North Shore-LIJ Health System is now **Northwell Health**

POLICY TITLE: Billing Compliance Policy	**ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**
POLICY #: 800.50	**CATEGORY:** Compliance and Ethics
System Approval Date: 9/15/16 **Site Implementation Date:** 10/28/16	**Effective Date:** 11/12 **Last Reviewed/Approved:** 11/12
Prepared by: Office of Corporate Compliance	**Superseded Policy(s)/#/Notations:** N/A

GENERAL STATEMENT of PURPOSE

The purpose of this policy is to affirm the commitment of Northwell Health to ensuring that its billing practices comply with applicable federal and state laws, regulations, guidelines and policies.

POLICY

In an effort to comply with applicable federal and state law, Northwell Health 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.

SCOPE

This policy applies to all members of the Northwell Health workforce including, but not limited to: employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at Northwell Health; faculty and students of the Hofstra Northwell School of Medicine conducting Research on behalf of the School of Medicine on or at any Northwell Health facility; and the faculty and students of the Hofstra Northwell School of Graduate Nursing & Physician Assistant Studies.

PROCEDURE/GUIDELINES

BILLING

1. The goal for any claim submission is 3 days from the service date. In order for inpatient cases and certain outpatient services to bill, the patient's medical chart is reviewed by Northwell Health's coding staff to ensure that the documentation supporting all claims is complete, 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 Northwell Health's Patient Accounting systems. These edits are designed to prevent potential billing errors.

MEDICARE

3. Medicare billing is done electronically and on a daily basis. Each day, the Medicare billers 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. Some reasons why the claim may not have been received by Medicare are as follows: the claim hit an Outpatient Code Editor (OCE) edit in the hospital billing system, the claim was missing required information or the claim had a manual bill hold on it. Once the issue is identified, the biller corrects it and resubmits the claim to Medicare, if appropriate.

4. On a daily basis, the Medicare billers also access claims corrections on Medicare's system to ensure that any claim that edited in Medicare's system is being researched and worked.

5. Medicare follow-up is done via working the daily Medicare remit. Any account that was not paid correctly is researched and re-billed for correct payment, if appropriate. In addition to the daily remits, follow-up work lists are worked daily.

MEDICAID

6. Medicaid billing is done daily. Each day, the Medicaid billers confirm that the claims they submitted the prior day were received by Medicaid via an acceptance/error report. If a claim was not received by Medicaid, the biller researches why. Some reasons why a claim may not have been received by Medicaid are as follows: the claim required information or the claim had a manual bill hold on it. Once the issue is identified, the biller corrects it and resubmits the claim to Medicaid, if appropriate.

   Medicaid follow-up is done via working the weekly Medicaid remit. Any account that was not paid correctly is researched and re-billed for correct payment, if appropriate. In addition to the daily remits, follow-up work lists are worked daily.

COMMERCIAL

7. For all Hospitals, commercial insurance and managed care claims first qualify for follow-up 21 days or 28 days from the initial billing of the claim depending on the dollar amount of the claim. Follow-up calls are placed every 10-18 days to confirm that the claim has been received and to confirm that the carrier has all required documentation needed to process the claim.

FINANCIAL ASSISTANCE UNIT (FAU)

8. If the patient states that he or she cannot afford to pay for the services, the patient will be referred to the FAU to determine whether he or she qualifies for financial assistance.

CHARGE ENTRY DOCUMENTATION

9. The Chargemaster shall be regularly updated with the most current guidelines for Healthcare Common Procedural Coding System (HCPCS) 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 Compliance.

UNBUNDLING

10. The use of billing individual codes for services that have been assigned an aggregate billing code (i.e., unbundling) is prohibited.

CREDIT BALANCES AND OVERPAYMENTS

11. Finance 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. For more detailed information on refunding credit balances to commercial insurance companies, please refer to Northwell Health's "Credit Review/Refund" policy.

12. All overpayments must be refunded and appropriately reported 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. See Northwell Health Policy #800.07- Compliance with Government-Funded Healthcare Claims and Cost Reporting Requirements.

BALANCE BILLING

13. Northwell Health 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.

DUPLICATE BILLING

14. Billing staff must not knowingly submit more than one claim for the same services and knowingly submitting the same claim to more than one primary payor is prohibited.

BILLING FOR DISCHARGE IN LIEU OF TRANSFER

15. Northwell Health shall ensure that the appropriate discharge disposition code is assigned in order to receive correct reimbursement from the payor.

IDENTIFICATION OF BILLING DISCREPANCIES

16. 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. Each facility must undertake the appropriate investigation to determine the root cause(s) of the discrepancy and work promptly to correct any adverse result of the variance.

MEDICARE SECONDARY PAYOR

17. Northwell Health's applicable facilities 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 payor for those services or items. Finance will determine payment priority in a manner that complies with applicable laws and regulations, including, without limitation, the Medicare Secondary Payer (MSP) provisions, and will not knowingly submit claims to payors, plans, and/or programs in the incorrect order of financial liability or bill Medicare as the primary payor where, by law and pursuant to the MSP provisions, it is the secondary payor.

BILLING EMPLOYEES: TRAINING AND COMPLIANCE

18. Employees are expected to share the responsibility for upholding company standards as well as billing standards. All billers receive training on applicable billing topics on a regular basis and must meet billing continuing education obligations. The Finance Department will maintain and make available to billing staff documentation of billing guidelines or billing requirements for the appropriate payor.

MONITORING AND AUDITING TO DETECT AND PREVENT BILLING DISCREPANCIES

19. Billing quality reviews will be performed periodically by representatives in Patient Accounts to ensure compliance with billing policies and applicable state and federal law. If any material billing issue is identified, billing staff 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.

20. The Office of Corporate Compliance performs 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.

21. Based on its audit findings and/or any investigations it undertakes, the Office of Corporate Compliance periodically will prioritize certain compliance activities as appropriate.

BILLING FOR PHYSICIANS WHO ARE NOT YET CREDENTIALED

22. Providers who are recently employed by Northwell, but are awaiting the credentialing process may not submit claims for services. Once credentialed, billing for services rendered may commence.

23. 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.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

Northwell Health Corporate Compliance Policy #800.07 - Compliance with Government-Funded Healthcare Claims and Cost Reporting Requirements

CLINICAL REFERENCES
N/A

FORMS
N/A

ATTACHMENTS
N/A

APPROVAL:	
System Administrative P&P Committee	8/25/16
System PICG/Clinical Operations Committee	9/15/16

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