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Owner	Lindy Nesbitt: Assistant VP Compliance & Senior Counsel
Area	Corporate Compliance
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References	CORP-010

Billing Compliance Policy

I. Policy Purpose & Statement of Policy:

The purpose of this document is to set forth Erie County Medical Center Corporation ("ECMCC")'s billing practices and ensure their compliance with applicable federal and state laws, regulations, guidelines and policies.

In an effort to comply with applicable federal and state law, ECMCC has billing standards and procedures that assist in ensuring that claims are timely, accurate and complete. To prevent the submission of erroneous billing claims, this policy also provides guidance to employees on certain key risk areas that affect billing for health care services.

All ECMCC affected individuals are required to follow this Policy. Affected Individuals are individuals who are covered by ECMCC's Compliance program requirements. This includes employees, senior administrators, managers, contractors, governing body, volunteers, students and corporate officers. ECMCC's Corporate Compliance Department shall provide education on the areas of law outlined below, and on ECMCC policies and procedures for detecting and preventing fraud, waste, and abuse.

II. Procedure

A. **Billing**

1. The goal for any claim submission is within 3 days after coding for inpatients and 5 days after coding for outpatient. In order for inpatient cases and certain outpatient services to bill, the patient's medical chart is reviewed by ECMCC's coding staff to ensure that the documentation supporting all claims is complete and accurate and

reflects reasonable and necessary services, and that the proper diagnosis/procedure codes are added to the patient 's account.

2. At the time of billing, the account must pass through a series of edits that have been built into ECMCC's Patient Accounting systems. These edits are designed to prevent potential billing errors.
3. All copayments, deductibles or coinsurances will be collected from the patient unless the patient has a demonstrable financial hardship or approved by administration under limited circumstances.
4. All affected individuals are responsible for conducting our business in an honest and ethical manner, and are expected to follow the elements outlined in the ECMCC Code of Conduct.
5. ECMCC submits claims only for services that are both ordered and performed.

B. **Medicare**. Medicare billing is done electronically and on a daily basis. Each day, the PFS System Analysts confirm that the claims they submitted the prior day were received by Medicare via an acceptance/error report. If a claim was not received by Medicare, the biller researches why. Reasons why the claim may not have been received by Medicare include that the claim may have hit an Outpatient Code Editor (OCE) edit in the hospital billing system, or the claim may have been missing required information. Once the issue is identified, the biller corrects it and resubmits the claim to Medicare, if appropriate.

C. **Commercial**. Commercial insurance and managed care claims first qualify for follow-up 21-45 days from the initial billing of the claim depending on the dollar amount of the claim. The goal is having a follow-up calls placed every 30 days to confirm that the claim has been received and to confirm that the carrier has all required documentation needed to process the claim.

D. **Financial Counseling Unit.** If the patient states that he or she cannot afford to pay for the services, the patient will be referred to the financial counseling to determine whether he or she qualifies for financial assistance.

E. **Charge Entry Documentation**. The chargemaster shall be regularly updated with the most current guidelines for Healthcare Common Procedural Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, and revenue codes. These codes must accurately describe the services ordered by the appropriate provider. Charge entry documentation shall not be altered in any way for any purpose. Billing personnel must immediately report any unresolved issues or questions regarding charge entry documentation to their supervisor, manager or the Director of Revenue Integrity.

F. **Unbundling**. The use of billing individual codes for services that have been assigned an aggregate billing code (i.e., unbundling) is prohibited. Edits are in place in Revenue Cycle systems to assist in preventing unbundling issues.

G. **Credit Balances and Overpayments**

1. The Patient Financial Services department will review credit balances for errors such as overpayments by an insurance company and/or another responsible party, duplicate payment/contractual entries, misapplied charges/credits and incorrect patient account adjustments. Once this review is performed, all confirmed overpayments must be refunded to or retracted by the applicable payors.
2. All overpayments must be refunded to the applicable federal and state payors within

60 days after identification or within such additional time period as may be agreed to by the payor. The corrective action will include correcting the underlying cause of the overpayment and taking remedial action to prevent the overpayment from recurring.

H. **Balance Billing**. ECMCC is prohibited from knowingly collecting or attempting to collect from any patient the difference between the total charges and what is contractually covered by a contracted insurer health plan, except for patient co-pay, co-insurance and deductible amounts for which the patient is accountable pursuant to the plan's benefit design.

I. **Duplicate Billing**. Affected individuals must not knowingly submit more than one claim for the same services and knowingly submitting the same claim to more than one primary payer is prohibited.

J. **Billing for Discharge in Lieu of Transfer**. ECMCC shall ensure that the appropriate discharge disposition code is assigned in order to receive correct reimbursement from the payer.

K. **Identification of Billing Discrepancies**. In the event a discrepancy is discovered subsequent to the submission of the claim, all attempts to void the claim or submit an adjusted claim, as appropriate, must be made in order to submit the correct claim for the services provided. An investigation must be undertaken to determine the root cause(s) of the discrepancy and work promptly to correct any adverse result of the variance.

L. **Medicare Secondary Payer**. ECMCC will ask each patient or his/her representative questions concerning the patient's health insurance and/or Medicare coverage status to determine whether Medicare is the primary payer for those services or items. Revenue Cycle will determine priority in a manner that complies with applicable laws and regulations, including the Medicare Secondary Payer (MSP) provisions, and will not knowingly submit claims to payers, plans and/or programs in the incorrect order of financial liability or bill Medicare as the primary payer where, by law and pursuant to the MSP provisions, it is the secondary payer.

M. **Revenue Cycle Employees: Training and Compliance**. As affected individuals, Patient Financial Services (PFS) employees are expected to share the responsibility for upholding company standards as well as billing standards. All PFS employees receive training on applicable billing topics on a regular basis. The Revenue Cycle Department will maintain and make available to billing staff documentation of billing guidelines or billing requirements for the appropriate payor.

N. **Monitoring and Auditing to Detect and Prevent Billing Discrepancies**

1. Billing quality reviews will be performed periodically by representatives in Revenue Integrity to ensure compliance with billing policies and applicable state and federal law. If any material billing issue is identified, Revenue Integrity and/or PFS employees must contact the Office of Corporate Compliance. The Office of Corporate Compliance will investigate such material billing issues and, if appropriate, work with the appropriate department(s) to resolve the issue. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education sessions.
2. The Office of Corporate Compliance oversees audits or, if appropriate, arranges for external audits of the billing processes on a regular basis to monitor compliance with billing policies and all applicable federal and state laws, as well as to identify and monitor risk areas. At the conclusion of each such audit, the Office of Corporate Compliance will discuss the audit findings with the appropriate department(s) and, if

necessary, work with the appropriate department(s) to resolve any identified issues. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education sessions regarding trends identified, if any.

3. **Audit Types**
    a. Proactive annual outside coding audits
    b. Random Audits
    c. Reported Billing/Coding concerns
    d. Focused Audits
    e. Credit Balance Audits

O. **Billing for Physicians Who Are Not Yet Credentialed**

1. Providers who are recently employed by ECMCC, but are awaiting the credentialing process may not submit claims for services. Once credentialed, billing for services rendered may commence.
2. Once credentialed, providers may not retrospectively bill Medicare/Medicaid beyond the permissible time period, as determined by the effective date of their enrollment. Providers are referred to their specific agreements with commercial insurers to determine whether they may bill retrospectively.

III. Risk Areas

The following is a list of specific risk areas regarding billing and coding compliance:

A. **Medical Necessity for Services.** ECMCC will submit claims to Medicare or Medicaid (or any other federally-funded health care program or private insurers) only for services that were medically necessary or that otherwise constituted a covered service. Medical necessity will be determined individually for each service or test provided or ordered by the responsible physician or other individual licensed to do so. A medically necessary service or test is defined as one that is reasonable and necessary for the diagnosis or treatment of an illness, injury or to improve the functioning of a malformed body member. Government and private insurers will only pay for services and tests that are medically necessary and will deny payments for those that are not medically necessary, such as routine physicals, many screening tests or tests conducted for research purposes. Every governmental claim form should be supported by a physician certification that the services were medically necessary for the health of the patient.

B. **Billing for Items or Services Not Actually Rendered**. Submitting a claim representing that a provider performed a service all or part of which was simply not performed is inappropriate, at a minimum, and possibly illegal. Only those medical services to patients that are consistent with acceptable standards of medical care may be billed. ECMCC will only bill for the actual services rendered, and only when those services were consistent with accepted standards of medical care. The billing for such services must comply with all applicable rules and regulations governing correct documentation, coding and billing.

C. **Correct Coding.** All federal and state regulations governing billing procedures are to be followed and all personnel responsible for billing will be trained in the appropriate rules

governing billing, coding and documentation. If the documentation in the medical record is unclear, then billing personnel must request clarification or additional information from the physician or provider of services. This includes when the appropriate code or diagnosis is unclear. Billing personnel cannot create coding or diagnostic information based upon their own interaction with the patient, from information provided from an earlier date of service, or based on what they might conclude is the probable or most likely diagnosis.

D. **Up coding.** This reflects the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the services provided to the patient. No ECMCC affected individual shall knowingly engage in any form of up coding. All federal and state regulations governing billing procedures will be followed.

E. **Billing Companies.** Any affected individual engaged to perform billing and coding services must comply with all billing regulations of Medicare, Medicaid and all third party payors and ECMCC requirements to generate accurate and complete billing documentation. They must have a Business Associate Agreement with the appropriate ECMCC department or entity in compliance with HIPAA regulations.

F. **Cost Reports.** ECMCC receives reimbursement under government programs requiring the submission of complete and accurate reports of its cost of operation and other information. These laws and regulations define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to the program beneficiaries. ECMCC cost reports will be prepared in compliance with all applicable state and federal regulations.

IV. Reporting

ECMCC affected individuals have the obligation to report any suspected issues or concerns regarding ECMCC fraud, waste, abuse, billing and or coding under the Federal and State False Claims Act. All ECMCC affected individuals must participate and/or cooperate in good faith with any investigation into a reported violation, be truthful with investigators and preserve documentation and/or records relevant to ongoing investigations.

V. Disciplinary Action

Disciplinary action for violation of this policy will be imposed as a part of a corrective action plan for all ECMCC affected individuals. *See Discipline for Compliance Policy. See Discipline for Compliance for Non-Employees Policy.*

VI. Reference:

Detecting and Preventing Fraud, Waste, Abuse and Misconduct Policy

ECMCC Code of Conduct

New York State, Medicaid Program, Information For All Providers, General Billing: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_ProvidersGeneral_Billing.pdf

ECMCC has developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations from these policies and procedures may be warranted in actual practice based upon individual patient characteristics and clinical judgment in unique care circumstances.

Approval Signatures

Step Description	Approver	Date
	Lindy Nesbitt: Assistant VP Compliance & Senior Counsel	Pending

Applicability

Erie County Medical Center