	Regulatory Compliance Policy	No. COMP-RCC 4.35
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	REPORTING OF OVERPAYMENTS TO FEDERAL HEALTH CARE PROGRAMS	**Effective Date:** 10-05-20
		Previous Versions Dated: 10-12-11; 08-01-08; 01-05-07; 01-23-12
		Corporate Review Dated: 10-05-20

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to ensure the appropriate handling of Overpayments received from Federal health care programs.

III. DEFINITIONS:

A. **"Compliance Officer"** means the compliance officer responsible for the implementation of Tenet's Compliance Program at the Tenet facility.

B. "**Federal health care programs**" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.

C. "**Identification**" of or "**Identified**" means that a determination has been made, through the exercise of "Reasonable Diligence," that an overpayment has been received, and the amount of the Overpayment has been quantified.

D. "**Ineligible person**" means an individual or entity who is currently excluded from participation in any Federal health care program; or has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded.

E. "**Lookback Period**" means six (6) years from receipt of an Overpayment.

F. "**Non-Routine Overpayment":** Overpayments identified through non-routine charging and billing processes. Examples of Non-Routine Overpayments include but are not limited to: re-bills identified through a Compliance Matter /investigation, Stark-related canceled claims, a risk-related case that was

originally billed without regard to the risk event and then required an adjustment or cancelled claim, DHS/OIG requested reviews, Third-party payer, Medicare Administrative Contractor (MAC) Comprehensive Error Rate Testing(CERT), MAC Target, Probe and Educate (TPE) reviews, Coding reviews, etc.

G. "**Operations Counsel**" means, in the case of a hospital, the the Tenet attorney responsible for hospital legal operations; in the case of a physician organization, its Tenet Physician Resources attorney responsible for physician practice legal operations, and in the case of a non-hospital outpatient facility, the USPI attorney responsible for the USPI or CareSpot facility's legal operations.

H. "**Overpayment**" means any funds that Tenet Facility receives or retains under any Federal health care program to which Tenet Facility, after applicable reconciliation, is not entitled to under such Federal health care program.

I. "**Other Patient Accounting Office**" means any Regional Billing Office, stand-alone Tenet Facility billing office, or non-hospital entity billing office utilizing a billing system other than PBAR/ACE.

J. "**Reasonable Diligence**" shall mean a timely, good faith investigation of credible information, which is generally 6 months from receipt of credible information, except in extraordinary circumstances. A determination that extraordinary circumstances exist that may permit extension of the reasonable diligence period beyond 6 months is a factually-specific determination that must be made and documented by Regulatory Counsel, if applicable. Examples of extraordinary circumstances may include unusually complex investigations, natural disasters, or a state of emergency.

K. "**Regulatory Counsel**" means the Tenet facility's assigned Regulatory Counsel.

L. "**Substantial Overpayment**" means any Overpayment of $100,000 or more.

IV. POLICY:

A Tenet Facility, through its respective Compliance Officer, must report and return any Overpayment received during the Lookback Period by the later of: (i) the date which is sixty (60) day after the date on which the Overpayment was Identified; or (ii) the date any corresponding cost report is due, if applicable.

Notwithstanding the foregoing, reporting and refunding of any Overpayment that is routinely reconciled with or adjusted pursuant to written payer policies and procedures shall be handled in accordance with such policies and procedures.

V. PROCEDURE:

A. Reporting and Returning Overpayments to the Payer

1. Except as described in Section A.2 below, refunding of Overpayments shall be done through claims adjustments, credit balance, self-reported refunds, or other reporting processes set forth by the applicable payer to report an overpayment. To the extent an Overpayment is calculated through the use of a statistical sampling methodology, the methodology must be described in the report. For all payers, the Tenet Facility's report shall include the information required by Attachment A, the Overpayment Refund Form. The Chief Compliance Officer or designee shall notify the payer, in writing, of any:

   a. Substantial Overpayment;

   b. Matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;

   c. The employment of or contracting with an ineligible person;

   d. Any other overpayment determined to be material by Regulatory Counsel and Compliance Officer as reportable.

2. To the extent a Tenet Entity is subject to a Corporate Integrity Agreement, Chief Compliance Officer or designee will evaluate all non-routine overpayments for potential reporting to Federal Health Care Program payors under the requirement to report all substantial overpayments.

3. Alternatively, a Tenet Facility may satisfy its refund obligations by making a disclosure under the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol and entering into a settlement in the respective protocol. A determination to proceed with protocol submission must be made at the direction of Tenet Regulatory Counsel.

B. Internal Reporting and Tracking of Overpayments

1. All Non-Routine Overpayments shall be tracked and reported through the Overpayment Approval Process as described in Attachment B.

VI. 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 performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. ATTACHMENTS:

- COMP-RCC 4.35A Overpayment Refund Form (Attachment A) (DTR)

- Attachment B - Compliance Related Overpayment Approval Process

Attachment B
Compliance Related Overpayment Approval Process