Billing Standards of Conduct Training
Billing Standards of Conduct Training

Agenda

- Introduction
- Medicare / HCFA/Federal Regulations
- Billing and Coding
- LMRP - Definition, Examples, and How They Work
- Standards of Conduct review-signature
MEDICARE REGULATIONS

☒ Section 230 Outpatient Hospital Services
☒ Section 1156 Obligations as A Provider
☒ Section 106 Fraud and Abuse
SECTION 230 - OUTPATIENT HOSPITAL SERVICES

This section defines coverage issues pertaining to the following outpatient services:

- Diagnostic Services
- Therapeutic Services (drug & biologicals, hemophilia clotting factors, immunosuppressive drugs, epoetin [EPO], immunizations)
- Hospital Psychiatric Services (i.e., coverage criteria, partial hospitalization, frequency and duration)
- Observation Services
Billing Standards of Conduct Training

Section 230 continued

Medicare contractors, the OIG and others are conducting postpayment audits and reviews of claims and are identifying numerous problems with Medicare billing, coding and coverage issues related to medical necessity, over-utilization, lack of medical documentation and billing non-covered services as if they were a Medicare covered benefit.

Medicare places the burden of knowledge about Medicare covered services with the provider. Providers are responsible for knowing which services meet Medicare coverage regulations. Knowingly billing for services not covered by Medicare is a fraudulent act. In spite of this, hospitals continue to bill inappropriately for routine recovery services, self-administered drugs and observation time.
Billing Standards of Conduct Training

Section 1156 - Obligations

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS & PENALTIES; HEARING & REVIEW [42 USC 1320c-5]

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act -

✧ will be provided economically and only when, and to the extent, medically necessary;

✧ will be of a quality which meets professionally recognized standards of health care; and

✧ will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by reviewing peer review organization in the exercise of its duties and responsibilities.
How does the government define fraud?
Billing Standards of Conduct Training

Definition of Fraud Section 106.1

- Billing for services that were not furnished
- Altering claims
- Duplicate billing
- Offering kick backs, soliciting, bribes, rebates, induce referrals of patients
- Falsely representing the nature of the services furnished (describing a non-covered service in a misleading way that makes it appear as if a covered service was actually furnished)
- Billing a person who has Medicare coverage to another person that is NOT eligible
- Repeatedly violating the participating agreement, assignment agreement, and the Maximum Allowable Actual Charge (MAAC) limits or limitation amount
- Completing certificates of medical necessity (CMN) for patients not personally and professionally known to the provider
Billing Standards of Conduct Training

Definition of Fraud continued

- Using another person’s Medicare card to obtain medical care
- Giving false information about provider ownership in a clinical laboratory
- Conspiring to submit or manipulate bills by a provider, a supplier, that result in a higher cost or charge to the program
- Billing procedures over a period of days when all treatments occurred in the same day or visit
- Using the adjustment payment process to generate fraudulent payments.
- Billing for gang visits (i.e. when a physician visits a facility, walks through and then bills for 20 visits without rendering any specific service to the patients, SNFs, Rehab facilities.)
- Completing a prohibited CMN by suppliers
Compliance is everyone’s responsibility.

Compliance with HCFA & Medicare billing rules is everyone’s responsibility.

No one can or should ask you to violate these guidelines.
WHAT SHOULD AN ORGANIZATION DO TO ENSURE COMPLIANCE?
RESPONSIBILITIES

✔ Scheduler must only schedule those services that meet criteria

✔ Charge Poster must be accurate:
  ⇔ No duplicate charges
  ⇔ No services not provided as per regulations
  ⇔ Accept no offer to charge post inaccurately -
    Immediately report to the Compliance Officer, supervisor, manager, director, etc., any attempts to improperly coerce you!!
  ⇔ Ensure all services were provided to patient
  ⇔ Enter charges with the correct date of service
WHAT ABOUT THE DEFINITION OF ABUSE?
Definition of Abuse - Section 106.2

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally.

The following are three standards the HCFA uses when judging whether abusive acts in billing were committed:

- Medically necessary
- Conform to professionally recognized standards
- Provided at a fair price
Billing Standards of Conduct Training

EXAMPLES OF ABUSE ACCORDING TO MEDICARE

- Charging in excess for services or supplies
- Providing medically unnecessary services or services that do NOT meet professionally recognized standards
- Billing Medicare based on a higher fee schedule than for non-Medicare patients
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare Secondary Payer regulation (MSP)
- Violating the participating physician/supplier agreement
- Breaches in the assignment agreements
- Violating the MAAC or limitation amount
Billing Standards of Conduct Training

LMRP’s

- Are developed by physicians
- Are distributed by the carrier to physicians (Part B)
- Are distributed by the Fiscal Intermediary to Hospitals (Part A)
- Make Local Medical Coverage Decisions under the Authority of 1862 of the Social Security Act
Billing Standards of Conduct Training

LMRP’s ARE USED FOR THE FOLLOWING PROVIDER SERVICES

- HOSPITAL OUTPATIENT
- SNF
- HOSPICE
- OUTPATIENT THERAPY
Billing Standards of Conduct Training

LMRP’S

PROVIDE GUIDANCE ON:

▫ WHETHER OR NOT AN ITEM/SERVICE IS COVERED
▫ UNDER WHAT CIRCUMSTANCES IT IS CONSIDERED REASONABLE, NECESSARY, AND APPROPRIATE FOR:
  ▫ THE DIAGNOSIS OR TREATMENT OF ILLNESS OR INJURY
  ▫ TO IMPROVE THE FUNCTIONING OF A MALFORMED BODY MEMBER
Billing Standards of Conduct Training

LMRP’S ARE ISSUED WHEN SPECIFIC ITEMS/SERVICES:

• Are Being Provided to the Extent That Raises Questions of Abuse or Over-Utilization

• Appear to Have Been Furnished Under Conditions Inconsistent With Standards of Practice

• Appear Not to Be Medically Reasonable and Necessary
Standards of Conduct

1. Standards of Conduct/Policies and Procedures
   - Unbundling
   - Balance Billing
   - Credit Balances - inadequate resolution of overpayments
   - Misuse of provider identification numbers
   - 3-Day Window DRG Payment
   - Duplicate Billing
   - Improper use of modifiers
   - Midlevel Billing
   - Routine Waiver of Co-pays & Deductibles
   - Professional Courtesy & Discounts
Standards of Conduct

2. Designation of a Compliance Officer and Committee
3. Training and Education
4. Effective Communication
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Reporting of Identified Issues and Corrective Action
Standards of Conduct

• A set of standards that clearly delineates policies with regard to fraud, waste and abuse.

• Provides **guidance** to employees on high risk areas in the billing industry.

• Compliance Standards of Conduct are made available to all employees and regularly updated and/or modified.
Standards of Conduct

- Every Employee:
  - Shares the responsibility for upholding company standards, as well as billing standards.
  - Is responsible and accountable for complying with the policies and procedures with regard to fraud, waste and abuse and all local, state, and federal statutes and regulations.
Standards of Conduct

• Violations of laws and regulations can have severe consequences.
• Non-compliance to any policy and procedure, or the Standards of Conduct may be grounds for disciplinary action, up to and including termination.
Integrity of documentation

- Charge entry information serves as source of physician’s independent decisions and practices.
- Charge entry information should not be altered in any way, even in the event of altering information for billing purposes.
- If documentation from provider is questionable, the provider should be contacted for clarification or resolution.
- Billing personnel shall immediately report to their supervisor, manager, director, or Compliance Officer, any unresolved issues or questions regarding charge entry documentation.
Unbundling

• Use of separate billing codes for services that have an aggregate billing code is not allowed.

• Certain services must be “bundled” or “unbundled” together for reimbursement purposes (depending on the regulations). Examples include 3-Day Window DRG Payment, global surgery services, injections, supplies, equipment, etc.

• Billing for these services bundled or unbundled results in over-billing and over-payment.
Balance Billing

- Balance Billing is the practice of billing patients the difference between the total charges and the covered amount.
- Administrative Financial Policy prohibits the practice of balance billing.
Reconciliation of Overpayments

• Overpayment is an improper or excessive payment made to a health care provider as a result of billing or claims processing errors.

• Credit balances must be worked consistently in order to meet the requirement of timely & accurately reporting.
Maintaining Confidentiality

• Billing personnel will not:
  – Disclose, discuss or release patient information to anyone at or outside except to carry out regular duties assigned.
  – Seek information about patients or employees for their own personal use.
  – Share or disclose any computer systems USERNAME or PASSWORD to anyone.
Use of Provider Identification Numbers

- Medicare does not pay amounts that are due a provider to any other person.
- A provider’s Unique Personal Identification Number (UPIN) is to be used only if that provider has actually rendered the services being billed for.
- All midlevels must have their own UPIN in order to bill professional services.
Outpatient Services in Connection with an Inpatient Stay

- Bundling of services performed within 3 days of an inpatient admission on the same inpatient bill.
- Pre- and Post-test procedures.
- Mandatory annual training.
Duplicate Billing

- Submission of more than one claim for the same services or,
- Submission of more than one claim to more than one payer for the same services.
- Repeated double billing can create liability under criminal, civil or administrative law... Particularly if the overpayment is not promptly refunded. (resolution of overpayments)
Proper Use of Modifiers

• A modifier provides the means by which the reporting provider can indicate a service or procedure that has been performed has been modified, but not change the definition of the code.

• Some examples include:
  – 54 Surgical Care Only
  – 55 Postoperative Management Only
  – 52 Reduced Services
Waiving Patient Copays or Deductibles

- A good faith effort to collect all co-pays and deductibles is the policy.
- Routine waiving of these amounts can be viewed as an attempt to retain the patient’s services.
- This is a violation of the Anti-Kickback Statute
Discounts and Professional Courtesies

• Waiving the fees for external professional and their families is not allowed at without proper approval of the VP Patient Revenue Management and/or CFO.
• This practice can give the appearance of trying to induce referrals from these professionals.
Identification of Billing Discrepancies

• In the event a discrepancy is discovered after the submission of a claim, an adjustment claim will be submitted.
Billing for Non-covered Services

- Non-covered services should be identified as such on all claims.
Records of Billing & Claims

• Billing Personnel will not:
  – falsify
  – intentionally destroy
  – withhold records

any records relating to any portion of the billing and claims submission function.
Integrity of the Chargemaster

• The chargemaster should be regularly updated with the most current guidelines for
  – HCPCS codes
  – ICD-9-CM codes
  – CPT codes
  – Revenue Codes
  – Other applicable codes

• These codes should be utilized and accurately describe the services ordered by physicians.
Compliance as an Element of Performance

• Incorporate Compliance as an element of job performance.
• Employees should be up to date on HCFA or Health Plan policies and legal requirements that apply to their position.
• Failure to do these things can result in:
  – Disciplinary Action
  – Termination
Other Components of the Compliance Plan

• Fraud Alerts
  – The OIG and HCFA periodically offer fraud alerts which are located on the internet.
  – Fraud Alerts deal with issues surrounding anti-kickback statues
  – The OIG is at www.dhhs.gov/progorg/oig
  – HCFA is at www.hcfa.gov
  – Fraud Alerts can be accessed on the Intranet Compliance Program site.
Why Do We Need Compliance?

- Lack of compliance can lead to investigations.
- Individual employees can be questioned during an investigation or subpoenaed to testify in court.
- If fraud & abuse is discovered, civil and criminal monetary penalties can be assessed.