	Regulatory Compliance Policy	No.	COMP-RCC 4.33
	Title:	Page:	1 of 3
	COMPLIANCE WITH FEDERAL HEALTH CARE CLAIMS AND COST REPORTING REQUIREMENTS	Effective Date:	09-27-11
		Previous Versions Dated:	08-01-08
		Corporate Review Dated:	07-17-19

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned 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 establish minimum requirements for ensuring accuracy in coding and submission of claims and cost reports to Federal health care programs. Additional requirements for particular types of claims may be set forth in other Tenet policies.

III. DEFINITIONS:

A. "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, 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 (PCIP) and Section 1011 Requests.

B. "Overpayment" means the amount of money Tenet has received in excess of the amount due and payable under any Federal health care program requirements, including applicable federal statutes, regulations, Medicare or other federal health care program payment manuals or Medicare Administrative Contractor Local Coverage Decisions. An Overpayment may be the result of non-adherence to Federal health care program requirements, errors by Tenet personnel, payment processing errors by the payer, or erroneous or incomplete information provided to Tenet by the patient or responsible party.

IV. POLICY:

A. Every Tenet Facility shall have processes and procedures to ensure that claims and/or cost report-related information that will be submitted to Federal health care programs are complete, accurate, reflect reasonable and necessary services, and comply with Federal health care program requirements. The relevant Federal

health care program requirements include, but are but not limited to, applicable federal statutes, regulations, Medicare or other Federal health care program payment manuals, or Medicare Administrative Contractor Local Coverage Decisions, and the National Correct Coding Initiative. Under no circumstances will claims or cost reports be coded, developed or submitted for the purpose of circumventing the Federal health care program regulations related to such claims or costs reports.

B. Claims and cost reports should be submitted only when appropriate documentation (including the medical record) is complete, accurate, and supports the claims or cost reports. Underlying data and assumptions used in connection with claims and cost report submission should be reasonable, consistent, and appropriately documented. Tenet Facilities should retain all relevant records supporting claims and cost reports and reflecting their efforts to comply with Federal health care program requirements in accordance with Administrative Policy AD 1.11, Records Management. Such documentation must also be available for audit and review.

C. Tenet, through the Audit Services, Ethics and Compliance and Quality Managements Departments, as well as Tenet Facility-based chart auditors, will periodically audit the claims. Such reviews would include, but not be limited to, charge description master, coding and use of modifiers. . Tenet Audit Services will audit internal processes related to the accuracy, completeness, and timeliness of financial reporting by Government Programs. Any Overpayments discovered will be handled in accordance with Regulatory Compliance Policy COMP-RCC 4.35, Reporting of Overpayments to Federal Health Care Programs.

D. Responsible Person

Each Tenet Facility Chief Financial Officer shall be responsible for assuring that all personnel adhere to the requirements of this policy that these procedures are implemented and followed at the Facility, and that instances of noncompliance with this policy are reported to the Hospital Compliance Officer.

E. Auditing and Monitoring

Tenet's Audit Services Department shall audit adherence to this policy.

F. 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.

V. REFERENCES:

- Administrative Policy AD 1.11, Records Management

- Regulatory Compliance Policy COMP-RCC 4.35, Reporting of Overpayments to Federal Health Care Programs

- OIG's Compliance Program Guidance for Hospitals (63 FR 8987; February 23, 1998)

- OIG's Supplemental Compliance Program Guidance for Hospitals (70 FR 4858; January 27, 2005)