# TRI-CITY HEALTHCARE DISTRICT
# AGENDA FOR A REGULAR MEETING
# OF THE AUDIT, COMPLIANCE AND ETHICS COMMITTEE
## July 26, 2018
## 8:30 a.m. – 10:30 a.m.
## Assembly Rm. 1
## Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

**The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"**

| | Agenda Item | Time Allotted | Action/ Recommendatio | Requestor/ Presenter |
|---|---|---|---|---|
| 1. | Call to order/Introduction of Scott Livingston, Interim Chief Compliance Officer | 5 min. | | Chair |
| 2. | Approval of Agenda | 2 min. | | Chair |
| 3. | Public Comments – Announcement<br>Comments may be made at this time by members of the public and Committee members on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee.<br>NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item. | 1 min. | | Standard |
| 4. | Ratification of Minutes- April 19, 2018 | 3 min. | Action | Chair |
| 5. | Old Business – None | -- | -- | -- |
| 6. | New Business – **Discussion and Possible Action**<br><br>A) Fiscal 2018 Financial Statement Audit Entrance – Moss Adams<br><br>B) Administrative Policies & Procedures:<br>1) 8610-262 – Ethics in Provision of Services<br><br>2) 8610-596 – Identify Theft (Red Flag Rules) | <br><br>30 min<br><br>10 min. | <br><br>Information Only<br><br>Action | <br><br>CFO/Moss Adams<br><br>CCO |
| 7. | Motion to go into Closed Session | | | |
| 8. | Closed Session | | | |
| | a) Approval of Audit, Compliance & Ethics Closed Session Minutes of April 19, 2018<br>(Authority: Government Code Section 54957.2) | 5 min. | Action | Chair |
| | b) Conference with Legal Counsel – Potential Litigation<br>(Authority: Government Code, Section 54956.9(d) 2 (2 Matters) | 30 | Information | Chair |
| 9. | Motion to go into open session | | | |

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|---|---|---|---|---|
| 10. | Open Session | | | |
| 11. | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1). | 1 min. | | |
| 12. | Committee Communications | 5 min. | | All |
| 13. | Date of Next Meeting: September 20, 2018 | 1 min. | | Chair |
| 14. | Adjournment | | | Chair |
| 15. | Total Time Budgeted for Meeting | 1.5 hours | | |

*Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.*

*Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.*

**Tri-City Medical Center**
**Audit, Compliance & Ethics Committee**
**April 19, 2018**
**Assembly Room 1**
**8:30 a.m-10:30 a. m.**

| | |
|---|---|
| **Members Present:** | Director Larry W. Schallock(Chair); Director James Dagostino; Director Julie Nygaard; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member |
| **Non-Voting Members**: | Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO; Carlos Cruz, CCO |
| **Others Present:**, | Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Contract Analyst – Paralegal; Patricia Guerra, Education Specialist |
| **Absent:** | Cary Mells, M.D.; Physician Member; Susan Bond, General Counsel; Faith Devine, Community Member |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to Order | The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. | | |
| 2. Approval of Agenda | **It was moved by Director Dagostino and seconded by Director Nygaard to approve the agenda as presented. The motion passed unanimously.** | **Agenda approved.** | |
| 3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item | There were no public comments. | | |
| 4. Ratification of minutes – January 18, 2018 | **It was moved by Mr. Leslie Schwartz and seconded Director Dagostino to approve the minutes of January 18, 2018, as presented. The motion passed unanimously.** | **Minutes ratified.** | |
| 5. Old Business<br>a) Discussion regarding FY2018 Financial Statement Audit Proposal | Mr. Ray Rivas, CFO reported at the committee's last meeting he was directed to obtain a proposal from Moss Adams to conduct the FY2018 Financial Statement Audit and if they came back with little to no increase the | **Recommendation to be sent to the Board of Directors to approve the Fiscal Year 2018 Financial** | Mr. Rivas |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | committee would consider engaging them to perform the Audit. Mr. Rivas reviewed the fees which reflected an overall decrease from FY2017 of $3,500. Discussion was held regarding the Single Audit Report which is a requirement of the HUD loan. Mr. Dietlin stated there is some work involved in preparing the Single Audit and Moss Adams must also attest to its validity. It was noted that there was a switch in audit partners last year and it is a good practice to rotate auditors every few years.<br><br>**It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to recommend approval of the FY2018 Financial Statement Audit Proposal as presented. The motion passed unanimously.** | **Statement Audit Proposal as presented.** | |
| 6. New Business<br><br>a) Administrative Policies & Procedures:<br><br>1) Fraud Recognition Response #395<br>2) Hospital Issued Notice of Non-coverage of Medicare-Covered Services (HINN) #398<br>3) Important Message from Medicare & Notification of Hospital Discharge Appeal Rights - #392<br>4) Medical Directorships - #572<br>5) Monitoring Compliance – Auditing & Reporting – Annual Compliance Work Plan - #552<br>6) Monitoring Compliance Auditing & Reporting – Compliance Reviews and Audits - #553<br>7) Physician & Allied Health Professional Service Contracts - #580<br>8) Sales of Items or Services to | 1) With regard to the Fraud Recognition Response policy it was recommended that the acronym HIM (Health Information Management) be spelled out for clarity. It was also suggested the 8610 policy prefix be struck throughout for consistency.<br><br>Discussion was held regarding the fact that Mr. Cruz is both the Compliance Officer and Privacy Officer and whether language in the policy should be amended to reflect that. Mr. Dietlin suggested the language in the policy remain as written as it creates flexibility for administrative changes in title and role as necessary.<br><br>2) There were no modifications to the Hospital Issued Notice of Non-Coverage of Medicare Covered Services policy.<br><br>3) There were no modifications to the Important Message from Medicare & Notification of Hospital Discharge Appeal | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| Physicians and Other Potential Referral Sources - #575 | Rights policy.<br><br>4) and 7) The Medical Directorships policy and Physician & Allied Health Professional Service Contracts policy were discussed simultaneously. Mr. Schwartz questioned the need for two separate policies. Mr. Cruz explained that the agreements for a Medical Directorship and Physician Contract are two different types of agreements. Mr. Livingstone noted it is possible that one physician could have both a Medical Directorship agreement and a Physician contract. Director Nygaard questioned if there is a mechanism in place to evaluate the results of the Directorships. Mr. Livingstone stated there is an evaluation tool that is being rolled out. Director Dagostino questioned if the physician needs to be on staff to serve as a Medical Director. Mr. Livingstone confirmed the physician must be on staff which is identified in the Medical Staff Bylaws.<br><br>5) and 6) The Monitoring Compliance – Auditing & Reporting – Annual Compliance Work Plan and Monitoring Compliance Auditing & Reporting – Compliance Reviews and Audits policy were rolled into one policy and describes the role of the Chief Compliance Officer.<br><br>8) Ms. Fitzwilliam requested clarification on what types of items are considered in the Sales of Items or Services to Physicians and Other Potential Referral Sources policy. Mr. Livingstone stated older type equipment that the hospital owns and is replacing would be an example. It was recommended that E. Procedure 8. be amended to read "The Audit, Compliance and Ethics Committee will oversee compliance with this policy." A typo was noted on page 48 (strike the duplicate phrase "any other").<br><br>**It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to recommend approval of the Administrative Policies & Procedures with amendments as described. The motion passed unanimously.** | **Recommendation to be sent to the Board of Directors to approve Administrative Policies with amendments as described; items to be added** | Ms. Donnellan |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | *Ms. Guerra left the meeting at 9:00 a.m.* | **to Board Agenda and included in agenda packet.** | |
| b) Chief Compliance Officer Report<br>1) Dashboard Update<br>2) Work Plan Update<br>3) Government Audit Trends | Mr. Carlos Cruz, CCO presented a Compliance Program report reviewing the following:<br><br>➢ Compliance Program Marketing<br>• "Meet and Greets" with Departments<br>• Staff Rounding<br>• Values Line Business Cards that include the five principles RIGHT.<br>• Newsletter on the five W's of the Compliance Program which provides a summary of what the compliance program is all about.<br><br>Mr. Cruz reported he recently attended and spoke at the Healthcare Compliance Association Institute in which nearly 3,000 people participated including staff from the Office of Inspector General, Centers for Medicare and Medicaid Services and Department of Justice.<br><br>Mr. Cruz discussed the National Compliance Trends as follows:<br><br>➢ CMS reviewed over 1 billion claim for proper reimbursement<br>➢ Large return on investment<br>• FY2016: $3.3 billion in payment recoveries<br>• FY2017: $2.6 billion in payment recoveries<br>➢ Opioid Fraud and Abuse<br>➢ Stark Law/Anti-Kickback Statute<br>➢ EHR related Fraud and Abuse (Meaningful Use Attestations)<br>➢ Telehealth & Telemedicine.<br><br>Ms. Fitzwilliam questioned how contracted staff is educated on compliance. Mr. Cruz stated vendors are required to follow our policies and procedures and are held to the same standard as an employee. | **Information Only.** | Ms. Donnellan |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | There was extensive discussion on Opioid use and steps the hospital is taking to monitor Opioid fraud and abuse. Mr. Cruz stated monthly audits are performed and we are working diligently with the Pyxis system, ensuring the system is locked down following use.<br><br>Mr. Cruz discussed the TCHD Compliance Program Dashboard which mirrors the plan and follows the "Seven Elements of an Effective Compliance Program" as follows:<br><br>1. Policies & Procedures<br>2. Standards of Conduct<br>3. Training and Education<br>4. Open Lines of Communication<br>5. Enforcement<br>6. Internal Auditing and Monitoring<br>7. Prompt Response<br><br>Lastly, Mr. Cruz provided a summary of the FY2018/19 Work Plan's Key Focus Areas as follows:<br><br>1. Compliance Office Structure<br>2. Compliance Program Marketing<br>3. Compliance Program Oversight<br>4. Compliance Policies & Procedures<br>5. Compliance Training and Education<br>6. Auditing and Monitoring<br>7. Open Lines of Communication<br>8. HIPAA Privacy and Security<br>9. Operational Support<br><br>Chairman Schallock complemented Mr. Cruz on his thorough and professional presentation. | | |
| 7. Motion to go into Closed Session | **It was moved by Ms. Fitzwilliam and seconded by Director Dagostino to go into closed session at 9:30 a.m. The motion passed unanimously.** | | |
| 11. Open Session | The committee returned to open session at 9:45 a.m. with | | |

| | Discussion | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | attendance as previously noted. | | |
| 12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1) | Chairperson Schallock reported no action was taken in closed session. | | |
| 13. Comments from Committee Members | There were no comments from members of the committee. | | |
| 14. Committee Openings | There are no committee openings. | **None** | |
| 15. Date of Next Meeting | Chairman Schallock recommended the May meeting be cancelled and the primary focus of the July 19th meeting would be the Audit Entrance Report by Moss Adams. | **The Committee's next meeting is scheduled for July 19, 2018.** | |
| 16. Adjournment | Chairman Schallock adjourned the meeting at 9:50 a.m. | | |

# AUDIT COMPLIANCE AND ETHICS COMMITTEE
## July 26, 2018

| Administrative Policies & Procedures | Policy # | Reason | Recommendations |
|---|---|---|---|
| 1. Ethics in Provision of Services | 262 | 3 year review, practice change | |
| 2. Identity Theft (Red Flag Rules) | 596 | 3 year review, practice change | |

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~

**ISSUE DATE: 7/97** **SUBJECT: ETHICS IN PROVISION OF SERVICES**

**REVISION DATE: 4/00; 5/02; 12/02, 12/03, 6/09, 05/12** **POLICY NUMBER: 8610-262**

| | |
|---|---|
| **Department Approval:** | **03/18** |
| **Administrative Policies & Procedures Committee Approval:** | **~~09/15~~04/18** |
| **Organizational Compliance Committee Approval Date(s)** | **04/18** |
| **Medical Executive Committee Approval Date(s):** | **05/18** |
| **Audit, Ethics and Compliance Committee Approval:** | **10/15** |
| **Board of Directors Approval:** | **10/15** |

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD) recognizes its responsibility to create a workplace culture based on ethical principles and to use those principles as a guide in determining how best to serve the needs of its patients and the community it serves. TCHD relies on its mission, values and philosophy statement, strategic plan, Code of Conduct, Compliance Plan and other guiding documents to provide a consistent, ethical framework for its business services and patient care operations.

B. **DEFINITIONS:**

| Ethical Tenet | Right | Responsibility |
|---|---|---|
| Beneficence Accountability | To respectful care | Advocacy |
| Autonomy | To Self-determination (To Privacy/Confidentiality) | Informed consent |
| Veracity Patient teaching | To truthful information | Informed consent |
| Justice | To Equal consideration for treatment | Collaboration to meet needs alternative choices |
| Fidelity | To deliver the care that is indicated/ordered | Competency/ Credentialing/ Appropriate services |

C. **POLICY:**

1. It is the basic responsibility of employees, medical staff and others to work cooperatively. To provide optimum patient care, proper functioning of the healthcare team, and efficient management of business. Employees will conduct themselves utilizing the tenets included in the TCHD Mission and Value statements and Code of Conduct in the performance of their duties and their interactions with others. It is also the expectation that employees will fully demonstrate and model the Professional Code of Ethics established by their professional organization or licensing body.
2. Supply contracts are approved or rejected based on best-value practices and the potential for **actual or the appearance of** conflicts of interest.
3. TCHD is committed to truth in advertising.
4. Patients with emergencies are treated without regard for ability to pay. The rights of all patients are valued without regard to race, color, creed/religion, sex, and national origin/ancestry.
5. Services are provided in a considerate and respectful manner, with regard to privacy and age specific needs allowing for expressions of personal values and beliefs as long as these do not jeopardize the safety or well-being of others. **Patient information will be accessed or disclosed only as permitted by law.**

6. Billing practices **and policies** have been developed so that customers are billed only for those services and care provided; bills include dates of service and itemized charges. Billing is based on **accurate, timely and complete records that** ~~appropriate~~ **meet** regulatory and other accepted standards.
7. Media policies and procedures have been established to ensure that patient rights and privacy are protected. At no time will any member of news media be allowed to obtain any type of information (verbal or written), without prior authorization from the Director of Marketing and Communications, **or designee. Employees should never give the impression that they are speaking on behalf of TCHD in any communication that may become public if they are not authorized to do so.**
8. The hospital's code of ethical business and professional behavior protects the integrity of clinical decision making, regardless of how the hospital compensates or shares financial risk with its leaders, managers, clinical staffs and licensed independent practitioners.

D. **REFERENCES:**

1. Administrative Policy Manual: Accounting of Disclosures of Protected Health Information (PHI) #8610-528
2. Administrative Policy Manual: Advance Health Care Directive #8610-354
3. Administrative Policy Manual: Patient Complaints & Grievances #8610-318
4. Administrative Policy Manual: Use and Disclosure of Protected Health Information: Records #8610-515
- ~~4.~~**5. Administrative Policy Manual: EMTALA: Emergency Medical Screening #8610-506**
- ~~5.~~**6. TCHD** Code of Conduct
- ~~6.~~**7.** Patient Care Services Policy Manual: Patient Rights & Responsibilities #8610-302
- ~~7.~~**8.** Physician Referral Service Protocol
- ~~8.~~**9.** Code of Ethics on the TCMC Intranet

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

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**ISSUE DATE:** 12/08 **SUBJECT:** Identity Theft (Red Flag Rules)

**REVISION DATE(S):** **POLICY NUMBER:** 8610-~~531~~596

| | |
|---|---|
| Department Approval: | 01/18 |
| Administrative Policies & Procedures Committee Approval: | ~~10/08~~01/18 |
| ~~Operations Team Committee Approval:~~ | ~~10/08~~ |
| Medical Executive Committee Approval: | 02/18 |
| Organizational Compliance Committee Approval: | 04/18 |
| Audit, Compliance and Ethics Committee Approval: | |
| ~~Professional Affairs Committee Approval:~~ | ~~11/08~~ |
| Board of Directors Approval: | 12/08 |

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A. **PURPOSE:**

1. To develop an Identity Theft Prevention Program that protects patients by reducing the risk of identity theft by establishing requirements for identifying, investigating and responding to identity theft red flags.~~To protect our patients, reduce risk from identity fraud, and minimize potential damage from fraudulent activities. TCMC is subject to 16 CFR 68.12 "Identify Theft Rules" which requires the hospital to establish an Identify Theft Prevention Program.~~

B. **POLICY:**

1. Tri-City Healthcare District (TCHD) is subject to Identity Theft Rules, 16 C.F.R. §~~section~~ 681, which requires ~~Tri-City Medical Center (TCMCHD)~~ to establish an Identity Theft Prevention Program (ITPP).~~Tri-City Medical Center is committed to the prevention of identity theft by strictly adhering to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.~~ TCHD maintains and administers an ITPP to detect, prevent and mitigate identity theft in connection with new or existing patient accounts.

~~B.~~2. TC~~MC~~HD collects registration and billing information to create patient accounts and/or bill for the provision of healthcare services. Patient accounts are a specific subset of covered accounts. ~~Tri-City Medical Center~~TC~~MC~~HD will address the issues of identity theft including:

   a. Identifying potential red flags that signal identity theft.
   b. Training appropriate staff to recognize and mitigate red flags.
   c. Notifying individuals and local law enforcement if personal information may have been compromised.
   d. Review red flag process routinely to protect against any changes in risk.

C. **DEFINITIONS:**

1. Red Flag: **A pattern, practice, or specific activity that indicates the possible existence of identity theft.** Warning signs of identity theft include but not limited to address discrepancy, name discrepancy, suspicious documents, conflicting personal information, and notice from patients or law enforcement.

~~2.~~D. **PROCEDURE:**

1. ~~1.~~ Verify identification of patient.
   a. Patient's identity should be verified with government issued photo identification **(ID)**. ~~Acceptable If the patient refuses or is unable to provide a photo ID~~

i. **Acceptable** government documentation **includes**:
   1) Passport
   2) Driver's license or equivalent
   3) Military ID
   4) Permanent resident card.

b. **Upon initial registration, adult patients should be asked to show documentation of identity that includes address information, with the following exceptions:**
   i. **If the patient requests emergency evaluation or treatment, TCMCHD will not delay a medical screening examination in order to obtain documents verifying identity.**
   ii. **TCMCHD staff may use professional judgment to waive the production of photo ID if a delay in care could put the patient's health and safety at risk.**

~~A.~~**c.** **When reviewing a patient's ID, TCMCHD should do the following:**~~S~~
   ~~B.~~**i.** Scrutinize to verify that it has not been altered or forged.
   ~~C.~~**ii.** Verify that the picture and physical description on the identification provided matches the appearance of the patient.
   ~~3.~~**iii.** Verify that the information on the identification is consistent with the information in the patient Medical Record.

~~D.~~**d.** **If a patient refuses or is unable to provide a photo ID, TCMCHD staff should document that photo ID was "not provided". In addition, the TCMCHD staff member should ask the patient for two (2) forms of non-photo ID, one of which has been issued by a state or federal agency (i.e., ~~Social Security~~Medicare ID card or number,~~and~~ utility bill or company or school ID). When the patient is under 18 or if the patient is unable due to their condition to produce ID, the responsible party's ID shall be requested**

~~1.~~**2.** Red Flags
a. Everyone shall be alert to potential red flags.
b. Below are examples of red flags to look for:
   ~~E.~~**i.** -Complaints or concerns from a patient relating to:
      1) Received a bill for someone else.
      2) Received a bill for services that were not received.
      3) Received information from Insurance Company for services that were not received.
      4) Collection notice for services never received.
   ~~F.~~**ii.** -The photograph on the identification does not resemble the patient.
   ~~G.~~**iii.** Identifying information given by the patient is not consistent with the patients' medical record.
   ~~H.~~**iv.** Social Security Number Red Flags:
      ~~i.~~**1)** ~~1)~~The social security number has not been issued.
      ~~I.~~**2)** The social security number is listed in Administration's Death Master File
      ~~J.~~**3)** The social security number is invalid.
      ~~K.~~**4)** The following numbers are always invalid:
         a) The first three digits are in the 800, 900, or 000 are in the 700 range above 772 or are 666.
         b) The fourth and fifth digits are 00.
         c) The last four digits are 0000.
      ~~b.~~**d)** ~~E.~~ The identifying information furnished by the patient including the Social Security Number are the same as another patient.
   ~~c.~~**v.** ~~F.~~ Other Red Flags:
      1) The address given by the patient does not exist or is a post office box.
      2) The phone number given is invalid, or is associated with a business, disconnected etc.
      ~~ii.~~**3)** ~~3)~~ The patient fails to provide identifying information after repeated tries.

~~L.~~4) The information provided by the patient differs from the informant in the medical record or is different on clinical examination.
~~M.~~5) The patient's signature does not match the signature in the medical record.
~~N.~~6) Notification from patient stating they are a victim of identity theft.
~~O.~~7) The entity received notice of address discrepancy from a consumer reporting agency.
8) Discrepancies in information provided by patient in the medical record.

~~P.~~3. **Investigations:**
- a. **TCHD shall investigate concerns involving potential identity theft associated with patient accounts.**
- ~~1.~~b. **If it is determined that a patient is a victim of identity theft, the following actions shall be taken:**
  - ~~a.~~i. **Promptly isolate and correct any inaccuracy in the patient's designated record set.~~;~~**
  - ~~b.~~ii. **Notify the patient in writing or by phone.~~;~~**
  - ~~c.~~iii. **Instruct billing areas to cease collection; if the account has been referred to a collection agency, instruct the collection agency to cease collection activity.~~;~~**
  - ~~d.~~iv. **Cooperate with any law enforcement investigation.~~;~~**
  - ~~e.~~v. **Ascertain whether an insurance company, government program, patient or other payeer has made payment on the account, notify the payeer of the incident and arrange for a refund of the amount paid.~~;~~**
  - ~~f.~~vi. **If an adverse report was made to a consumer reporting agency, notify the agency of the incident and explain that the account was not the responsibility of the patient~~; and~~.**
  - vii. **Notify all other TCHD departments as necessary to resolve and/or restore the accuracy of account information.**

4. **Remediation:**
- a. **When identity theft is confirmed, any documents identified as not belonging to the patient shall be segregated and any information relating to the identity theft shall be removed, marked in error or suppressed (as applicable to whether paper documents or electronic systems are affected).**

5. **Address Discrepancy**
- a. **When TC~~M~~CHD receives a notice of address discrepancy from a consumer reporting agency, TC~~M~~CHD shall verify that the report relates to a patient about whom the information is requested.**

~~2.~~6. **~~TCHD~~Administrative Policy: 8610-395~~,~~ Fraud Recognition ~~and~~ Response, details all measures taken by TCHD when identity theft has been identified.**

## E. RELATED DOCUMENT(S):

~~3.~~1. **Administrative Policy: 395 Fraud Recognition Response**
2. **Patient Care Services Procedure: Medical Record, Making Corrections to Documentation**

## ~~Q.~~F. REFERENCE(S):

1. ~~16 CFR 68.12 "~~Identify Theft Rules~~"~~, **CFR Title 16 Div. § 681.**
2. Federal Register Vol. 72, No. 217~~,~~ ~~November 9,~~ (2007).
3. **Federal Trade Commission (2008). New 'red flag' requirements for financial institutions and creditors will help fight identity theft. FTC** Business Alert~~, June 2008~~.
~~3.~~4. **Identity Theft Rules: Interim Final Rule and Request for Comment - Amendment of the Definition of "Creditor" in the Original Red Flags Rule, CFR Title 16 § 681 (2012).**
5. **Red Flag Program Clarification Act of 2010, 15 U.S.C. 1681m(e)(4), Pub. L. 111-319, 124 Stat. 3457 (2010).**