SUBJECT: Billing and Claims Reimbursement **POLICY: CC-09**
EFFECTIVE DATE: September, 2012 **ISSUED BY: Administration**
TJC REF: None **PAGE: 1 of 6**

POLICY:

Noyes Health promotes full compliance with all relevant billing and claims reimbursement requirements by requiring all personnel involved in billing and claims submission to maintain high ethical standards and a strong knowledge of all laws and regulations related to the billing function.

PROCEDURE:

I. General Policies and Procedures:

A. All persons who are involved in any aspect of billing and claims reimbursement activities will be held to a high standard with respect to knowing and adhering to the requirements and standards for participation in the health care industry, including but not limited to, all rules and regulations pertaining to claims submission and reimbursement under the Medicare and Medicaid programs.

B. All such persons will be properly credentialed by the appropriate professional organization.

1. Accurate billing and claims submission requires cooperation and effective communication between members of billing staff and clinical staff members.

a. An effective billing program requires that all persons involved in the patient care process (i.e., clinical or administrative staff) be diligent with respect to proper documentation.

1. Failure to document patient care properly may result in the improper submission of claims in the event that:

a. The admitting or registration personnel fail to give a Medicare beneficiary the notices and information required by the program.

b. Clinical staff fail to document the time spent, services provided, and materials used in the patient's care.

c. An affiliated department misidentifies a service.

d. Data entry personnel apply a charge to the wrong patient account.

e. A code is incorrectly applied by medical records staff.

2. Members of each staff should seek clarification regarding billing and coding practices between departments when questions arise.

   a. In the event that a department cannot address a particular billing or coding question, outside resources (i.e., compliance consultant, legal counsel, or the Medicare Intermediary) should be contacted for assistance.

   b. The inquiry and answer obtained should be properly documented in writing and the Corporate Compliance Officer should be notified.

3. It is essential that all clinical staff document physician and other professional services in an accurate, organized, legible, and timely manner, and in accordance with any medical staff policy related to documentation and maintenance of patient records to ensure that services are properly billed.

   a. Billing staff should only submit claims when there is appropriate clinical documentation to support fully the claim and when the documentation fulfills the applicable maintenance requirements for such documentation in accordance with the records retention policy.

   b. The documentation should include patient records and must:

      1. Identify the length of time spent conducting the service, where required.

      2. Identify the individual providing the service.

      3. Identify, where appropriate, the person or persons supervising the provider of the service.

      4. Fully support the services rendered, as well as the codes and diagnoses to be utilized for each claim.

II. Specific Policies and Procedures:

A. Bill only for the items or services actually rendered.

1. Claims for reimbursement must include adequate information to indicate that the service billed for was actually rendered.

2. Such information should include the date and time the service was rendered or the item provided, the identity of the person to whom the service was rendered or the item provided, a description of the service rendered or the item provided, and the identity of the person providing the service or item for which reimbursement is sought.

B. Bill only for medically necessary services.

1. Claims should only be submitted for services that Noyes Health has reason to believe are medically necessary and that were ordered by a physician or other appropriately licensed provider.

2. Reimbursement under Medicare for any such services must be "reasonable and necessary" according to the standards for Medicare reimbursement set forth in applicable statutes and regulations.

3. Should any question arise regarding the "medically necessity" of a service, adequate documentation to prove the medical necessity of the service must be provided and reviewed prior to submitting any claim for reimbursement.

C. Double-check all billing codes.

1. Claims should only be submitted when the correct billing code has been assigned to the item or service as intended by the payer (including Medicare and Medicaid).

2. Care should be taken to ensure that claims are submitted according to the correct Diagnosis Related Group (DRG).

a. Should any questions arise regarding the proper code to be assigned to an item or service, resolution of the issue should be obtained from appropriate management personnel (with the advice from the Corporate Compliance Officer, compliance consultant, or legal counsel, as needed), the fiscal intermediary, or payer **prior** to any claim submission.

D. Collect copayments and/or deductibles.

1. Claims may not be compliant if the patient has not been charged with the appropriate copayment or deductible, unless the patient to whom the item was provided or service was rendered is determined to be indigent under the patient financial policies.

E. Ensure that all claims have been properly bundled.

1. Make sure that all claims are bundled and that global billing codes are properly assigned prior to the submission of claims.

2. Check all claims to ensure there is no duplication of codes for multiple portions of the same service (i.e., removal of multiple lesions or tumors).

F. Scrutinize carefully all cost reports.

1. Verify that all information contained in cost reports is accurate, ensuring specifically that:

a. Costs are not claimed unless based on appropriate and accurate documentation.

b. Allocations of costs to various cost centers are accurately made and supported by verifiable and auditable data.

c. Unallowable costs to various cost centers are accurately made and supported by verifiable and auditable data.

d. Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement.

e. Costs are properly classified.

f. Adjustments are made to account for the results of the fiscal intermediary's prior year audit and:

1. Are not claimed for reimbursement, or

2. Are not claimed for reimbursement, but are clearly identified as "protested," if applicable, on the cost report.

g. All related parties are identified on Form 339, which is submitted with the cost report, and all related party charges are reduced to reflect costs.

h. Requests for exceptions to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data, and the Corporation's procedures for reporting bad debts on the cost report are in accordance with all applicable laws.

i. Procedures are in place and documented for promptly notifying the intermediary or other applicable payer of errors discovered after the submission of the Corporation's cost report.

G. Ensure that claims are submitted only for services provided by Noyes Health or "under arrangements" with other suppliers/providers.

H. Ensure that no duplicate billing occurs.

1. Check all claims to make sure that no more than one claim is submitted for the service for which reimbursement is sought.

I. Report patient transfers accurately.

1. When billing involves services for a patient transferred to another hospital, only a per diem amount rather than the full DRG amount is charged.

J. Do not submit claims for improperly referred patients.

1. If Noyes Health becomes aware of any contracts or arrangements which might violate the Antikickback Statute, Stark Law, or other anti-referral law, the Corporate Compliance Officer and the Chief Financial Officer should be advised immediately.

a. Claims which may have been submitted as a result of improper referral arrangement should be identified and no claims for reimbursement from Medicare or Medicaid should be sought for the treatment of such patients.

K. Review of current formal billing policies and procedures.

1. All billing manuals and policies for compliance with all billing requirements will be reviewed annually and revised as appropriate and necessary.

L. Review of current informal billing policies and procedures.

1. Informal billing practices will be reviewed annually for compliance with all proper billing requirements and revised as necessary and appropriate.

M. Refund all credit balances.

1. Credit balances will be refunded in a timely and appropriate manner.

III. Discovery of Billing Errors:

A. If a billing error is discovered, the error should be immediately reported to the Director of Revenue Cycle and the Corporate Compliance Officer.

1. Should any report be made to the Director of Revenue Cycle, he or she must immediately make a report to the Corporate Compliance Officer.

2. Appropriate steps will be taken to investigate the cause of the error and to prevent its recurrence.

B. Any overpayment received as a result of such billing error will be promptly repaid to the appropriate payer.

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Signature: Amy Dollard Date: 9/27/12