

Name: Froedtert Health Billing Compliance Policy

Last Review
Date: 06/27/2021

Next Review
Date: 06/27/2024

Description: Hospital, Ambulatory Surgery and Professional Billing, FH Affiliate Billing, Compliance Policy, Provider Billing, Provider Coding, Billing Compliance, Compliance, Revenue Cycle

Policy
Number: FH-COM.95

Origination
Date: 06/19/2018

Supersedes: Hospital Billing Compliance Policy Professional/Physician Coding and Billing, Quality Assurance and Compliance Policy

Purpose: This policy sets forth basic documentation, coding and billing standards for health care items or services that are being billed to a patient or his/her third-party payer to promote prevention, detection and correction of any actual or potential billing errors.

This policy applies to all health care items and/or services that are billed under a Froedtert Affiliate tax identification number.

Definitions:

- A. **Abuse/Waste** – For the purposes of this policy, abuse is usually an unintentional practice that directly or indirectly results in an improper payment to the health care provider. Examples of abusive practices may include ongoing billing or coding errors without corrective actions taken.
- B. **Coding or Billing Error** – For the purposes of this policy, the wrong code or misuse of a code or modifier related to coding a patient encounter for reporting and billing purposes. Errors can result from systems-related or unintentional issues. Examples of an issue may include services provided outside correct provider scope of practice or inadequate provider supervision, which may not be billable.
- C. **Fraud** – For the purposes of this policy, fraud includes knowingly submitting, or causing to be submitted false claims or making misrepresentations of fact to obtain improper payments for which no entitlement would otherwise exist. Examples of fraud may include: a payment is received for services not rendered, services already covered under another claim, or documentation does not support or represent services charged.
- D. **Froedtert Health (FH) Affiliate** – For the purposes of this policy, Froedtert Health affiliate includes: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc.; St. Joseph's Community Hospital of West Bend, Inc.; New Berlin & Pewaukee Hospitals Froedtert & The Medical College of Wisconsin Community Physicians, Inc., West Bend Surgery Center, LLC, Froedtert Surgery Center, LLC; ; Drexel Town Square Surgery Center LLC; Menomonee Falls Surgery Center, LLC; Holy Family Medical Center, and any other entity that becomes controlled by Froedtert Health after adoption of this policy also may be considered an affiliate.

- E. **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.

- F. **Provider** – For the purpose of this policy, a provider is any physician or advanced practice provider that provides clinical services that are billed by an FH Affiliate or wholly own subsidiary whether employed, contracted or a member of the medical staff.

- G. **Billing** – The coding and/or abstracting of services on behalf of an FH Affiliate for the purpose of claim submission for payment. The billing function includes assignment of any claim information including ICD diagnosis(es) and procedure code(s), the assignment of any HCPCS Level I CPT procedure(s), HCPCS Level II procedure or service code(s), and any applicable modifier(s).

- H. **Third-Party Billing Contractor (Contractor)** – A service or company that is contracted to assist a health care provider process claims, or review claims for proper billing.

- I. **Health Care Provider** – A provider of medical or health services and any other person who bills, or is paid for health care services in the normal course of business.

Policy: **General:**

- A. Billing and coding will be in compliance with all applicable state and federal laws and regulations.

- B. All appropriate costs will be accurately reported on the facility cost reports.

- C. All individuals are prohibited from knowingly submitting a claim for payment to any federally or state funded program that includes or is based on inaccurate or false information, or documentation (see Addendum A for the Federal False Claims Act and the State False Claims Provisions).

Documentation, Coding & Billing Standards:

- A. It is the responsibility of each clinical department to implement a process so that health care items or services are documented before the submission of a claim for payment of those health care items or

services.

- B. No health care items or services should be billed unless there is documentation in the LHR to support the items or services.
- C. Services will not be billed unless performed.
- D. Services or tests that are not or cannot be performed, or are cancelled prior to starting, for any reason, are not submitted for payment. Discontinued procedures may be submitted with the appropriate codes and modifiers. Contact the Patient Financial Services Department (PFS) for specific questions on how to bill these accurately.
- E. Claims for clinical services will be charged and coded accurately according to current calendar or fiscal year official coding guidelines and according to the supporting documentation of the services provided in the LHR.
- F. Only charges that accurately describe the care, services and supplies provided to patients will be submitted for payment.
- G. Charges requiring CPT/HCPCS codes will be submitted in accordance with government and other official guidelines for the current fiscal or calendar year.
- H. Upcoding, unbundling or any misrepresentation of services is prohibited.
- I. Duplicate claim(s) from the same provider for the same item/service or for the same date of service, will not be submitted.
- J. Claims for services that are not considered medically necessary for payment will be submitted according to payer requirements. (For example, non-covered services)
- K. Services that require an order from a licensed provider will only be billed when a valid order is documented in the LHR.
- L. Unclear, missing or conflicting orders or documentation will be clarified with the ordering or performing provider prior to services being performed.

- M. All individuals involved with teaching physicians, residents and medical students will meet all the billing, documentation and supervision requirements required by Medicare for billable physician services.
- N. Providers are responsible for selecting the accurate procedure and/or service codes, diagnosis(es) code(s) for their services.
- O. Providers are responsible for closing patient encounters according to the established policy.

Reporting, Monitoring, Auditing and Investigations:

- A. All individuals are responsible for promptly reporting actual or potential documentation, coding, charging, billing and payment errors to their leaders, with notification to the FH Compliance Department or the FH Compliance Hotline.
- B. The FH Corporate Compliance Hotline may be used by individuals to anonymously report actual or potential improper billing practices or payments.
- C. Individuals that receive government audit or other notices must notify and forward documents to the FH Compliance Department promptly (e.g., DOJ, OIG, CMS, and other government agencies according to the Regulatory Agencies Contact Policy FH.COM.110). You must contact compliance via email at complianceregulatorynotification@froedtert.com.
- D. Prior to initiation of any external review of billing, coding, or charging practices, the FH Compliance Department must be contacted. Operational departments should not contract for an external audit or review without consulting with Compliance first. You may contact the compliance department at the email comphotl@froedtert.com
- E. Clinical departments must develop department-specific procedures or workflows to establish correct and accurate charge capture and billing practices. Prebilling reviews are preferred whenever possible.
- F. Leaders should establish a method to monitor for correct charging and documentation according to requirements on a routine basis, which should include, confirming there is the proper level of supervision required and individuals are practicing within their scope of practice.
- G. The responsible manager(s) and designated staff must maintain an accurate charge master for services the department provides. Refer to organizational Charge Master Integrity and Compliance Policies.

- H. Facility and operational department charges will be reviewed by the department responsible leader at least annually to ensure accurate use of codes and manage any updated guidance. This review includes the evaluation and management (E/M) charge criteria documents maintained by ambulatory clinics.

Training & Education:

- A. Employees and providers involved with the billing process will be educated about appropriate charge use, codes and workflows/ procedures, along with applicable laws and regulations governing requirements for correct charging and coding and the necessary supporting documentation. This education will be coordinated by their leader as part of their onboarding and refreshed annually as needed.

Corrective Actions:

- A. Responsible leaders must correct identified erroneous or inaccurate coding, documentation and billing practices.
- B. If inaccuracies are discovered in bills that have already been submitted to a payer, immediate steps will be taken to alert the payer and correct the bill in accordance with the payer's guidelines and requirements.
- C. If improper payments are identified, the responsible leader must notify the appropriate individual or department so corrections and refunds can be made promptly (within 30-60 days, according to payer requirements).
- D. When the supporting documentation used to assign diagnosis(es) or procedure codes is ambiguous, conflicting or unclear, the department or coder/biller must contact the ordering or performing provider to clarify and amend the patient LHR.
- E. Charges, corrections and credits must be submitted according to organizational policy. Refer to organizational Charge Capture Policy(ies).
- F. Controls should be implemented when possible to prevent billing for services that may not be billable. For example, Medicare CCI, OCE edits and other custom prebilling edits for known problem prone issues will prompt review and proper claim management.

Related [Charge Capture](#)

Policies: [Charge Master Integrity and Compliance](#)

[Compliance Reporting, Hotline and Non-Retaliation](#)

[Froedtert Health \(FH\) Outpatient Hospital Services Evaluation and Management Visit Level Creation, Revision, and Use](#)

[Hospital Coding Quality Monitoring](#)

Reference

- Details:
- A. FH Professional Billing Compliance Regulatory Manual (On Compliance Scout page)
 - B. [Medicare Fraud and Abuse: Prevention, Detection and Reporting Booklet](#) (CMS Site)
 - C. Summary of Federal and State False Claims Laws -
<https://intranet.froedtert.com/upload/docs/Froedtert%20Health/Departments/Compliance/Summary%20of%20Federal%20and%20State%20False%20Claims%20Laws.pdf>
 - D. Regulatory Agency Contacts Policy FH.COM.110.

Collaborators: Jennifer Anderson

Issuing Authority: FH Corporate Policy Committee

Distribution: Froedtert Health

Reference Type: Federal Law Including CMS, Wisconsin State Law

Additional Attachments: [Addendum A-Summary of Federal and State False Claims Laws.pdf](#)

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