AHRC Nassau Compliance Program Policies and Procedures	
SUBJECT: Billing, Coding and Documentation Policy	
APPROVED BY: Board of Directors	**EFFECTIVE: 5/15/23**
Reviewed: 6/5/24	**PAGE 1 OF 4**

A. POLICY

AHRC Nassau (the "Agency") is dedicated to maintaining integrity in the billing, coding and documentation of the items and services it provides. In conformity with our basic mission and values, billing claims may only be submitted for actual services rendered and appropriately documented, and only when those items and services are provided in a manner that is consistent with accepted standards of medical care.

1. Accurate and Truthful Billing. All billing must be accurate and truthful. Affected Individuals may never misrepresent claims to, or on behalf of, a patient or third-party payer. Knowingly false statements or intentional omissions of material information by any personnel - whether to a government payer (such as Medicare or Medicaid), to a commercial payer or to a patient - will not be tolerated. Deliberate misstatements to any payers or service recipients will expose the personnel involved to disciplinary action, up to and including termination of employment or affiliation with Agency. All disciplinary actions taken by Agency will be in Agency's sole discretion in accordance with, among other things, our Compliance Program policies and procedures. Affected Individuals who engage in fraudulent billing practices also risk exposure to criminal penalties.

Affected Individuals must avoid not only deliberate misstatements relating to claims Agency submits, but reckless ones as well. Affected Individuals must also avoid submitting information relating to Agency's claims with either a deliberate ignorance or a reckless disregard of its falsity or truth. Thus, if Affected Individuals have any question as to the truth or accuracy of any claims-related to documentation for billing purposes, or if there is material information that is missing, the claim for the services in question must be held until the uncertainties are resolved. Anything less is strictly prohibited.

2. Adequate Documentation. Billing must always be based on timely, accurate and complete documentation that demonstrates the medical necessity for the item or service provided and the appropriateness of the claim submitted. This medical documentation must comport with all applicable requirements. It is the responsibility of the medical professional to ensure that, prior to submitting charge documents for billing, the documentation for the item or service provided is clear and in conformity with such requirements. Each medical professional involved in the documentation process has an obligation to be aware of relevant Federal health care program requirements and to ensure that their documentation is accurate.

In order to ensure accurate medical record documentation, Agency's medical professionals will compile medical records that, to the extent required:

(a) are clear and legible;

(b) include the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression/diagnosis, plan of care, date and identity and signature of the physician/practitioner; and

(c) clearly show the rationale for ordering diagnostic and other ancillary services (if any); and

(d) support the CPT, HCPCS and ICD-10 codes used for claims submission.

3. Correct Coding. All Federal and State regulations governing correct coding procedures will be followed. All relevant personnel will be trained in the appropriate rules governing billing and coding. Procedural or diagnostic codes (i.e., CPT/HCPCS/ICD-10 codes) may never be selected simply on the basis of whether a given code guarantees or enhances payment. In addition, no defaults to a particular code may ever be used; rather, only those codes that appropriately correspond to the item or service actually rendered and documented in the medical record may be selected. The selected codes must be accurate and as specific as possible, and must meet the payer's applicable coding requirements.

If billing personnel are uncertain for any reason as to what the proper code(s) should be, no claim will be processed until adequate information or clarification is received from the medical professional who provided the service. Affected Individuals may not select procedural or diagnosis codes based on their own interaction with a patient, from information provided during an earlier date of service, or based on what they might conclude is the probable or most likely procedure or diagnosis code.

If a claim is denied or if a payer requests additional information about a claim, any changes/corrections made to the codes that have been previously submitted must be supported by clear documentation in the medical record. It is prohibited for any Agency personnel to change a code simply in order to bypass a payer's edit, and to receive payment to which Agency would otherwise not be entitled. Agency does not provide financial incentives to physicians/[practitioners], employees, or others to code claims in a manner that would improperly enhance reimbursement.

4. Medical Necessity for Items and Services. Agency will only submit claims to Medicare, Medicaid, any other Federal health care program and other third party payers for items and services that are medically necessary or that otherwise constitute a covered item or service. Medical necessity will be determined individually for each item or service provided or ordered by the responsible medical professional. [Medicare considers items and services to be reasonable and necessary if they are "for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.'' *42 U.S.C. 1395y(a)(1)(A).* When Agency provides services to a Medicare beneficiary, Agency will only bill for those items and services that meet the Medicare standard of being reasonable and necessary for the diagnosis and treatment of a patient.]

5. Compliance with Federal and State Laws Regarding the Submission of Claims. Affected Individuals must comply with all applicable Federal and New York State laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) New York State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided to all personnel, who will receive training on these laws as part of Agency's Compliance Program. Affected Individuals should consult with the Compliance Officer (who may confer with Agency's legal counsel, as necessary and appropriate) if they have questions about the application of these laws to their job.

6. Prompt Refunding of Overpayments. Agency does not knowingly retain any payments that it is not entitled to keep and will promptly report, return and explain any overpayments identified in accordance with applicable law and contractual requirements. It is our policy to not retain any funds which are received as a result of an overpayment and to report, return and explain any overpayments within 60 days from the date the overpayment was identified. See Compliance Program *Protocols for Investigations and Implementing Corrective Action, Including Discipline.*

7. Waivers from Medicare Patients. If a physician/practitioner deems it clinically appropriate to provide an item or service that Medicare Part B may find to be medically unnecessary under its standards and thus not reimbursable, the ordering physician/practitioner needs to have the patient complete and sign a Medicare "Advance Beneficiary Notice of Non-coverage" ("ABN") prior to provision of the item or service. This notice informs the patient that the item or service may not be covered by Medicare and that he or she may be liable for paying for the service. In cases in which "medically unnecessary" services are performed for a Medicare patient, the patient generally may not be billed for the item or service without an ABN having been completed.]

8. No Routine Waiver of Co-Payments, Co-Insurance and Deductible Amounts. Agency does not routinely waive co-payments, co-insurance and deductible amounts. A waiver of such amounts may only be appropriate if the patient has a documented financial need and if it is in accordance with applicable legal and payer requirements. In general, Agency will not waive any patient's co-payment, co-insurance or deductible unless the patient has an actual financial need and that need is documented and maintained in an appropriate record. Otherwise, all service recipients will be billed pursuant to normal procedures for collecting these amounts. Unpaid co-payments, co-insurance and deductible amounts will only be written off if normal, reasonable and good-faith collection efforts have failed and after appropriate consideration is given to the cost of further collection efforts.

9. Secondary Payer Rules. Affected Individuals responsible for billing must ensure that all secondary payer rules are followed so that incorrect billing and overpayments can be prevented. In particular, Agency recognizes that Medicaid is the payer of last resort. In accordance with applicable Medicaid requirements, Agency has instituted procedures reasonably designed to identify payers other than Medicaid, and will make all reasonable and required efforts to identify other primary or secondary payers, or other responsible parties, and to bill accordingly.

10. Correct Use of Provider Identification Numbers. Every insurer to whom claims for payment are submitted, requires the use of identifying numbers on the claim form (e.g., National Provider Identification numbers [, tax identification numbers, group provider numbers]). Including the appropriate identifying numbers on claim submissions is essential to allow for timely processing of the claim. Moreover, the physician or provider who actually provided the service must be accurately and correctly reflected on the claim, consistent with payer requirements. The use of another's name or identification number, in lieu of the actual provider of service, may be considered fraud. If Affected Individuals have any questions regarding the correct use of identifying numbers in connection with claims for payment, they should contact the Compliance Officer.

11. Billing Software. Agency will take all reasonable steps to ensure that its billing software reliably and accurately reflects up-to-date procedural, diagnosis and other codes, so that its claims for items and services may be submitted according to the most recent Federal, State and/or payer requirements and/or contractual requirements.

12. Retention of Records. All records that demonstrate Agency's right to receive payment from payers, will be retained for a period of no less than ten (10) years from the date the items or services were provided or such time as required by law.

13. Compliance Reviews and Training. Agency will conduct compliance assurance reviews on a regular basis, implement corrective action, as necessary and appropriate, and will educate and train Affected Individuals regarding applicable billing, coding and documentation requirements in accordance with the following policies:

- Compliance Monitoring, Risk Assessment and Training, and
- Protocols for Investigations and Implementing Corrective Action, Including Discipline.