

Billing Compliance Plan

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I. Overview of Compliance Program

A. Objective

ABC Billing Company is a third party Medical billing company, established under all applicable Laws of the State of (Florida). Today, healthcare providers rely on Medical Billing Companies such as ABC Billing Company to provide claims submissions in a timely manner as required by the Client's (provider's) Health Insurance Contract, Applicable State and/or Federal Health Insurance Laws, or the Patient's Health Benefit Manual/Summary Plan Description. Claims submission is performed only after the proper processes have been performed such as Verification of Current Health Benefits, Verification of the patient's Coordination of Benefits, and Verification of the claim address. The claims process doesn't end with the submission of the claim. The claims process also includes claim follow-up which could include the resubmission of the claim due to a Not On File explanation by the insurance company, the discovery of an additional health insurance policy, the submission of an authorized appeal of an improperly paid Provider insurance contract claim, an unpaid claim or a claim denial or patient billing as authorized by State Law or the provider's Health Insurance contract for denied claims, co-pays, deductibles, or co-insurance. The management and staff will conduct applicable continual education on Federal and State insurance billing requirements, HIPAA changes, and any other training requirements such as with patient identify theft prevention. The Billing Company management and staff are dedicated with the continual compliance through high ethical standards, understanding and complying with applicable federal health insurance billing regulations, the Billing Company's Compliance Plan, and expects the same commitment from its employees and clients. Employees of ABC Billing Company are required to be currently certified as Medical Billers by any State Board of Education Certified, Medical Billing Certifying Organization, Agency, or Association such as The Medical Association of Billers.

B. Organization

ABC Billing Company has designated certain employees with the additional duty requirement to maintain and manage its Compliance Program. The list of employees is included in Attachment A. ABC Billing Company has designated (**Tinkerbell**) as the Compliance Officer. The Compliance Officer has primary responsibility for implementing and managing the billing company's compliance plan. The Compliance Officer is authorized to report directly to the owner(s) of ABC Billing Company regarding Compliance Issues, any Compliance Violations or complaints.

The Compliance Officer, with the assistance of the leadership of ABC Billing Company, assists in the review, revision and formulation of appropriate policies to monitor the billing and coding process, (2) develops proprietary educational training to the medical billing company's personnel and staff, (3) coordinates the review of medical records, superbills, and related billing documents and (4) works with all staff members in the updating and training of compliance plans, addresses specific employee and patient concerns, and when appropriate, may initiate corrective action to address compliance

issues, which action may include suspensions and termination, and (5) maintains compliance and refund logs.

C. Application

This Compliance Program applies to all present and future employees of ABC Billing Company. The Compliance Program applies to any and all medical billing or coding procedures for medical care rendered by the physicians and ancillary medical personnel of any contracted client of ABC Billing Company.

II. Compliance

A. Code of Conduct

In order to provide a written commitment to act legally and ethically in the performance of medical coding and medical billing at the ABC Medical Billing Company. All present and future employees are required to sign a Code of Conduct and Non-Disclosure Agreement.

Policy

The basic principles of the ABC Medical Billing Company Code of Conduct are:

1. Be honest and ethical. Under no circumstances will any and all information entrusted to an ABC Medical Billing Company employee or consultant be used for illicit, unethical, or illegal means.
2. Obey the laws. If at anytime an employee is uncertain about State/Federal laws or applicable regulations have jurisdiction over any and all information entrusted to the ABC Medical Billing Company, the employee is required to seek assistance from their immediate supervisors.
3. Every employee or consultant must be completely truthful and have supporting documentation to support any statement or claim. For example, if it is said, it is illegal to charge a patient more than the Medicare allowable. The claim or statement to provide validity must be provided through a valid document from Medicare or the law that supposedly makes it illegal. Unconfirmed statements or something that was "heard" from someone else will not be accepted. Medical record documentation received from the provider should be 100% true, accurate, complete, and timely and in accordance with applicable State and Federal laws. Medical claims should be 100% true, accurate, and complete, in accordance with current applicable State/Federal Laws, and health insurance company claims guidelines. . In the event there may be doubt as to the truthfulness of patient demographic and health insurance information received from the provider, the information should be 100% verified for accuracy prior to the submission of the claim. A record of said verification will be entered into the patient's electronic account or medical record. The verification will list the date and time of verification, how verification was

obtained (website printout or phone call), if by phone call, the name of the health insurance company representative that provided the verification and the phone number that was called. When obtaining and verifying insurance/claims information, the following information will be obtained and updated in the account/record

- a. Whether or not the member belongs to an HMO.
- b. The sponsor of the health care coverage.
- c. If the carrier is due to workers Compensation or a personal injury:
 - (1) The name of the employer providing health care coverage
 - (2) The date the injury was reported to the workers compensation carrier.
 - (3) The name of the adjustor and the claim number (Workers Comp or Auto Claim).
 - (4) Whether the patient has hired the services of an attorney (Personal Injury)
- d. if the carrier is primary or secondary.

4. Under NO circumstances will any claim be submitted, either by paper or electronic means without having the information 100% verified and contains NO errors. In the event the information is found to be invalid, the employee or consultant will contact the patient, member or guarantor by phone or certified mail/return receipt to obtain any and all current information. Any information obtained from the patient will be 100% verified.

5. Patients expect that their private, financial, and personal health information (HPI) to be secure from improper release and/or identification theft. Confidential information concerning ABC Medical Billing Company's policies and procedures or intellectual property should also be protected. The fact that a telephone is the least secure method of communication, under NO circumstances will any patient information be discussed on the telephone except during authorized and validated HIPAA transactions. Under no circumstances will any protected and private patient information be placed into outgoing written or electronic correspondence that is sent to someone other than the patient or those authorized by the patient, in writing, to receive said information. Data sent to an insurance company as an attachment will be sanitized to remove those patients who is not contracted to receive health benefits from that particular insurance company. For example, John Smith has insurance with Aetna and Blue Cross. Aetna submitted payment with an attached remittance containing 20 other patient names. Before sending the claim to Blue Cross, the names and claims information of those 20 other patients are to be removed from the remittance. The sanitation process is as follows:

- (a) The original remittance is copied and filed appropriately.
- (b) The data on the copy is blackened out using a black marker.
- (c) White Out is used to cover the black markings.
- (d) The remittance is reviewed by holding it up to a light to see if the data is showing through the black marker and white out.

6. Any paperwork containing a patient's personal information will be protected from viewing by anyone else in the billing company that has no reason to access this information, at all times. Paper documents no longer necessary for claims processing,

patient billing, authorized HIPAA transactions, or administrative processes will be destroyed using appropriate and approved methods such as shredding or using a HIPAA approved document disposal company. Simply throwing the paper into the trashcan is unacceptable.

7. Any possible FTC Identity Theft Red Flag issues will be brought to the attention of both the Identity Theft Compliance and Protection Officer (**Bullwinkle**), the HIPAA Security Officer and the Compliance Officer (**Tinkerbell**). Failure to protect personal, financial and/or PHI may be grounds for immediate termination.

The Federal Trade Commission Identity Theft Red Flags are as follows:

1. A fraud alert included with a consumer report.
2. Notice of a credit freeze in response to a request for a consumer report.
3. A consumer reporting agency providing a notice of address discrepancy.
4. Unusual credit activity, such as an increased number of accounts or inquiries.
5. Documents provided for identification appearing altered or forged.
6. Photograph on ID inconsistent with appearance of customer.
7. Information on ID inconsistent with information provided by person opening account.
8. Information on ID, such as signature, inconsistent with information on file at financial institution.
9. Application appearing forged or altered or destroyed and reassembled.
10. Information on ID not matching any address in the consumer report, Social Security number has not been issued or appears on the Social Security Administration's Death Master File, a file of information associated with Social Security numbers of those who are deceased.
11. Lack of correlation between Social Security number range and date of birth.
12. Personal identifying information associated with known fraud activity.
13. Suspicious addresses supplied, such as a mail drop or prison, or phone numbers associated with pagers or answering service.
14. Social Security number provided matching that submitted by another person opening an account or other customers.
15. An address or phone number matching that supplied by a large number of applicants.
16. The person opening the account unable to supply identifying information in response to notification that the application is incomplete.
17. Personal information inconsistent with information already on file at financial institution or creditor.
18. Person opening account or customer unable to correctly answer challenge questions.
19. Shortly after change of address, creditor receiving request for additional users of account.
20. Most of available credit used for cash advances, jewelry or electronics, plus customer fails to make first payment.
21. Drastic change in payment patterns, use of available credit or spending patterns.

22. An account that has been inactive for a lengthy time suddenly exhibiting unusual activity.
23. Mail sent to customer repeatedly returned as undeliverable despite ongoing transactions on active account.
24. Financial institution or creditor notified that customer is not receiving paper account statements.
25. Financial institution or creditor notified of unauthorized charges or transactions on customer's account.
26. Financial institution or creditor notified that it has opened a fraudulent account for a person engaged in identity theft.

Not all of the above FTC Red Flags relate to medical billing. Red Flags of concern are the following

a. **complaints where a patient says they were never seen by the provider.**

This is a complaint that should be taken seriously. The person complaining is directed to submit a notarized and current copy of their State drivers license that contains their photograph and signature. The documents from the provider will be reviewed to see if they obtained and copied the State drivers license at the time of registration. The photograph and signature are compared to see if they are identical. If they are not identical, the account will be placed on hold. The practice will be informed of the possibility of identity theft so that they can take the appropriate actions in the event the person who is using the false identity returns. The real patient will be informed of the results of the investigation so that they can take all appropriate actions that occur with identity theft.

b. **complaints of never receiving a statement.**

This can be a tactic by some patients to get out of paying their bill. The patient has moved and uses their old address as their current address. Have the patient send you a notarized copy of their current drivers license AND a copy of their current utility bill such as electric bill. These two documents can be used to verify the current address because the utility bill is commonly used by State license or Identification issuing stations as proof of a current and valid address. If the patient becomes angry and belligerent when asked to prove their current address, this is a sure sign of someone who doesn't want to pay their bill. It is up to the patient to prove and verify their current and valid information. Angry and belligerent patients are referred to your supervisor for resolution.

c. **The bill I received is not for me.** The identity thief may sometimes obtain the address of a real person and use that address as their own. For example. Jim Smith finds the address for John Wayne. When Jim Smith goes to a provider, he uses his real name but uses John Wayne's address. John Wayne gets the bills and calls the practice to let them know he got Jim Smith's bill. Jim Smith may go further and use John Wayne's name and address. The account is placed on hold and flagged as a possible identify theft

account. The address used is documented in the account notes and removed from the account so that once the real address is obtained, the real patient will receive past and current bills.

d. You get multiple EOBs for the same patient for multiple recent dates of service.

You see that John Wayne was seen on January 3, 10, 21, and 29. All for different medical conditions. The EOBs show the claims were denied as service terminated. When reviewing the chart, the January 3rd date of service documents a 6 foot tall black male. The January 10 date of service shows a 6 foot white male. The same is for the rest of the dates of service. It is possible the real John Wayne is the 6 foot black male who may have had his wallet stolen. The fake John Wayne uses the real John Wayne's insurance card. The fake John Wayne got away with the other visits because he was seen by different providers of the practice. You do not bill the real John Wayne for the fake John Wayne's visits. You flag the account in the event the fake John Wayne visits the practice.

e. Patient presents coverage through Medicare Part B even though the patient's personal information reflects that they may not be covered under Medicare Part B. The patient may actually have Medicare Part B or the patient may be using a stolen or borrowed Medicare Part B card. Under no circumstances will a claim be submitted when it has been determined that a stolen or borrowed Medicare Identification Card has been provided. Medicare and the appropriate law enforcement agencies will be contacted. The real patient will be informed, in writing of the unauthorized use of their Medicare ID card. Discovery will be annotated in the patient's medical and financial record. The practice will be informed in order to flag the account in the event the identity thief chooses to seek additional care.

With any possible identity theft situation, the practice is to be notified. The practice may have to change their registration policies to obtain identification to verify the patient's real identification and current address. Prevention, identification, education and patient cooperation is the best way to help combat identity theft as well as losses due to identity theft. Take all complaints seriously!!!

8. If any employee is presented with any Red Flag circumstance listed above, the Red Flag Compliance Officer (Bullwinkle) is to be informed immediately. The account is placed on hold during the identity theft investigation.

9. Any employee found to be involved with the theft of a patient's personal, financial or medical information will be terminated immediately with a recommendation to the State Attorney for possible criminal prosecution.

10. Report conduct that concerns you. If you believe that any activity may be illegal, unethical or otherwise troubling, you are required to report it to your supervisor. You may report your concerns to the company Compliance Officer. Reports may be made

anonymously. There is a policy of non-retaliation for any good faith report of possible improper activity.

Enforcement

An individual's failure to live up to these policies may result in disciplinary action, including suspension, termination, and or monetary fines consistent with ABC Medical Billing Company's medical billing policy and applicable State and Federal laws. For violations of applicable State and/or Federal laws, individuals may also face criminal and civil, and monetary penalties. All new hires are required to sign a copy of the Code of Conduct during new hire training. Any employee found in violation of any applicable State and/or Federal law will face immediate termination and possible prosecution by the appropriate legal authorities.

B. Fraud and Abuse

Objective

To assist employees of the ABC Medical Billing staff in preventing the submission of erroneous claims or engaging in unlawful conduct that is contrary to current State and Federal health insurance laws, policies and rules.

Policy

Federal and State laws extensively regulate health care activities to prevent fraud and abuse. Fraud is defined as obtaining or attempting to obtain services or payments by dishonest means with intent, knowledge and willingness. Abuse is defined as medical or billing practices that are inconsistent with acceptable medical, business, or fiscal standards. Examples of fraud could be any of the following:

- (1) Charging for a service that was not performed.
- (2) Unbundling of claims: Billing separately for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.
- (3) Double billing: Charging more or twice than once for the same service.
- (4) Upcoding: Charging for a more complex service than was performed. This usually involves billing for longer or more complex office visits (for example, charging for a comprehensive visit when the patient was seen only briefly), but it also can involve charging for a more complex procedure than was performed or for more expensive equipment than was delivered. Medicare documentation guidelines describe what the various levels of service should involve.

(5) Miscoding: Using a code number that does not apply to the procedure.

(6) Kickbacks: Receiving payment or other benefit for making a referral. Indirect kickbacks can involve overpayment for something of value. For example, a supplier whose business depends on physician referrals may pay excessive rent to physicians who own the premises and refer patients. Another example would be a mobile testing service that performs diagnostic tests in a doctor's office. Kickbacks can distort medical decision-making, cause overutilization, increase costs, and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. They can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests.

(7) Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.

(8) Providing unnecessary services or ordering unnecessary tests

Areas considered as potentially abusive include:

1. Incorrect billing to Medicare, Medicaid and commercial carriers.
2. Increasing charges to Medicare patients and not to others.
3. Submitting claims for non-medically necessary services.
4. Over utilization of services

The Office of Inspector General published, in the Federal Register, Vol 63, No. 243, has listed the following as risk areas-

(1) **Billing for items or services not actually documented**

Under No circumstances will any employee of ABC Medical Billing Company submit a claim for any service that is undocumented. If ordered to do so, the employee will report the order to the Compliance Officer, who will report the incident to the owners/managers of ABC Billing Company. Any employee found in violation of this order will be subject to immediate termination with possible prosecution by the State Legal Authorities.

(2) **Unbundling;**

Coders must follow current National Correct Coding Initiative (NCCI) guidelines when submitting a claim to the insurance company. If NCCI shows the procedures performed to be bundled or inclusive with another procedure performed during the same service, no unbundling will be performed and that includes the use of Modifier -59 to justify the unbundling.

(3) Upcoding

Coders will code the appropriate CPT code based on CPT coding guidelines and the documentation contained in the medical record. AN Evaluation and Management will be coded based on the 1997 Evaluation and Management Documentation Guidelines and the medical record documentation. In the event that the medical record is missing the documentation for the required key components of a History, Examination, Medical Decision Making and/or Provider Signature. The chart will be returned to the provider for completion. The medical record will NOT be returned to the provider for additional documentation that could cause the claim to be upcoded to a higher level of CPT Code. For example, if the documentation only supports a 99213, the record will not be returned to the provider so that the provider adds additional documentation to cause the claim to be coded as a 99215.

(4) Inappropriate balance billing

ABC Billing Company will comply with applicable State health Insurance Laws such as Florida Statute 641.3154, which prohibits the balance billing of an HMO patient when the HMO accepts liability for the claim. In addition, ABC Billing Company will not violate any current provider health insurance contract that prohibits balance billing of the carrier member when payment is issued by the contracted carrier that is equal to the provider contracted payment amount. Medicaid patients will not be balance billed in accordance with Florida Statute 409 and the Florida Medicaid provider manual. Patient billing will only occur as the situation allows such as the following:

(a) For any and all patients, including Medicare, HMOs, contracted and non-contracted insurance companies, the amounts applied by the patient's health insurance company to the patient's deductible, co-pay or co-insurance.

(b) For non-par insurance companies that are NOT Health Maintenance Organizations under the jurisdiction of Florida Statute 641.3154, the patient will be billed for amounts that are the difference between the provider's usual and customary provider charges and the non-par insurance company payment. The patient can appeal the payment of their benefit as per their contract with their insurance company. ABC Billing company will enforce the member's contract with their insurance company by requiring the member to appeal the payment of their health benefit.

(c) For HMO patients where their health benefits are under the jurisdiction of the Employee Income Security Act (ERISA), as defined in Federal law, 29 USC 18, sec. 1003(a) 1144(a) and 29 CFR 2560-503-1. The member will be required to appeal the payment of their health benefit. The HMO member will NOT be balanced billed per FS 641.3154 unless allowed through Federal laws that supersede State Law.

(d) For commercial insurance companies that are not an HMO, under NO circumstance will ABC Insurance Company make any attempt to collect more than the total amount of the provider's usual and customary provider charges when you combine the insurance and patient payments. An overpayment will be returned to the entity that caused the overpayment to occur or to whom the insurance company designates to receive the overpayment.

(5) Inadequate resolution of overpayments;

(a) Amounts of payments that exceed the provider's billed usual and customary charges must be returned to the entity that caused the payment to be exceeded. Under normal circumstances if the insurance company made the overpayment, the insurance company will have the exceeded amount returned to them unless they request, in writing, that the overpayment is sent to the patient. When an overpayment is sent to the patient or insurance company and the overpayment is returned due to refusal by the patient or insurance company, the overpayment will be sent to the Florida Treasurer pursuant to applicable State Law. Neither the provider or ABC Billing Company is entitled to keep overpayments.

(b) When processing end of month reports, the provider will be informed of all overpayments with any and all supporting documentation such as EOBs to support the return(refund) of the overpayment. It is the provider's responsibility to return the overpayment to the appropriate entity. The provider will inform ABC Billing Company that the overpayment has been returned (refunded), the check date, check number, and to whom the refund was made so that ABC billing company can make the appropriate entries into the patient's electronic account. ABC Billing Company is not responsible or liable for the provider's or provider's staff's refusal to return any overpayments. In the event this circumstance occurs, the provider will be informed, by the Compliance Officer, in writing, regarding the requirement to issue refund of identified overpayments. The Compliance Officer will inform the appropriate State authority of the identified overpayment and required refund. The provider's continual refusal to issue a refund may be grounds for immediate termination of the billing contract between the provider and ABC Billing Company.

(c) An insurance company that submits a claim for an alleged overpayment, that has been received in a timely manner, either directly or through a business associate, will submit the claim in accordance with Florida Statutes 641.3155 or 627.6131. The claim will be researched for completeness and accuracy. If the claim was received in an untimely manner, the claim will be denied for that reason. ABC Billing Company will inform the insurance company of the claim denial by Certified Mail/Return Receipt. If the claim has insufficient evidence to support payment, the insurance company will be informed of the request for supporting documentation by Certified Mail/Return Receipt within the timeframe allocated in the applicable State Laws. If the insurance company does not supply the requested information within the State Law time frame, the claim will be denied by Certified Mail/Return Receipt.

(d) If the insurance company's claim was received in a timely manner with the appropriate supporting documentation, the provider will be provided with a copy of the claim/documentation so that the provider can issue the appropriate claim payment. ABC Billing Company will annotate the account with the insurance company's claim and claim payment, if any. ABC Billing Company will verify any and all insurance information that has been provided as supporting documentation if the insurance company's claim is to be refunded due to another insurance company being primary. If the supporting documentation proves to be valid, a claim will be sent to the identified insurance company. The claim will have a copy of the overpayment letter attached to prevent any and all timely filing denials. Any timely filing denials will be appealed and if appropriate, the patient will be billed. The prevention of an overpayment request due to the presence of additional insurance, can be prevented through increased data collection by the provider's staff and through verifying insurance coverage prior to sending any claim.

(6) Lack of integrity in computer systems;

ABC Medical Billing Company's Computer Security Officer is responsible for ensuring that all software purchased and used by ABC Billing Company complies with current HIPAA Security Laws as well as software copyright. Under no circumstances will any bootleg or illegal software be installed into ABC Billing Company's computer systems. Failure to comply with this directive may be grounds for immediate termination of the employee. Any damages caused by the bootleg software will be paid for by the employee that installed the bootleg software. All employees will undergo Computer Security training as part of their inprocessing and as an ongoing training program.

(7) Computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;

ABC Medical Billing Company will use current HIPAA Security Certified medical billing software. The Computer Security Officer will establish management approved levels of employee security to limit the users access to the different areas of the billing software. For example, a level 1 user will have access to the patient demographic area so that they can look but not make any changes to any information. A level 5 user will have the ability to perform data entry only with no ability to make changes. The user level and access ability will be based on the duties of the ABC Medical Billing Company employee. Security passwords will be assigned by the Computer Security Officer only. Changes to passwords will be made on a monthly basis or when an employee leaves the employment of ABC Medical Billing Company. Data personnel that are hired to enter data will undergo background screening prior to being hired. Data entry personnel will undergo specialized training to discourage any and all forms of improper data entry. Entering improper or unauthorized data is grounds for immediate termination and possible prosecution by State Legal Authorities. The data entry person exposes themselves to possible litigation by the person/patient damaged by the person's illegal and unauthorized act. ABC Medical Billing Company is not responsible for the employees legal bills if found to have performed an unauthorized and illegal act. The management of ABC Billing Company will be informed of any and all computer security

violations. Computer security training will be included as part of any and all new employees training and as an ongoing training program to be conducted on a quarterly or on an as needed basis.

(8) **Failure to maintain the confidentiality of information/records;**

Medical Records are the property of the provider as indicated in applicable State and/or Federal Law. Records of patient treatment and patient financial information is considered personal and private. This information is protected by State and Federal laws such as the Health Insurance Portability and Accountability Act (HIPPA). The telephone is the least secure method of communication and as such, a person speaking on the telephone may or may not be speaking directly with the patient, even when someone identifies themselves as the patient. Any requests for information or records must be made, in writing, and verified prior to the release of the requested information. Authorization for the Release of information, as authorized by State and/or Federal Privacy laws, is required prior to allowing the requested information to be released. Under no circumstance with patient information be discussed outside the work area. This includes the break areas, waiting rooms, other non-work areas or within the hearing of visitors or other patients.

(9) **Knowing misuse of provider identification numbers, which results in improper billing**

ABC Billing Company is entrusted, by the provider with certain personal and professional information to be used with normal and legal claims processing. The Staff of ABC Billing Company will keep that and any other information personal and private. Misuse of provider and patient information is illegal, unethical, and unauthorized. Attempts to commit fraud by wrongfully misusing provider information to submit claims for services never rendered by the provider is grounds for immediate termination and possible prosecution.

(10) **Outpatient services rendered in connection with inpatient stays;**

All claims submitted will be properly and correctly coded based on current CPT, and ICD-9 standards and guidelines. Health Record documentation supports each procedure selected by ABC Medical Billing Company's Certified Coders. Coders and Billers are prohibited from submitting false claims. Outpatient services will be coded and billed as such. Inpatient claims will not be billed as outpatient services. Employees found to be in violation of this policy will be immediately terminated. Claims paid for fraudulent claims will have the payment returned to the entity that rendered payment. If the provider or provider's staff orders the submission of claims knowing to be wrong or fraudulent may be grounds for termination of the coding and billing contract. The appropriate authorities may have to be informed of the provider or provider staff actions

(11) **Duplicate billing in an attempt to gain duplicate payment**

Claims will be submitted, via paper or electronic means, on the day the data has been completed in the billing software program and within the claims submission timeframe outlined in applicable laws, provider contracts and patient benefit manuals. The claims submission department will securely store any and all files processed and transmitted.

Verification reports will be obtained from the insurance company and clearinghouse. Electronic claims will resubmitted in the event of an invalid transmission report from the insurance company or clearinghouse. The only other time a claim will be submitted is in the event of a report from the insurance company regarding a Not On File (NOF) claim. The claim will be resubmitted on paper using Certified Mail/Delivery Confirmation. Under no circumstance will a claim be submitted in a time frame less than the claim resubmission time frame outlined in applicable State Law or based on the age of the unpaid claim. When investigating unpaid claims, a claim that is over sixty (60) days old will be investigated to determine if the original claim is on file or not on file with the insurance company. If found not on file, the claim resubmission will be performed immediate. Documentation to show the submission will be attached to the resubmitted claim. The resubmitted claim will have proof of original submission attached to the claim. Medicare and Medicaid claims not on file will be resubmitted, no earlier than 60 days from the original submission date. Resubmission will be through electronic means after ensuring and verifying that all claims data is 100% true, accurate and complete.

(12) Billing for discharge in lieu of transfer

Claims and patient statements will be submitted for payment for services rendered based on the documentation in the medical record. If there is no documentation of a valid patient visit that contains the documentation as required by CPT, no claim will be submitted. The provider will be informed of the no claims submission. If there was a valid patient visit, the provider has thirty (30) days from the date of discharge as outlined in applicable State or Federal Law, to ensure completeness of the record. Claims will not be submitted after the timeframes outlined in applicable law, provider contracts and patient benefit manuals.

(13) Failure to properly use modifiers;

ABC Billing Company's Certified Coders will use any and all appropriate CPT and HCPCS Modifiers approved by the American Medical Association and the Centers for Medicare and Medicaid Services to report certain services that require the use of a modifier. Coders will restrict themselves to use only the modifiers listed in Appendix A of the current CPT Manual. Coders will not use modifiers as a means of unbundling services identified as bundled in the National Correct Coding Initiatives (NCCI) edits.

(14) Billing company incentives that violate the anti-kickback statute or other similar Federal or State statute or regulation;

ABC Medical Billing Company is reimbursed based on a flat fee per claim. This is done to prevent the possibility of up coding in order to increase revenue. ABC Billing Company will ensure compliance with any and all applicable State and Federal Laws and regulations. ABC Billing Company employees will not offer discounts to patients that could violate their personal health insurance contract, or State/Federal laws. ABC Billing Company will not accept any orders or demands from the client providers that could be in violation of State/Federal laws/Regulations. Said orders or demands could be grounds for immediate termination of the working contract between the provider client and ABC Billing Company. Any attempts by the provider client to order ABC Billing Company or

any of its employees to violate any State/Federal laws/ Regulations may have to be reported to the appropriate regulatory organization or agency.

**(15) Routine waiver of copayments and billing third-party insurance only; and
• Discounts and professional courtesy.**

Providers establish their usual and customary charges for services rendered to patients who make a freedom of choice decision to seek care and establish a patient-provider relationship. Patients obtain health care coverage through a personal/financial decision without involvement of an employer or as a benefit of employment via a contract with a health insurance company. Said contract establishes benefits that are provided and benefits that are excluded. The contract establishes a patient or member's out of pocket expenses such as deductibles, co pays and coinsurance amounts. Providers may make a freedom of choice decision to be contracted with the patient's personal health insurance company. As part of the contract, the provider may have agreed to accept reimbursement that is lower than the provider's usual and customary charges. In addition, the provider contract may or may not allow patient billing after payment of the contracted reimbursement fee. There may be instances where the provider has no contract with the patients health insurance company. The provider prior to accepting the patient must inform the patient that he/she is not contracted with their insurance company and any financial situations that may result from treatment, claims submission and claims payment. This allows the patient to make a freedom of choice decision to continue with the medical care having full knowledge of any possible out of pocket expenses as a result of payments that are less than the providers charges, copayments, deductibles and coinsurance. ABC Billing Company will make best efforts to ensure the provider's and patient's compliance with the health insurance company contracts as long as compliance does not violate State/Federal laws/Regulations. ABC Billing Company will use best efforts and standard industry standard patient collections from uninsured patients by collecting the provider's full usual and customary provider charges unless there is a reimbursement contract between the provider and patient that allows the patient to pay less than the provider's usual and customary charges. ABC Billing Company will make best efforts to collect patient co-pays, deductibles and coinsurance amounts where patient billing is not prohibited. ABC Billing Company will make best efforts to collect health insurance contract payment amounts. Under No circumstances will ABC Billing Company waive or dismiss copayments, deductibles, coinsurance or insurance payments that are less than the contracted payment amount. In the event the provider has no contract with the patient's health insurance company with both patient and provider entering into a patient-provider agreement, and the patient's insurance company paid less than the providers charges, ABC Billing Company is obligated to make best efforts to collect, from the patient, the difference between the providers charges and insurance payment with the exception of a Medicare or Medicaid HMO. In the event of a Medicare and Medicaid HMO, payment should be the current Medicare/Medicaid allowable for the region where the services were rendered. If payment is less than the allowed amount, ABC Billing Company will make best efforts to collect the correct amount from the insurance company and not the patient where patient billing is prohibited. Waivers of

copayments, deductibles or coinsurance is allowed only under the following circumstances:

- (a) The cost to collect is more than the amount that is due.
- (b) Every effort to collect has been made without success, to and including the use of a contracted debt collection agency by the provider. Under this circumstance, a waiver must be approved by the provider.
- (c) In the event the patient proves they are financially unable to pay their copayment, coinsurance, deductibles or remaining debt amount with uninsured patients.

Physicians who have health insurance also have a contractual requirement to pay copays, deductibles, and coinsurance amounts after their health insurance company pays their health benefit claim. ABC Medical Billing Company is obligated to collect these contracted amounts. Professional discounts are now discouraged and will not be accepted by ABC Billing Company. ABC Billing Company will not engage in any practice that could be a contract violation in addition to a possible violation of State and/or Federal laws/Regulations. If ordered to provide a professional discount, ABC Billing Company will have no choice but to refuse and consider termination of the physician-billing agent contract/relationship. ABC Billing Company may have no other options than to report the incident to the appropriate regulatory authorities.

Submission of non-compliant or erroneous claims may result in serious consequences for ABC Medical Billing Company, including monetary penalties, exclusion and, under certain circumstances, criminal penalties. ABC Medical Billing Company cannot be held responsible for erroneous, incomplete, or inaccurate information supplied by the medical practice and/or patient. It is the medical practice's requirement to ensure that any and all information obtained from a patient or the patient's health insurance company(s) is true, accurate, correct and has been verified for accuracy. This will ensure that all claims are 100% true, accurate and complete.

The Office of the Inspector General ("OIG") of the U.S. Department of Health and Human Services is responsible for protecting the integrity of Federal health care programs, including Medicare and Medicaid. To help health care providers and medical billers prevent erroneous or unlawful claims for payment by these programs, the OIG has identified risk areas where providers may be vulnerable to fraud and abuse. The risk areas for physician practices include:

1. Unbundling of services;
2. Billing for services not rendered or not provided as claimed;
3. Billing for services not documented;
4. Billing for non-covered services as if covered;
5. Submitting claims for items or services that are not reasonable and necessary;
6. Coding using one or two middle levels of service codes exclusively (also known as

“clustering”);

7. Upcoding the level of service provided;
8. Inappropriate balance billing when accepting assignment;
9. Inadequate resolution of overpayments;
10. Computer software that steers toward entry of services not provided;
11. Knowing misuse of provider identification numbers;
12. Duplicate billing;
13. Failure to properly use modifiers;
14. Routine waiver of co-payments, coinsurances and deductibles; and
15. Discounts for service.

ABC Medical Billing Company will use best efforts to keep a watchful eye out for the above risk factors and will inform the provider of any possible risk areas identified so that they can be corrected. It is the provider’s responsibility to ensure these risk areas do not occur. ABC Medical Billing Company will never allow it’s professional integrity to be compromised even at the risk of losing a client. ABC Medical Billing Company has a legal and ethical requirement to report the findings of the above risk areas to the appropriate regulatory authorities if the provider makes a freedom of choice decision to allow the above risk areas to continue without correction. Employees of ABC Medical Billing Company found to be in violation of the above risk areas are subject to immediate termination with possible prosecution by the appropriate legal authorities.

C. Audit Policy

Objective

To ensure compliance is upheld across all medical billing and coding areas. ABC Medical Billing Company will create an audit trail for billing and coding compliance activity.

Policy

ABC Medical Billing Company will conduct the following types of audits.

Billing Review Audits – Conducted, monthly or on an as needed basis, by the individual departmental leaders in accordance with the medical billing company’s policies and procedures on medical billing, current industry standards and guidelines and applicable State/Federal laws/Regulations.

Investigative Audits – Conducted when an issue is brought to the attention of the provider or medical billing company staff and employees or discovered during a routine billing or quality assurance audit. These can consist of a review of payment postings, letters from patients, insurance companies, attorneys, or regulatory agencies, daily, weekly and/or end of month reports, documentation from the provider office or medical records, etc. Reports of outcomes are shared with the appropriate personnel and the provider.

Federal or State initiated focused audits – Conducted as initiated by requests for documentation or refund requests. The Compliance Officer will coordinate and assess all documentation to be submitted for review and assist the leadership and provider in formulating a response.

Research billing compliance audits – Conducted to assess medical coding and billing of claims. Medical records and/or superbills will be reviewed to ensure compliance with CMS’s 1995 or 1997 Evaluation and Management documentation guidelines, current CPT and ICD-9-CM coding standards and National CCI edit standards and guidelines. Claims will be reviewed to determine the completeness and accuracy of the data submitted to the insurance company.

HIPAA compliance audits – Conducted on an ongoing basis through electronic means and other methods to assure compliance with the privacy rules and regulations.

D. Anti-Kickback, Physician Self-Referral, and Conflict of Interest Policies

Objective

To ensure that ABC Billing Company personnel comply with Federal and State law regarding kickbacks, self-referrals, and conflicts of interest.

Policy

ABC Billing Company personnel will not engage in activities that violate Federal and State laws and ABC Billing Company policies and rules regarding provider kickbacks, self-referrals, and conflicts of interest.

The following is a brief description of the Federal anti-kickback and physician self-referral laws.

(a) Federal anti-kickback law:

The Federal anti-kickback law provides both criminal and civil penalties for individuals and entities that knowingly offer, pay, solicit or receive bribes, kickbacks or other remuneration in order to induce business that is reimbursable by Medicare, Medicaid, or other government programs. The law has been broadly interpreted to mean that it will be

violated if even one purpose of the relationship (as opposed to a sole or primary purpose) is the inducement of referrals. Violation of the anti-kickback law is a felony, punishable by significant fines and imprisonment (5 years in prison, \$500,000 fine), in addition to the imposition of civil monetary penalties (\$50,000 per kickback) and exclusion from participation in the Medicare and Medicaid programs. The exclusion remedy may be imposed in an administrative proceeding, even in the absence of any criminal proceeding or investigation.

(b) Federal physician self-referral law:

The Federal physician self-referral law, commonly known as the “Stark” law, prohibits a physician from referring Medicare and Medicaid patients for “designated health services” to entities with which the physician (or an immediate family member) has a financial or “compensation arrangement,” unless an exception applies. The “designated health services” covered by the law include, among other things, durable medical equipment, inpatient and outpatient hospital services, radiology and radiation therapy, clinical laboratory services, and outpatient prescription drugs. Under the Stark law, a “compensation arrangement” includes almost any arrangement involving remuneration (direct or indirect) of any sort and includes a physician’s relationship with any other provider or vendor. This is because compensation arrangements can affect a physician’s decision to refer a patient for a designated health service, and if so, to whom.

Unlike the Anti-kickback law, the Stark law imposes a blanket prohibition on referrals between those involved in any sort of “compensation arrangement.” The existence of a compensation arrangement alone, regardless of the parties’ intent, prohibits a physician from referring Medicare or Medicaid patients for any one of the designated health services unless an exception applies. The penalties for violating the Stark Law include possible civil monetary penalties and exclusion from the Medicare and Medicaid programs.

(c) Professional Courtesy.

The term “professional courtesy” is the practice by a physician of waiving all, or a part, of the fee for services provided to the physician's office staff, other physicians, and/or their families. In recent times, “professional courtesy” has come to also mean the waiver of coinsurance obligations or other out-of-pocket expenses for physicians or their families (i.e., “insurance only” billing), and similar payment arrangements by hospitals or other institutions for services provided to their medical staffs or employees.

In general, whether a professional courtesy arrangement runs afoul of the fraud and abuse laws is determined by two factors: (i) how the recipients of the professional courtesy are selected; and (ii) how the professional courtesy is extended. If recipients are selected in a manner that directly or indirectly takes into account their ability to affect past or future referrals, the anti-kickback statute -- which prohibits giving anything of value to generate Federal health care program business -- may be implicated. If the professional courtesy is extended through a waiver of copayment obligations (i.e., “insurance only” billing), other statutes may be implicated, including the prohibition of inducements to beneficiaries,

section 1128A(a)(5) of the Act (codified at 42 U.S.C. 1320a-7a(a)(5)). Claims submitted as a result of either practice may also implicate the civil False Claims Act.

ABC Billing Company will, under no circumstances, allow any possible violations of the above laws, even when ordered by the provider or professional friends of the provider. Any client who demands that ABC Medical Billing Company provide a professional discount for amounts owed by another provider or professional that is contractually required to be paid by the patient could be grounds for immediate termination of the provider-billing agent contract, in addition to ABC Medical Billing Company being required to report the incident to the appropriate regulatory authorities.

E. Corrective Action Policy

Objective

To ensure that non-compliant practices are addressed and corrected in an appropriate manner.

Policy

Noncompliant practices discovered or determined by the Compliance Officer, employees of the medical billing company or by others and brought to the attention of the Compliance Officer, will be handled exclusively by the Compliance Officer and will otherwise be subject to applicable ABC Billing Company policy.

Typically, the Compliance Officer will review the practices in question and, if appropriate will formulate a Corrective Action Plan for immediate implementation. In most instances, the Compliance Officer will meet with the providers or staff involved and/or with the medical billing company leadership and present the Corrective Action Plan. In some cases, this may not be practicable, and the Compliance Officer will present a written plan to the provider and/or medical billing company leadership in lieu of a meeting.

A Corrective Action Plan may include a period of billing review and the retraining and re-education of providers and staff.

A Corrective Action Plan may include a written letter of warning to the provider, to the medical billing staff member or reprimand, imposition of terms of probation and a recommendation of the restriction, suspension or termination of employment and/or ABC Billing Company appointments, in accordance with company policy. The provider has the responsibility of resolving any internal issues identified.

Employees also should be aware that the law may provide for monetary and criminal penalties.

F. Speaking with Government Agents

Objective

To instruct ABC Medical Billing Company personnel how to respond to requests for information from government agents.

Policy

If a government agent contacts you or if you receive a search warrant or a subpoena, here are the steps to take:

1. Contact the Compliance Officer and senior leadership of the medical billing company.
2. Do not be alarmed. Always request identification.
3. It is the ABC Medical Billing Company's preference that an ABC Medical Billing Company representative or legal representative is present whenever a government agent interviews an ABC Medical Billing Company staff member.
4. Do not feel intimidated or rushed by the agent. No interview or discussion should take place in a patient care area frequented by visitors.

Some additional information that you should know:

- A government agent may contact you by phone, letter, and/or personal visits to the office or home. Since proper identification cannot be obtained in a phone call, we suggest you defer any response until the agent's identity can be verified. A personal meeting is more appropriate.
- You must comply with a search warrant even if it is served after, when you are unable to direct it to the Compliance Officer. If a search warrant is presented, it is important to obtain the name of the agent and request a receipt for the documentation that may be taken. It is appropriate to ask that the agent write down exactly what documents are being sought. When possible, you should make a descriptive list of the documents.

G. Employment Policy

Objective

To ensure that the ABC Medical Billing Company does not employ individuals who are barred or sanctioned from participating in Federal or State health care programs.

Policy

ABC Medical Billing Company abides by federal requirements precluding the employment of individuals who have been sanctioned by the United States Government or excluded from participation in federal programs.

Federal law prohibits certain individuals and businesses from participating in Federally-funded health care programs. Individuals/Entities can be excluded for convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans. Under this law, The Office Inspector General of the Department of Health and Human Services (the “OIG”) has established a program to exclude individuals and entities in violation of Sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities (LEIE). The LEIE is available at <http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html>.

ABC Medical Billing Company’s practice is to screen all prospective new hires against exclusion lists maintained by the Office of Inspector General (“OIG”) of the U.S. Department of Health and Human Services and the GSA prior to the commencement of employment. If it is found that the prospective employee is sanctioned or barred, the prospective employee will be informed that their request for employment is denied.

H. Education and Training Policy for Employees Involved in Billing

1. Training for New Hires

Objective

To ensure that individuals who bill for their professional services, who supervise others who bill, or who are involved with the generation or submission of bills or claims for reimbursement receive billing compliance training shortly after starting work at ABC Medical Billing Company.

Policy

New hires who are involved in the generation or submission of claims for reimbursement, are required to receive billing compliance training within thirty days of hire. This requirement is fulfilled by attendance at a one-day New Hire Training session, which is given as needed upon the hiring of a new employee. New hires will not be permitted to perform any medical billing function until they have completed this training.

2. Qualification Standards for Medical Billing Personnel

Objective

To ensure that medical billing personnel hired are adequately educated and trained.

Policy

All medical billing personnel must have a basic understanding and training of the following elements:

- Medical Anatomy and Physiology
- Medical Terminology
- Insurance Terminology

- Documentation Standards (1995 or 1997 E/M Documentation Guidelines)
- Current Procedural Terminology (CPT)
- International Classification of Disease (ICD)
- Use of Modifiers
- Regulatory Compliance
- The CMS 1500 Form
- How to read and understand an EOB, EOMB, and Remittance
- Medicare Billing and Appeals Process
- Medicaid Billing and Appeals Process
- Tricare, Veterans Administration, Federal Employees, and CHAMPVA billing
- Private Health Insurance such as PPO, HMO, POS, and Traditional Policies
- Workers Compensation Claims Requirements
- Personal Injury Claims Requirements
- The Patient's Benefit Manual and Patient's Requirements for Claims and Appeals
- Coordination of Benefits
- Federal Laws such as ERISA, Stark, Anti-Kickback and False Claims
- State Laws regarding Insurance, HMO, Timely Filing, Refunds, Balance Billing, PIP, Medical Records, Debt Collection, Workers Compensation, Prisoner healthcare, and Medical Terminology.
- The provider insurance contracts
- Processing Payments, Appealing denials, Processing demands for claims information.
- Accounts receivables.

The technical skills of medical billers should be assessed, both orally and via a pre-employment written test, to the satisfaction of the medical billing company leadership. All medical billing personnel must be provided with regular in-house monthly or quarterly training and education opportunities both internal and external.

- Unless already certified as a Medical Biller through one of the many Medical Billing certifying organizations, such as the Medical Association of Billers, all medical billing personnel should have the opportunity to undergo certification to enhance their knowledge of medical billing and compliance functions.

- All medical billing personnel will obtain professional certification within two years of hire. Certification will be through any nationally recognized certifying organization or association. Examples are: The Medical Association of Billers (MAB). Certification will be at the employees personal expense. Recertification will be in accordance with the Certifying organization or Association and also, at the employees personal expense. In the event of an accidental laps of recertification, the employee will have ninety (90) days to become recertified. If certification or recertification is not performed, the employee may be terminated without cause or placed into a non-billing position within the company.

I. Billing Company Compliance Responsibilities

Objective

To ensure that the medical billing company is prepared to address its compliance obligations.

Policy

The medical billing company's policies and procedures shall, at a minimum, include the following features:

1. written policies and procedures for billing activities undertaken by medical billing personnel;
2. educational and training programs to address billing issues of particular importance to the company;
3. a program for ensuring, and documenting, that all new personnel, receive training with regard to proper billing;
4. a monitoring plan to review compliance, with the results of such reviews being reported to the Compliance Officer;
5. monthly reports of medical billing statistics for use in monthly, quarterly and/or yearly reports;
6. a system that tracks billing or compliance issues, such as a payment posting log, accounts receivables report or aging report, and the resolution of those issues, reporting to the Compliance Officer;
7. the use of compliance as an element in evaluating the performance of employees, managers and supervisors who have responsibility for billing;
8. an annual review of the existing compliance plan in order to identify the need for changes and to identify specific compliance objectives during the succeeding year; and
9. a program for developing corrective action plans when compliance issues are identified.

(1) Superbills or Encounter Forms

Objective

To ensure that superbills or encounter forms used by client providers are reviewed annually for changes and revisions and are otherwise compliant.

Policy

1. Providers will document current and correct CPT 4 and ICD-9 codes for billing their services via encounter forms or superbills.
2. The billing company will assist, as needed, by making recommended changes to the client at least every January and whenever there are official changes to codes and descriptions.
3. The billing company will retain the copies of the superbill/encounter forms as part of the patient's financial record in accordance with the records retention policy.

(2) Record Retention

Objective

To ensure that the medical billing company retains copies of medical records in an appropriate manner.

Policy

The copies of the patient medical records, superbills, and related administrative billing records shall be retained in their original or legally reproduced form for a period as defined in accordance with applicable State and Federal Laws.

ABC Medical Billing Company has the option to scan all medical record/superbill copies and store the scanned images on CD or DVD and then return the copies to the provider or destroy the copies in accordance with applicable State law.

In the event of the termination of the contract, ABC Medical Billing Company will return all claims data to the provider, in a manner that is requested by the provider so as to protect patient privacy regarding the claims and medical information on the visit.

J. Consultants

Objective

To ensure that outside billing consultants are retained only in accordance with ABC Medical Billing Company's policy.

Policy

The Compliance Officer must review and approve in advance any engagement of outside billing consultant or other entities involved in billing, coding, collections or related activities and must provide a copy of any reports prepared by such consultants or other entities.

ABC Medical Billing Company cannot knowingly hire as employees or engage as a provider or contractor any ineligible person. To prevent hiring or contracting with any ineligible person, all consultants and entities must be screened through the HHS/OIG List of Excluded Individuals/Entities (See Section II.G. of this manual).

III. Medical Billing Guidelines

A. Medical Billing Policy

Objective

Professional billing should reflect the services rendered, be appropriately documented and based upon medical necessity.

Policy

1. ABC Medical Billing Company requires the provider to select the CPT and ICD-9-CM codes billed for reimbursement. Providers are responsible for knowledge of the codes and modifiers billed frequently in their practice.
2. Providers must use their own billing numbers; they may not use other providers' numbers when awaiting receipt of their own numbers.
3. Services rendered should be appropriate and medically necessary.
4. Sound billing practices are based on accurate information in the Medical Record and related documents which convey clearly and legibly what the physician did, the correct date of service and physician presence during all procedures.
5. The information obtained by the provider's staff, such as patient demographic information, insurance information, authorizations and precertifications, and whether the service being billed is a covered service, must be verified as accurate by the provider's staff prior to being sent to the billing company.
6. The physician's staff should make best efforts to collect patient balances at the time of service. These amounts include co-pays, deductibles, and full charges for uninsured patients. These amounts are to be reported and posted to the patient's accounts.
7. The Medical Record and related documents should be protected. Medical records should not be backdated. Any amendment or addition of records should be in the form of a signed addendum with the current date (not the date of the earlier record). The provider should avoid squeezing in notes on a progress sheet. The record should document the active, rather than the passive voice wherever possible, e.g., "I performed the endoscopy," rather than "the endoscopy was performed."

8. Claims will be submitted by paper or by electronic means, in a timely manner, as regulated by State/Federal Law, the provider's and patient's health insurance contract, immediately upon receipt of a completed and legible medical record and superbill and correctly entered into ABC Billing Company's billing software, without errors. The claim will be undergo review for missing or inaccurate data and then be corrected prior to being sent.

9. Claims that are incorrectly paid, unpaid, or denied for reasons other than timely filing, will be appealed only if there is receipt of permission by the patient, in accordance with 29 CFR 2560-503-1 and the appeals process outlined in the patient benefit manual, or in accordance with the provider contract. Appeals should be sent to the address in the patient's benefit manual or in the provider's contract within the timeframe required under Federal or State law or per the terms of the provider's contract. All appeals must have any and all supporting documentation attached to the appeal to provide foundation to the appeal.

10. Payments received by the provider will be sent to the billing company in a timely manner. The payment will be posted in the patient's account and reviewed for accuracy pursuant to State or Federal Law, or per the terms of the provider's insurance contract. A daily posting report will be produced and checked for complete accuracy. The provider is responsible to ensure that all payments received are reported to the billing company.

11. The medical billing company is not responsible for denied claims that are a result of records that are missing, sent to the billing company in an untimely manner, that are illegible, incomplete, incorrect information not verified by the provider's office, or services that are not a benefit or are not medically necessary.

12. Under no circumstances will billing information be released without the proper authorization. Billing information could be released to the patient, on the phone, only after verifying the identification of the caller that the caller is the patient. Each call will be handled in a professional manner.

B. Coding

Objective

To ensure that providers select accurate diagnostic and procedure codes for services billed in their names.

Policy

1. Each provider is responsible for choosing the CPT 4, ICD-9-CM, HCPCS codes, and Modifiers for services to patients billed and rendered under his or her name.

2. The medical billing company will monitor whether the codes chosen by the provider are supported by the medical record documentation for that code in order to ensure that accurate codes are billed.

3. The medical billing company staff is responsible for notifying the provider when there is a mismatch between the code chosen by the provider and the staff's determination of the appropriate code for the service. This can be accomplished in a number of ways such as fax, phone call, or letter.

4. In no event should the code for services be changed by billing staff personnel without informing and having the written consent of the provider.

C. Non-Physician Practitioner Billing Practices

Objective

To clarify the requirements for billing by non-physician practitioners for their services.

Policy

Non-physician practitioner (NPP) services rendered within their scope of practice, as specified by state law, are independently reimbursable under the Medicare program. NPPs who are eligible for direct billing include Nurse Practitioners, Certified Nurse Specialists, Physician Assistants, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Audiologists, and Registered Dietitians. However, NPPs that are included in a facility cost report are not billable independently or under the "incident to" regulations

- There are no restrictions as to the category, level or place of service imposed on NPPs billing under their individual provider numbers. All services are subject to the State description of the NPP's scope of practice.
- General physician supervision is required when service charges are submitted directly under the NPP's individual provider number. General supervision means that the physician need not be physically present when an NPP is performing a service, but must be immediately available for consultation.
- Physicians are not required to countersign notes entered by NPPs for claims that will be directly submitted by the NPP.

The following guidelines will assist in billing directly for services provided by NPPs:

1. Obtain provider identification numbers for all NPPs within specific insurance regulations and policies. NPP provider numbers are required to submit direct claims to certain insurers for reimbursement.

2. Bill only for services provided by NPPs who have independent provider numbers, and who do not appear on a facility cost report for the services they are billing for directly.
3. Bill only for professional services that are separately provided by NPPs. Duplicate services provided by an NPP and a physician on the same day to the same patient are not separately billable.
4. Periodically review individual insurance payer regulations and policies for accurate NPP reimbursement.
5. Periodically review supporting documentation for services submitted for reimbursement.

“Incident To” Services

Objective

To clarify the “incident to” provision for services billed by physicians and non-physician practitioners to all payers.

Policy

“Incident to” services are services that are furnished by other persons incident to a physician’s professional services in the **physician’s office** (whether located in a separate office suite or within an institution). “Incident to” billing is available for services provided in a patient’s home if the physician is also present in the patient’s home. The requirement of the physician’s presence in the patient’s home makes “incident to” billing in this location essentially meaningless.

The following information is pertinent for billing NPP services as “incident to” a physician’s services.

1. Service must be an integral part of the doctor’s diagnosis or treatment.
2. Physician must initiate care.
3. Any new conditions must be evaluated by the physician.
4. Service must be performed in a doctor’s office (or patient’s home). “Incident to” billing is not allowed in a hospital inpatient or outpatient setting under any circumstances.
5. Services are subject to direct physician supervision. Direct supervision requires the physician to be present within the office suite and immediately available throughout the service. The physician need not be present in the room with the patient and NPP during the procedure but must be in the office suite, assuring availability if needed.

6. Services must be performed by an employee, leased employee, or independent contractor of the physician or an employee of the entity that employs the physician. For the NPP's service to be billed as incident to a physician's service, the NPP must represent an expense incurred by the physician or the entity that employs the physician. NPPs not directly or indirectly employed by the physician are reimbursable through facility payments made based on hospital cost reports and their services cannot be billed as "incident to" a physician's services.

7. Physicians are not required to countersign clinical notes entered by NPPs for claims submitted under the "incident to" provision for reimbursement reasons, but may be asked to do so for quality of care considerations.

Shared Visits

Objective

To correctly bill for patient encounters that are shared or split between a physician and a nonphysician practitioner.

Policy

Office/Clinic Setting: Under Medicare's rules, when an evaluation and management ("E/M") services is a shared/split service between a physician and a non-physician practitioner, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. In this case, the physician reports the service. If the requirements for "incident to" are not met, the service must be billed under the non-physician practitioner's UPIN/PIN.

Hospital Inpatient/Outpatient/Emergency Department Setting: When a hospital inpatient/outpatient or emergency department E/M service is shared between a physician and a non-physician practitioner from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN and the level of visit determined by linking the notes of the physician and NPP. However, if there was no face-to-face encounter between the patient and the physician, the service may only be billed under the NPP's UPIN/PIN.

D. Diagnostic Supervisory Regulations Objective

Apprise physicians, non-physician practitioners, and billing staff of the rules regarding supervision of diagnostic tests.

Purpose

Medicare regulations establish three levels of supervision required for furnishing and billing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient.

1. **General Supervision** – The procedure is performed under the physician’s overall direction and control. The physician does not have to be physically present for the procedure. The training of the non-physician personnel performing the procedure and the maintenance of equipment and supplies is the responsibility of the physician.
2. **Direct supervision** –The physician must be present in the office suite and available for assistance and direction throughout the performance of the procedure. The physician does not have to be in the room during the procedure.
3. **Personal supervision** – The physician must be in the room during the entire procedure.

There are additional levels of supervision covering independent psychologists, audiologists and physical therapists. Each diagnostic test will have a level of supervision required next to the code. The codes cover diagnostic testing in all specialties.

E. Concurrent Care

Objective

To bill for concurrent care correctly.

Policy

“Concurrent Care” is the term used by Medicare for describing ongoing care rendered to a patient by more than one physician or non-physician practitioner on the same day. Concurrent care may be inpatient or outpatient, but most frequently occurs in an inpatient setting. It is generally inappropriate and deemed not medically necessary for more than one physician of the same or similar specialty to render the same or similar service to the same patient on the same day whether or not for the same condition. To determine the medical necessity of concurrent care, claims are subject to review of diagnosis codes and the specialties of all physicians billing for services to a patient on a single day.

It should be remembered that Medicare is not in a position to determine which of the physicians is “primary” or “attending”. When after review of the documentation, concurrent care cannot be found to be medically necessary, most carriers’ policies will pay the physician whose claim is submitted first and deny the subsequent claims on the same day. Patients presenting with multiple conditions requiring multiple specialty physicians to provide medical care on a daily basis should be billed by those physicians in accordance with the condition they are treating.

F. Physicians at Teaching Hospitals

Objective

To ensure that all services provided by residents are correctly billed under the Physicians At Teaching Hospital (“PATH”) Medicare regulations.

Policy

Teaching Hospitals are governed by the 1996 Federal PATH regulations. The PATH regulations, among other things, set forth the rules governing how an attending physician may bill Medicare for services where all or some part of the services have been rendered by a resident. The regulations address the issues of necessary physician presence and medical record documentation needed to bill for professional services. Under the PATH regulations, in order for an attending to bill for his/her services where a resident has seen the patient and has already documented services, the attending must also see the patient and properly “link” to the resident’s documentation. The attending may not bill for his/her services based upon a countersignature alone, but must instead provide written documentation of his/her own findings and commentary and sign the note.

Similarly, under the PATH regulations, where a resident is performing some part of a surgery and the attending is not present throughout, the attending must define the key portion for which he or she was present. The attending or other appropriate individual may attest to the attending’s presence, if present throughout. If not present throughout, the attending must attest to his/her presence during the key portions of the surgery or procedure and describe the key portions.

IV. Collection Policies

A. Collection of Health Insurance Co-payments, Deductibles, and Coinsurance Objective

To clarify the obligation to collect co-payments, deductibles, and coinsurance from patients.

Policy

Most healthcare insurance contracts with patients and/or employers requires patients to share the cost of the health insurance benefit. Cost sharing is met through the imposition of health insurance deductibles, coinsurances and copayments. These cost sharing mechanisms are imposed by the individual insurance company and are part of the contract with the patient.

Routine or consistent waiver of the patients cost sharing responsibility is considered an abusive practice by the Center for Medicare and Medicaid Services (“CMS”) and may be seen as a violation of the individual health care insurance contract.

The waiver of deductibles and coinsurance may be construed as a physician's willingness to accept a lower reimbursement than the published fee which includes the patient's cost sharing for the covered benefit.

The Provider's office must make best efforts to perform the following:

1. All co-payments, coinsurances, and deductibles must be collected, as far as reasonable, at the time of service.
2. Physician practices will make at least one documented attempt to collect coinsurances, co-payments, and deductibles.
3. Patients can be considered for financial hardship, by the provider, with the appropriate assessment. (See Sample Patient Financial Hardship Policy). Physicians may waive their entire fee, including co-payments, by not billing for their services.

B. Patient Account Credit Balances

Objective

To establish a standard operating procedure for resolving credit balances.

Policy

Credit balances accumulate if there is a failure to refund either the patient and/or the insurance carrier once the actual expected payment for a service has been fully reimbursed. Payments that are received over and above the actual charge or agreed contractual reimbursement represent credit balances.

1. The assessment of credit balances must be incorporated into the operational management of accounts receivables.
2. Credit balance refunds should be made within thirty days of discovery. The provider will be informed of any credit balance with the end of month report. It is the provider's responsibility to ensure refunds are issued. Once a refund is issued, the provider will send a copy of the refund to the billing company for documentation in the patient's financial record. Steps toward resolution of credit balances should be documented.
3. The amounts of any credit balance should be removed from the active accounts and placed in a holding account pending the processing of a refund to the appropriate party.
4. Each patient account program should be able to report credit balances and track their resolution.
5. Designated staff members should manage reports on a regular basis and record all resolution(s)

C. Professional Courtesy

Objective

To standardize and clarify the regulations regarding professional courtesy.

Policy

Professional and employee courtesy, once a common practice, is no longer acceptable

D. Advance Beneficiary Notices

Objective

To ensure that the provider provides Advance Beneficiary Notices (“ABNs”) (CMS-R-131) to Medicare beneficiaries as required under Medicare regulations.

Policy

Medicare rules require physicians and NPPs to provide Medicare beneficiaries with a written notice before providing certain services for which Medicare may not pay as a covered service. An ABN should be given before providing any service that could be deemed by Medicare to be not reasonable and necessary or outside the permitted frequency. An ABN is not required, however, for services that are never covered by Medicare, such as cosmetic surgery.

All ABNs must be given using CMS-R-131.

The Provider must use modifier GY, to be placed on the claim to notify Medicare that the patient signed the ABN form.

If the billing company is aware of a service that may be denied by Medicare and the provider did not have the patient sign an ABN form, and in the event the claim is denied, the patient cannot be billed for services received. A copy of the signed ABN form will be provided to ABC Billing Company with a copy of the medical record, superbill and verified insurance information.

E. Patient Financial Hardship

Objective

To provide an appropriate basis and method to reduce fees for patients who are uninsured or less able to afford professional services.

Policy

1. ABC Medical Billing Company requires providers to provide the highest standard of professional services to patients with the requirement by the patient to pay for those services. The exception is with emergency care where the EMTALA law requires the provider to render services to patients regardless of the patient's ability to pay.
2. If patients are eligible for Medicaid benefits, the provider's staff should help them in the enrollment process or direct them to others who can assist them.
3. Where patients are unable to pay for services based upon their financial situation (e.g., no insurance coverage and income 3x or less the Federal Poverty Level) or other hardship (e.g., recent high medical bills for the patient or a dependent), and are not eligible for Medicare or Medicaid, the provider should consider whether the patient is offered an opportunity to pay lower fees or no fees for services based upon a pre established sliding scale for professional fees.
4. If the patient contacts the billing company about their medical bill, the patient must contact the provider and provide the provider with written evidence of income or high medical expenses. Sources of verification of income include: tax returns, paycheck stubs, and W-9 statement. Sources of verification of medical expenses include official physician bills and explanations of benefits ("EOBs").
5. Financial need, high medical expenses, or other hardship may also be documented by patient interviews and questionnaires. In this instance, the provider may wish to obtain a current utility bill or other form of reliable documentation from the patient to establish the patient's name and residence.
6. The patient's ability to pay and the number of services that may be covered by the sliding scale may be determined for each episode of care, or for a predetermined number of services.
7. This policy is intended to assist patients who state that they are having a financial hardship and to give relief primarily to uninsured individuals with low income, recent high medical bills or other extenuating factors such as unemployment, many dependents or high living expenses in the area of residence.
8. If the provider utilizes the sliding scale for fees for some patients, it must do so for all. If a reduction in fees is sought based upon hardships other than low income only (e.g., recent high medical bills, unemployment, etc), departments should rely on the information gathered from the patient and endeavor to make any adjustments in fees in a consistent manner.
9. This policy should not permit waivers of co pays or deductibles for insured individuals, and is not related to issues of bad debt or contractual adjustments based on managed care fee for service or unrelated administrative adjustments for individual circumstances.

F. Payment Accommodation Policy aka Time Payment Plans

Objective

To provide an appropriate basis and method to or arrange a payment plan for patients who do not qualify for reduced fees.

Policy

1. Where a patient is not a candidate for sliding scale fee reduction, but requires some accommodation with payment, the billing company can instruct the patient that they may enter into an arrangement with the patient to pay the provider's usual and customary fee over a period of time, rather than in one payment at the time of service.

2. The following are recommended guidelines to a provider for payment of the full amount of a patient balance over time, if the provider has not developed a time payment plan:

Obtain a deposit as part of the payment plan arrangement:

- For balances up to \$500, secure a 10% deposit
- For balances greater than \$500, secure a 20% deposit

Establish a 1-12 month payment plan arrangement with fixed monthly payments (plan based on balance after deposit)

- Balances \$0-\$100: 1-2 months
- Balances \$100-\$500: up to 4 months
- Balances \$500-\$1000: up to 12 months

Under certain circumstances, where there is an outstanding self-pay account balance, the provider may wish to offer a negotiated contracted discount to the patient to resolve and settle an outstanding balance. A contracted discount is where the provider enters into a written contract with the patient just as the provider enters into a contract with an insurance company.

When working with the patient about establishing a time payment plan, the provider or staff should not ask the patient how much they can pay each month. This usually results in the patient saying they can pay only \$5.00 per month and then the provider is stuck receiving payments over many years that do not cover the cost of billing the patient.

The provider should ask the patient how long it will take to pay the debt. Most patients will say 3-4 months. Always make sure time payment plans are in writing. The billing company should have these accounts specially coded to keep track of whether the patient is keeping to their end of the contract. If the patient pays less than the agreed amount or refuses to make their payments, the account should be sent to the provider's debt collection agency.

G. Debt Collection Agency

Objective

To provide guidance with delinquent accounts sent to a debt collection agency.

Policy

1. A debt collection agency is an independent business that has been contractually hired by the provider to collect said delinquent debts owed by a patient or health insurance company. The debt collection agency is a business associate of the physician or provider.
2. The debt collection agency does not work for ABC Billing Company. ABC Billing Company is not responsible for the actions of the contracted debt collection agency.
3. The delinquent account will be sent to the debt collection agency when all normal efforts to bill the patient for copayments, deductibles, and coinsurance has failed with the patient failing or refusing to pay what is owed to the provider. Accounts will also be sent to the debt collection agency when
 - (a) the patient does not honor their commitment to the signed time payment plan or
 - (b) statements to the patient have been returned to ABC Medical Billing Company, by the United States Postal Service as a bad address when documented as a moved and left no forward address or forward time as expired.
4. Accounts under commercial insurance responsibility where the insurance company has refused to remit payment, paid less than the providers usual and customary charges, denied payment, or refused to respond to any and all efforts to resolve the claims payment, will be sent to the provider's debt collection agency with no patient responsibility attached.

Policy.

Refunds

Objective

To establish a standard operating procedure for refunds to manage accounts receivable efficiently and to ensure that all refund balances are processed in a timely manner.

Patient Refunds

1. Patient refunds must be identified and reported to the provider with the end of month reports. All supporting documentation such as EOBs and copies of all payments, should accompany the refund paperwork. The refunding of the patient should be by the provider. Copies of all refunds issued should be reported to the billing company to be entered into the patient's financial accounts.
2. It is the responsibility of the billing company to ensure that all refunds are valid and accurate. If the patient has a debt that is owed from another visit, then the refund should be applied to the debt. Any credit balances left over would still be refunded to the patient. If the patient has a debt that was sent to the provider's debt collection agency, the refund amount should be adjusted against the amount with the debt collection agency.
3. In the event a refund is issued, and the refund is returned as a mail return or refused by the patient, the funds should be handled in accordance with State Law regarding unclaimed funds.

Insurance Refunds

1. Refunds to an insurance company should be reviewed to determine who receives the refund. Under normal conditions, a refund is issued to the insurance company that caused the account to be in a refund status. Some insurance companies want the patient refunded instead. If this occurs, make sure that the patient's account is noted with the insurance company's representative's name that ordered the refund to be sent to the patient.
2. If the provider is not contracted with the insurance company, the billing company can contact the insurance company and inform the insurance company that a refund is due to them, but the provider has an outstanding claim that remains unpaid. The billing company could attempt to negotiate with the insurance company regarding the unpaid claim. If the insurance company does not wish to pay the claim within a reasonable timeframe, the refund due to the insurance company is offset against the unpaid claim. This is identical to what insurance companies do to providers when an insurance company feels it is owed money by providers.

Policy:

HIPAA Privacy

Objective

To safeguard the privacy of all patients and to protect the confidentiality and security of patient information.

To fulfill this responsibility and to comply with the Health Insurance Portability and Accountability Act of 1996 and its related regulations (“HIPAA”), ABC Medical Billing Company has implemented policies and standard procedures to protect the confidentiality and security of identified patient health information (“PHI”) in all of its activities that requires the use and disclosure of PHI.

Additionally, ABC Medical Billing Company requires mandatory HIPAA training programs designed to capture all members of its workforce and provide detailed training regarding its policies and standard procedures. ABC Medical Billing Company has put in place a Privacy Officer who is dedicated, full time, to the day-to-day administration and implementation of HIPAA compliance. To further facilitate these privacy compliance efforts:

1. All employees are required as a condition for their employment, to complete HIPAA training.
2. All vendor contracts that require the disclosure of PHI must have a Business Associate Addendum included as part of the underlying contract.
3. All patients visiting the provider for the first time, must receive a hard copy of the provider’s Notice of Privacy Practices describing their HIPAA rights with respect to the use and disclosure of their PHI.
4. The administration and investigation of all patient complaints made with respect to Privacy of their PHI will be handled by the Privacy Officer. If an employee is approached by a patient with a privacy complaint, call the Privacy Officer at ABC Medical Billing Company. All patient privacy complaints are handled discreetly, thoroughly investigated, resolved and logged.
5. There is a zero tolerance policy with employees accessing patient information for purposes not related to treatment, payment or health care operations.

Frequently Used Terms

Billing Compliance Plan

ABC Medical Billing Company’s Compliance Plan covers billing, and HIPAA issues and applies to all members of ABC Medical Billing Company.

CCI

Correct Coding Initiative is a national system of reviewing CPT codes that are performed during a visit. The CCI edits are created by CMS and approved by the American Medical Association. CCI edits inform the provider, medical biller, and insurance industry of PT codes that are deemed to be included with each other, otherwise known as bundled, or

mutually exclusive with each other, otherwise known as codes that cannot be billed at the same visit, they must be billed during separate visits.

Centers for Medicare and Medicaid Services (“CMS”)

Agency within the U.S. Department of Health and Human Services that administers the Medicare, Medicaid, and State Children’s Health Insurance programs.

Concurrent Care

Term used by Medicare for describing ongoing care rendered to a patient by more than one physician or non-physician practitioner on the same day.

CPT-4

Current Procedural Terminology, 4th Edition (“CPT-4”) is the coding system used by Medicare, Medicaid, and private payors to describe medical, surgical, and diagnostic services.

Department of Health and Human Services (“DHHS”)

The United States government's principal agency for protecting the health of all Americans and providing essential human services; DHHS agencies include the Office of Inspector General and the Centers for Medicare and Medicaid Services.

ICD-9-CM Codes

The International Classification of Diseases, 9th Revision, Clinical Modification (“ICD-9”) is the diagnostic coding system used by Medicare, Medicaid, and private payors.

Incident To

Services that are furnished by other persons incident to physician’s professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.

Office of Inspector General (“OIG”)

The Office of the Inspector General of the U.S. Department of Health and Human Services is responsible for protecting the integrity of Federal health care programs, including Medicare and Medicaid.

Shared Visits

An evaluation and management (“E/M”) service shared or split between a physician and a nonphysician practitioner; shared visits are subject to specific Medicare billing rules.