TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
Office of Institutional Compliance

Texas Tech University Health Sciences Center El Paso
Billing Compliance Procedure

Policy: Billing Compliance Advisory Committee (BCAC) Reports Pro	
Approved Date: November 9, 2015	**Effective Date:** November 9, 2015
TTUHSC El Paso Billing Compliance Website: http://elpaso.ttuhsc.edu/compliance/BillingCompliance/	

Procedure Statement

The purpose of this procedure is to outline the reports produced for presentation at the Billing Compliance Advisory Committee (BCAC) meeting.

Procedure

1. The Director of Billing Compliance chairs the BCAC meeting, and is responsible to assure that the following documents are compiled and placed in presentation state prior to the BCAC meeting.

2. Upon the close of the quarterly audits, the compilation of reports will begin, in order to ensure that there is adequate time to prepare the documentation and to double check the data for accuracy. The audit close will be three weeks prior to the BCAC meeting.

3. The reports will be stored in a shared folder for the BCAC meeting members, and will be compiled into an online presentation for the meeting.

4. The following documents will be created by service line and stored in the shared folder folders labeled by each service line's name; e.g. Internal Medicine, etc.

5. The following documents will be compiled for the service line audited during the quarter.
   a. The MD Audit Combined Provider Summary
      i. This report details the department score as well as the individual provider scores

   b. The Percent Of Error Billing Error Based On Dollar Amount Report
      i. This report is compiled by compliance office staff and is based on the MD Audit Payment Report (exported in an excel format)
      ii. Under coded accounts represent a business risk for the organization and results in a loss of revenue
      iii. Over coded accounts represent a regulatory risk to the organization as we have inappropriately billed the payor and must refund monies within the 60 day window as described by the Affordable Care Act
      iv. Providers that over code between 10% and 14.99% will be highlighted in yellow as this is approaching the mark where the provider will be re-audited during the next quarter
      v. Providers that over code 15% or more will be highlighted in red and will be re-audited during the next quarter
      vi. This report will be produced in a separate format that will allow training of provider audits as well as YTD results for each service line

c. The MD Audit Refund/Rebill Report (exported in an PDF format)
   i. This report provides detailed reasons concerning the overpayment or underpayment and identifies the accounts by provider

d. The MD Audit Combined Audit Transactions Worksheet will be by service line and stored in the BCAC Shared File for committee members to view
   i. This report highlights codes changed by the auditor.

Service chair and service administrator or report distribution:

1. At the conclusion of the BCAC meeting the following documents will be compiled and distributed to the Service Line Chairs and the Service Line Administrators

2. The documents will be distributed in hard copy format to the appropriate departments and will require a signature of the person accepting the documents on behalf of the Service Line Chairs and the Service Line Administrator

3. The BCAC Chair will schedule a follow-up meeting with the Service Line Chair and the Service Line Administrator to review the hardcopy documents

4. The distribution shall include the following:

   a. The MD Audit Combined Provider Summary

      i. This report details the department score as well as the individual provider scores

   b. The Percent Of Billing Error Based On Dollar Amount Report

      i. This report is compiled by compliance office staff and is based on the MD Audit Payment Report (exported in an excel format)

      ii. Under coded accounts represent a business risk for the organization and results in a loss of revenue

      iii. Over coded accounts represent a regulatory risk to the organization as we have inappropriately billed the payor and must refund monies within the 60 day window as described by the Affordable Care Act

      iv. Providers that over code between 10% and 14.99% will be highlighted in yellow as this is approaching the mark where the provider will be re-audited during the next quarter

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vi. This report will be produced in a separate format that will allow training of provider audits as well as YTD results for each service line

c. The MD Audit Refund/Rebill Report (exported in an PDF format)

i. This report provides detailed reasons concerning the overpayment or underpayment and identifies the accounts by provider.

Frequency of Review

This policy shall be reviewed no later than November in each odd-numbered year.

Review Date: November 2015

Revision Date: