patient, bed, accommodation code, physician Patient Status Order, etc.

   iii. Discuss ideas for corrective action by departments exhibiting late charges.
   
   iv. Ensure corrective actions are implemented no later than 30 days from the date the late charge rate was reported.
   
   v. 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:

   i. Medical Audit Committee meeting agenda and minutes;
   
   ii. Signed roster of Medical Audit Committee meeting attendees;
   
   iii. Corrective action plans;
   
   iv. Summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party-defense) completed during the month.

b. Tenet Facilities Mmust submit all required documentation electronically via MASS.
5. Reporting to Compliance Committee

The CFO will provide a report to the Hospital Compliance Committee when a Hospital department average error rate is 10% or greater 3 months rolling. Any systemic charging issues shall be reported to the entity Compliance Officer as required by Regulatory Compliance Policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues. The Compliance Officer or the Compliance Committee shall determine if further audits are required for evaluation and will coordinate this through appropriate channels.

J. Responsible Person

The Tenet Entity CFO (or other relevant Tenet Entity leadership) are responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed, and that instances of noncompliance with this policy are reported to the responsible Compliance Officer.

H. 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 and its Records Retention Schedule
- Regulatory Compliance Policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Matters
- SOX Control A.02.03 Revenue Charge Capture and SOX Control A.02.06 Midnight Census Control

https://portal.etenet.com/departments/AuditServices/Pages/Audit%20Resources.aspx

-National Health Care Billing Audit Guidelines | AAMAS


VII. ATTACHMENTS:

Attachment A: Third-Party Audit Policy Statement
Attachment B: Medical Audit Committee Agenda Template