	SECTION: Compliance	NO: CMP 019
	TITLE: Accurate Billing and Coding	DISTRIBUTION: Corporate and all Facilities
Original Date of Issue: 03/01/2018	**Date of Approval:**	
Revised: 06/2023		

Scope:

All Team Members of Summit Behavioral Healthcare, LLC (Summit BHC), including facilities and their employees, independent contractors and professional staff, Summit Board of Managers (Summit BHC Board), and other individuals authorized to act on behalf of Summit BHC.

Purpose:

To outline the controls in place to support Team Members at Summit BHC, its subsidiaries and affiliates in ensuring timely, accurate and complete billing and coding for services provided and billed by Summit BHC.

Policy:

Summit BHC is committed to preventing fraud, waste, and abuse in billing and coding, and will submit only claims that are truthful, accurate, for medically necessary services, and that are supported by adequate documentation. Timely, accurate and complete documentation is important to clinical patient care. Clinical documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for billing and coding documentation.

Procedure:

General Principles of Clinical Documentation

A. Clinical staff should document all professional services in an accurate, organized, legible, and timely manner.

B. The clinical documentation should fully support the services rendered and the intensity of the patient evaluation and/or treatment, including clinical thought processes and the complexity of medical decision-making.

C. The medical record entry should include the reason for the encounter; the relevant history; physical exam results; prior diagnostic test results; assessments, clinical impression, or diagnosis; plan of care; date of service; place of service; and legible identity of the provider.

D. All entries to the medical record should be dated and signed by the provider of the service or item. The signature may be handwritten or electronic.

E. The rationale for ordering and the review of laboratory results and any other ancillary services should be documented.

F. The documented plan of care should include treatments and medication, frequency and dosage, referrals and consultations, patient/family education, and specific instructions for follow-up.

G. Appropriate health risk factors should be identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis should be documented.

H. To maintain an accurate record, the provider should create the clinical documentation during or shortly after rendering the service.

I. The provider of the items and/or services is responsible for ensuring that documentation is accurate, legible, and complete.

J. Clinical documentation must support the codes utilized for billing purposes, and other applicable requirements.

Billing and Claims Submission

Billing for Medically Necessary Services

A. Billing staff should bill only for medically necessary services. Under Medicare, "medical necessity" is defined as items or services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

    i. Claims should be submitted for items and services that Summit BHC reasonably believes are medically necessary and that were ordered by an appropriately licensed provider.

    ii. Prior to submitting a claim for reimbursement, billing staff should review the clinical record to ensure there is adequate documentation to support the medical necessity of the item or service. If additional information is needed, the billing staff shall contact the provider to clarify an order, item, or service.

    iii. Billing staff should ensure the diagnosis and procedure codes submitted on the reimbursement claim are based on accurate documentation within the medical record and contain only valid and specific codes.

B. Billing staff should double check all billing codes prior to submitting a claim for reimbursement.

    i. Correct Codes: Billing staff should report all healthcare data elements (e.g. diagnosis and procedure codes, present on admission indicator, discharge status) and submit claims only when the correct billing code has been assigned to the item or service. Billing staff should comply with Medicare's National Coverage Determinations, Local Coverage Determinations, and payor-specific billing requirements, as applicable.

ii. Unreasonable or Unnecessary Services: Billing staff should ensure that documentation supports that services rendered are medically reasonable and necessary.

iii. Unbundling: Billing staff should ensure that all claims are properly bundled and all global billing codes are properly assigned prior to submission of claims.

iv. Non-Covered Services: Billing staff should ensure that no claims are submitted for non-covered services.

v. Duplication: Billing staff should check all claims to ensure there is no duplication of codes for multiple portions of the same service, and to ensure that no more than one claim is submitted for the item of service for which reimbursement is sought.

vi. Misuse of Provider Numbers: Billing staff should submit claims using the Medicare provider number of the provider rendering the item or service.

vii. Coding Modifiers: Billing staff shall ensure that all claims use proper coding modifiers to reflect the specific circumstances of an item or service that has been provided.

viii. Clustering: Billing staff shall not engage in "clustering," which is the practice of charging for one middle level of service exclusively, under the philosophy that some charges will be higher, some charges lower, and the charges will average out over an extended period.

ix. Upcoding: Billing staff shall not engage in "upcoding," which is the practice of billing for a more expensive service than the one actually performed.

x. Items or Services Not Provided: Billing staff shall not bill for items or services not rendered or not provided.

C. Should any questions arise regarding the proper code to be assigned to an item or service, or there is conflicting, incomplete, or ambiguous information in the health record relevant to the proper code, billing staff should seek assistance and resolution from appropriate management personnel, the fiscal intermediary, or payor prior to the claim submission, and query the provider for clarification and additional documentation, as necessary.

D. All billing manuals and policies will be reviewed by the SVP of Quality and Compliance and [Summit BHC Revenue Cycle Director] at least bi-annually and revised as appropriate and necessary.

Identifying and Reporting Billing Errors

A. Billing staff should not submit claims for improperly referred patients.

i. If Summit BHC becomes aware of any contracts or arrangement that may violate the federal Anti-Kickback Statute, federal Physician Self-Referral Law, or any other federal

or state kickback or self-referral law, the contracts and/or arrangements should be immediately reported to the Compliance Department.

ii. When claims have been submitted because of an improper referral arrangement, billing staff, in conjunction with the Compliance Department, should diligently work to identify those claims and immediately discontinue submitting claims for reimbursement for the treatment of such patients.

B. False claims and billing fraud may take a variety of different forms, including, but not limited to, false statements supporting claims for payment, misrepresentation of material facts, concealment of material facts, theft of benefits or payments from the party entitled to receive them, or retaining an overpayment, as defined by law.

C. If a Team Member has any reason to believe that anyone (including the Team Member himself or herself) is engaging in questionable or problematic billing practices, that Team Member shall immediately report the practice to their supervisor and the Compliance Department. Failure to act when a Team Member has knowledge that someone is engaged in false billing practices shall be considered a breach of that Team Member's responsibilities, which shall subject the Team Member to disciplinary action by Summit BHC, up to and including termination.

i. Once a billing error has been reported, the [SVP of Quality and Compliance] should take appropriate steps to investigate the cause of the error and to prevent its recurrence.

ii. Any overpayment received because of any billing errors will be promptly repaid to the appropriate payor as required by the payor or relevant federal or state law. If, in resolving a billing error, Summit BHC determines that it has received an overpayment from any federal healthcare programs, Summit BHC shall comply with CMP 015- Reporting and Returning of Overpayments Policy.

Training

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

B. Billing staff and other Team Members responsible for coding and documentation shall receive training on appropriate coding and billing as appropriate.

C. The coding and billing training may be conducted either in-house by qualified Summit BHC personnel or by an external source. In addition, such coding and billing training may be a part of other compliance trainings.