A. To establish routine monitoring of the health care claims billed under the Froedtert Health’s tax identification numbers in order to identify potential risk areas for improper documentation and billing of health care items and services by staff members and contractors.

B. To establish expectations in which departments understand their accountability for monitoring their charging and billing process to ensure it is performed accurately and in compliance with all applicable laws and regulations.

Definitions:

A. Abuse – For the purposes of this policy, abuse is an unintentional practice that directly or indirectly results in an improper payment to the healthcare provider.

B. Fraudulent – For the purposes of this policy, fraudulent is defined as knowingly or should have known submission of false claims resulting in improper payments, including but not limited to where a payment is received for services not rendered, care that is medically unnecessary, services already covered under another claim, miscoded, or where documentation does not support or represent services charged.

C. Legal Healthcare Record (LHR) – Any documentation related to the health of a patient prepared by or under the supervision of a Health Care Provider. The LHR is the record that would be printed or copied and released when the medical record is requested.

D. PFS – Refers to the Froedtert Health Patient Financial Services department.

E. RI – Refers to the Froedtert Health Revenue Integrity department.

Policy:

A. General:
1. Froedtert Health, its staff members, and its contractors are committed to billing in accordance with the laws, rules, regulations, and policies set forth by the federal and state governments.

2. All individuals are responsible for conducting our business in an honest and ethical manner, and are expected to follow the elements outlined in the Froedtert Health Code of Corporate Ethics Policy.

3. Froedtert Health submits claims only for services that are both ordered and performed.

4. Services or tests that cannot be performed are not submitted for reimbursement. Surgical procedures that are terminated after the patient is prepped and draped, and anesthesia has begun may be able to be billed based on documentation with the application of the appropriate modifier.

5. Froedtert Health prohibits individuals from knowingly submitting a claim for payment to any federally or state funded program that includes false or fraudulent information, or is based on false or fraudulent documentation. See Addendum A for the Federal False Claims act and the State False Claims Provisions.
6. All staff members and contractors are responsible for preventing, detecting, and correcting actual or potential fraudulent entries on any bills or claims.

7. All staff members and contractors are responsible for promptly reporting actual or potential improper payments caused by an improper billing issue, to their leaders, the PFS Department, or the Compliance Department. These improper payments may result from intentional, systems related or unintentional issues.

B. Hospital Clinical Departments:
1. Are responsible for submitting charges that accurately represent the care, services, and supplies provided to patients.
2. Must develop department-specific procedures to ensure that their charge processes work correctly and that errors are promptly identified.
3. Are responsible for including written documentation in the Legal Healthcare Record that supports the services they provide and bill for.
   a. The documentation must be accurate, timely, and complete.
   b. Documentation must support the medical necessity for services provided with valid provider orders as required.
4. Are responsible to monitor for correct charging and documentation according to requirements on a routine basis.
5. Must submit charges, corrections, and credits per Hospital policy. Refer to Charge Capture Policy – FH–FIN.025.
   a. Charges requiring CPT/HCPCS codes are submitted in accordance with government guidelines.
   b. Charges should be reviewed at least annually to ensure appropriate use of codes. Including the evaluation and management (E/M) charge criteria grids maintained by ambulatory clinics.
   c. Responsible manager and applicable staff must maintain an accurate charge master for services the department provides. Refer to Charge Master Integrity and Compliance Policy – FH–FIN.028.

C. Revenue Integrity Department (RI):
1. Will maintain and distribute charge capture guidelines to all clinical staff that perform charge capture activities.
2. Will educate designated clinical staff that perform charge capture activities on established guidelines as needed.
3. Will perform periodic charge capture monitoring and audits to provide department feedback.

D. Patient Financial Services Department (PFS):
1. Is responsible for claims being correctly prepared and submitted in accordance with regulations, Hospital, and departmental policy whether the activities are performed by hospital staff or an outsourced vendor.
2. Must have procedures that:
   a. Avoid and prevent erroneous, fraudulent or abusive billing practices.
   b. Monitor billing activities to detect any deliberate or accidental occurrences of incorrect billing.
   c. Monitor CMS publications to stay current with CMS billing guidelines.
   d. Correct erroneous, fraudulent or abusive billing practices,
   e. Promptly report and coordinate repayment of overpayments received for erroneous or fraudulent billing. Any overpayments identified require repayment within 60 days from the time that a quantified overpayment is calculated.
   f. Have billing edits in place, where possible, to prevent billing for services that are medically unnecessary as covered services.
3. In coordination with the Compliance Department, will develop an annual Billing Compliance Plan that will identify indicators that will be monitored during that fiscal year to assist in detecting and preventing inappropriate, inaccurate, fraudulent, or false billing practices.

4. Will be responsible for monitoring the quality of work for each individual performing governmental billing. Results will be reviewed by the PFS Management on at least a biannual basis (whether employed or contracted).
   a. A more frequent and comprehensive audit/review schedule will be initiated if needed based on the results of the routine monitoring.
   b. If inaccuracies are discovered during this routine audit immediate feedback will be provided to the staff member and additional training, disciplinary actions (if required) and correction will occur.

7. Will immediately notify the Compliance Department of any possible noncompliant situation that could or did occur that would possibly result in inappropriate receipt of governmental funds.

E. **Corporate Compliance Department:**

1. Will engage in specific compliance efforts to detect and prevent fraud, waste, and abuse.

2. Will investigate and evaluate reported or referred issues to determine necessary corrective actions.

3. Will perform selective billing compliance audits as a supplement to those audits and monitoring activities performed by the clinical department, RI department and PFS department as part of the Compliance Department annual audit plan.

4. In coordination with Revenue Cycle Management and Clinical Department leaders, will develop an annual Billing Compliance Plan that will identify indicators that will be monitored during that fiscal year to assist in detecting and preventing inappropriate, inaccurate, fraudulent, or false billing practices.

E. **Other:**

1. Pre-billing monitoring/auditing are preferred when possible.

2. If a post-billing review is conducted, Froedtert Health shall repay overpayment(s) identified on any internal or external coding review regardless of the error rate, to the appropriate payer and in accordance with payer refund policies.

3. Educational opportunities identified through billing quality monitoring should be communicated to the individual, as applicable.

4. Educational sessions to address identified errors should be considered for the appropriate audience to prevent further occurrences. Documentation of those sessions (including content and attendance) will be retained by the Department’s leadership.

5. Compliance with this policy will be monitored by the Froedtert Health Corporate Compliance Program and reported to the Froedtert Health Compliance Committee.

6. The Froedtert Health Corporate Compliance Hotline (414–259–0220) is maintained as a means for individuals to anonymously report actual or potential billing or payment wrongdoings.

**Related Policies:** Charge Master Integrity and Compliance

**Issuing Authority:** FH Corporate Policy Committee

**Distribution:** Froedtert Health
Reference

Type: FH-COM.035 Attachment092815.doc

Attachments: FH-COM.035 Attachment092815.doc

Content Details URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=43b93LJN9D4o