DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Responding to Governmental Requests for Hospital Claims Reviews or Surveys
PAGE: 1 of 3	**REPLACES POLICY:** 7/1/13, 6/1/14, 1/1/18, 2/1/19, 2/1/20, 12/1/21
EFFECTIVE DATE: July 1, 2024	**REFERENCE NUMBER:** REGS.GEN.013
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated hospitals, Shared Services Centers (SSC), and the Medicare Service Center (MSC). The scope of this policy does not apply to Physician Services Group or ASCs (reference REGS.OSG.012), Home Health/Hospice Agencies (reference REGS.HHA.002), Recovery Audit Contractor (RAC) reviews, Medicare Advantage, Managed Medicaid, other 'Commercial' Managed Care plans or reviews for non-HCA Healthcare facilities.

PURPOSE: To establish a consistent process for handling external claim reviews, Comparative Billing Reports (CBRs), and/or surveys conducted by a governmental entity or its agent. The notification of a claim review can originate from, but is not limited to, the Office of Inspector General (OIG), Unified Program Integrity Contractor (UPIC), the Centers for Medicare and Medicaid Services (CMS) and its contractors, a State Medicaid Agency, or a company contracted by the governmental entity to perform the review. The facility's legal operations counsel should immediately be notified and sent a copy of any request or subpoena from the Department of Justice (DOJ).

POLICY: Each entity is required to submit governmental requests for claim reviews, Comparative Billing Reports or surveys to the Regs Helpline as outlined in the Governmental Entity Review Matrix. The matrix outlines the most common types of requests and the various actions entities must take in response to the request. The requests are categorized into three priorities:

Priority 1: Those review requests that must be submitted to the Regs Helpline and await Regs guidance before proceeding. Regs will provide guidance upon receipt of the request and approve the response before submission. These agencies are typically the UPIC and OIG Federal reviews.

Priority 2: Those review requests that must be submitted to the Regs Helpline for notification but do not require action from Regs before proceeding with the request. For these reviews, Regs will acknowledge receipt of the notification and instruct the entity to proceed with the request. The entity submitting the request to the Regs Helpline will receive a checklist to use in completing the review. A call may be requested if additional guidance is needed.

Priority 3: Those reviews that are not required to be submitted to the Regs Helpline. For these requests, the entity submitting the request to the Regs Helpline may proceed with submission of requested information without contacting Regs for guidance or review.

Common Review Types:

Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO): offers information regarding beneficiary complaints, hospital discharge and skilled service termination appeals, and Immediate Advocacy. Also serves as CMS review contractor for short stay reviews and higher-weighted DRG reviews.

Comparative Billing Reports (CBRs): disseminated to the Medicare provider community to provide insight into Medicare policy and regional billing trends.

HCA Healthcare

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Comprehensive Error Rate Testing Contractor (CERT): collects documentation and performs reviews on statistically valid random samples of Medicare Fee for Service (FFS) claims to produce an annual improper payment rate.

Medicaid Integrity Program (MIP): reviews to prevent and reduce provider fraud, waste, and abuse in the Medicaid program.

Office of Inspector General (OIG): provides oversight of the Medicare and Medicaid program and conducts reviews to improve these programs and prevent or detect fraud, waste, or abuse.

Payment Error Rate Measurement (PERM): measures improper payments in Medicaid and CHIP and produces error rates for each program.

Targeted Probe and Educate (TPE): a MAC review of a small sample of claims conducted to determine if a provider-specific billing error exists. Probes can be conducted prepayment or post-payment.

Quality Improvement Organization (QIO): monitors the appropriateness, effectiveness, and quality of care provided to Medicare patients.

Supplemental Medical Review Contractor (SMRC): conducts medical review of Medicare Part A and B claims to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices.

Unified Program Integrity Contractor (UPIC): performs Medicare and Medicaid program integrity reviews, including the identification of suspected fraud, waste and abuse.

PROCEDURE:

For all Priority 1 and Priority 2:

1. The Facility and/or the SSC must notify the Ethics and Compliance Officers (ECOs) at both the facility and the SSC of receipt of a letter for a claim review.
2. ECOs must notify other senior leaders, such as the CFO or CEO, as appropriate.
3. ECO must immediately submit the request to the Regs Helpline.
4. Facility/SSC should follow the Governmental Entity Review Matrix, checklist and other direction provided by Regs which includes:
   a) Proceed with gathering requested documents.
   b) Only provide documentation related to the specific line item(s) or issue requested by the governmental entity.
   c) Ensure all requested information included in the notification received from the governmental entity is included in the records.
   d) If a facility is unable to meet the records submission deadline, contact the governmental entity and ask for an extension.
   e) Follow the specific instructions provided by a governmental entity such as completing a medical record and/or claims review. The instructions may include submitting a corrected

claim, providing a response letter, or documenting root cause and corrective action.

5. The facility ECO is responsible for tracking Governmental Entity Reviews and providing a quarterly report to the Facility Ethics and Compliance Committee.

Additional Guidance for **Priority 1 Reviews:**

Regs will:
- Provide guidance on responding to Priority 1 reviews;
- Determine, in conjunction with the facility if an extension is necessary;
- Determine if assistance from legal counsel is necessary;
- Review all submissions for Priority 1 reviews;
- Review the results received from Priority 1 reviews and advise the facility as to next steps;
- Follow the progress of the review through to final resolution;
- Develop education or system enhancements based on review results; and
- Submit a quarterly report to senior management for reviews where extrapolation may be involved.

The facility and/or SSC will:
- Notify Regs immediately upon receipt of a request;
- Respond to the request according to directions provided by Regs;
- Notify Regs when the results are received; and
- Complete any action steps, including any rebills or appeals, as directed by Regs.

REFERENCES:

1. Governmental Entity Review Matrix
2. Reporting Compliance Issues and Occurrences to the Corporate Office Policy, EC.025
3. Claim Reprocessing Tool Requirements for Tracking Compliance Rebills/Refunds Policy, PARA.PP.COMP.013
4. Medicare Program Integrity Manual Chapter 4
5. Responding to Governmental Requests for Non-Hospital Entities Claims Reviews or Surveys Policy, REGS.OSG.012
6. Responding to Governmental Requests for Home Health or Hospice Agencies Claims Reviews or Surveys, REGS.HHA.002