Our Lady of Lourdes Health Care Services, Inc. & Affiliates including
Our Lady of Lourdes Medical Center
Lourdes Medical Center of Burlington County
Administrative and General Policy

POLICY NUMBER:	LHS AS0019CCP
NURSING CODE:	
PAGE NUMBER:	

TITLE: Billing Code of Conduct Statement

ACCOUNTABILITY:

President and Chief Executive Officer

OBJECTIVES:

RELATION TO MISSION:

Our Lady of Lourdes, a Catholic Health System – a member of Catholic Health East - dedicated to its Franciscan Tradition of serving all, will demonstrate the value of **Integrity** by fostering the ethical and moral behavior of associates through adherence to the Billing Code of Conduct Statement.

RELATION TO OPERATION:

The Billing Code of Conduct Statement provides guidance to all of Our Lady of Lourdes Health Care Services, Inc. and Affiliates (OLLHCS, Inc.), trustees, officers, managers, supervisors, associates, contractors, volunteers, students and others and assists us in carrying out our daily billing activities within appropriate ethical and legal standards.

POLICY:

1) The following policies specifically address Billing Code of Conduct. This policy must be maintained in addition to the Corporate Compliance Code of Conduct (see OLLHCS, Inc.'s policy AS0002CCP) already in effect.

2) In keeping with OLLHCS, Inc.'s mission and goals the trustees, officers, managers, supervisors, associates, contractors, volunteers, students and others are required to comply with the following guidelines. Instances of non-compliance should be immediately reported and corrective actions taken in a timely manner.

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a) Deal openly and honestly with fellow associates, customers, contractors, government entities and others.
b) Practice good faith in transactions occurring during the course of business.
c) Preserve patient confidentiality unless there is written permission to divulge information, except as required by law. (See OLLHCS, Inc. policy AS0001PRI)
d) Ensure third party bills are submitted in accordance with third party reimbursement policies.
e) Establish quality checks to monitor accurate coding with respect to documented procedures performed.
f) Create internal review procedures to guard against double billing.
g) Provide informative and relevant guidelines for billing tests and evaluative procedures. These guidelines should be revised regularly to reflect regulatory/third party payor updates. (See OLLHCS, Inc.'s policy AS0021CCP – Monitoring Billing Compliance.)
h) Ensure that cash received relates solely to entitled reimbursement.
i) Maintain a compensation structure for billing department coders and billing consultants that does not provide incentives to improperly upcode claims.
j) Establish policies and procedures to assure compliance with all applicable statutes, regulations and program requirements and private payor plans regarding cost report issues.

3) OLLHCS, Inc. promotes full compliance with all relevant billing and claim reimbursement requirements by requiring all personnel involved in billing and claims submission to maintain high ethical standards and a strong knowledge of all laws and regulations related to the billing function. (See OLLHCS, Inc.'s policy AS0020CCP – Billing Training and Education.)

4) Ensure that all persons who are involved in any aspect of OLLHCS, Inc.'s billing and claims reimbursement activities will be held to a high standard with respect to knowing and adhering to the requirements and standards for participation in the health care industry, including but not limited to, all rules and regulations pertaining to claims submission and reimbursement under the Medicare, Medicaid and other Federal programs.

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5) All such persons will be properly credentialed by the appropriate professional organization if required to be so by their specific job descriptions. (See OLLHCS, Inc.'s policy AS0315PER – Licensure Verification.)

6) Accurate billing and claims submission requires cooperation and effective communication between members of billing staff and clinical staff members. An effective billing program requires that all persons involved in the patient care process (i.e., clinical or administrative staff) be diligent with respect to proper documentation.

   a) Failure to document patient care properly may result in the improper submission of claims by OLLHCS, Inc. because:

      i) The admitting or registration personnel failed to give a Medicare beneficiary the notices and information required by the program.

      ii) Clinical staff failed to document the time spent, services provided, and materials used in the patient's care.

      iii) An ancillary department misidentified a service.

      iv) Data-entry personnel applied a charge to the wrong patient account.

      v) A code was incorrectly applied by Health Information Management (HIM) staff.

7) Members of each staff should seek clarification regarding billing and coding practices between departments when questions arise. In the event that a department cannot address a particular billing or coding question, the Director of the Revenue Management & Compliance Department should be contacted for assistance. If need be, outside resources (i.e., legal counsel or the Medicare Intermediary) should also be contacted for assistance.

   a) The inquiry and the answer obtained thereto should be properly documented in writing

   b) The response should be made available to the Director of Compliance & Privacy Officer.

8) It is essential that all clinical staff document physician and other professional services in an accurate, organized, legible, and timely manner and in accordance with any Medical Staff

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Policy related to documentation and maintenance of patient records to ensure that services are properly billed. (See the respective Medical Staff By-laws or Rules and Regulations.)

a) Billing staff should only submit claims when there is appropriate clinical documentation to support fully the claim and when the documentation fulfills the applicable maintenance requirements for such documentation in accordance with OLLHCS, Inc.'s records retention policy (See OLLHCS, Inc.'s policy AS0016CCP – Documentation and Retention Requirements.) The documentation should include patient records and must

i) identify the length of time spent conducting the service

ii) identify the individual providing the service

iii) identify, where appropriate, the person or persons supervising the provider of the service

iv) fully support the services rendered, as well as the codes and diagnoses to be utilized for each claim

9) Bill only for items or services actually rendered.

a) Never submit a claim for reimbursement without adequate information to indicate that the service billed for was actually rendered.

b) Such information should include the date and time the service was rendered or the item provided, the identity of the person to whom the service was rendered or the item provided, a description of the service rendered or item provided, and the identity of the person providing the service or item for which reimbursement is sought.

10) Bill only for medically necessary services. Claims should only be submitted for services that OLLHCS, Inc. has reason to believe are medically necessary and that were ordered by a physician or other appropriately licensed provider.

a) Reimbursement under Medicare for any such services must be "reasonable and necessary" according to the standards for Medicare reimbursement set forth in applicable statutes and regulations.

b) Should any question arise regarding the "medical necessity" of a service, adequate documentation to prove the medical necessity of the service must be provided and reviewed prior to submitting any claim for reimbursement.

11) Double-check all billing codes. Claims should only be submitted when the correct billing code has been assigned to the item or service as intended by the payer (including Medicare and Medicaid).

a) Care should be taken to ensure that claims are submitted according to the correct Diagnosis Related Group (DRG).

b) Should any questions arise regarding the proper code to be assigned to an item or service, resolution of the issue should be obtained from the Director of Revenue Management & Compliance (with the advice from legal counsel or other consultants, as needed), the Intermediary, or payer prior to any claim submission.

12) Do not routinely waive any co-payment or deductible. Claims may not be submitted if the patient has not been charged with the appropriate co-payment or deductible, unless the patient to whom the item was provided or service was rendered is determined to be indigent.

13) Ensure that all claims have been properly bundled. Make sure that all claims are bundled and that global billing codes are properly assigned prior to the submission of claims. Check all claims to make sure that there is no duplication of codes for multiple portions of the same service (i.e., removal of multiple lesions or tumors).

14) Scrutinize carefully all cost reports. Verify that all information contained in cost reports is accurate, ensuring specifically that

a) Costs are not claimed unless based on appropriate and accurate documentation.

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b) Allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data.

c) Unallowable costs to various cost centers are accurately made and supportable by verifiable and auditable data.

d. Accounts containing both allowable and unallowable costs arc analyzed to determine the unallowable amount that should not be claimed for reimbursement.

e. Costs are properly classified.

f. Adjustments are made to account for the results of the intermediary's prior year audit and

   a. Are not claimed for reimbursement or

   b. Are claimed for reimbursement but are clearly identified as "protested," if applicable, on the cost report.

g. All related parties are identified on Form 339, which is submitted with the cost report, and all related party charges are reduced to reflect costs.

h. Requests for exceptions to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data, and OLLHCS, Inc.'s procedures for reporting bad debts on the cost report are in accordance with all applicable law.

i. Procedures are in place and documented for notifying promptly the Intermediary or other applicable payer of errors discovered after the submission of OLLHCS, Inc.'s cost reports.

15) Ensure that all claims are submitted in accordance with the DRG 72-Hour Window Rule.

a) Identify all outpatient services that may not be billed separately from an outpatient stay occurring within the 72-hour period immediately preceding the date of the patient's admission to the hospital.

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i) The hospital's computer system has been programmed to identify those patients whose outpatient services (which were obtained within the previous 72 hours) exactly match the admitting ICD-9 code.

(1) The outpatient charges will be captured and billed in conjunction with inpatient charges.

16) Ensure that claims are submitted *only* for services provided by OLLHCS, Inc. or "under arrangements" with other suppliers/providers.

17) Ensure that no duplicate billing occurs.

a) Check all claims to make sure that no more than one claim is submitted for the service for which reimbursement is sought.

18) Report patient transfers accurately.

a) Make sure that when billing involves services for a patient transferred to another hospital, only a per diem amount rather than the full DRG amount is charged.

19) Refund credit balances accurately.

a) Remove credit balance accounts from active accounts and place them in a holding account until the reimbursement claim is processed to the appropriate payer program.

20) Do not submit claims for improperly referred patients.

a) If OLLHCS, Inc. becomes aware of any contracts or arrangements which might violate the Anti-kickback Statute, Stark Law, or other anti-referral law, the Patient Financial Services Department and the Director of Compliance & Privacy Officer should be advised immediately.

i) Patients who may have received services due to an improper referral arrangement should be identified and no claims for reimbursement from Medicare or Medicaid should be sought for the treatment of such patients.

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ii) See also the following OLLHCS, Inc. policies regarding Physician Issues, Payments and Discounts, and In Exempt Status for information regarding compliance with the Anti-kickback Statute and Stark Law.

(1) AS0022CCP - Financial Arrangements with Physicians and Other Referral Sources

(2) AS0023CCP - Corporate Compliance - Patient Referrals

21) Review of current formal billing policies and procedures.

a) The Patient Financial Services department and the Revenue Management & Compliance departments should review the current "formal" billing manual and policies for compliance with all billing requirements and revise as appropriate and necessary.

22) Review of current informal billing policies and procedures.

a) The Patient Financial Services department and the Revenue Management & Compliance departments review "informal" billing practices for compliance with all proper billing requirements (i.e., what to do when the computer will not accept when the processor enters what he or she believes to be the appropriate code), and revised as necessary and appropriate.

23) Refund all credit balances.

a) Refund all credit balances in a timely and appropriate manner.

24) Discovery of Billing Errors. If a billing error is discovered, the error should be immediately reported to the Director of Revenue Management & Compliance and the Director of Compliance & Privacy Officer.

a) Appropriate steps will be taken to investigate the cause of the error and to prevent its recurrence.

25) Any overpayment received as a result of such billing error will be promptly repaid to the appropriate payer (with interest, if appropriate).

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26) To assure that associates from the following departments:
    a) Patient Financial Services
    b) General Accounting
    c) HIM
    d) Corporate Compliance
    e) Financial Counseling / Insurance verification, and
    f) Revenue Management & Compliance

    are informed of this Billing Code of Conduct Statement, signature of its receipt and acceptance is required from associates from these departments only. (See Exhibit A) However, at no time is this Billing Code of Conduct to be followed as a replacement for sound ethical and professional judgment.

APPROVED BY: ______________________________
Alexander J. Hatala, President and Chief Executive Officer

ORIGINAL & REVISION DATE(s): 03/22/00, 07/09/03, 05/24/06; 04/25/07; 05/31/09

NEW EFFECTIVE DATE: 05/31/12

REQUIRES REAUTHORIZATION IN: 05/31/15

AS0019CCP
Billing Code of Conduct Statement

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EXHIBIT A
STATEMENT OF UNDERSTANDING OF
AND COMPLIANCE WITH
THE BILLING
CODE OF CONDUCT STATEMENT

I certify that I have read and understand the Billing Code of Conduct Statement and agree to abide by it during the entire term of my employment. I acknowledge that I have a duty to report any alleged or suspected violation of the Billing Code of Conduct Statement to the Director of Compliance and Privacy Officer. Unless otherwise noted below, I am not aware of any possible violation of the Billing Code of Conduct Statement.

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Further, I certify that I am not aware of any additional circumstances, other that those disclosed above, that could represent a potential violation of the Billing Code of Conduct Statement. I will report any potential violation of which I become aware promptly to the Director of Compliance and Privacy Officer. I understand that any violation of the Billing Code of Conduct Statement or any other corporate compliance policy or procedure is grounds for disciplinary action, up to and including discharge from employment.

____________________	____________________
Name (Print)	Signature
____________________	____________________
Date	Position

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