DEPARTMENT: Regulatory Compliance Support	**PROCESS DESCRIPTION:** Refunds for Medically Unnecessary Services for Federal Payers
PAGE: 1 of 2	**REPLACES PROCESS DATED:** 1/1/13
EFFECTIVE DATE: May 1, 2019	**REFERENCE NUMBER:** REGS.GEN.012
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: Company-affiliated hospitals, Corporate departments, and Parallon Business Performance Group (PBPG), specifically:

Hospital Administration, Hospital Clinical Quality/Performance Improvement, Medical Director, Medical Staff Office, Clinical Services Group (CSG), Physician Services Group (PSG), Regulatory Compliance Support (Regs), Legal, PBPG Corporate, and Parallon Shared Services Centers (SSCs)

PURPOSE: To specify a process for making refunds to federally-funded payers for services that are determined to be medically unnecessary.

POLICY: After a claim has been paid, when a determination has been made that a service provided to a patient is not medically necessary, the appropriate refund will be made to any federally-funded payer. A written summary of the services determined to be medically unnecessary will be forwarded to the Corporate Regulatory Compliance Support (Regs) department. Regs will review the summary, calculate the refund amount, and communicate refund instructions to the applicable Shared Services Center (SSC). Following the Procedure below, the SSC will confirm to Regs that the applicable refunds have been made within the 30-day guideline.

DEFINITIONS:

Federally-funded payers – Medicare Fee-for-Service (Medicare FFS), TRICARE and Medicaid.

Medically necessary/medical necessity/reasonable and necessary – for purposes of this policy, these terms will be considered interchangeable. Medicare pays for items and services that are considered "reasonable and necessary" for the treatment of a disease or condition. However, Medicare does not provide a definition of "reasonable and necessary," nor does it provide a list of services that are "medically necessary." Instead, the determination of reasonable and necessary care is typically based on:

- accepted standards of medical practice and the medical circumstances of the individual patient as determined by that patient's physicians/practitioners,
- Federal and state laws, and when applicable,
- National and Local Coverage Determinations (NCDs/LCDs) – Medicare decisions that generally describe the criteria and coverage limitations that apply to particular services, procedures or devices for coverage and payment purposes. See the Medicare – National and Local Coverage Determinations Policy, REGS.GEN.011.

PROCEDURE: When Regs receives the determination that the service was not medically necessary, the following steps will be taken:

1. Regs will organize the review results and determinations by patient and payer.

DEPARTMENT: Regulatory Compliance Support	**PROCESS DESCRIPTION:** Refunds for Medically Unnecessary Services for Federal Payers
PAGE: 2 of 2	**REPLACES PROCESS DATED:** 1/1/13
EFFECTIVE DATE: May 1, 2019	**REFERENCE NUMBER:** REGS.GEN.012
APPROVED BY: Ethics and Compliance Policy Committee	

2. Regs will identify cases with federal-funded payer financial classes with a determination that the items/services were not medically necessary.
3. For those cases with a final determination of medically unnecessary services, Regs will determine the refund due.
4. Regs will provide a list of the patient(s), the revised billing information, including the estimated refund amount to the SSC. Regs will also provide any relevant rebilling guidance and instruction.
5. The SSC will rebill the claims as instructed by Regs. The SSC shall contact Regs if they question and/or disagree with Regs as to how the claim should be rebilled. The SSC shall also contact Regs if the federally-funded payer will not allow an account to be rebilled through the normal claims reprocessing process. Regs will work with the SSC to process the refund according to the payer's direction.
6. The SSC will validate the rebilling of the claim and provide Regs with confirmation of the rebilled amount and date.
7. Regs will notify the hospital, Legal and CSG of the final determinations and refunds.
8. Regs will maintain a file of all results, determinations and refunds.

REFERENCES:

1. SSA § 1862 (a)(1)(A)
2. Medicare Medical National Coverage Determination Manual 100-03
3. Medicare Program Integrity Manual 100-08, Chapter 13, Local Coverage Determinations
4. HCA Healthcare Policy: Correction of Errors Related to Federal and State Healthcare Program FFS Reimbursement, REGS.GEN.015
5. Parallon Policy: Claim Reprocessing Tool Requirements for Tracking Compliance Rebills/Refunds, PARA.PP.COMP.013
6. HCA Healthcare Policy: Medicare – National and Local Coverage Determinations Policy, REGS.GEN.011