

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Correction of Errors Related to Federal and State Healthcare Program FFS Reimbursement
PAGE: 1 of 3	REPLACES POLICY DATED:
EFFECTIVE DATE: January 1, 2017	REFERENCE NUMBER: REGS.GEN.015
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated facilities, including, but not limited to, hospitals, ambulatory surgery centers, home health centers, home health agencies, physician practices, outpatient imaging centers, freestanding radiation oncology centers, service centers, transfer centers, HealthTrust Workforce Solutions, joint ventures and all Corporate Departments, Groups, Divisions and Markets.

PURPOSE: To establish a process to (1) report and return identified and quantified overpayments from Federal healthcare programs, and (2) collect underpayments due to the Company from Federal healthcare programs.

POLICY: The Company will exercise reasonable diligence to review potential payment errors. Potential overpayments will be identified and quantified in a timely manner. Overpayments that have been identified and quantified will be reported and refunded to the appropriate Federal healthcare program within 30 days, when practicable, but in no event later than 60 days from the date of identification and quantification of the overpayment. Cost report overpayments will be handled as outlined in Company policy RB.009 – Reporting of Cost Report Overpayments. The Company will report errors that require collection of underpayments to the appropriate Federal healthcare program in a timely manner.

DEFINITIONS:

Federal healthcare program: 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 (other than the health insurance program under chapter 89 of title 5 of the United States Code — the Federal Employees Health Benefit Program); or any State health care program, as defined in 42 U.S.C. § 1320a-7(h).

Federal healthcare programs include, at a minimum, the following:

- Medicare Program, Parts A & B (Title XVIII of the Social Security Act); (but not Medicare managed care plans)
- Medicaid (Title XIX of the Social Security Act); (but not Medicaid managed care plans)
- Federal Prison Hospitals (prisoners);
- Indian Health Service;
- OWCP (workers' compensation for federal employees);
- Public Health Service;
- Railroad Retirement Board;
- The Black Lung Program;
- TRICARE/CHAMPUS/Department of Defense healthcare programs (Chapter 55 of Title 10, United States Code); and
- Veterans Administration (VA).

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Identified: The date on which the Company has or should have determined, through the exercise of reasonable diligence, that an overpayment has been received from a Federal healthcare program, and has quantified the overpayment amount.

Overpayment: Any funds that the Company has received or retained under a Federal healthcare program to which the Company, after applicable reconciliation, is not entitled.

Reasonable Diligence: In response to obtaining credible information of a potential overpayment, conducting both proactive compliance activities in good faith by qualified individuals at Company to monitor for the receipt of overpayments; and research in good faith and in a timely manner by qualified individuals at the Company. Company efforts to review, report and return a potential overpayment should typically be completed within a period of up to eight months (six months for the timely review and up to two months for reporting and returning the identified and quantified overpayment). However, complex matters and refund calculations may result in extending this time frame.

PROCEDURE:

1. Anyone who has credible information about a pattern of potential overpayments from a Federal healthcare program must report the information to (i) a supervisor or member of management, (ii) the Facility/ Shared Service Center Ethics and Compliance Officer (ECO), and/or (iii) the Ethics Line. This notification should include a narrative description of the matter based on current knowledge, with as much specificity as possible, to assist in further review. For example, a detailed description of the issue, the type of service (inpatient, outpatient, hospital, physician, etc.), and the affected service line(s) (e.g., radiology, oncology, lab, etc.). Generally, isolated clerical errors, unintended patient specific coding/charging/billing errors, or any other non-repetitive errors (*i.e.*, errors that only affect a single claim or handful of claims) resulting in an overpayment should be dealt with in the ordinary course of business and shall be refunded within 60 days.
2. The person to whom the report is made will be responsible for submitting the issue to the Regs Helpline at <http://trinisys.app.medcity.net/regshelpline> (with a copy to the applicable Facility/ Shared Service Center ECO), within three (3) business days of when the matter was first raised.
3. Regulatory Compliance Support (Regs) personnel, along with the appropriate personnel with operational responsibility for the areas involved, will engage in, or facilitate, the exercise of reasonable diligence, including conducting a review into matters at issue.
4. Based upon the findings of the reasonable diligence, Regs will consult, as necessary and appropriate, with responsible operators, Legal, Ethics & Compliance, Parallon, and other relevant parties with substantive knowledge of the

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issue, to determine if an overpayment has been identified. This would include a determination as to the initial matter and the appropriate timeframe to be addressed.

5. If an overpayment is identified:
 - a. Regs will take prompt action to (i) notify the appropriate personnel with operational responsibility for the impacted claims of the overpayment amount, and (ii) coordinate with such personnel regarding the method for reporting and returning the overpayment.
 - b. Management of the areas with operational responsibility will correct the cause of the overpayment on a going forward basis and take other remedial actions as may be necessary to minimize recurrence. In addition, other appropriate corrective actions should be undertaken, which may include education and training of staff, revisions to policies, processes or systems, information system changes, ongoing monitoring and auditing, disciplinary actions for personnel consistent with Company policies and procedures.

6. The appropriate personnel with operational responsibility will work within their respective organization to ensure that the overpayment will be timely reported and returned within 30 days, when practicable, but in no event later than 60 days from the date of identification and quantification. Depending on the situation, the refund may be made by check, claims adjustment, charge correction, credit balance or other government-approved process for reporting and returning of overpayments.

7. All other Company reviews or audits (e.g., Revenue Integrity, Coding Reviews, and Internal Audit OPPS) must have processes to ensure that identified and quantified overpayments are reported and returned within 30 days, when practicable, but in no event later than 60 days from the date of identification and quantification, and that any patterns of potential billing errors are referred to the Regs Helpline.

8. If an underpayment error is identified, the Company may request additional payment, as permissible.

REFERENCES:

1. Medicare Program: Reporting and Returning Overpayment Final Rule, February 12, 2016
2. Reporting Compliance Issues and Occurrences to the Corporate Office – [EC.025](#)